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BUREAU OF STATE AUDITS

California Department of Corrections:

Utilizing Managed Care Practices Could Ensure More Cost-Effective and Standardized Health Care

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

Dear Governor and Legislative Leaders:

As required by the 1999-2000 Budget Act (Chapter 50, Statutes of 1999), the Bureau of State Audits presents its audit report concerning the California Department of Corrections' (department) medical operations.

This report concludes that the department has only partially adopted the comprehensive practices used by managed care organizations to ensure cost-effective medical services. For example, the department cannot effectively determine what aspects of its operations need improvement because it lacks a comprehensive review process and a modern, statewide information management structure. In addition, unlike managed care organizations, it has not developed systemwide treatment guidelines that are designed to create more uniform care. Further, key operating data, such as total medical costs or nursing costs per inmate vary significantly among its 33 institutions, but the department does not routinely analyze such data, so it does not know whether low-cost institutions are operating optimally or providing a level of services below that of other institutions. Finally, the department could reduce its health care costs if it increased the number of pharmaceutical products it purchases under competitively bid contracts and increased its efforts to monitor the prescribing practices at all its institutions.

Respectfully submitted,

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SUMMARY

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Our review of the California Department of Corrections' (department) medical operations revealed:

- ☑ *Compared to managed care organizations, which use comprehensive methods to contain costs and ensure uniform care, the department's methods are limited.*
- ☑ *Despite its objective of providing consistency in services, litigation has caused different levels of care at certain facilities.*
- ☑ *Medical operating costs per inmate vary widely among institutions, and the department does not analyze the cost variances. As a result, it does not know whether low-cost institutions are operating optimally or simply providing a level of services below other institutions.*
- ☑ *Rapidly growing pharmacy costs could be reduced if the department employed more competitive contracting methods.*

RESULTS IN BRIEF

The Budget Act of 1999 directed the Bureau of State Audits to audit the California Department of Corrections (department) to determine whether it appropriately and effectively manages its medical operations. As part of the audit, we were to include recommendations for operating the department's facilities in a managed care environment. We found the department has just begun to develop an infrastructure for inmate health care that is standard in managed care organizations; therefore, it has only partially adopted the comprehensive practices these organizations use to ensure cost-effective medical services.

The department does not fully or adequately use various managed care practices. For example, there is no comprehensive process for review of health care operations at its 33 institutions. Without such a process, the department cannot effectively determine what aspects of its operations need improvement. The department also lacks a modern statewide information management structure, including networking capabilities, which restricts its ability to gather and analyze data. The deputy director in charge of the department's health care services division acknowledges that its ability to manage the health care operation is limited by its lack of data and staff to analyze the data.

The department also has not developed systemwide treatment guidelines or analyzed medical outcomes for the purpose of making patient care for its 150,000 inmates more uniform and cost-effective. At present, the level of care varies among institutions, in part because of lawsuits that inmates successfully brought against the department charging inadequate health care at specific facilities. The department believes that certain court-imposed services it currently offers at only a few facilities should be implemented at all of them; however, it has not obtained sufficient resources to do so.

Key operating data, such as costs per inmate for nurses and medical technical assistants (MTAs), length of hospital stays, and total medical costs also vary significantly among institutions. For example, some facilities pay more than four times as

much for nursing costs per inmate than others do. Likewise, some institutions incur salary costs, including overtime, for MTAs that are nearly twice what other institutions pay per inmate. The department does not routinely analyze comprehensive data on its medical services, so it does not know why health care costs vary so widely or whether the institutions with the lowest costs are operating optimally or simply providing a level of services below that of other institutions. Similarly, it does not know whether its highest-cost facilities are inefficient or provide excessive care, and thus present opportunities for potential savings. The department performs limited reviews in certain circumstances, but it cannot readily improve care or cut unnecessary costs until it institutes a comprehensive, systematic analysis of its operations.

The department has implemented one program that was designed to reduce unnecessary patient visits. Five years ago, it began collecting $5 co-payments from inmates to curtail unnecessary visits to the doctor. The program has not generated the expected revenue, nor has the department analyzed the program to assess whether it actually has reduced visits sufficient to offset the operating costs. The department cannot demonstrate that the program is cost-effective, so we recommend that it be eliminated.

The department also could reduce its health care costs by purchasing more of its pharmaceuticals using contracts, taking advantage of more competitive contracting techniques, and increasing its efforts to monitor prescribing practices at all 33 institutions. Contracted prices allow the department to purchase medications at more competitive prices, yet it has obtained contracted prices for only 40 percent of its purchases. Additionally, an inadequate data collection system for its pharmacy operations presents obstacles for the department to achieve greater efficiency and effectiveness through assessing physicians' prescription practices at its various institutions. Further, the department's drug formulary is outdated, although it is an important management tool intended to ensure that institutions prescribe the most appropriate and cost-effective medications. Moreover, the department reports that it experiences difficulties due to the many vacancies in its pharmacist positions.

A final issue we examined was the licensing of the department's correctional treatment centers (CTCs). The department has not yet licensed all its CTCs, as required. As of December 1999, only 2 of a planned 16 CTCs were licensed, and we question whether the department is providing an authorized level of care at the

remaining facilities. Contrary to the department's assertion, the Department of Health Services, which licenses the CTCs, told us it was unaware of the kinds of care the unlicensed CTCs provide.

RECOMMENDATIONS

To improve the management of its health care operations and better employ managed care practices, the department should take the following actions:

- Report to the Legislature on its progress in adopting managed care practices. As part of the report, it should identify the infrastructure requirements, such as data collection and staffing, which will allow it to comprehensively and systematically review its medical operations. Additionally, it should identify the potential savings that could be realized through a more efficient operation. In the meantime, it should perform proactive and systematic reviews of its medical operations to the extent possible.

- Identify which services differ because of litigation or other reasons to determine what additional resources it needs to remedy any inconsistencies, and then seek the appropriate budgetary changes to ensure a consistent level of care at each facility.

- Work with the Department of Health Services to ensure that all CTCs become licensed and that those CTCs not yet licensed provide only the level of care appropriate for an unlicensed facility.

- Discontinue its policy requiring inmates to pay for a portion of health care visits.

- Periodically review key operating data such as information on costs and lengths of stay, investigate inconsistent or unusual data, take steps to minimize unnecessary costs, and then verify the corrective action resulted in the desired change.

- Take appropriate steps to reduce overtime payments for MTAs.

To improve the prices that it pays for its pharmaceutical purchases and to ensure that its institutions follow appropriate practices for prescribing drugs, the department should take the following actions:

- Ensure that its methods for procuring pharmaceuticals allow for the fullest amount of competition possible and work with the Department of General Services to expand the number of drugs placed on the statewide contract.

- Explore other procurement processes that provide greater savings than the department currently enjoys.

- Identify the conditions that are limiting its ability to collect and report data on its pharmaceutical operations and propose changes.

- Ensure that its pharmaceutical operations are staffed properly by addressing conditions that have led to vacancies among its pharmacists.

- Monitor drug usage periodically, including physician prescription practices, so information regarding the most appropriate and cost-effective drugs is available. Use this information to update its formulary regularly.

AGENCY COMMENTS

The department generally agrees with our recommendations and outlines certain corrective actions. However, it contends that it may be premature to report to the Legislature on its progress in adopting managed care. Rather, the department believes that implementing activities proposed in the governor's budget for fiscal year 2000-01 will enable it to incorporate cost management techniques, which may or may not mirror managed care, and improve the quality of care provided. ■

INTRODUCTION

BACKGROUND

The California Department of Corrections (department) operates all state prisons and supervises parolees' re-entry into society. Its 33 prisons currently house more than 150,000 inmates. Its budget for fiscal year 1999-2000 is $4.6 billion.

The department is required to provide medically necessary health care to inmates. In 1992, the department established a health care services division, whose mission is to manage and deliver health care statewide to the inmate population consistent with adopted standards for quality and scope of services within a custodial environment. The health care services division oversees the delivery of medical, dental, and psychiatric services at the institutions.

Health Care Services Division Responsibilities

- Provides medical, dental, and psychiatric services for the department's 33 prison facilities in California.
- Operates four acute-care hospitals.
- Provides additional care through 16 correctional treatment centers, one skilled nursing facility, and 12 outpatient housing units.
- Contracts with community hospitals for care not provided in division facilities.

To accomplish its mission, the division operates four licensed hospitals, a skilled nursing facility, 16 correctional treatment centers (CTCs), and 12 outpatient housing units. Each licensed hospital provides 24-hour acute care services to patients who require a high level of care. These hospitals offer medical, nursing, surgical, anesthesia, laboratory, radiology, pharmacy, and dietary services. The State's Department of Health Services inspects each licensed facility to ensure that medical services, staffing levels, and safety matters comply with state regulations. The skilled nursing facility also is licensed. It provides 24-hour care to patients who are less acutely ill or injured and who primarily need skilled nursing care on an extended basis. The CTCs are supposed to be licensed as well. As we discuss in Chapter 1, the department is working toward licensing its CTCs, but as of December 1999 only a few CTCs had been licensed. CTCs provide professional health care services to patients whose illnesses or injuries are less acute than patients requiring hospitalization. The remaining health care facilities, outpatient housing units, are not licensed. They typically house inmates who do not require admission to a licensed health care facility but who must be monitored or isolated from the general prison population. Figure 1 shows the location of the various state prisons and the nature of the medical services each provides.

FIGURE 1

Location of Hospitals and Other Medical Facilities in California's Prison System

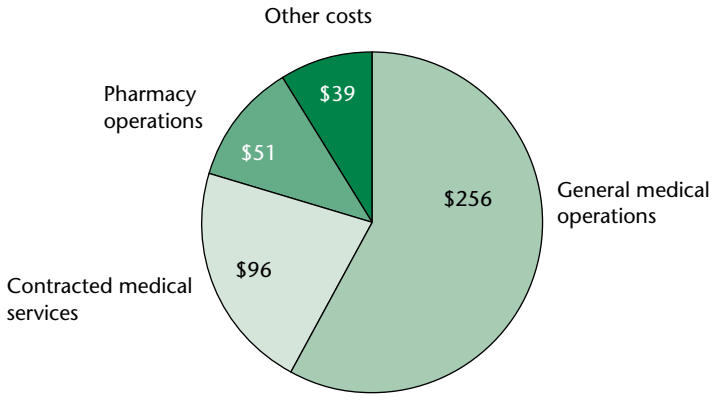
The department hires physicians, psychiatrists, dentists, nurses, pharmacists, and other medical staff to provide medical services at these facilities. It also contracts with outside physicians, nurses, pharmacists, and other medical staff to obtain specialized services its own staff cannot provide or to fill temporary staff vacancies. Finally, it contracts with various community hospitals for services that cannot be provided in its own facilities.

HEALTH CARE SERVICES DIVISION COSTS

In fiscal year 1998-99, the division spent $442 million on operations and $33 million for services provided by the Department of Mental Health. Its operating costs included $256 million for general medical expenses (salaries for state employees, such as doctors, nurses, and assistants), $96 million for contracted medical services (contracts with community hospitals, specialty care, registry, ambulance, lab, and outpatient care), $51 million for pharmaceuticals (drugs and related supplies), and $39 million for the remaining costs, such as administrative expenses and medical supplies. Figure 2 shows the breakdown of the division's costs by these major categories.

FIGURE 2

Breakdown of Division's Costs for Fiscal Year 1998-99 by Major Category* (In Millions)



* The amounts shown above do not include $33 million that the department spends for services provided by the Department of Mental Health.

Per inmate, the division spent approximately $1,700 on general medical operations, $640 on contracted medical services, $339 on pharmacy costs, and $260 for the remaining costs. Based on the most recent national data published by the U.S. Department of Justice, which tallied information from fiscal year 1995-96, California's correctional system ranked among the biggest spenders in the nation, spending $2,770 per inmate on medical care alone, and $22,210 per inmate in total. The national average was $2,386 for medical care and $20,100 for total costs, 14 percent and 10 percent less than California's costs, respectively.

When comparing California to other states, it is important to recognize that all state prison systems do not deliver similar health services. The department contends that, in response to litigation, California has a larger, more extensive mental health program than other state prison systems, which adds substantially to the cost of health care. Litigation has shaped much of the department's current health care delivery system. During the 1980s and 1990s, inmates filed various class action lawsuits alleging deficiencies with health care, leading the courts to order the department to remedy the deficiencies.

In certain cases, the litigation has led to improvements statewide. In response to one lawsuit contending that inmates with psychiatric conditions were unable to receive necessary and adequate mental health treatment, the department implemented a comprehensive mental health treatment system. Other lawsuits have affected the delivery of care at specific institutions. The department has spent a significant amount of resources to comply with the various court actions.

SCOPE AND METHODOLOGY

The Budget Act of 1999 (Chapter 50, Statutes of 1999, Item 5240-001-0001, Provision 22) directed the Bureau of State Audits (bureau) to audit the California Department of Corrections to determine whether it appropriately and effectively manages its medical operations. The audit was to focus on the provision of medical services, other than psychiatric services, and include recommendations for operating medical facilities in a managed care environment that would avoid the waste of medical resources while ensuring quality and accessible care consistent with federal court mandates.

Specifically, the bureau was to review the procurement of medical services and determine whether individual institutions inappropriately awarded medical contracts on a sole-source basis. In addition, we were to review the effectiveness of the department's utilization review system, standards of care, and inmate co-payment system. Finally, we were to review the appropriateness of its staffing levels, the staffing mix, and the acuity mix (the mix of patients by level of care provided) for the beds in the medical facilities at the State's prisons.

To review the department's procurement process and determine whether individual institutions inappropriately awarded medical contracts on a sole-source basis, we tested 38 medical contracts active during fiscal year 1998-99, interviewed department staff, analyzed contracting data, and reviewed laws and regulations. The 38 contracts that we tested represent a variety of medical services and institutions. Additionally, we tested the department's various processes for awarding contracts. For those contracts that must undergo a competitive bidding process, we determined whether they were bid appropriately or whether the department properly sought approval to award the contract to a sole source. For those department contracts that are exempt from traditional competitive bidding requirements because of state regulations, we determined whether the department had appropriate processes for ensuring that it obtained value. Based on our review, nothing came to our attention that would indicate that the department is awarding contracts inappropriately.

To determine the effectiveness of the department's utilization review system and standards of care, as well as the appropriateness of its staffing levels, staffing mix, and acuity mix of beds in medical facilities, we visited 6 of the 33 institutions, interviewed key officials at the institutions and at the department's headquarters, and analyzed various department records. Analysis Group/Economics, an outside consultant with expertise in managed health care systems, assisted us.

Our consultant assisted us in comparing the department's management practices to those in the managed care environment. To make this comparison, we evaluated the practices the department uses to control uniformity of and overall access to care (also called utilization management) within its institutions. We also reviewed several lawsuits that have affected levels of care at some institutions.

To develop an understanding of actual department practices relative to widely recognized ambulatory care protocols for a specific condition, a physician who served as our medical expert reviewed a sample of patient charts of insulin-dependent diabetic inmates at certain facilities. Finally, to determine whether the department's acuity mix was appropriate, we reviewed its records summarizing the patients' conditions.

To review the department's staffing levels and mix, we compared the wages for nurses and other staff at the 33 institutions on a per-inmate basis. We also reviewed other factors that we believed would indicate appropriate cost-containment practices, such as overtime payments, lengths of stay in the hospitals, and occupancy rates. In each case, we compared data among the department's 33 institutions, rather than comparing data to other health care systems. Given the unique nature of providing health care within a correctional system, we believe that comparing the department's costs to non-correctional systems would not provide a useful comparison. We were not able to obtain similar information from other correctional systems.

We focused particular attention on the department's pharmacy operations, as they represent the fastest growing component of its health care costs. Our consultant provided expertise for an analysis of pharmaceutical purchases to determine how the prices the department pays compare with what other procurement systems pay. We also analyzed the extent of department purchasing that occurs through contracted pricing. Further, we interviewed key staff at the department and the Department of General Services, which negotiates pharmaceutical contracts for certain state agencies, including the department.

Finally, to determine the effectiveness of the department's implementation of an inmate co-payment program, we attempted to discover if the program met its goal of reducing health care visits. The department has not collected the necessary information to make this determination, so we limited our review to obtaining an understanding of the co-payment program through interviews and department documents. ■

CHAPTER 1

The Department Does Not Consistently Employ Managed Care Practices

CHAPTER SUMMARY

The California Department of Corrections (department) has just begun to develop an infrastructure that is standard for managed care organizations. Thus, it has not implemented many of the comprehensive processes that managed care organizations typically use to ensure cost-effective medical services. The department has 33 health care facilities, but it lacks a comprehensive review process to ensure that each provides a uniform level of care. For example, the department primarily focuses on determining whether requested services are necessary, reducing the length of inmates' community hospital stays, and reviewing hospital invoices to prevent overpayments. Although these efforts are valuable, a more comprehensive approach also would include reviewing the outcomes of medical procedures and developing uniform treatment guidelines and protocols.

Many of the department's operating costs and statistics, such as total medical costs, nursing costs, or the length of hospital stays, vary significantly among facilities. The department does not, however, perform detailed, systematic reviews of variances, so it cannot determine whether the high costs at certain facilities are justified or whether low costs at other facilities are indications of efficient operations or below-standard operations. The deputy director in charge of the health care services division acknowledges that the department manages its data much differently than managed health care organizations would and further believes that the department is "crippled by the lack of data and staff to analyze the data."

Finally, due to litigation, some facilities have different levels of care than do others. For example, two women's facilities have more extensive health care services than other facilities have. The department states that its attempts to obtain the resources to expand these programs to other institutions have been unsuccessful.

By using more managed care practices, the department will have greater assurance that the quality and standards of its medical services are consistent across all institutions. It also will be able to identify those employing "best practice" strategies to minimize costs while maintaining adequate care and to ensure that all other institutions adopt similar strategies.

COMPARED TO MANAGED CARE ORGANIZATIONS, THE DEPARTMENT'S METHODS TO CONTAIN COSTS AND ENSURE UNIFORM SERVICES ARE LIMITED

Unlike managed care organizations, the department lacks systematic processes designed to improve care and control costs.

Over the past decade, managed care organizations have become the prevalent vehicle for delivering quality, cost-effective health care. To effectively and efficiently run their health care operations, managed care organizations employ several key practices to identify inefficient practices or unusual cost variations, take appropriate steps to improve care and reduce costs, and then monitor changes to ensure they achieve anticipated benefits. The department's own methods, however, do not follow a similar, comprehensive structure. It lacks a systematic process for some practices, such as physician profiling and outcome studies, which are intended to improve treatment guidelines, control costs, and create more uniform care. In other instances, such as prevention programs, the department uses these practices at only a few facilities.

As shown in Table 1, most managed care practices focus on reducing costs and improving the uniformity and quality of care. For example, establishing treatment guidelines and protocols ensures uniform care but also reduces costs by directing providers to apply the most cost-effective treatments first. Other practices, such as concurrent reviews, which assess the need for continuing inpatient treatment, and monitoring cost differences, focus mainly on containing costs by reducing the length of hospital stays or identifying other cost-saving practices.

Our report focuses on several, but not all, of the practices shown in Table 1. We first focus on "utilization management" practices. These methods affect uniformity of and overall access to care and include establishing treatment guidelines and protocols and performing outcome studies. We also assess cost-containment methods, such as monitoring cost variances.

TABLE 1

To What Extent Has the Department Adopted Managed Care Practices?

Practices	Desired Effect on Costs and Quality of Care	Extent of Department's Practices			Comments
		Comprehensive	Limited	None	
Gatekeeping/Preauthorization	Ensure that inmates receive only approved services.	■			Has a systemwide process.
Treatment guidelines and protocols			■		Standards of care are limited to broad, mission-level items. Detailed guidelines and protocols exist in the chronic care program, which is implemented at only a few facilities.
Concurrent review	Reduce length of stays.		■		Active in community hospitals, less active program for in-house care.
Drug formularies			■		Formulary is out-of-date, and no system exists to monitor prescribing patterns.
Data collection systems	Support cost-saving and quality improvement efforts.		■		Some data are collected at each facility, but no effective method of sharing data between facilities and/or headquarters (such as a computer network) exists.
Identification and monitoring of cost variances			■		No systemwide analysis of staffing costs, identification of necessary changes, and follow-up to verify that desired changes occurred.
Outcome studies	Ensure uniform care and outcomes; identify optimal care.			■	No proactive and systematic review of outcomes.
Physician profiling and benchmarking				■	No benchmarking or profiling systems in place.
Prevention programs	Avoid onset of disease; reduce hospitalization costs.		■		Formal programs are limited to a few facilities under court-order.
Quality assurance programs			■		Reviews death cases and unusual events. An ongoing quality assurance program exists only at a few facilities under court order.
Continuous quality improvement programs	Continuously improve care guidelines and protocols; reduce costs.		■		Care guidelines and protocols are limited. No systemwide process to proactively identify, improve, and monitor changes.
Education and training programs			■		None of the education focuses on cost-containment.

In managed care organizations, we would expect a consistent and standardized level of medical services to be delivered to all patients, even across various facilities. However, although the department has adopted certain utilization management techniques and standards of care, it does not have a comprehensive approach designed to ensure that the institutions are consistently providing quality care. Specifically, the department does not have effective systems to analyze medical outcomes and implement a program where treatment guidelines and protocols are established, reviewed, and improved on a continuous basis. Similarly, it lacks a systematic process for reviewing its health care costs, such as salaries or overtime; containing the costs; and monitoring its action to ensure desired results. Litigation targeted to specific facilities further widens the gap in standards of care among the 33 institutions.

THE DEPARTMENT DOES NOT COMPLETE PROACTIVE, SYSTEMATIC REVIEWS OF ITS HEALTH CARE SYSTEM

The department can perform limited analyses and reviews of health care services, but it does not conduct comprehensive reviews that are systematic and proactive. Currently, its only reviews are "after-the-fact" reviews, which identify problems and needed action only in response to certain incidents. If the department followed managed care practices more closely, it would collect and review medical information from each institution to identify and rectify any recurring problems preventing it from improving the quality of medical care and reducing its costs.

The department's reviews are reactive in nature and do not focus on the cost-effectiveness of care.

The department's assistant deputy director in charge of health care policy told us that "after-the-fact" reviews follow unusual incidents, such as patient deaths, to aid in identifying problems and making policy changes to correct them. We do not question the merit of such reviews but are concerned that they are reactive in nature and do not focus on the cost-effectiveness of care. They also require the department to undergo the time-consuming process of collecting many bulky paper files from each institution. Although the department does keep records, such as patient charts, it cannot easily collect data from individual institutions because it lacks a systemwide information technology structure. Managed care organizations have more comprehensive databases and computer infrastructures that allow them to perform more proactive studies and investigate more than just isolated incidents.

If the department operated more like a managed care organization, we would expect it to systematically review data from each institution with the overall goal of focusing on broader, more comprehensive issues, such as continuously improving the quality of medical care while also reducing its costs. For example, it could develop or modify treatment protocols and analyze the outcomes of hospital treatment. In addition, it could compare information among institutions to ensure that medical services are consistent and standardized.

The department acknowledges that it is "crippled by the lack of data and staff to analyze the data."

The deputy director in charge of the health care services division (deputy director) acknowledges that the department's data management is far different from a managed health care organization's and believes that the department is "crippled by the lack of data and staff to analyze the data." The deputy director believes the lack of a modern information technology structure, including networking capabilities at the institutions coupled with insufficient staff, limits the department's ability to manage its health care system. Although she recognizes that comprehensive information is important for making decisions, she has been reluctant to burden staff with additional information-reporting duties in the absence of an efficient way to report the data electronically.

In its 1997 annual report on health care, the department acknowledged that the rapid growth of the inmate population had severely strained its ability to manage and plan appropriate and cost-effective health care services. The report stated that the current system for managing information was too inefficient, costly, and labor-intensive to meet the department's needs. It concluded that the department must take steps to better handle the massive amounts of information necessary for managing information and delivering health care services statewide. The department tried to procure an information system that would improve its data collection problems but was unsuccessful. No new information system is currently planned.

The Department's Utilization Management Process Is Limited

Despite its inability to perform comprehensive and systematic reviews of its health care delivery system, the department has tried to adopt certain utilization management techniques similar to those found in a managed care organization. The department implemented its utilization management program in April 1996. As part of the program, it has adopted three types of techniques: prospective, concurrent, and retrospective reviews.

Prospective reviews require a utilization management nurse to predetermine whether requests for health services are medically necessary. Concurrent reviews include such areas as admission reviews, which ensure that hospitalization is appropriate, and continued-stay reviews, which assess the need for continuing inpatient treatment. Retrospective reviews as employed by the department consist solely of reviewing the invoices for all inpatient and outpatient services provided by contractors.

The department's retrospective reviews of care provided focus solely on invoices rather than on improving treatment guidelines by studying medical outcomes.

All these reviews are valuable; however, the department's processes have limitations. First, its retrospective review process focuses solely on invoices rather than improving treatment guidelines by studying medical outcomes. The department does not review outcomes on a comprehensive basis by comparing information among institutions, and individual institutions are not directed to review these outcomes. In the managed care environment, outcome analysis is an essential part of an organization's efforts to continuously improve its treatment guidelines and protocols, which in turn improve the quality of its medical care. Additionally, most components of the department's utilization management process focus on inmates hospitalized in community facilities. The department conducts only limited and informal reviews of the inmates hospitalized in its own facilities. Finally, the department's utilization management nurses are at times assigned other duties as well, so they can sometimes devote only limited attention to utilization management matters.

Even if the department implemented a comprehensive review process that included a review of medical outcomes, we are concerned that problems with its record keeping would continue to limit the review's effectiveness. Although the department has a database capable of summarizing patient stays by diagnosis code, the institutions do not always record these codes for each patient. We reviewed diagnosis codes for fiscal year 1998-99 and found 1,770 patients whose diagnoses had not been coded. If the department does not record the codes for all discharges, it lacks information necessary to perform effective reviews that would aid in identifying the most common medical conditions for purposes of tracking costs and developing treatment guidelines.

The Process to Ensure Consistent Standards of Care Is Limited and Affected by Lawsuits

The department has published systemwide standards of care, but policy decisions and litigation at individual institutions appear to have created inconsistent levels of care. Additionally, although the published standards attempt to create uniformity in health services among the institutions, they have limited usefulness because they lack the detailed treatment guidelines and protocols that managed care organizations include. The department cannot verify that each institution is following the systemwide standards, nor can it enforce the standards because its reviews of medical services at its 33 institutions are limited. A further obstacle is the autonomy of the institutions, resulting in little sharing of information on their health care operations.

Managed care organizations typically establish their standards of care on two levels. First, broadly set goals and mission statements establish the organization's overall standards. Second, more detailed treatment guidelines and protocols address myriad medical conditions and serve to achieve the goals set out in the broader standards. Moreover, the standards can be modified as necessary, based on outcome studies. The department has broadly defined standards, but it has not established treatment guidelines and protocols, except in its recently developed chronic care program in place at only a few institutions. Instead, it relies upon the individual discretion and judgment of its physicians, which of course varies. Although even managed care organizations recognize that physicians must use their own judgment in some cases, treatment guidelines and protocols would help the department establish a structure, consistent with its mission and goals, to ensure consistency of care.

Unlike managed care organizations, the department has not established treatment guidelines and protocols, except in its recently developed chronic care program in place at only a few institutions.

The department generally has not issued treatment guidelines and protocols, but it does periodically distribute various directives to the institutions. However, it still has no comprehensive and systematic process for determining whether the institutions are providing an acceptable level of care. Each institution has a great deal of autonomy in managing its health care operations, and there appears to be differences in the institutions' internal processes for managing the care provided. Additionally, there appears to be little sharing among the institutions and headquarters of best practices or common problems.

Differences among facilities also appear to have resulted from litigation directed at specific facilities. An August 1997 federal lawsuit (Shumate lawsuit) directed at two women's facilities—the

Central California Women's Facility and the California Institution for Women—required improvements to the care provided, such as health screening exams and medical care for chronic diseases such as diabetes, HIV, or seizure disorders. Although not required by the lawsuit, the department plans to expand the programs, policies, and procedures it implemented at these facilities to its two remaining women's facilities. The department noted that an expanded program would require additional staff, contractors, pharmacy supplies, and medical equipment. Based on this information, the department seems to acknowledge that a different standard of care exists at the two women's facilities not subject to the lawsuit. Moreover, the chronic care services implemented as a result of this lawsuit have not been extended to any men's facilities.

The Pelican Bay State Prison (Pelican Bay) offers another example of disparate services resulting from litigation. In January 1995, a federal lawsuit (Madrid lawsuit) required the department to increase this prison's psychiatric and other health care services. The department acknowledged that Pelican Bay has significantly higher costs per inmate and offers a broader range of health care services than most other institutions because of its efforts in response to the Madrid lawsuit.

The differences in care that result from litigation point to a discrepancy between the department's objective of providing consistent services and the reality that some facilities receive different levels of care than other facilities.

These two examples point to a discrepancy between the department's stated objective of providing consistent services and the reality that two of the four women's facilities receive different levels of care than other facilities, and that Pelican Bay offers a broader range of services than other facilities.

We spoke to the department about the extent to which it believes it is appropriate to expand programs established at the three institutions because of the Shumate and Madrid lawsuits to the remaining institutions. The deputy director acknowledged that several changes at the two women's facilities resulting from the Shumate lawsuit should extend to all institutions, but stated that the department has been unable to obtain the resources to do so. The women's facilities have chronic care and quality-assurance programs, and their staff are standardizing and improving the documentation of inmates' medical records. On the other hand, she stated that it would not be appropriate to implement many of the services mandated for Pelican Bay at other prisons because these services represent a level of care far in excess of what is available in the community. The deputy director used court-mandated staffing as an example. She states that staffing at Pelican Bay is above and beyond what should be

required. Thus, even if the department received additional resources to standardize its services, certain inmates would continue to receive different levels of care than others because it does not believe that all Pelican Bay services should be standardized.

Diabetic patients in a women's facility received monitoring tests much more frequently than patients in a men's facility.

Finally, our medical expert found an example where the level of care is inconsistent among institutions. Specifically, our expert's review of the medical files for a sample of 40 diabetic patients at two institutions found that the percentage of inmates receiving tests at recommended intervals varied significantly between the institutions. The results show that women receive monitoring tests much more frequently than men, with the men consistently well below nationally recommended guidelines. The details of this review appear in Appendix A.

We also found variation in health care costs among institutions, which we discuss later in this chapter. Given the cost variation and the examples above, the potential that other inconsistencies in care exist is significant. Until the department comprehensively reviews the levels of care provided in each institution, it cannot take appropriate steps to ensure that the care is consistent and standardized to the extent possible.

SOME MEDICAL FACILITIES ARE NOT YET LICENSED

Another aspect of the department's management of its health care system is how it determines which medical facilities care for which patients. The department has established different types of facilities designed to provide different levels of care. However, it has not yet completed its evolution from unlicensed to licensed facilities to the extent required, and questions exist as to whether it is providing the authorized level of care in certain facilities that are yet to be licensed.

The department operates a variety of facilities. Its licensed hospitals provide acute care services to patients with sudden illnesses or injuries subject to rapid changes in condition that require a high level of care. The department's correctional treatment centers (CTCs) provide subacute care, which is given to patients with less urgent conditions who still require professional care. For example, patients receiving post-operative treatment are classified as receiving subacute care. Outpatient housing units, formerly called infirmaries, include beds for

inmates who have health conditions that require them to be isolated from the prison yard or monitored. They are not intended to provide acute or subacute care.

We attempted to review the appropriateness of the department's acuity mix, which is the mix of patients by level of care provided. We compared the department's relevant data to data compiled for hospitals statewide; however, the unique demographics of California's prison population make such comparisons difficult. Instead, we evaluated data on the acuity mix for each type of facility: hospitals, CTCs, and outpatient housing units. This information showed the following acuity level categories: acute, subacute, inpatient psychiatric, and other (including outpatient care). The data indicated that patients generally were cared for in the appropriate type of facility, but the percentage of patients within each acuity category varied significantly across similar institutions. We could not determine whether this variation indicated inappropriate placement of patients because the data did not contain complete and detailed disease diagnosis information that in turn would help us determine which acuity level actually was required to treat the patient. Therefore, we cannot conclude whether the department consistently made appropriate decisions as to the optimal use of its facilities.

Although the department is trying to get its 16 correctional treatment centers licensed, only 2 are licensed as of December 1999.

One issue that still must be addressed fully is the licensing of the department's CTCs. Several years ago, the department was out of compliance with state regulations because it was providing inpatient care in its unlicensed infirmaries. To resolve this issue, the department has been trying to get CTCs licensed at 16 of the institutions. Significant effort and resources are involved in preparing the CTCs to be licensed. For example, the department must construct appropriate facilities. It also must ensure that various prerequisites are in place, such as appropriate staffing, processes, and standards of care. As of December 1999, only 2 of the 16 CTCs were licensed, and the department had submitted applications for 3 others. Due to various delays, the department estimates that all CTCs will not be licensed until 2002. In the meantime, the department has staffed the CTCs and is operating those facilities that will be licensed as CTCs.

The Department of Health Services (Health Services) is responsible for licensing the CTCs. In a letter to the department dated December 1998, Health Services expressed concern that only a few of the department's CTCs were licensed or applying for licenses. The letter also stated that if the department was providing "inpatient level" health services at its facilities, it probably

needed to be licensed to do so. Health Services concluded that the statutes do not authorize it to permit a facility that requires a license to continue operating without one. It cautioned that if it received a complaint about any unlicensed health facility, and if it were to confirm the complaint, it would order the department to "cease and desist" until the facility was licensed.

Correctional treatment centers that provide an "inpatient level" of health services probably need to be licensed, according to Health Services.

We questioned the department about the type of care the CTCs provide. According to the deputy director, CTCs care for patients requiring supervised health care, such as preparation for surgery, postoperative recovery, and care for mental health patients. The department's manuals define "inpatient" as a patient who receives room, board, and continuous general nursing care in an area where patients stay at least overnight. The types of care the CTCs provide, as well as the inmates' lengthy average stays, lead us to believe that CTCs provide inpatient care.

We asked the department whether Health Services had granted permission for the department to operate its CTCs that are not yet licensed as it currently does. The department stated that Health Services had not formally approved the centers' operations, but it was aware that they are operating. However, staff at Health Services told us that they were aware the department was working toward licensing its CTCs, but did not know what types of care any unlicensed facilities currently provide.

The deputy director contends that all patients in the CTCs that are not yet licensed receive the 24-hour nursing care that is required by state regulations. She further states that the primary issues that the department needs to address to license the CTCs involve physical plant renovations, rather than care issues. Nevertheless, it is important for the department to communicate with Health Services to ensure it provides only the level of care appropriate for an unlicensed facility in those CTCs that are not yet licensed.

OPPORTUNITIES EXIST FOR THE DEPARTMENT TO BETTER CONTAIN COSTS

The department collects data for many items, but its efforts to interpret and analyze the data for cost-containment purposes are limited. We observed wide variations among institutions for such operating cost items as amount spent per inmate for total medical costs, nursing costs, and overtime pay. The number of hospital days required for similar conditions also varied. Managed

In contrast to managed care organizations, the department could not demonstrate that it had a systematic process to identify unusual costs or take action to contain the costs.

care organizations routinely collect such data and try to identify and eliminate unusual or avoidable costs and then monitor their efforts to determine whether the costs have been reduced or eliminated. In contrast, the department could not explain the specific reasons for the differences or demonstrate that it had a systematic process to identify unusual costs or take corrective action to contain them. As a result, we are uncertain whether the department is using its staff effectively or otherwise operating efficiently.

Overall Costs Vary Dramatically Among Facilities

We grouped each of the 33 facilities into one of three categories: hospitals, CTCs, and outpatient housing units. We evaluated the total costs of medical care at the 33 facilities and noted significant variations in the costs. We then assessed portions of those costs, such as nursing salaries and overtime, and reviewed the number of hospital days required to treat certain common medical conditions and the occupancy rates for the department's medical facility beds.

We separated facilities that are reception centers because they provide special medical, dental, and psychiatric exams for new inmates and have higher costs. We also separated the California Medical Facility because it serves the whole department and provides specialized psychiatric services so it has unusually high costs.

As shown in Table 2, the total medical costs per inmate vary significantly for CTCs and outpatient housing units. For example, CTCs without reception centers range from $1,668 per inmate to $5,465. Similarly, outpatient housing units with reception centers range widely, with a low of $1,580 and a high of $3,868 per inmate.

When we asked the department to explain the variation in costs, it told us that certain facilities incur higher costs because of their size, missions, or court-imposed requirements. In addition, the department noted that some hospitals or CTCs act as "hubs" that provide medical services for nearby institutions. (Hub facilities are either hospitals or CTCs, which already are grouped separately in our tables.)

Although the explanations could be valid, the department could not demonstrate specific, detailed analyses to help isolate the unique conditions that would explain why one CTC would have

TABLE 2

Total Annual Medical Cost per Inmate (Fiscal Year 1998-99)

	Low	Average	High
Hospitals*			
With reception centers	$4,687	$ 4,728	$4,768
Without reception centers	4,297	4,625	4,953
California Medical Facility†		16,685	
Correctional Treatment Centers			
With reception centers	2,387	3,416	6,350
Without reception centers	1,668	2,617	5,465
Outpatient Housing Units			
With reception centers	1,580	2,695	3,868
Without reception centers	1,146	1,629	2,079

* This group includes the Skilled Nursing Facility at the Central California Women's Facility.

† The California Medical Facility is separate because it serves the whole department and provides specialized psychiatric services, and thus, has unusually high costs.

Without routine analyses, it is difficult to determine whether the department's facilities with the lowest costs represent well-managed units or are facilities with sub-standard medical care.

annual medical costs per inmate more than three times higher than another. Managed care organizations routinely analyze the costs at each facility, often using unexplained variations as starting points for further study that, in turn, might lead to improved operating practices and reduced costs. Absent such analyses, it is difficult to determine whether the department's facilities with the lowest costs represent well-managed units that have optimized their use of resources, and thus, should be held up as standards for the others, or whether they provide substandard medical care. Similarly, it is difficult to determine whether the highest-cost facilities are inefficient or provide excessive care, and thus, represent opportunities for potential savings.

Variation in Salary Data Raises Questions About the Effective Use of Medical Staff

In addition to our analysis of the department's total medical costs per inmate, we reviewed certain parts of total costs—specifically, salary costs per inmate. The department establishes the staffing levels at each facility by using either a predetermined staffing formula or by requesting additional staff during

the annual state budgeting process. The department states that, based on the formula, it receives one physician for every 525 inmates added to the total inmate population. Similarly, it receives one dentist and one dental assistant for every 950 new inmates. If an institution determines that, in addition to the physicians or dentists, it needs medical or support staff to meet increased workload demands, it must justify its needs and compete for resources with other organizations, both within the department and the State as a whole. The department also can allocate individual staff positions within its 33 health care facilities to best serve its needs.

Costs per inmate for RNs and MTAs varied significantly among facilities with similar purposes.

We attempted to review the staffing levels at each institution and assess whether the department employs an ideal mixture of physicians, nurses, and other staff. We were unable to compare the staffing levels and mixtures at the department to outside benchmarks, such as managed care organizations, because the custody and physical environment of a prison system is so different from private health care systems. Similarly, we were unable to obtain staffing data from other states' prison systems for comparison. As an alternative, we compared the staffing levels of facilities within the department. Specifically, we compared two different cost factors per inmate: registered nurse (RN) costs per inmate and medical technical assistant (MTA) costs per inmate.

We found significant variation in RN and MTA costs per inmate among hospital facilities, CTC facilities, and outpatient housing units. As shown in Tables 3 and 4, we also identified facilities that operate as reception centers and grouped them together within each primary group of hospitals, CTCs, and outpatient housing units, so that facilities with similar purposes are displayed together.

As Table 3 shows, costs for RNs at CTCs with reception centers ranged from $154 per inmate to $692 per inmate. Likewise, costs at outpatient housing units without reception centers varied from $45 per inmate to $185. Salary costs also varied for MTAs. As Table 4 shows, for example, costs at CTCs without reception centers ranged from $205 to $516 per inmate.

TABLE 3

Salaries per Inmate for Registered Nurses (Fiscal Year 1998-99)

	Low	Average	High
Hospitals*			
With reception centers	$492	$ 508	$523
Without reception centers	523	625	726
California Medical Facility†		1,510	
Correctional Treatment Centers			
With reception centers	154	311	692
Without reception centers	184	252	442
Outpatient Housing Units			
With reception centers	100	305	648
Without reception centers	45	129	185

* This group includes the Skilled Nursing Facility at the Central California Women's Facility.

† The California Medical Facility is separate because it serves the whole department and provides specialized psychiatric services, and thus, has unusually high costs.

Managed care organizations as large as the department's health care system regularly analyze these types of salary costs and seek to minimize unusual variations. Such analyses ideally would help the organization spot unusual trends or problems, take prompt corrective action, and then verify whether the correction produces the intended result. For example, if a departmental analysis found that nursing salaries per inmate decreased below a specific benchmark, it might indicate that the inmate population has grown rapidly so more nurses are needed. Conversely, a similar decrease could indicate that the facility has successfully minimized avoidable costs such as overtime. However, without analyzing these cost factors, the department cannot distinguish between facilities that are effectively managing their medical staff and those that are not.

TABLE 4

Salaries per Inmate for Medical Technical Assistants (Fiscal Year 1998-99)

	Low	Average	High
Hospitals*			
With reception centers	$451	$ 547	$642
Without reception centers	368	398	428
California Medical Facility†		1,970	
Correctional Treatment Centers			
With reception centers	261	317	383
Without reception centers	205	295	516
Outpatient Housing Units			
With reception centers	269	304	353
Without reception centers	151	225	299

* This group includes the Skilled Nursing Facility at the Central California Women's Facility.

† The California Medical Facility is separate because it serves the whole department and provides specialized psychiatric services, and thus, has unusually high costs.

Restrictive Staffing Requirements Contribute to High Overtime Rates for MTAs

MTAs are paid 54 percent of the total health care overtime pay but represent only 22 percent of the total health care payroll.

MTAs fill a unique role in the department. They are licensed nurses (typically licensed vocational nurses, or LVNs) but are also custody officers. These qualifications allow them to serve either as a custody officer, if required, during the delivery of health care or as a medical assistant who distributes medications and takes vital signs or medical histories. Provisions in the contract between the State and the MTAs' bargaining unit require these positions to be "posted"; that is, if an MTA is absent, the position must be filled only by another MTA, even if overtime pay is necessary. This policy contributes to higher-than-average overtime for MTAs. In fiscal year 1998-99, MTAs were paid $6.3 million in overtime, about 12 percent of their overall pay. In fact, MTAs are paid about 54 percent of the department's total health care overtime pay, even though they represent just 22 percent of the total health care payroll.

According to several staff at facilities we visited, some of the MTA positions could reasonably be left unattended for a shift, or filled by an RN, if it were not for the requirement that the posts be filled with MTAs. The department has requested that some MTA posts be designated as "non-critical" so they can remain vacant under certain conditions, but the bargaining unit has not agreed to that change. Nevertheless, we believe that minimizing the amount of overtime paid to MTAs is important, so the department should monitor their overtime and take appropriate steps to reduce it.

Wide Ranges in Hospital Stays and Occupancy Rates Illustrate Weaknesses in the Department's Cost-Containment Efforts

We also identified other factors the department should monitor to contain costs properly. Managed care organizations, for example, closely monitor the number of hospital days required to treat a particular disease or injury. As discussed earlier, the overall utilization management effort works to control several factors, including the number of days patients spend in the hospital. Each day can cost thousands of dollars, so even small deviations from the optimal number of days to treat an illness or injury can cost millions of dollars for an organization as large as the department.

Because each day can cost thousands of dollars, even small deviations from the optimal number of days to treat an illness or injury can cost millions for an organization as large as the department.

We reviewed the department's records for all patients admitted to community hospitals, the department's hospitals, CTCs, and outpatient housing units, and we found significant variations in the average stays for specific diseases or injuries. For example, in fiscal year 1998-99, more than 800 inmates were admitted for digestive system diseases. Table 5 shows the variation in the average length of stay for inmates with these diseases in the department's in-house beds.

TABLE 5

Average Length of Stay for Digestive System Diseases Treated in Department Facilities (Fiscal Year 1998-99)

	In-House (In Days)		
	Low	Average	High
Hospitals*			
Excluding California Medical Facility	6.9	17.6	25.3
California Medical Facility†		59.4	
Correctional Treatment Centers	1.2	6.5	14.3
Outpatient Housing Units	1.0	5.5	27.5

* This group includes the Skilled Nursing Facility at the Central California Women's Facility.

† The California Medical Facility is separate because it serves the whole department and provides specialized psychiatric services, and thus, is unique.

As shown in Table 5, the average stay at individual CTCs ranged from 1.2 to 14.3 days and the average stay at individual department hospitals varied between 6.9 and 25.3 days. Although the department collects data on inmates' diseases, injuries, and length of hospital stays, it cannot demonstrate that it systematically reviews that data to identify unusual patterns and contain costs. The lengths of stays in the department's own facilities vary considerably. A detailed and systematic review of the data would uncover why and might reveal potential cost savings.

Similar variations occur in the average stays for inmates treated in community hospitals rather than in the department's own facilities. Table 6 shows that the average stay in community hospitals for inmates sent from CTCs ranged from 2.5 to 11.2 days. Again, the broad variation illustrates a need to study the data and determine whether closer monitoring could reduce hospitalization costs.

TABLE 6

Average Length of Stay for Digestive System Diseases Treated in Community Hospitals (Fiscal Year 1998-99)

	Community Hospitals (In Days)		
	Low	Average	High
Hospitals*			
Excluding California Medical Facility	2.3	4.2	5.7
California Medical Facility†		2.1	
Correctional Treatment Centers	2.5	5.1	11.2
Outpatient Housing Units	2.5	4.0	7.0

* This group includes the Skilled Nursing Facility at the Central California Women's Facility.

† The California Medical Facility is separate because it serves the whole department and provides specialized psychiatric services, and thus, is unique.

We further found that the occupancy rates for the department's hospital, CTC, and outpatient housing unit beds vary, as shown in Table 7. Once again, the department could not demonstrate that it analyzes the variation in its occupancy rates, identifies unusual trends or patterns, takes appropriate corrective action, and, finally, monitors its actions to ensure that it attained the desired result.

The variations for each factor cited do not automatically indicate problems, but the department should consider them worthy of further study. According to the department, it does not conduct the comprehensive data analyses we have suggested, yet it does use data in its decision-making processes. The department indicated that it has used occupancy rate information to assist in placing individual patients and to evaluate whether to close some of the more remote CTCs. The department told us that it has used salary and length-of-stay data in its budget planning meetings as well. Nevertheless, both our analysis and the department's statements indicate that its use of cost data is limited.

TABLE 7

Percent of Total Bed Occupancy (Fiscal Year 1998-99)

	Low	Average	High
Hospitals*			
Excluding California Medical Facility	59.9%	70.9%	91.8%
California Medical Facility†		80.3	
Correctional Treatment Centers	35.8	65.2	78.2
Outpatient Housing Units	22.6	50.5	77.7

* This group includes the Skilled Nursing Facility at the Central California Women's Facility.

† The California Medical Facility is separate because it serves the whole department and provides specialized psychiatric services, and thus, is unique.

The Department Has Not Measured the Benefits of Its Co-payment Program

Because it cannot demonstrate that its inmate co-payment program is cost-effective, we recommend that the department eliminate it.

The inmate co-payment program further demonstrates the department's incomplete analysis of cost data. This program has not generated the $1.7 million originally estimated and the department has never measured whether it really reduces patient visits. We recommend that the department eliminate this program because it cannot demonstrate that it is cost-effective.

State law authorizes the department to charge inmates a $5 co-payment for each medical visit they request. Beginning in November 1994, the department began charging inmates the co-payment, although the fee is waived if inmates do not have any funds in their trust accounts. The fee is not charged for certain services, such as emergency, mental health, follow-up, inpatient care, and diagnosis or treatment of communicable diseases. Despite initial estimates that the co-payment program would generate $1.7 million each year, actual collections have averaged $654,000 per year over the past four years. The department could not explain how it estimated the $1.7 million in revenue or give us a current estimate of the cost to administer the program. However, in December 1993, it estimated that the annual costs to operate the co-payment program would be $3.2 million.

Based on these figures, we concluded that the program would need to reduce health care visits sufficient to offset its operating costs to be cost-effective. Since its inception, however, the department has not collected information to help it make that determination. Before implementing the program, the department completed an analysis that suggested that requiring co-payments would reduce inmate visits by 50 percent. That analysis further estimated that inmates averaged about 0.9 health care visits per month. If the co-payment program actually has reduced visits by 50 percent, we would expect inmates to currently make 0.45 visits per month, or about 5 or 6 visits per year. The department is unable to demonstrate that it calculates the number of current visits or that the program has reduced health care visits—in short, that it can justify the program at all—so we believe the program should be abandoned.

CHALLENGES IN PROVIDING QUALITY HEALTH CARE WILL CONTINUE TO CONFRONT THE DEPARTMENT

The department is faced with the dilemma of employing effective and modern health care management techniques with fewer resources.

The department established the health care services division in 1992 in recognition of the growing importance of correctional health care and the risk that court intervention posed to its ability to manage its health care programs. Since that time, the division has grown and has implemented new processes, such as its utilization management program. The department also has made significant changes due to requirements imposed by various court actions. In recent years, however, rather than simply reacting to court mandates, the department has attempted to move toward a more proactive approach to delivering health care. New challenges lie ahead as the department is faced with the dilemma of employing effective and modern health care management techniques in a proactive manner with fewer resources.

The department is downsizing as the growth of the inmate population starts to level off. It has instituted a hiring freeze and proposed permanent employee reductions. As of November 1999, headquarters for the health care services division had 58.5 vacancies out of 227 authorized positions. The department has stated that these vacancies have required individual units to reprioritize workload and delay less critical activities.

In September 1999, the department developed a restructuring plan that, in part, proposed to cut the division's workforce by 106 positions, including some of the vacancies, and its budget by $7.4 million. The deputy director reports that the plan has

undergone extensive revision and believes that it will call for reducing significantly fewer positions. Though the extent and impact of the planned reductions is unknown at this time, in an environment of dwindling resources it is even more critical that the department employ managed care practices that will ensure that it is operating cost-effectively to provide appropriate care to its inmate population.

RECOMMENDATIONS

To improve the management of its health care operations and better employ the management practices used by managed care organizations, the department should take the following actions:

- Report to the Legislature on its progress in adopting managed care techniques and the specific barriers that preclude it from operating more effectively in a managed care environment. The report should identify any resources, including staff, needed to develop the infrastructure necessary to collect and analyze data that will allow it to comprehensively and systematically review its medical operations. When identifying any resources needed, the department should report to what extent costs can be reduced because of a more efficient environment. In the meantime, it should proactively review its medical operations to the extent possible.

- Ensure that each facility operates in an optimal manner by periodically reviewing key operating data, such as costs and lengths of stay, and investigate unusual or inconsistent data. Further, it should take appropriate steps to minimize unnecessary costs and verify that the corrective action resulted in the desired change. Such reviews should be limited to those where the potential savings can reasonably be expected to exceed the evaluation costs.

- Identify the specific areas where the level of medical care, such as chronic care services, differs because of litigation or other reasons. If differences exist, it should determine the additional resources, including staff, necessary to remedy any inconsistencies, and seek the appropriate budgetary changes to ensure a consistent level of care at each facility to the extent possible.

- Work with Health Services to ensure that all CTCs become licensed and that the department is providing only the level of care appropriate for an unlicensed facility in those not yet licensed.

- Take appropriate steps to reduce overtime payments for MTAs. It should identify specific MTA posts that, on a temporary basis, could be left vacant or be filled with other qualified personnel, and seek appropriate agreements with the MTAs' bargaining unit.

- Discontinue its policy requiring inmates to pay for a portion of health care visits because the department has not demonstrated that this co-payment program is cost-effective. ■

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CHAPTER 2

Different Contracting Methods and Other Improvements Could Reduce Rising Pharmacy Costs

CHAPTER SUMMARY

Pharmacy costs are the fastest growing component of the California Department of Corrections' (department) health costs—increasing from $24.5 million to $51.1 million over the past three fiscal years. Two groups of new drugs used to treat mental health conditions and HIV have contributed significantly to this rise in costs. Opportunities exist, however, to reduce pharmacy costs by taking advantage of more competitive contracting methods and improving efforts to monitor how physicians prescribe drugs at the department's 33 institutions.

PHARMACY COSTS FOR THE DEPARTMENT ARE INCREASING FASTER THAN FOR THE GENERAL POPULATION

The department's pharmacy costs increased from $24.5 million in fiscal year 1996-97 to $51.1 million in fiscal year 1998-99.

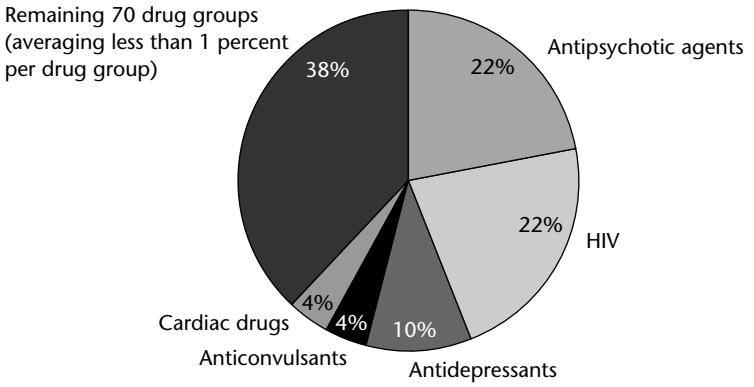
Along with personnel costs and contracted medical services, pharmacy and medical supplies make up the department's primary health care costs. Per inmate, pharmacy and medical supply costs have grown more than 29 percent per year, in contrast to annual growth of only 2 percent for personnel costs and 10 percent for contracted medical services. From fiscal year 1996-97 to fiscal year 1998-99, nationwide expenditures on prescription drugs grew 12.9 percent annually. The department's pharmacy expenditures per inmate, excluding medical supply costs, have grown more than 39 percent annually during the same time period. In fiscal year 1998-99, the department spent $51.1 million on drugs, or $339 per inmate, compared with $24.5 million, or $175 per inmate, in fiscal year 1996-97.

One reason for the rapid rise in pharmaceutical expenditures is that the growth rate of two therapeutic classes of drugs—antipsychotic agents and HIV medications—has increased exponentially during these fiscal years. Of the 75 drug therapy groups

that account for 99 percent of the department's drug expenditures, these two classes are the largest. As shown in Figure 3, they account for 44 percent of total drug costs.

FIGURE 3

Antipsychotic and HIV Drugs Compose a Major Portion of Drug Costs



Note: This figure is based on an analysis of the department's 75 drug therapy groups with the highest expenditures for the 12-month period October 1998 through September 1999. These 75 drug groups account for 99 percent of the department's drug expenditures.

To illustrate the exponential growth rate of antipsychotic and HIV drugs, we calculated the recent rise in expenditures for the two drugs with the highest expenditures in these categories, the antipsychotic agents Olanzapine and Risperidone.[1] Expenditures for Risperidone increased 62 percent annually from fiscal year 1996-97 through 1998-99. For Olanzapine, which had only six months of sales in fiscal year 1996-97, the annual rate of growth from fiscal year 1997-98 through 1998-99 was 313 percent. The annual increase for HIV therapies is equally astronomical; the mix of drugs varies by year, but the annual growth rate as a whole is more than 80 percent from fiscal year 1996-97 through 1998-99.

We first considered the possibility that costs for antipsychotic and HIV drugs alone drove the increase in the department's pharmaceutical expenditures because, in many cases, there are no lower-cost substitutes available. If we excluded these two classes of drugs from the total costs, the department's pharmacy expenditures drop to $214 per inmate while the annual growth rate falls from 39 percent to 22 percent for fiscal years 1996-97 through 1998-99. Even with these adjustments, the growth rate

[1] The brand names, as shown in Appendix B, for Olanzapine and Risperidone are Zyprexa and Risperdal.

is still well above the rate for nationwide expenditures on prescription drugs, indicating that there are factors other than a general increase in costs. In light of these findings, we concluded that it was important to analyze the overall pharmaceutical contracting process to determine how the department might save money.

MORE COMPETITIVE CONTRACTING METHODS COULD SAVE MILLIONS OF DOLLARS

The department participates in a statewide contracting arrangement known as a master agreement, which is designed to achieve competitive prices for the drugs that state agencies may purchase through it; however, the savings achieved through its current process could be greater. As part of its master agreement process, the State has secured individual contracts with manufacturers for only 40 percent of the drugs that the department purchases and does not employ methods that allow for the fullest amount of competition possible. The department could save millions of dollars if the State encouraged greater competition among drug manufacturers through more effective contracting techniques.

The Department Purchases Only 40 Percent of Its Drugs on Contract

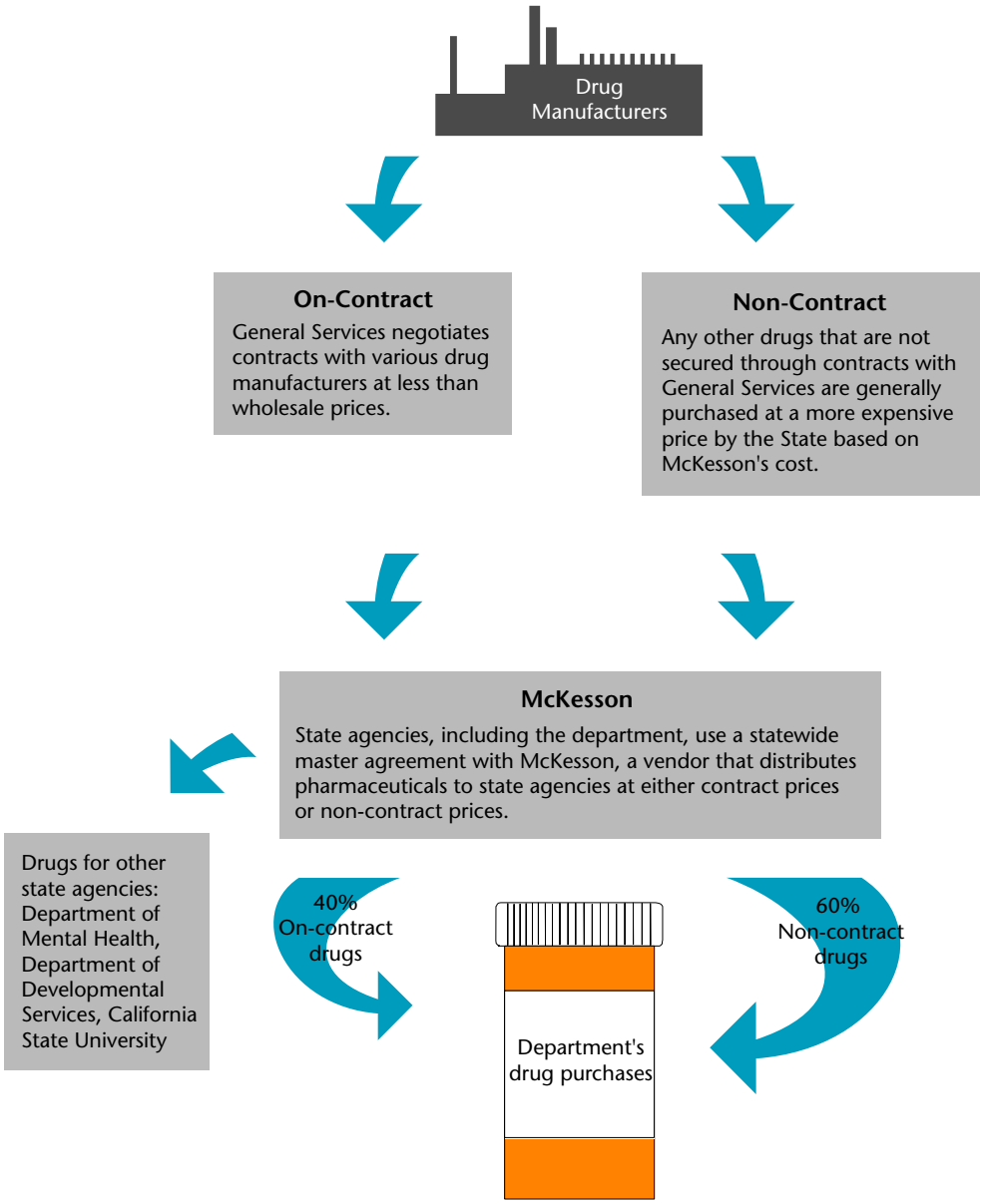
When the department has to purchase its drugs without benefit of negotiated contracts, as it often does, it generally pays higher prices.

The department has a statewide master agreement with McKesson Drug Company (McKesson), which also distributes pharmaceuticals to other participating state agencies. McKesson distributes some drugs that are purchased at less-than-wholesale prices through contracts the State's Department of General Services (General Services) has negotiated with various drug manufacturers. Currently, about 760 drug products[2] fit into this category. They are known as "on-contract" drugs. Any drug products not secured through this process generally are purchased at a higher price based on McKesson's cost, and are referred to as "non-contract" drugs. For the six-month period April through September 1999, net expenditures for on-contract drugs were $12.6 million, and net expenditures for non-contract drugs were more than $18 million, indicating that 60 percent of drugs were purchased without contracts. Figure 4 illustrates the department's process for purchasing on-contract or non-contract pharmaceuticals.

[2] We use the term "drug products" because some drugs are manufactured and packaged in various forms, such as caplets or tablets, dosages, or packages. For example, purchases in a 100-unit bottle of 100 milligram caplets or a 60-unit box of 50 milligram tablets represent two drug products.

FIGURE 4

The Process for Securing On-Contract and Non-Contract Drugs



The department clearly could save money if it purchased more drugs on-contract. During the six-month period represented, it spent $18 million on more than 6,000 non-contract drug products. Of these 6,000, only 150 accounted for more than $14 million, or nearly 80 percent of the $18 million. We estimate the department could save up to $2.6 million annually if it could purchase these 150 non-contract drug products on the same terms as it purchases the on-contract drugs. We calculated

this estimate by comparing the extent of the discount from average wholesale price obtained for the on-contract drugs to that of the non-contract drugs.

We recognize that the department might not be able to achieve the same savings on all drugs that it currently purchases without contracts. However, our findings indicate that the department could potentially save millions of dollars if it purchased more pharmaceuticals at contract prices. Attempts to obtain more drugs at contract prices would be focused most effectively on the 150 drug products that comprise nearly 80 percent of the non-contract purchases.

The department could save up to $2.6 million per year if it purchased 150 non-contract drug products on the same terms as it purchases on-contract drugs.

Although the master agreement process was designed to provide agencies competitive prices, the actual competition among drug manufacturers is limited. Under the current process, General Services invites the manufacturers to bid on the drugs agencies require. According to the department, past contracts have contained as many as 2,000 drug products. The latest two-year contract cycle, however, resulted in only 760 drug products even though General Services requested bids for 1,400. Other drug products must be purchased without contracts, either because General Services received no acceptable bids for them or manufacturers found the contract provisions too restrictive and did not bid.

It appears as though procurement process problems also have contributed to the low number of drug products under contract. We spoke to the General Services contract administrator, who said he is the only staff member assigned to obtaining contracts with the various drug manufacturers. He said time constraints kept him from negotiating more drug contracts. When potential contractors' bids did not comply with the State's usual terms and conditions, he said he did not have sufficient time to persuade bidders to modify their bids, and thus, could not award a contract to those bidders. He further told us that he was unable to dedicate his full attention to the drug contracts because he also has other contracting duties, such as responding to bid protests. Finally, according to the contract administrator, a supplemental bid for drug contracts should have occurred in April 1999 but did not because of problems with the McKesson contract. The contract administrator believes that the supplemental bid, which is expected to add up to 200 additional drug products to the 760 items currently on contract, will occur early in 2000.

It also appears as though a misunderstanding between staff at the department and at General Services has further limited competition. The department believes that state contracting statutes and regulations preclude it from obtaining more competitive prices because of certain restrictions. Specifically, the department believes that General Services cannot enter into contract negotiations on therapeutic drug classes in which drugs are clinically but not generically interchangeable. Examples of such drugs are those that have the same therapeutic purpose, such as relieving headache pain, but are made by different manufacturers. According to the department, the clinically interchangeable drugs cannot be bid competitively. When drug manufacturers are not required to compete against one another, they have no incentives to extend a price consideration to the State. In the private sector, it is common practice for manufacturers of brand name drugs to bid competitively for a therapeutic drug class and not on specific drugs.

Although it is common practice in the private sector, the department is not benefitting from having manufacturers of brand name drugs bid competitively for a therapeutic class of drugs.

However, our discussions with the contract administrator at General Services reveal that no such statutory or regulatory restrictions prohibit it from using an alternative contracting method designed to solicit more competitive bids for drugs within a therapeutic class. Nevertheless, the technique has not been actively pursued. The consequence of the department's current contracting process is that non-generic drugs are distributed to the department at a premium price because drug manufacturers have no incentives to reduce their prices.

The Department Should Pursue Other Procurement Methods

In addition to improving its contracting methods, the department could explore other ways to cut pharmacy costs. Our review found that other entities obtain more favorable prices for pharmaceuticals than does the department. One example is the State's Department of Health Services (Health Services), which purchases pharmaceuticals for recipients of the federal Medicaid program in California (Medi-Cal). The Medi-Cal program uses two techniques to obtain better prices. Initially, it negotiates directly with drug manufacturers when they want a specific drug added to the Medi-Cal list of contract drugs. Once it evaluates five criteria—the drug's cost, efficacy, safety, potential for misuse, and need, it negotiates directly with the manufacturers to obtain discounted prices. More importantly, the Medi-Cal program also periodically reviews all drugs within a therapeutic class and then includes on the Medi-Cal list only those with the highest therapeutic value at an acceptable cost. During this review, it reevaluates

each drug using the five criteria. According to Health Services, this review process creates competition because the drug manufacturers know that the review might result in a drug's removal from the Medi-Cal list.

The Medi-Cal program is not the only entity obtaining better prices for its pharmaceuticals. Various federal agencies are getting better prices through the federal supply schedule. Under this process, federal law requires manufacturers to provide drugs at a discount of at least 24 percent of the average manufacturer price. To estimate the savings available to the department if it were able to get a similar discount, we compared the department's prices for its 25 drugs with the highest expenditures to those of the federal supply schedule. These top 25 drugs account for more than 65 percent of the department's pharmaceutical expenditures from October 1998 through September 1999. If the department could have secured the same 25 drugs at the federal supply schedule price, it could have saved approximately $8.9 million in that 12-month period. See Appendix B for the analysis of savings using prices from the federal supply schedule.

If the department secured its top 25 drugs at the same prices paid by federal agencies, it could save $8.9 million annually.

The department also could save money on the remaining drugs that account for 35 percent of its pharmaceutical expenditures. The department stated it made past inquiries regarding whether it could participate in the federal supply schedule but did not actively pursue the issue. However, the savings we estimate illustrate the value of pursuing alternative procurement methods. The department should fully explore the possibility of participating in existing, more successful procurement processes. If this is not possible, it still could adopt successful techniques used in these processes.

THE DEPARTMENT DOES NOT EFFECTIVELY MONITOR PHYSICIANS' PRESCRIPTION PATTERNS AND PRACTICES

An outdated and inadequate data collection system presents obstacles for the department to achieve greater efficiency and effectiveness through assessing physicians' prescription practices at its various institutions. Further, the department has not updated its drug formulary in the past few years, although it is an important management tool that managed care organizations reevaluate on an ongoing basis.

The data collection system at each facility is outmoded to track basic patient prescription information such as the patient's name and inmate number, the dosage and quantity of the drug prescribed, drug interactions, and physician-prescribing information. The computers at each pharmacy are not linked in a network, nor are they directly connected to department headquarters, so the department cannot gather comprehensive information about physicians' prescription practices without requiring the institutions to gather most of the information manually, a cumbersome and time-consuming process.

Because the computers at each pharmacy are not linked to headquarters, the department cannot efficiently gather information about prescribing practices by physicians.

Additionally, the present data collection system is missing key components that would enable each pharmacy to run efficiently and effectively. Some missing components include updated drug interactions, automated price updates, inventory control, security controls against alteration of databases, and prescription histories. Further, the current data system lacks standardization in the data collected, resulting in inconsistent information. For example, some institutions do not include over-the-counter drugs in the data collected, while others do.

The department states that it is unable to compile data from its 33 institutions on any regular basis because its system is not automated and institutions have insufficient staff to collect and analyze the data. Managed care organizations have processes that allow for the efficient monitoring of prescription practices and even provide immediate information to physicians on the prices of the drugs they are prescribing. Unlike these organizations, the department is unable to use important information that would allow it to plan for effective purchasing and ensure that its physicians follow appropriate practices for prescribing medications. According to the department, McKesson, its pharmaceutical distributor, recently provided a system at headquarters that allows limited monitoring capability. However, that system apparently provides the department information only on purchases rather than uses.

The department states that it experiences further difficulties due to the many vacancies in its pharmacist positions. According to the department, it is unable to compensate these employees at market rates. We found, however, the department pharmacies are run much differently than community pharmacies are run. The department maintains a ratio of two pharmacists to each pharmacy assistant. Outside the department, the ratio is more typically the opposite: two assistants for every pharmacist. As a result, pharmacists must perform routine functions in addition

to their regular duties, much of which assistants could do at a lower cost. Improvements in automation and staffing realignments could allow pharmacists to take a more proactive role in monitoring prescription patterns, analyzing therapeutic drug classes, and educating physicians. For example, community hospitals and managed care organizations often include pharmacists on ward rounds to help ensure appropriate prescribing practices. Additionally, allowing pharmacists to focus on the more fulfilling aspects of their job could help the department recruit and retain pharmacy professionals.

The department believes that the pharmacists' bargaining unit needs to initiate action to increase pharmacists' compensation.

The department commented that it believes the pharmacists' bargaining unit must initiate action to increase pharmacists' compensation. Additionally, it told us that it has tried to increase the number of pharmacy assistants in all its pharmacies as a cost-efficient means to process an ever-rising prescription volume, but its requests for additional funding have mostly been unsuccessful. It further stated that most of its pharmacies would require expansion to accommodate more staff because of their limited workspace. Nevertheless, we believe the department should focus further attention on these issues.

The Department Should Update Its Drug Formulary

The department's ineffective data collection system is not its only problem. A well-managed health care operation would monitor prescription patterns as a basis for developing and updating its drug formulary, a listing of approved or preferred drugs that physicians and pharmacists are expected to follow. The department has not kept its formulary updated, thus limiting its effectiveness.

The department adopted a drug formulary process as a means of promoting appropriate and cost-effective use of pharmaceuticals. Its drug formulary provides physicians with a listing of drugs for use in treating patients as well as with dosing information, indicated precautions, restrictions, and cost indicators. The process calls for a drug formulary committee, an advisory group composed of physicians and pharmacists, to evaluate drugs for possible addition to or deletion from the drug formulary and to monitor and control drugs acquired outside the formulary.

An updated formulary, based on ongoing and effective monitoring of drug usage, is an important management tool. It establishes standardized and cost-effective drug-prescribing practices among institutions by identifying the most effective drugs, the best

combination of drugs under each circumstance, and the most desired drugs at an appropriate price. Deviations from the formulary should be controlled carefully.

However, the department is not using this management tool as intended. In fact, it has not updated its formulary in a few years. It states that it has not done so because it lacks physician and pharmacy staff to review therapies. An outdated listing forces physicians to prescribe so many purchases outside the formulary that the entire process is rendered less effective.

RECOMMENDATIONS

To improve the prices that it pays for its pharmaceutical purchases and to ensure that its institutions follow appropriate practices for prescribing drugs, the department should take the following actions:

- Ensure that its methods for procuring pharmaceuticals allow for the fullest amount of competition possible. To do this, it should identify obstacles that are limiting competition and take action to eliminate them. The department should work with General Services to ensure that as many items are placed on the contract as possible and that changes are made to the process to allow manufacturers to bid competitively to supply therapeutic drug classes when drugs are clinically interchangeable.

- Explore other procurement processes, including the federal supply schedule, that could save it more money. Work with legislative and administration leaders to fully explore its ability to participate in these processes. If such participation is not possible, the department still should revise its current contracting process to adopt techniques used in other, more successful, processes to allow for greater competition and higher savings.

- Identify conditions that are limiting its ability to collect and report data on its pharmaceutical operations and propose needed action so information can be readily accessible and used to increase efficiency and effectiveness.

- Ensure that its pharmaceutical operations are staffed properly by addressing conditions that have led to vacancies among its pharmacists. If the problem is unattractive compensation, the

department should pursue the means to improve it by working with the pharmacists' bargaining unit. Additionally, the department should consider whether it has the appropriate division of responsibilities between its pharmacists and pharmacy assistants and whether a realignment of staff is warranted. Finally, if the pharmacies lack sufficient workspace to operate properly, the department should identify its needs and take steps to obtain the additional space.

- Monitor and document drug usage, including physician prescription practices, periodically so that information regarding the most appropriate and cost-effective drugs is available when developing and updating the department's drug formulary. Further, the department should update its formulary regularly and use it to control which drugs can be prescribed routinely.

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

Respectfully submitted,

MARY P. NOBLE
Acting State Auditor

Date: January 25, 2000

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APPENDIX A

The Department's Level of Care for Diabetic Inmates Is Inconsistent and Does Not Always Comply With Nationally Recognized Guidelines

We reviewed the care received by a sample of inmates with diabetes and found inconsistencies among the California Department of Corrections' (department) institutions. Further, the department's level of care does not always comply with nationally recognized guidelines. Even though proper ambulatory care can substantially reduce hospitalizations for complications related to diabetes, the department's data reveal that inmates with diabetic complications comprise a significant number of inpatient days at department and community facilities, suggesting the care of diabetic inmates can be improved.

A widely used tool for quality audits in the health care environment is to select a sample of patient charts for review. Therefore, a physician who served as our medical expert reviewed a sample of charts for insulin-dependent inmates. He chose this condition because it is an ambulatory care sensitive condition,[3] which means that if appropriate ambulatory care, such as regular visits to the doctor for required health tests, is provided, hospitalization for diabetic complications could be reduced substantially. In the case of insulin-dependent diabetes, the American Diabetes Association has established well-developed, nationally recognized guidelines for care.

Our medical expert reviewed the charts of 20 male and 20 female insulin-dependent diabetics from two facilities: the California State Prison in Los Angeles County (a men's facility) and the Central California Women's Facility. In particular, he checked to see whether the patients underwent several monitoring tests that are widely recognized as guidelines for managing diabetes. These tests are for blood glucose levels over a period of

[3] Other ambulatory care sensitive conditions include asthma, iron deficiency anemia, bacterial pneumonia, and hypertension among others. There is no reason to believe that diabetes is managed any better or worse than any other ambulatory care sensitive conditions.

time and tests of the patients' eyes, urine, and cholesterol. In addition, the guidelines call for diabetics to have annual foot exams. The results of the analysis are shown in Table 8.

TABLE 8

The Department's Compliance With Guidelines for Care Established by the American Diabetes Association

Monitoring Test*	Recommended Frequency	Percentage of Male Inmates Receiving Test	Percentage of Female Inmates Receiving Test
Blood glucose test	At least twice a year	15%	95 %
Urine test	Annually	25	95
Retinal test	Annually	40	85
Cholesterol test	Annually	40	100
Foot exam	Annually	40	50

* If a test should be performed annually, we allowed for a three-month lag to permit the facilities to perform the test within 15 months of the last test or insulin start date. Additionally, we considered the department as having complied if it ordered a test to be given, regardless of whether evidence of test results existed.

Inconsistencies in Levels of Care Exist Among Institutions

Table 8 shows the percentages of diabetics who received the recommended monitoring tests. When comparing the percentages of male and female inmates who received the tests, we found significant inconsistency between the men's and women's facilities. For example, the guidelines call for blood glucose testing at least twice a year. Only 15 percent of the male inmates received the recommended frequency of blood glucose testing, while 95 percent of the female inmates received the recommended testing. Likewise, we see differences between the men's and women's facilities when comparing percentages of inmates who received the remaining tests.

Overall, more women received the tests than men did. This may be due in part to the court order the women's facility is under, resulting from lawsuits filed concerning the medical care received

at the facility. This data then leads us to believe that different levels of care can result from litigation, which may place more scrutiny on the care provided.

Our medical expert tried to interpret the charts as favorably as possible. For example, when charts went back for many years and the care appeared to have improved in recent years, he considered only the two most recent years of data. He also increased the allowed interval on annual tests to 15 months. Finally, he considered the department to have complied with the guidelines if it ordered the tests, regardless of whether he saw evidence of test results. Despite this, the results for the men's facilities were consistently well below the recommended guidelines.

We recognize that the compliance with these guidelines is not ideal even outside the department. Various recent studies of diabetes care in the general population do not provide definitive benchmarks that could be used to compare to the department. However, they do indicate that compliance with the recommended guidelines declines when diabetics are elderly or live in rural areas, suggesting that access to care may affect compliance.

The department states that it lacks the automated data collection systems that would allow it to identify all inmates with chronic medical conditions such as diabetes and provide appropriate follow-up with recognized standards. It further states that even if it were able to identify all cases requiring follow-up, it would be impossible to achieve complete compliance given the constraints of operating a health care delivery system in a correctional environment. The department cites inmate transfers, institutional lockdowns, and restrictive housing settings as posing limitations that disrupt patient follow-up.

Nevertheless, we believe the department can improve its care. The high level of care we found for female diabetic inmates is evidence that the standard can be met in the prison environment. Certain institutions may have more lockdowns and other security restrictions than others, but such disruptions should merely delay—not prevent—the department from providing inmates with the ongoing care needed to avoid diabetic complications.

Finally, our medical consultant analyzed data indicating that inmates are being admitted into department or community facilities for complications of diabetes. In fiscal year 1997-98,

343 patients spent 4,921 inpatient days in facilities for complications of diabetes, while in fiscal year 1998-99, 375 patients spent 3,436 days. These relatively high figures, coupled with the low percentages of compliance with recommended guidelines for male diabetic inmates, suggest that the department could reduce the number of inpatient days, and their associated costs, if it improved its care for diabetic patients.

APPENDIX B

A Comparison of the Prices Paid for the Department's Top 25 Drugs

The following is an analysis of the prices the department paid for its 25 drugs with highest expenditures compared with those paid by entities participating in the federal supply schedule (FSS) for the 12-month period ending September 1999. In total, these 25 drugs account for more than 65 percent of the department's pharmaceutical expenditures. In the table below, we estimated potential savings for each drug by taking the percentage difference between the weighted unit costs for the department and FSS and multiplied the result by the total net cost. Based on this calculation, if the department were able to secure the same 25 drugs at the FSS price, it could save as much as $8.9 million.

Rank	Brand Name	Net Costs	Department's Weighted Unit Costs	FSS Weighted Unit Costs	Savings Using FSS	Therapeutic Class
1	Zyprexa	$7,623,865	$ 499.72	$447.21	$ 801,107	Antipsychotic Agents
2	Risperdal	3,423,863	778.99	496.93	1,239,727	Antipsychotic Agents
3	Viracept	2,572,214	488.36	345.88	750,449	Antiretroviral Agents
4	Prozac	2,306,258	829.43	707.99	337,668	Antidepressants
5	Epivir	1,852,876	213.27	202.39	94,525	Antiretroviral Agents
6	Combivir	1,797,488	719.70	681.68	94,957	Antiretroviral Agents
7	Zerit	1,783,856	225.01	139.33	679,262	Antiretroviral Agents
8	Depakote	1,601,839	241.32	138.28	683,961	Miscellaneous Anticonvulsants
9	Zoloft	1,395,381	428.96	297.08	428,998	Antidepressants
10	Prilosec	1,396,129	1,448.98	844.18	582,740	Miscellaneous GI Drugs
11	Paxil	1,212,499	162.62	104.28	434,985	Antidepressants
12	Vasotec	1,021,617	301.43	226.59	253,650	Cardiac Drugs
13	Crixivan	883,196	307.31	225.28	235,751	Antiretroviral Agents
14	Fortovase	878,299	163.56	160.82	14,713	Antiretroviral Agents
15	Intron A	738,647	108.11	71.50	250,133	Antineoplastic Agents
16	Adalat CC	686,488	215.64	86.16	412,198	Cardiac Drugs
17	Rebetron	652,729	586.41	435.82	167,621	Antivirals
18	Diflucan	635,299	662.77	470.74	184,071	Antifungal Antibiotics
19	BuSpar	581,322	260.51	164.73	213,731	Misc. Anxiolytics and Sedatives
20	Dilantin Kapseals	558,659	115.54	69.78	221,259	Hydantoins
21	Neurontin	537,136	66.73	46.22	165,093	Miscellaneous Anticonvulsants
22	Viramune	518,533	367.25	258.05	154,183	Antiretroviral Agents
23	Cipro	478,333	294.02	171.77	198,885	Quinolones
24	Mevacor	454,859	250.91	175.41	136,869	Antilipemic Agents
25	Sustiva	450,804	328.19	245.35	113,790	Antiretroviral Agents
Total savings on top 25 drugs					**$ 8,850,326**	

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Agency's comments provided as text only.

Memorandum

California Department of Corrections
C.A. Terhune
Director
1515 S Street
Sacramento, California 95814

Date: January 13, 2000

To: Mary P. Noble
State Auditor (A)
Bureau of State Audits

Subject: **RESPONSE TO BUREAU OF STATE AUDITS' REPORT ON "CALIFORNIA DEPARTMENT OF CORRECTIONS: UTILIZING MANAGED CARE PRACTICES COULD ENSURE MORE COST-EFFECTIVE AND STANDARDIZED HEALTH CARE"**

This memorandum serves as the California Department of Corrections (CDC) Health Care Services Division (HCSD) response to the issues identified in the recent Bureau of State Audits report concerning the delivery of medical services in the CDC. The Bureau was charged in the 1999/2000 Budget Act with auditing four aspects of CDC health care delivery to determine "whether the department appropriately and effectively manages its medical operations."

The CDC is pleased to note that the Bureau of State Audits' review of one of the key areas it was charged with auditing, HCSD's procurement and contracting processes, noted no irregularities.

I appreciate the opportunity to respond to the issues identified by your audit team. If you have any questions, please contact Susann J. Steinberg, M.D., Deputy Director, Health Care Services Division, at (916) 323-0229, or E. A. Mitchell, Assistant Director, Office of Compliance, at (916) 358-2494.

(Signed by: C. A. Terhune)

C. A. TERHUNE
Director
Department of Corrections

This serves as the California Department of Corrections (CDC), Health Care Services Division (HCSD) response to the issues identified in the recent Bureau of State Audits report concerning the delivery of medical services in the CDC. The Bureau was charged in the 1999/2000 Budget Act with investigating four aspects of CDC health care delivery to determine "whether the department appropriately and effectively manages its medical operations."

The CDC is pleased to note that the Bureau of State Audits' review of HCSD's procurement and contracting processes noted no irregularities. The response is organized around the recommendations as listed at the end of the Report's two chapters and some of the associated findings. The following provides our response to the recommendations and respective implementation activities in those areas of concern.

CHAPTER 1

Recommendation: "To improve the management of its health care operations and better employ the management practices used by managed care organizations, the department should take the following actions:

"Report to the legislature on its progress in adopting managed care techniques and the specific barriers that preclude it from operating more effectively in a managed care environment. The report should identify any resources, including staff, needed to develop the infrastructure necessary to collect and analyze data that will allow it to comprehensively and systematically review its medical operations. When identifying any resources needed, the department should report to what extent costs can be reduced because of a more efficient environment. In the meantime, it should perform proactive reviews of its medical operations to the extent possible."

The Department recognizes the adoption of managed care techniques as one means of improving the management of health care operations. We note, however, the difficulties that both the state structure and the correctional environment pose to fully functioning under that model. As one example, the managed care programs in the community are relatively free to operate in an autonomous fashion and can implement changes quickly which readily will produce cost savings. In contrast, the CDC must operate under personnel and contract requirements imposed on state agencies, and must obtain resources through a state budget process that has an inherent lag of more than a year between initial requests for funding and the realization of those resources. Even redirection or reallocation of resources often require concurrence of control agencies outside the Department and Agency.

Another crucial system problem which the HCSD faces is that health care is not the primary mission of the Department, as it is for managed health care organizations. In delivering health care in the correctional environment, it is unavoidable that custodial requirements will impinge upon the health care delivery system. For example, whereas a

patient in the community with a casted arm or leg may be instructed to go home and rest, a high security inmate with a casted arm or leg may not be permitted to return to his cell due to concerns over the safety of the inmate, staff, or other inmates. In addition, private managed care providers subscribe a healthier clientele than CDC does; and CDC cannot refuse to cover inmates due to pre-existing health conditions or inmates' previous life style choices that have had a detrimental impact on their health care.

The CDC believes the Auditor recognizes the difficulty in comparing prison health care to that in the community. Recognizing these differences between the correctional health care environment and the community managed care environment, CDC is nonetheless committed to not only looking at managed care principles but other types of cost management systems and practices that would be most appropriate in a correctional health care setting. The Federal Court has traditionally looked to community standards of care, not managed care principles, in defining quality level of care.

Recognizing the issues surrounding the delivery of quality level of care, the Governor has taken proactive steps to fund key initiatives which support the assessment and provision of quality health care to the inmate population. These initiatives are funded in the Governor's Budget and are summarized below. In total, the Governor's Budget proposes 110 positions and nearly $7 million for FY 2000/01 to implement these initiatives which incorporate evaluative and cost containment components in the health care services delivery system:

- Hire a contractor, knowledgeable about application of quality management principles in the correctional environment, to establish a framework for evaluation of the CDC inmate medical delivery system.
- Establish a Quality Management Assessment Team within the HCSD to evaluate, on an institution-by-institution basis, the quality of medical care delivered at all CDC institutions.
- Evaluate inmate appeals related to health care issues, in part because these appeals may serve to warn of potential access and quality problems.
- Begin an institution-by-institution assessment of medical services and develop a plan, including implementation steps, for necessary changes for institutions to provide appropriate medical care.
- Extend improvements in medical care, resulting from recent class-action litigation, to all institutions housing female inmates.
- Add additional Utilization Management (UM) staff at hospital institutions and create a centralized UM system.

The CDC has adopted many of the UM principles found in the private managed care environment. The mission of the Department's UM program is to ensure CDC provides quality standard medical services in the most cost effective manner. The UM program primarily focuses on determining whether requested services are necessary, reducing the length of inmates' community hospital stays, and reviewing hospital invoices to avoid

overpayments. Furthermore, CDC does apply a conservative treatment standard based on the adopted Medical Standards of Care, which incorporates both medical necessity and medically proven beneficial outcomes. UM reviews access to care for cost effectiveness and proper level of care, both prospectively and concurrently. Cost containment is also a program objective, and training provided for UM staff has included significant segments on cost containment. Additionally, the UM Program Guidelines were revised in 1999. CDC UM is making efforts to develop a systematic data collection program through a standard UM database.

Information systems are essential to effective management of health care organizations. The Department continues to be committed to building upon its existing management information systems to ensure reliable information for operational and patient needs. The HCSD's Health Care Cost and Utilization Program represents one of the essential building blocks for an evolving and ultimately comprehensive information system.

(1)* Because the CDC intends to perform an institution-by-institution evaluation of its medical services, it may be premature to "report to the Legislature on its progress in adopting managed care techniques". Rather, it believes that implementing the activities proposed in the Governor's Budget will enable it to incorporate cost management techniques, which may or may not mirror managed care, in the delivery system and improve the quality of care provided.

<u>Recommendation</u>: "Ensure that each facility operates in an optimal manner by periodically reviewing key operating data, such as costs and lengths of stay, for each facility, and investigate data that appears unusual or inconsistent. Further it should take appropriate steps to minimize unnecessary costs and then verify that the corrective action resulted in the desired change. Such reviews should be limited to those where the potential savings can reasonably be expected to exceed the evaluation costs."

The Department does take steps to minimize unnecessary costs and to verify the results of corrective actions. The Department conducts routine monthly fiscal reviews of each institution's health care actual and projected expenditures to identify and understand deviations from budgeted expenditures. The data collection system addressed in the context of the prior recommendation is an essential first step toward developing the administrative tools to maximize this review. In the interim, CDC is developing a comprehensive review tool to assist in evaluating institutional standardization that will likely minimize costs and increase standard quality of care. The Governor's Budget includes resources to increase UM staff and continue training, ensuring statewide standardization of the UM Program, quality medical care and ability to plan for statistical data outcome review.

The Auditor's report notes from review of operational data, such as cost per inmate for nursing and cost per inmate for total medical care, that there is a significant variation between institutions. Some of the variation for the cost per inmate directly relates to the

*California State Auditor's comments on this response are on page 65.

health care mission of each institution, location, and available community resources including medical staff available to hire. Additionally, institutions may be designated as medical "hubs" or referral centers for the costly, specialized treatment of diseases such as HIV.

The report also notes that the number of hospital days required for similar conditions vary. Many factors influence the placement of sick inmates including available resources within CDC, custody levels and costs of transportation and/or guarding as well as security concerns. Additionally, discharge placement availability affects the length of stay at any facility. An inmate may be retained in an in-house medical bed, for security reasons, for a condition (such as a casted leg or a wired jaw) that would be discharged to home bed rest in the community. The length of stay may continue to be inconsistent while Correctional Treatment Center (CTC) construction continues. It should be noted that, although the number of CDC admissions to community facilities may have increased, the length of community stays have decreased since the inception of UM through thorough, consistent concurrent review.

In its introductory statements, the report notes that California's correctional system is "...among the biggest spenders in the nation, spending $2,770 per inmate on medical care..." as compared to a nationwide average of $2,386 per inmate for medical care. Using these costs and the corresponding total per inmate costs, California's health care cost (the cited costs include mental health expenditure as well medical and dental costs) amounts to 12.5 percent of total inmate costs, not substantially different than the national average of 11.9 percent. CDC's cost is considerably less than the $3,540 per inmate spent on health care in the federal prison system. As noted in the report, the mental health coverage provided to CDC inmates exceeds (due to litigation) that provided to inmates in virtually all other states. This mental health coverage contributes to the higher than average costs, as does the generally higher cost of living in California. In addition, this $2,770 expenditure on inmate health care is conservative when compared to the $5,100 subscriber fee that the State and a single state employee spend annually for medical (Kaiser), dental (Delta), and vision care.

<u>Recommendation</u>: "Identify the specific areas where the level of medical care, such as chronic care services, differ because of litigation or other reasons. If differences exist, it should determine the additional resources, including staff necessary to remedy any inconsistencies and seek appropriate budgetary changes to ensure a consistent level of care at each facility to the extent possible."

The CDC has recognized that, due to institution-specific class action litigation, there is a discrepancy in the medical services available between some institutions. Governor Davis' FY 2000/2001 Budget includes an initiative to assess the medical services in place in each institution and develop an institution by institution plan for medical care improvements. Individual variance, depending on the institutional and health care missions, will be included in the assessment.

Establishment of a Quality Management Assessment Team (hereafter "team") is proposed in the Governor's Budget. The proposed team would be made up of physician and nurse consultants and conduct regular quality reviews of health care programs at all institutions, including access to care, the quality of care, continuity and follow-up care. The team will recommend solutions to CDC and institution management and oversee implementation of the recommendations. A contractor, knowledgeable about quality management in a correctional environment, will assist in developing the tools which the team will use in their evaluations. Under another aspect of this initiative, staff will evaluate inmate appeals related to health care issues, in part because these appeals may serve as an "early warning" of access and quality problems. Another part of the initiative contained in the Governor's Budget will be an assessment of health care/custody interface issues which impact the access to delivery of health care. The Budget also includes funding to perpetuate programs put in place at two female institutions under litigation and extend them to the other institutions housing female inmates.

Recommendation: "Work with the Department of Health Services to ensure that all CTCs become licensed and that the department is providing only the level of care appropriate for an unlicensed facility in those not yet licensed."

The CDC has made the Department of Health Services (DHS) aware of its plan regarding the development and licensure of CTCs. In particular, they are aware of our need to obtain capital outlay funding to renovate existing CDC health care facilities to meet health facility licensing requirements. Two CTCs have been licensed and CDC has submitted applications for licensure of another three CTCs, with licensing inspections expected during the next ninety days. Renovations have recently been completed at another four institutions and applications will be made for licensure of these facilities shortly. Capital outlay funding for four of the remaining seven CTC sites was requested in the Governor's FY 1999/2000 Budget and the other three are included in the Governor's FY 2000/2001 Budget. However, action by the Legislature reduced funding for three of the projects in the FY 1999/2000 Budget and the cuts to one of those projects was so substantial that it has been resubmitted in the FY 2000/2001 Budget. Delays in the renovation process will extended the schedule for licensure of this last group of seven facilities. CDC will continue to work with DHS towards licensure of all of the remaining planned CTCs as physical renovations are completed. Even with the delays in licensure, CDC remains the only entity in California that has successfully licensed CTCs.

The CDC contends that all inmate-patients housed in the facilities that are not yet licensed receive the appropriate care based on patient needs as related to staffing and medical care. Renovations required for CTC licensure primarily impact support services, such as medical records, pharmacy, and dietary services. Inmates requiring hospital level of treatment are transferred to community or CDC hospitals.

Recommendation: "Take appropriate steps to reduce overtime payments for medical technical assistants (MTAs). It should identify specific MTA posts that,

on a temporary basis, could be left vacant, or could be filled by other qualified personnel, and seek appropriate agreements with the MTAs' bargaining unit.

The HCSD is taking steps to reduce all overtime and has successfully reduced MTA overtime from $6.9 million in FY 1997/1998 to $6.3 million in FY 1998/1999. This was done despite adding additional inmates and an increasing shortage of MTA staff available to the Department. The effort to reduce overtime will continue through the proposed centralized hiring of MTAs and an augmentation in the Governor's Budget for the MTA recruitment program. The Department has worked with the bargaining units to reach agreement to use Registered Nurses (RNs) in a voluntary basis to perform medical tasks associated with MTA vacant posts. In addition, the Department will continue to implement evaluation of critical and non-critical post coverage for MTAs and RNs and to hire permanent intermittent MTA and RN employees, when available. Institution Health Care Managers also will closely monitor excessive sick leave usage consistent with the bargaining unit agreements. They will also continue to work aggressively with Return to Work Coordinators to reduce the amount of Non-industrial disability and Industrial disability time for employees.

There are numerous factors that contribute to seemingly higher levels of overtime for MTAs and for RNs that are not mentioned in the Auditor's report. In addition to MTAs being posted positions, there are several other factors contributing to high overtime use by MTAs. MTAs and RNs are the only health care employees who work in posts that require 24 hour, 7 day a week, 365 days a year direct patient care. Direct patient care cannot be unstaffed without serious medical and legal consequences. There are no contract alternatives available for MTAs as Licensed Vocational Nurses in the community are not peace officers and bargaining unit agreements do not allow use of contract labor. Registries are used, in addition to overtime, to fill behind RN vacancies. Using RNs in place of MTAs violates state rules and collective bargaining agreements that prohibit out of class work related to the MTA's peace officer duties. There is a chronic vacancy rate of about 9 percent for the MTA classification statewide. Each MTA hired must attend a two week basic academy training for correctional officers that is not considered in relief factors. Each MTA receives 24 hours a year in continuing education leave that has no relief factor recognized. This alone amounts to 21,864 hours of overtime for the 910 MTAs currently employed.

<u>Recommendation</u>: "Discontinue its policy that requires inmates pay for a portion of health care visits because the department has not demonstrated that this co-payment program is cost-effective."

The policy requiring inmates to pay for a portion of health care visits (co-payment program) was initiated by the Legislature as urgency legislation in 1994. Discontinuation of this program would require a General Fund allocation to offset lost revenue and would require modification of regulations. (2)

CHAPTER 2

Recommendation: "To improve the prices that it pays for its pharmaceutical purchases and to ensure that its institutions follow appropriate practices for prescribing drugs, the department should take the following actions:

"Ensure that its methods for procuring pharmaceuticals allow for the fullest amount of competition possible. To do this, it should identify those obstacles that are limiting competition in its current process and take actions to eliminate them. The department should work with the department of general services to ensure that as many items are placed on the contract as possible and that changes made to the process to allow manufacturers to bid competitively to supply therapeutic drug classes where drugs are clinically interchangeable."

Any effort to improve the current contract process must involve a concerted effort by the CDC and the Department of General Services (DGS), as well as the Departments of Mental Health (DMH), Developmental Services (DDS), the California Youth Authority (CYA), the California State University System (CSU) and several small State users of the pharmaceutical contract. CDC welcomes the opportunity to work with the DGS and the other departments in effecting changes to improve the statewide pharmaceuticals contract process.

The CDC's total drug expenditures are just part of the entire picture used by the DGS to solicit bids from pharmaceutical manufacturers and wholesale distributors. Not all drug manufacturers will bid on pharmaceuticals. The contract awarded by the DGS included approximately 50 percent of the items sent out to bid. As a result, all agencies using the contract must purchase half of their necessary pharmaceuticals off contract.

The CDC will continue to work with the DGS, DMH, DDS, and other participating agencies to identify those barriers, either procedural or regulatory that impact the cost-effectiveness of the contract.

Recommendation: "Explore other procurement processes, including the Federal Supply Schedule, that could save it more money. Work with legislative and administrative leaders to fully explore its ability to participate in these processes. If such participation is not possible, the department should still revise its current contracting process to adopt techniques used in other, more successful processes to allow for greater competition and higher savings."

The Auditor's report cites two entities that have negotiated better prices or developed better ways to reduce pharmaceutical costs, Medi-Cal and the Federal Supply Schedule (FSS). CDC will investigate the feasibility of participating in the FSS and the possibility of participating in the system used by the DHS in purchasing drugs for Medi-Cal.

However, Medi-Cal drug contracting procedures are complex and totally removed from the rules and regulations that guide the DGS pharmaceutical contract manager. Even with their large volume and purchasing power, the Medi-Cal system does not obtain the degree of savings of the FSS. In addition, the total dollar amount of both the Medi-Cal and FSS contract dwarfs the CDC's pharmaceutical expenditures. For example, Medi-Cal drug purchases were $1.7 billion in FY 1998/99; the CDC drug purchases were $51 million (or 3 percent of the Medi-Cal volume) for the same time period. Since CDC would not be able to guarantee similar dollar volumes of sales, it is unrealistic to assume that CDC could achieve the same discounts if it were to contract on its own.

The report indicates "Federal law requires manufacturers to provide drugs at discount of at least 24 percent of the average manufacturer price" for federal purchasers. There currently is no State law in place that would guarantee the same or similar reductions in contracted drug prices. With such a law, it might be possible for the State to obtain medications at the same as or close to Federal prices.

California's Medi-Cal program and various federal agencies have made significant strides in the pharmaceutical contract process over the last decade. To achieve this, both entities have a substantial number of staff pharmacists and other staff whose primary function is to negotiate better prices and contracts. Medi-Cal has a significant number of pharmacists whose only job is to pursue contract drug prices and issues. CDC is not presently staffed for this function.

In the event that neither the FSS nor the Medi-Cal system is available to the CDC, the Department will continue to explore other aggressive pharmaceuticals contracting options.

Recommendation: "Identify those conditions that are limiting the ability to collect and report data on its pharmaceutical operations and propose needed action so that information can be readily accessible and used to increase efficiency and effectiveness."

The Department is analyzing options to improve the data collection system for monitoring drug use patterns and physician prescribing patterns within the prison system. The current pharmacy software used by CDC pharmacy departments was developed over 15 years ago and is a DOS-based system. Although it met needs at that time, when the CDC population was less than half of what it is today, the program is no longer able to provide the level of sophisticated information that the Department requires to efficiently and effectively manage a large population, more extensive health care needs within the prisons, and more frequent transfers of inmates within and between institutions.

The Department has convened task forces to look at the issue of improving pharmaceutical services (pharmaceutical care) within the prison system. One group is looking at the issue of automation support in the form of contemporary pharmacy software. This software would, at a minimum address concerns brought out by the Auditor's report and by internal reviews of CDC pharmacy operations.

Another task force is evaluating options for automated equipment that would improve CDC's drug dispensing, administration and utilization monitoring and controls. This equipment should be flexible and expandable to allow for changing trends in the automated delivery of pharmaceuticals.

The Department is also currently putting in place an emergency contract for pharmaceutical services. As part of this contract, the contractor will be asked to evaluate the efficiency of CDC's pharmacy dispensing services.

Recommendation: "Ensure that its pharmaceutical operations are properly staffed by addressing conditions that have led to vacancies among its pharmacists. If the problem is unattractive compensation, the department should pursue means to improve it by working with the pharmacists bargaining unit. Additionally the department should consider whether it has the appropriate division of responsibilities between its pharmacists and pharmacy assistants and whether a realignment of staff is warranted. Finally, if the pharmacies lack sufficient workspace to operate properly, the department should identify its needs and take steps to obtain the additional space."

A significantly higher compensation for pharmacists in the community has prevented CDC from competing in the marketplace. The CDC and other State agencies have experienced difficulty in retaining and recruiting pharmacists. The most recent union contract for state pharmacists included a 9 percent salary increase, yet the pharmacist vacancy rate for CDC is still approximately 25 percent, with some pharmacies over 50 percent. CDC cannot unilaterally adjust pharmacist salary levels.

Pharmacy licensure requires a pharmacist-in-charge as well as a working pharmacist who oversees the pharmacy technicians. As it explores the need for additional pharmacy staffing, the Department will move toward use of more pharmacy technicians, in keeping with the community standard. However, the combination of licensing requirements and space constraints may preclude CDC's reaching the full two-to-one model.

The Department is putting in place an emergency contract for pharmaceutical services. It provides for on-going pharmacy services to fill routine prescriptions in institutions with significant (e.g., 50 percent or more) pharmacist vacancies.

The space originally provided for pharmacies in the older institutions was based on the services required a number of years ago. The number of prescriptions filled and the

number of working pharmacy professionals per institution were considerably less than today. As with automation, system needs have outgrown the original design. An assessment of pharmacy workspace is needed to identify fully the needs and options for providing adequate workspace. Alternate methods to provide space, including modular pharmacies and service area pharmacies will be explored.

<u>Recommendation</u>: "Monitor and document drug usage, including physician prescription practices, periodically so that information regarding the most appropriate and cost-effective drugs is available when developing and updating the department's drug formulary. Further the department should update its formulary regularly and use it to control which drugs can be prescribed routinely."

The Department is currently putting in place an emergency contract for pharmaceutical services. It provides for on-going pharmacy services to fill routine prescriptions in institutions with significant (e.g., 50 percent or more) pharmacist vacancies. The contractor will also be asked to evaluate the efficiency of pharmacy dispensing services and physician prescription practices, provide updating of the formulary, and track non-formulary usage by physician and institution.

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COMMENTS

California State Auditor's Comments on the Response From the California Department of Corrections

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

(1) The department indicates that it may be premature to report to the Legislature on its progress in adopting managed care techniques because it intends to perform an evaluation of each institution's medical services. Although it may require some time to perform such an evaluation, we believe that by January 15, 2001, the department should submit an initial report to the Legislature. Reporting by that date would allow the department to comment on its progress as well as any planned actions proposed in the governor's budget for fiscal year 2001-02. Additionally, the department should report annually to the Legislature on its progress until it has completed its adoption of managed care techniques.

(2) The department states that the policy requiring inmates to pay for a portion of health care visits was initiated by the Legislature. However, the legislation authorized, but did not require, the department to implement the policy. Thus, we believe that the department could discontinue the co-payment program without legislative action.

Additionally, as discussed in our report, the department estimated in 1993 that its annual administrative costs for the co-payment program would total $3.2 million. Therefore, it appears that the department should realize some cost savings to offset the loss of revenues that have recently averaged $654,000 annually.

cc: Members of the Legislature
Office of the Lieutenant Governor
Attorney General
State Controller
Legislative Analyst
Assembly Office of Research
Senate Office of Research
Assembly Majority/Minority Consultants
Senate Majority/Minority Consultants
Capitol Press Corps