IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF CALIFORNIA

MARCIANO PLATA , et al., Plaintiffs v. ARNOLD SCHWARZENEGGER, et al., Defendants,	NO. C01-1351-T.E.H. **APPENDIX OF EXHIBITS IN SUPPORT OF THE RECEIVER'S SECOND BI-MONTHLY REPORT**

APPENDIX OF EXHIBITS

Exhibit #'s

1. July 24, 2006 Letter to Governor Schwarzenegger from Receiver Robert Sillen.
2. August 2006 State Controller's Review Report re CDCR Healthcare Delivery System.
3. August 25, 2006 Letter to State Controller Steve Westly from Receiver Robert Sillen.
4. July 27, 2006 Letter to Receiver Robert Sillen from Molly Arnold, Chief Counsel, Department of Finance.
5. July 26, 2006 DCHCS Effective Medical Services Contract Process Project Team Report.
6. September 7, 2006 California Prison Health Care Receivership Request for Proposal for Health Care Contracts Document Management System Integrator.
7. August 18, 2006 California Prison Health Care Receivership Request for Proposal for the Improvement and Management of the CDCR Adult Prison Pharmacy System.
8. August 11, 2006 letter to Todd Jerue, Program Budget Manager, Department of Finance from Jared Goldman, Receiver's Staff Attorney.
9. California Prison Health Care Receivership Corp. Statement of Expenses.
10. August 29, 2006 California Prison System Assessment of Organizational Structures.

EXHIBIT 1

California Prison Health Care Receivership
Office of the Receiver

July 24, 2006

Governor Arnold Schwarzenegger
State of California
State Capitol Building
Sacramento, CA 95814

Assemblymember Fabian Nuñez
Speaker of the Assembly
State Capitol
P.O. Box 942849
Sacramento, CA 94249-0046

Senator Don Perata
Senate President pro Tem
State Capitol, Suite 205
Sacramento, CA 95814

Dear Governor Schwarzenegger, Assemblymember Nuñez and Senator Perata:

This is to provide some additional perspective for the upcoming Special Session of the Legislature called for by the Governor in recognition of the crisis in the California prison system.

As you are aware, Judge Henderson took the drastic action of placing the medical care system under a Federal Receivership after years of well-documented State neglect of the medical needs of its inmate population. The medical crisis, however, is, in part, a byproduct of the growing overpopulation problem in California's prisons. It cannot be fully resolved until appropriate corrective action is applied to both of these problems in a thoughtful, coordinated manner. In short, the overcrowding and medical crises are integrally related. I believe that the Special Session, if used effectively, presents an opportunity to make headway on both crises and maximizes the impact of the tremendous tax dollars involved. In this spirit, I offer the following points.

1. It will not be possible to raise access to, and quality of, medical care to constitutional levels with overpopulation at its current levels. Other key issues contributing to the medical crisis include staffing for healthcare and custody functions, instability in the leadership of CDCR down through, at least, the warden

level, and the decrepit physical condition of many of the California prisons. The extreme overcrowding of the system, however, makes the challenge of providing constitutionally adequate medical care dramatically more difficult.

2. While I do not believe that the State can realistically "build its way" out of the chronic overcrowding crisis, new major construction must be a component of mitigating the current acute crisis. Maximizing taxpayer benefit from such projects, however, demands "smart" programming for any new construction. Conventional programming wherein conventional prisons are built (with traditional medical and mental health "components" allocated within each) has failed in the past and will certainly fail again, if pursued.

3. Initial data indicates that the "smart" use of $1 billion ($2 billion including finance costs) would be to construct two multi-purpose medical/mental health facilities rather than two conventional prisons. By so doing, inmate/patients may be appropriately placed by disease category (e.g., acute care, long-term care/skilled nursing care, chronic care, care for the seriously mentally ill, crisis care for the mentally ill, hospice and palliative care, "home" care and assisted living care) and custody/security levels to create a system of care which is sadly missing today. The current waste of taxpayer money resulting from duplicative service locations in so many prisons across the State is enormous and is a significant barrier to providing cost effective, constitutional care. I can assure you that this is the approach the Receivership will have to take in any case in the very near future and would involve, most likely, taxpayer dollars similar to that being proposed for the Special Session. I would suggest that amount can be spent only once, rather than twice, in the described "smart" manner.

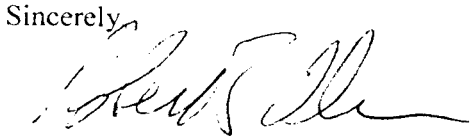
4. The State would achieve the same benefit with respect to prison overcrowding under the aforementioned scenario (#3) as it would under the current proposal to construct two conventional prisons because moving ill inmates into the new medical facilities will free up the same number of inmate beds that would have been made available by building new conventional prisons. Thus, by engaging in "smart programming," the State can simultaneously accomplish its dual goals of reducing overcrowding and improving the delivery of medical, mental health and dental care – and make a tremendous stride forward toward the ultimate return of the medical care system to the State.

5. Whatever construction is be accomplished, the location is critical. Any new facility should be situated in, or immediately adjacent to, major urban areas. The reality in California today is a tremendous shortage of qualified healthcare personnel (physicians, nurses, technologists, therapists, etc.) and severe competition for them. Locating new facilities in rural areas would only exacerbate the nearly impossible-to-solve (and quite expensive) dilemma of recruiting and retaining highly trained, competent, healthcare staff.

I am prepared to discuss these issues with you further should you so desire and to participate in any way that we see as mutually acceptable during the Special Session.

In time, a constitutionally adequate medical care system will be created by the Receivership. The Special Session is, potentially, a significant step toward a cooperative, collaborative relationship which will maximize the use of large sums of taxpayer dollars, mitigate some of the current waste and inefficiencies in the State prison system, and result in an approach which has a beneficial impact on both prison overcrowding as well as raising access to and quality of medical care to constitutional levels.

Sincerely,



Robert Sillen
Receiver

EXHIBIT 2

CALIFORNIA DEPARTMENT OF CORRECTIONS AND REHABILITATION

Review Report

HEALTHCARE DELIVERY SYSTEM

STEVE WESTLY
California State Controller

August 2006

STEVE WESTLY
California State Controller

August 2, 2006

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

Dear Mr. Sillen:

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

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

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

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

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

Sincerely,

/s/

STEVE WESTLY
State Controller

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

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Review Report

Summary of Findings

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

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

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

Following is a summary of the SCO's findings.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Introduction

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

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

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

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

Overview of the CDCR's Inmate Healthcare Delivery System

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

Review Scope and Methodology

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

The SCO performed the following procedures.

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

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

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

Analysis of the CDCR's Inmate Healthcare Expenditures

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

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

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

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

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

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

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

Findings

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

CONTRACT MANAGEMENT

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

FINDING 2—CDCR's contract negotiation process is deficient

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

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

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

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

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

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

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

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

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

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

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

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

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

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

FINDING 4—Opportunity for significant State savings delayed for years

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

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

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

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

Following is a chronology of events relative to this issue.

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

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

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

UTILIZATION MANAGEMENT

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

FINDING 5—Need for outside hospital services increased

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

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

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

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

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

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

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

FINDING 6—CDCR's utilization management process is ineffective

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

INTERNAL CONTROL OVER PAYMENTS

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

The HCCUP analysts' specific duties include:

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

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

FINDING 8—State prisons' internal control is ineffective

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Recommendations

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

Recommendation 1

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

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

Recommendation 2

Improve the CDCR's contract management system by:

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

Recommendation 3

Improve the utilization management (UM) process by:

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

Recommendation 4

Strengthen internal control over payment by:

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

Appendix A—
Comparison of Healthcare Budget and Expenditures

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

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

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

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

Appendix B—
Comparison of Expenditures for Contracted Services

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

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

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

Source: CDCR accounting records

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

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

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

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

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

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

Appendix D—
List of Acronyms

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

State Controller's Office
Division of Audits
Post Office Box 942850
Sacramento, California 94250-5874

http://www.sco.ca.gov

S06-PRS-900

EXHIBIT 3

California Prison Health Care Receivership
Office of the Receiver

August 25, 2006

STEVE WESTLY
California State Controller
300 Capitol Mass, Suite 1850
Sacramento, CA 95814

Re: 2006 Fiscal Review of the CDCR Inmate Healthcare Delivery System

Dear Mr. Westly:

Thank you for your letter of August 2, 2006 and the attached Healthcare Delivery System Audit ("Audit"). After review, my staff and I find the Audit to be a useful tool regarding efforts by the Office of the Receiver to improve the Division of Correctional Health Care Services procurement, management, and payment process concerning contracted services from private hospitals, clinical registries, and other private providers.

As you know, in February 2006 the Court's Correctional Expert, John Hagar, reported to the Honorable Thelton E. Henderson that the State's system for procuring and paying for clinical contracts had all but collapsed. In response the Court issued a series of orders, one of which required the State, under the direction of the Receiver, to develop and implement an entirely new system for procuring, managing, and paying for necessary outside medical services. Following my appointment in April 2006 I became personally involved with this project, which is managed on a day-to-day basis by Mr. Hagar, my Chief of Staff and Jared Goldman, my attorney. The new contract management program that is being developed, and which should be implemented on a pilot basis by late 2006, will establish policies, controls, and practices that address the concerns raised by your recent audit. I have asked Mr. Hagar and Mr. Goldman to meet with your staff no later than mid-October 2006 to explain the structure of the new contract process.

Meanwhile I want to go on record concerning the findings of the 2006 Audit. In this regard, five points should be emphasized.

1. The Office of the Receiver agrees with the Audit's primary findings. Health care contracts are not adequately managed; the negotiation process is deficient; prior audit recommendations have not been adequately implemented; delays with in-prison dialysis treatment are problematic; there has not been adequate planning concerning the use of special needs, infirmary, correctional treatment, long term, and acute care beds; utilization management is not effective; and inadequate staffing, training, and policies in the prisons have created a failure to manage billing abuses and shortcomings.

2. The Office of the Receiver also agrees with the Recommendations set forth at pages 30-31 of the Audit. Recommendations 2 and 4 will be encompassed by the new contract management system mentioned above. Recommendations 1 and 3 will take somewhat longer to implement, but are equally important. My Office will also keep you informed concerning our progress regarding effective bed utilization and strengthening utilization management.

3. Given the scope of the audit and its timing, it is not surprising that the Division of Correctional Health Care Services has found certain errors in the Audit. In my opinion, the errors do not warrant changes in either your overall findings or recommendations. I have asked Mr. Hagar and Mr. Goldman to evaluate the Health Care Services findings and to arrange for a discussion of the perceived errors at the October meeting.

4. My review of the underlying causes concerning the failure by the California Department of Corrections and Rehabilitation ("CDCR") to manage its contracts indicates that what appears to be an agency specific issue is actually a State-wide problem. Despite prior audit findings, as well as the documented need for additional staff, more appropriate and better paying contract positions, and adequate information technology, the State, through its control agencies, failed to respond to CDCR requests for the minimum funding and programs necessary to manage a truly massive outside contract system. Without question, additional resources and support will be needed to address these problems in a timely manner. I want to assure you that I will take whatever steps are necessary to ensure that corrective action is timely, appropriate, and sustainable.

5. Sound fiscal management of all aspects of prison medical care services is an important priority for the Office of the Receiver. Of even greater importance, however, is the need to improve the care and services provided to prisoner/patients. The current unconstitutional levels of care are simply unacceptable. Therefore, while I anticipate achieving fiscal savings through sound management and controls, it is likely that prison medical expenses will increase in the future as necessary services begin to be provided, through contract and by Health Care Services clinicians, to the patients for whom I am responsible.

Again, thank you for conducting the audit, and the professional manner with which your staff worked with the health care staff at CDCR. If questions arise, do not hesitate to contact me.

Sincerely,

Robert Sillen
Receiver

c: John Hagar
Jared Goldman
Peter Farber-Szekrenyi, Dr., P.H.
James Tilton

EXHIBIT 4

DEPARTMENT OF FINANCE
OFFICE OF THE DIRECTOR

ARNOLD SCHWARZENEGGER, GOVERNOR
STATE CAPITOL ■ ROOM 1145 ■ SACRAMENTO CA ■ 95814-4998 ■ WWW.DOF.CA.GOV

July 27, 2006

Mr. Robert Sillen, Receiver
California Prison Healthcare Receivership
VIA EMAIL: cpr.inc@comcast.net

Dear Mr. Sillen:

Enclosed is a copy of the California Department of Corrections and Rehabilitation Division of Health Care budget item from the 2006 Budget Act, as adopted by the Legislature, the Governor's veto message pertaining to his veto of Provision (6) of that item, and his sustaining message regarding Provision (7) of that item.

In response to your letter dated July 14, 2006, I confirm that the Director of Finance will not unilaterally transfer funds appropriated under Schedule (5) of this budget item. The transfer will occur only in response to specific directions of the Receiver or the court, and only for the purpose of funding costs resulting from actions by the Receiver or the court.

Sincerely,

Molly E. Arnold
Chief Counsel

Enclosure

Cc w/ enclosure:
Michael Genest, Director, Department of Finance
Todd Jerue, Program Budget Manager, Department of Finance
Deputy Jon Wolff, Office of the Attorney General
Dr. Peter Farber-Szekrenyi, Director, Division of Correctional Health Care Services
John Hagar, Chief of Staff, Office of the Receiver
Jared Goldman, Staff Attorney, Office of the Receiver

Item 5225-002-0001—For support of Department of Corrections and Rehabilitation. I delete Provision 6.

I am deleting Provision 6, which would limit the expenditure of funds appropriated for the Inmate Dental Plan required by the *Perez v. Tilton* lawsuit pending the submission of the court required staffing study to the Joint Legislative Budget Committee (JLBC). The Administration will provide this report to the JLBC when it is available; however, I am vetoing this language because it could limit the Department's ability to implement this plan and meet court requirements.

I am sustaining Provision 7, which will require the Department to establish guidelines for the use of telemedicine, establish performance targets, and provide the Legislature with a written report regarding meeting the performance targets. The Administration is supportive of establishing appropriate guidelines and performance measures. However, compliance will be at the discretion of the Receiver appointed by the federal court in *Plata v. Schwarzenegger* to oversee the provision of medical services to inmates.

5225-002-0001—For support of the Department of Corrections and Rehabilitation..... 1,516,637,000

Schedule:

(1) 10-Corrections and Rehabilitation Administration..... 8,283,000

(2) 25.01-Adult Corrections and Rehabilitation Operations..... 65,256,000

(3) 25.02-Adult Corrections and rehabilitation Operations-Distributed..... −65,256,000

(4) 50-Correctional Health Care Services..... 1,410,447,000

(5) 97-Unallocated..... 100,000,000

(6) Reimbursements..... −2,093,000

Provisions:

1. On February 14, 2006, the United States District Court in the case of Plata v. Schwarzenegger (No. C01-1351 THE) suspended the exercise by the Secretary of the California Department of Corrections and Rehabilitation of all powers related to the administration, control, management, operation, and financing of the California prison medical health care system. The court ordered that all such powers vested in the Secretary of the California Department of Corrections and Rehabilitation were to be performed by a receiver appointed by the court commencing April 17, 2006, until further order of the court. The Director of Health Services is to administer this item to the extent directed by the receiver.

2. Notwithstanding any other provision of law, the amount available for expenditure in Schedule (5) is for the purpose of funding costs for the Department of Corrections and Rehabilita-

tion, including the operations of the Office of the California Prison Receivership, and any other state agency or department that is involved in the provision of health care to California inmates, including the costs of capital projects, resulting from actions by the receiver or the court in Plata v. Schwarzenegger. From any amount available in Schedule (5), the Director of Finance may authorize the transfer of funds from Schedule (5) for the purpose of augmenting the amount available for expenditure in any other schedule in this item, or any other appropriation in Section 2.00 to a department or agency that is involved in the provision of health care to California inmates. The Director of Finance shall notify the Chairperson of the Joint Legislative Budget Committee and the chairpersons of the fiscal committees in each house of the Legislature no later than 10 days after the effective date of the transfer. The notification to the Legislature shall include information regarding the purpose of the expenditures and the expected outcome of those expenditures.

3. No later than March 1, 2007, the Department of Corrections and Rehabilitation shall submit a report to the Legislature that provides the guidelines for the goals and performance measures of the delivery of health care services and how the department will compare their performance to those measures to determine whether they are providing the appropriate level of care.
4. Notwithstanding any other provision of law, the Department of Corrections and Rehabilitation is not required to competitively bid for health services contracts in cases where contracting experience or history indicates that only one qualified bid will be received.
5. Notwithstanding Section 13324 of the Government Code or Section 32.00 of this act, no state employee shall be held personally liable for any expenditure or the creation of any indebtedness in excess of the amounts appropriated therefore as a result of complying with the directions of the Receiver or orders of the United States District court in Plata v. Schwarzenegger.

Item | Amount

6. Of the amount appropriated in Schedule (4), $21,487,000 is for the purpose of complying with the Perez v. Hickman settlement agreement. Of this amount, $14,080,000 is appropriated for the purpose of establishing 124 positions, as well as equipment and contract costs, beginning on July 1, 2006. The remaining $7,407,000 appropriated for the purpose of establishing 202 positions later in the fiscal year shall not be expended until (a) the California Department of Corrections and Rehabilitation provides the Joint Legislative Budget Committee with a copy of the staffing study required under the Perez v. Hickman settlement agreement, and (b) the Department of Finance provides the Joint Legislative Budget Committee with a letter stating the extent to which the staffing levels authorized in this act are consistent with the findings of the staffing study. Within 60 days of the receipt of the study and letter, the Joint Legislative Budget Committee shall notify the California Department of Corrections and Rehabilitation and the Department of Finance whether it finds these expenditures for the positions are consistent with the staffing study. Any funds subject to this provision that are not expended shall revert to the General Fund.
7. On or before January 1, 2007, the Department of Corrections and Rehabilitation shall establish guidelines concerning the conditions under which inmates needing special medical care are provided with a physician consultation through telemedicine rather than an in-person visit at an outside medical facility. The guidelines should take into consideration factors including, but not limited to, whether (a) a telemedicine consultation is medically appropriate, (b) a medical specialist is available to conduct a telemedicine consultation in a timely manner, and (c) the inmate in need of medical specialty services is assigned to a prison that has received telemedicine resources as part of the Plata v. Schwarzenegger rollout. Based on these guidelines, by March 1, 2007, the department shall establish monthly performance targets for prisons with a telemedicine capability

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regarding the total number and percentage of medical specialty consultations that are conducted by telemedicine rather than at community medical facilities, and provide a copy of the performance targets to the Joint Legislative Budget Committee. By June 30, 2007, the department shall provide a written report to the Joint Legislative Budget Committee on the extent to which the prisons achieved their performance targets. The report shall include any factors that may have prevented the department from meeting its performance targets, as well as the total estimated savings from using telemedicine.

8. The Department of Finance shall immediately notify the Joint Legislative Budget Committee and the fiscal committees in each house of the Legislature when expenditures pursuant to Provision 2 are occurring at a rate that would exhaust the level of funding in Schedule (5) prior to the end of the fiscal year.
9. Any funds in Schedule (5) that are not expended by June 30, 2007, shall revert to the General Fund.

[illegible] ..... [illegible]

EXHIBIT 5

Division of Correctional Health Care Services

Effective Medical Services Contract Process

Project Team Report

Improved Contract Processes

Project Sponsor: Peter Farber-Szekrenyi, Dr. P.H.
Project Director: Ted Rauh
July 26, 2006

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I. Purpose of Team Report

This report presents the Team's recommended health care services contract processes that when implemented by the California Department of Corrections and Rehabilitation (CDCR) and its Division of Correctional Health Care Services (DCHCS), will ensure the timely procurement of medical services contracts. The contract processes achieve the processing and efficiency goals established by the Receiver; satisfy the State of California's responsibility to exercise stewardship over the expenditure of public funds; can be efficiently monitored and evaluated; and, are adaptive to the best practices readily available in information technology.

This report provides a summary of the Team's evaluation of the current CDCR contract processes and proposes improvements to them. The Team's evaluation of the current processes focused on three areas of contract administration. These areas are: 1) The contract bid, negotiation, award, and tracking process; 2) The appropriate use of information technology to manage, track, and provide monitoring of the contract process; and, 3) The statutory and regulatory requirements, external review and approval, and the legislative intent of those requirements as they provide structure or impediments to an effective contract process. The Team also reviewed contract approval flow, the information required, the forms used, the methods of information transmittal, and resource allocations and organizational structures needed for an effective contracting system.

The Team also surveyed the contract systems and practices of other hospital systems and correctional institutions – state and local – that make similar use of medical service providers to determine what practices they use and which of those may be appropriate to be used at CDCR. The results of this work have been considered by the Team. The results of these surveys have been or will be reported to the Receiver by separate cover.

A. New Contract Processing System Performance Measures

The Receiver established three performance measures for the Team to utilize in developing a new contract processing system. These measures are:

1."Timelines for Execution of Contracts:

a. Non-competitive bid contracts will be executed in 30 days;

b. Competitive bid contracts will be executed in 60 days.

2. Number of Individuals Preparing, Reviewing and Approving Each Contract: Each contract will be prepared, reviewed and approved by no more than four individuals. For example, the contract may be prepared by a contract analyst, reviewed by a budget analyst, reviewed by an attorney and approved by a director.

3. Competitive Bidding: Competitive bidding requirements will be streamlined to provide, at a minimum, that contracts for services under $100,000 will be bid using an informal competitive process. Contract analysts will be allowed to fulfill the informal competitive process by surveying 3 potential providers by phone (with appropriate documentation) or in writing."

B. Background Necessitating Action to Improve the Health Care Contracting System

In the federal suit, Plata v. Schwarzenegger (Plata) filed in 2001, Plata alleged statewide deficiencies in the medical services delivery system. Following Hearings in 2005, the Court appointed Mr. Robert Sillen to serve as the Receiver (Receiver) in this action. The Court has also appointed Mr. John Hagar as its Correctional Expert (Expert). The Expert prepared a report on CDCR's medical services contracting and found a number of very serious deficiencies. The Expert found that the current contracting process has significantly contributed to deterioration of the health care services provided to CDCR inmate-patients. Major backlogs in contract invoice payments have lead to delays

or withholds of contractor provided medical services. Service provider contracts have expired before replacement contracts were negotiated and in force. The Expert noted that in 2004 the California State Auditor found extensive problems with CDCR's contracting process. The Expert summarizes the audit findings as follows. **"These [2004] audits found numerous serious fiscal problems, including but not limited to failing to competitively bid when appropriate, flawed negotiating practices, agreeing to excessive rates of compensation, failing to ensure discounts, failing to follow CDCR contract manual requirements, failing to secure required approval for exception cases in non-emergency situations, failing to ensure that only valid claims were paid, failing to implement appropriate utilization management policies and procedures, and failing to staff institutions with the appropriate personnel trained to conduct adequate contract negotiations."** The Expert noted that the State agency response to these problems was ineffectual. In addition, changes to bid exemption processes by DGS in response to the audit coupled with the failure of the state to provide adequate resources and training has served to further exacerbate the problem.

C. Order Re State Contracts

The Court issued an Order on March 30, 2006 directing CDCR to, among other things, develop a new contracting process. The specific requirements in the Order pertaining to the contacting process are as follows:

"1. CDCR, working with the Expert under the direction of the Receiver, and the State entities responsible for contract negotiations, management, and payment (including but not limited to DGS, Department of Finance, and the Department of Personnel Administration) shall establish a team of employees/experts ('Team") who shall develop and institute health care oriented policies and standards to govern CDCR medical contract management. These policies and standards shall consider both the need for timely on-going care and the fiscal concerns of the State, including but not limited to the State Auditor findings of 2004.

2. The Team shall consider the following changes to State policy and procedure:

(a) Combining the two CDCR units currently responsible for health care contract management and accounting.

(b) Development of simplified template contracts applicable to heath services providers.

(c) Streamlining the exception process for bidding requirements.

(d) Evaluating and recommending changes in legislation conducive to cost effective and timely contract services.

(e) Developing new and streamlined forms for contract processing.

(f) Establishing an information technology sub-group to evaluate and report on the purchase of a computerized statewide database to manage all CDCR medical contracts.

The Team shall also determine whether an outside consultant, skilled in health care contracts, should assist the Team concerning their recommendations.

3. The Team shall approach its task with the goal of implementing new contract policies and procedures, controls, and a training program, within 180 days from the date of this Order."

II. Analysis of the Existing Contract System

A. Who Does What

- Department of General Services

The State Legislature has designated the Department of General Services (DGS) the state agency responsible for overseeing the state contracting system. As such DGS establishes general contract terms; establishes and oversees contracting policy and procedures to assure compliance with State law, fairness, stewardship and "best practices"; is statutorily vested with approval authority for services contracts; services as hearing officer for bid protests; and , consults with agencies and provides training on contracting issues. DGS implements Legislative policy and the Public Contract

Code which requires competitive bidding. DGS is statutorily vested with authority to approve certain types of exemptions from competitive bidding.

- CDCR/DCHCS

CDCR's health care contract program is carried out by several organizational units. Developing statements of work (SOW), securing bidder/contractor information, carrying out contract negotiations, and developing/executing emergency services contracts are all tasks performed at varying degrees by institution staff. This contract workload at the institution level has been understaffed and a recent budget augmentation has increased institution contract staffing from 7 positions to 40 positions. Larger service agreements and master agreements are the responsibility of DCHCS headquarters contract staff. DCHCS staff develops the SOWs for these contracts, develops rates, and conducts contract negotiations on SOW, DCHCS terms and conditions, and rates. Contract assembly, management of the bid process, interface with DGS and contract awards are the responsibility of contract staff within OBS. Resources allocated to each organization involved in the contract program are shown on table 1. The actual number of staff available to work on contracting duties is significantly less than the allocations shown below. The OBS vacancy rate has averaged over 21% for the past 12 months and has spiked as high as 31%. DCHCS's headquarters contract staff has experienced a 24% vacancy rate for the past 12 months and has spiked as high as 45%. The 33 additional institution contract staff allocations were just recently approved and are nearly all filled.

TABLE 1

Current CDCR Resources Associated with Health Care Contracting

Position Classification	OBS	DCHCS HQ	Institutions
CEA	0.2		
SSM III	0	.3	
SSM II	0.4	1.0	
SSM I	3.0	2.0	
AGPA/SSA	15.8	12.0	40
Admin Support	0	1.0	

B. Contract Workload

Health care contract workload has significantly increased over the past 5 years. DCHCS's health care contract expenditures have increased from $154,859,373 in fiscal year 2000-1 to $408,708,790 (reported as of May Chart H) in fiscal year 2005-6. In order to provide "Continuity of Medical Care" to inmates, the institutions must utilize a variety of medical services, such as, but not limited to, hospitals, physicians, medical groups, ambulances, emergency care and paraprofessional services. These medical services are obtained by either competitively bidding the service; requesting an exemption from bidding; or, are exempt from bidding by policy or statute. The CDCR processes individual agreements in addition to Master Agreements. Master Agreements are prepared by headquarters in an effort to reduce the number of individual contracts and to achieve economy of scale savings for the Department. The Notice to Proceed (NTP) process is used to accomplish fund shifts within master agreements. This process is being replaced with a less staff intensive, and more effective fund allocation/encumbrance management system. Historically, CDCR operated under a blanket exemption from DGS for a variety of medical services contracts. Since 2005, CDCR has operated under more specific and some time-limited exemptions with direction to pursue more competitive bidding where appropriate. Currently, CDCR processes approximately 2647 agreements annually (includes NTPs) over the past 5 years. Listed below are the current contract processes and estimated numbers:

- 1627 Notice to Proceeds 9NTPs);
- 342 Competitively Bid Agreements;
- 678 Exempt from Bidding and Non-Competitive bid Agreements.

Table 2 provides a detailed breakdown of the average number of contracts processed per year over the past 5 years (July 1, 2001 thru June 30 2006).

TABLE 2
Overall Totals for Various Contract Processes

Institution	Individual Exempt Contract	Individual Sole Source	Combined Total Individual Exempt & Sole Source	Individual Bid	Master Bid	Master Exempt	Master Sole Source	HQ Total	Overall Total (inc. HQ & Inst.)
5 Yr Total:	2074	322	2396	1145	566	837	155	2703	5099
Annual Average:	414.8	64	479	229	113	167	31	541	1019.8

Table 3 lists the number of Individual Exempt and Sole Source Contracts processed for each institution listed over the same five year period. Institutions make use of all of the types of contracts (Master bid, master exempt, etc) but also need specific specialty services that are provided by means of individual exempt contracts and individual sole source contracts. These categories of contract require the most resources from institution contract analysts. These types of contracts are used extensively at institutions such as California Men's Colony (CMC) – 41 contracts averaged per year, San Quentin (SQ) – 41 contracts averaged per year, and Pelican Bay State Prison (PBSP) – 35 contracts averaged per year. There is little use of these types of contracts at California State Prison – Sacramento (SAC) – 3 contracts averaged per year, or Deuel Vocational Institute (DVI) – 5 contracts averaged per year. The yearly average for the 32 facilities that make some use of these contracts is 15.

TABLE 3
Institution Use of Individual Exempt and Sole Source Contracts

Institution	Individual Exempt Contracts	Individual Sole Source	Combined Total Individual Exempt & Sole Source
ASP	74	13	87
CAL	68	9	77
CCC	107	22	129
CCI	25	4	29
CCWF	56	4	60
CEN	56	10	66
CIM	83	14	97
CIW	71	18	89
CMC	182	25	207
CMF	77	17	94
COR	74	6	80
CRC	24	5	29
CSA	70	9	79
CTC	1	0	1
CTF	30	3	33
CVSP	41	1	42
DVI	25	1	26
FSP	25	7	32
HDSP	85	8	93
ISP	51	4	55
KVSP	2	4	6
LAC	144	23	167
MCSP	21	4	25
NCWF	2	1	3
NKSP	29	7	36
PB	142	31	173
PVP	23	4	27
RJD	26	8	34
SAC	15	1	16
SCC	97	11	108
SOL	53	7	60
SQ	177	26	203
SVSP	48	9	57
VSPW	52	2	54
WSP	18	4	22

DCHCS has extensive experience in procuring health care services by means of contracts. Based on this experience DCHCS believes that while the bid process may be effective in some instances when procuring health care services, it may not be effective in other circumstances. For example, DCHCS does not believe that competitive bidding is feasible for remote institutions when there is only one provider or other special circumstance. Indeed, provision 27 of 5225-001-001 of last year's Budget Act and included in this year's Budget Act provides: "Notwithstanding any other provision of law, the Department of Corrections and Rehabilitation is not required to competitively bid for health services in cases where contracting experience or history indicates that only one qualified bid will be received." DCHCS also does not believe bidding is feasible or economical where services are provided by hospitals. Contracted hospitals provide a range of medical services that vary based on the specialties and services offered (e.g., medical guarded units). No single bid process effectively provides for these differences. Other examples, where bidding is not feasible include services of doctors who have privileges to practice at specific hospitals. These doctors have arrangements with the hospitals that are not in contract with DCHCS. DCHCS is interested in the professional care it receives from each hospital and relies on the hospital to maintain specialists on call that provide the desired services. In addition, DCHCS has found that certain medical specialists cannot be successfully bid. Recent attempts to bid specialty services in cardiology and ophthalmology have not been effective. In some cases, DCHCS can obtain exemptions provided by DGS upon a showing of these factors.

DCHCS has health services expertise and a thorough understanding of the health care service providers serving in each area where CDCR institutions reside. DCHCS has both health care professionals and is augmenting contract analyst resources at each institution. DCHCS has gone through an extensive review of the health care services it contracts for. With involvement from institution staff DCHCS has determined, based on current conditions, which health care services should be bid or not bid and which should have a bidding process pursed to determine if a competitive market place exists. The services are categorized in this fashion on Table 4. DCHCS recognizes that the availability and/or interest of health care service providers changes over time. Given these facts, DCHCS does not see Table 4 as a permanent list of what services are bid or not bid, but rather an assessment of what conditions are today. DCHCS is committed to public stewardship and will periodically assess each region of the state and/or type of health care service to determine if factors have changed regarding the availability of providers and/or the existence of a competitive pool of interested bidders.

TABLE 4
Bid and Non Bid Health Care Services

Not Biddable Due to Failed Bids/ Experience/or associated with Hospitals		Currently Bid and Believe Can be Bid	
▪ Anesthesiology	▪ Audiology	▪ Dental Assistant/Hygienst	▪ Dentist
▪ Blood bank	▪ Burn Unit	▪ Dietician	▪ EEG
▪ Cardiology	▪ Cardiopulmonart	▪ EKG	▪ General Medical Clinical Lab
▪ Cardiovascular	▪ Dialysis	▪ General Medical Speech	▪ General Medical Surgical
▪ Drug & Alcohol Counseling	▪ Emergency Medicine	▪ Hearing Aid Services	▪ Inmate Laboratory Services
▪ Family Practice	▪ Hospital	▪ Laboratory	▪ Lic. Clinical Social Services
▪ Ophthalmology	▪ Perinatology	▪ MFT Services (Primary)	▪ MRI/Mobile MRI/CT Scans
▪ Portable Lithotripsy	▪ Sleep Apnea Testing	▪ PET Scans	▪ Nursing-Registry
▪ Surgery Post OP	▪ Surgery Pre OP	▪ Occupational/Rec. Therapists	▪ Optometry
▪ Trauma	▪ Hospitalists	▪ Orthotics & Prosthesis	▪ Pharmacists
▪ Rentinal Surgery	▪ Physical Therapists	▪ Pharm Techs	▪ Phlebotomy Services
▪ Ultrasound Testing		▪ Physicians Registry	▪ Psych Techs
		▪ Psychiatrists Registry	▪ Psychologists Registry
		▪ Radiology	▪ Respiratory Care Practitioner
Te		▪ Technicians Lab	▪ Technicians X-Ray/Radiology

Additional Specialties Determined Non Biddable Based Results of Bidding Pool Exercise		Remaining Specialties Determined as Possibly Biddable		
▪ Allergy	▪ Anesthesiology on-site	▪ Dermotology	▪ Ear, Nose & Throat	▪ Gastroenterology
▪ Colon and Rectal	▪ Endocrinology & Metabolism	▪ Hematology	▪ Immunology	▪ Infectious Disease
▪ Geriatric Medicine	▪ Gynecology	▪ Internal Medicine	▪ Nephrology	▪ Neurology
▪ Maternal & Fetal Medicine	▪ Maxillofacial Services	▪ Oncology	▪ Oral Surgery	▪ Pain Management
▪ Obstetrics	▪ Rheumatology	▪ Orthopedic	▪ Plastic Surgery	▪ Pathology
▪ Thoracic Medicine	▪ Vascular Medicine	▪ Pulmonary Medicine	▪ Podiatry	▪ Urology
		▪ Surgery General		

DCHCS is conducting a survey of other state and local correctional systems to find out how they manage their contracted health care services. As of the date of this Report, not all survey participants have provided information. For those State agencies that have, New York provides for all of its specialty services through non-bid contracts. New York does bid a few medical services such as dialysis and laboratory services. The State of Nevada utilizes Preferred Provider Organizations for its medical services. Once all the responses are received from survey participants, the Team will provide a summary of the survey results to the Receiver.

C. Current Contracting Processes

The Team presented flow charts and detailed step by step analysis for the current contract processes at the June 16, 2006 Receiver meeting. Table 5 summarizes the average time spent by each organization when processing a contract through one of the current contract processes. These processing times assume a smooth process with general agreement on the SOW, contract terms and rates. Negotiation time on any of these areas can increase the typical time to complete the process. An individual bid contract can take from approximately 4 ½ months to 7 ½ months if it is protested. Within this time CDCR utilizes 63 days to process contracts that are not protested. A statewide bid contract can take from approximately 6 ½ months to 10 months if is protested. Within this time CDCR utilizes 116 days to process contracts that are not protested. Exempt from bid contracts require approximately 6 ½ + months to process. Within this time CDCR utilizes 107 days to process contracts.

TABLE 5
Summary of Time by Organization and Contract Process Type
All figures in Business Days

CONTRACT PROCESS TYPE	RAO	INST.	OBS	OBS/DIV.	DIV.	CONT.	DGS	PROTESTS	TOTAL
Individual Bid	2	5	30	2	22	16	22	65	164
Statewide Bid	2	5	75	2	39	16	22	65	226
Exempt Individual	3	5	79	0	20	29	13	0	149
Exempt Statewide	3	5	79	0	20	29	13	0	149

Process descriptions and detailed analysis of each contract process was provided to the Receiver as part of the June 16, Receiver meeting. This analysis included a review of each step – actions taken, reasons for them, and what can be done to reduce/eliminate the actions or the time they take. Key factors driving the times taken to complete each process include: staff vacancies, process inefficiency, lack of adequate staff training, complexity of work/decision processes, contractor delay resulting from failure to respond in a timely fashion at various times in the contract process, delay in the negotiation process due to failure to reach agreement on rates and/or SOW, contractor issues with standard terms, contract management deficiencies (e. g. Failure to identify contract needs until the need for services is urgent), bid – no-bid exemption decision process and, contract approvals delayed by management review levels.

D. Lessons Learned

As a result of the Team's review of current practices 13 areas or "Lessons Learned" were identified. These areas of concern need to be addressed to ensure any changes to improve the health care contracting system are successful. The following briefly describes each area and identifies how and when it should be addressed.

1. Appropriate staffing levels for all contract processing and management functions – Upon acceptance of the proposed contracting system a workload and staffing level analysis should be performed to establish staffing levels.
2. Staff Training – Training for staff involved in the contract process is underway and will be updated once the decision on the new contracting process is made. Training for contract managers (primarily institution health care professionals) needs to be developed and implemented as soon as possible.
3. Dedicated support staff – As part of the workload analysis called for above an evaluation is needed to ensure institution contract managers have the support needed to carry out their responsibilities.
4. Responsibility for bid-non-bid health care contract decisions and contract approvals – a recommendation for legislative action to vest these authorities within DCHCS is made.
5 Increased delegation of contract responsibility to institutions – a recommendation for increased institution contract authority is contained in the recommendations for a new contract process.
6. Who should be responsible for master contracts – a recommendation for how master contracts should be managed is contained in the recommendations for a new contract process.
7. Eliminate the existing NTP process contract amendment workload – a recommendation to remove this workload and manage the fund balances of master agreements was made to the Receiver at the July 16, 2006 meeting and it was accepted. An implementation approach and plan are being developed.
8. IT will play an integral part in improving process efficiency – CDCR's CIO is leading an effort to develop a contract information system that includes contract tracking, information depositories and system connectivity. The progress on this work effort is reported to the Receiver every two weeks.
9. Establish standard contract terms which cannot be deviated from in negotiations – An initial review of all of CDCR's contract terms has been conducted and the documents have been substantially reduced in size and complexity. Some requirements will be placed in a document that contractors can refer to as needed. Boilerplate standard terms

and conditions are being consolidated. This work will be completed by August 31, 2006 and will be available for use after that time.

10. Establish SOW templates which cannot be deviated from in negotiations – A process is underway to review all of the most recent SOWs for contracts the DCHCS has entered into or is planning to contract for in the future. This review will be carried out by health professionals to ensure that the DCHCS's "best practices" and other policies reflecting level and type of care are reflected in the SOWs. After this review is completed the resulting SOWs will become the standards used for future procurements. A policy and procedure is also being developed to ensure that these documents are routinely reviewed and modified whenever the DCHCS changes a policy or "best practices" procedure that impacts one or more SOWs.
11. Establish standard rates which cannot be deviated from in negotiations – A contract has been awarded to a health care rates expert to assist the DCHCS to establish rates for all health care services contracts. The standardized rate development work will be completed by September 28, 2006.
12. Establish/enhance contract process monitoring and auditing – recommendations are made regarding CDCR's auditing functions an the establishment of internal monitoring and Quality Assurance/Quality Control functions within DCHCS.
13. Securing Proof of Insurance, Licensure and Permits without slowing down the contract process – a recommendation on how to handle this issue is included with the new contract process.
14. Personnel Services Contract protest process and State Personnel Board (SPB) challenge process – the contract protest process for Personnel Services is included in the recommendations regarding a new contract process. The SPB challenge process will be affected by actions of other agencies to increase the compensation for health professionals so that the DCHCS can recruit and retain staff and rely less on contracted staff support. Proper managed care includes utilizing the lowest cost, effective method to provide health care services and contract managers are accountable if they make use of contract resources when eligible lists are available to fill vacancies. Improved compensation and effective contract utilization will likely significantly reduce union challenges through SPB.

III. New Contract Processes

A. Overview

The key underpinnings of the proposed contract process are:

- Legislative Authority granting contracting authority for health services contracts to DCHCS with concurrent decision authority for bid and non bid contract decisions;
- DGS maintains authority over the state's general contract terms and conditions, and retains responsibility for managing the bid contract protest process.
- Consolidation of OBS contract processing staff within the DCHCS and appropriate organization and staffing of the DCHCS's contracting program;
- Improved contract management at the institution level with contract authority delegated for contracts under $25,000 per year;
- Appropriate contract management responsibility and staffing within the institutions, and training for contract managers and contract analysts;
- Establishment and maintenance of standard SOWs, compensation rates, and contract terms and conditions with a negotiation policy of not deviating from these standards;

- Purchase/Development, implementation, and maintenance of an efficient IT system that facilitates contract processing and tracking through depositories, a contract information system and connectivity;
- Establishment of an internal contract planning, monitoring and program improvement function within the DCHCS;
- Enhance CDCR's audit program so that it can provide appropriate and timely ongoing review of the DCHCS's contracting program;
- Establishment of a quality assurance/quality control function reporting to DCHCS management/Receiver to evaluate the performance of the health care services contract program.
- Implement streamlined contract processes that generate improved contracting mechanisms that are useful to institution health care professionals; and,
- Use health care contracting costs, availability of health care contract services, and the quality of these services as a key consideration in the managed care decisions and institution placement decisions for patient inmates.

B. Who Does What

- Health Care Services Contract Responsibility

The Team recommends that the current relationship between DGS and DCHCS be changed as it relates to health care services contracts. Health care services contracts pose unique circumstances with respect to the types of services, the kinds of providers, market conditions, and the circumstances under which health care must be provided. Given these factors, the Team recommends that DGS continue to review any changes proposed by DCHCS to the State's general contracting terms and conditions. However, DCHCS needs to be legally vested with authority to carry out a contracting program including decisions on when bidding is and is not feasible and final approval authority for contracts. DCHCS would carry out its full bid-contracting program in accordance with the State's existing code and DGS' contracting requirements. In the event of a bid contract protest, the protest would be heard and decided by DGS as it is now. Legislative authority to DCHCS would include a process through which the Director of DCHCS would conduct a periodic review of the types of contract health care services being utilized by DCHCS and would certify the services and areas of the state where the non bid contract program would continue. DCHCS would have sufficient authority to establish fair and open bid and non bid contract processes that provide needed health care contractors. CDCR would conduct ongoing audits of DCHCS's contracting program and the State Auditor would be requested to provide periodic audits as well.

- CDCR/DCHCS

CDCR currently has two organizations responsible for parts of the contract processing program – OBS for contract processing, the bid process and contract awarding; DCHCS resources for SOWs, rates, business terms and negotiations; and, DCHCS institution staff for contract management negotiations, information gathering, and processing. These organizations are separated spatially and even though their functions are well defined, improved efficiency and effectiveness will be achieved with their consolidation within the DCHCS. The Team proposes that the health services contract staff in OBS be moved to the DCHCS because health services technical knowledge and expertise resides in the DCHCS and the contract function is a direct provider of inmate-patient health care services.

The Team Recommends that CDCR's internal audit program be directed and enabled to carry out a comprehensive audit of DCHCS's contract program. The audit activities should be continuous during the first few years of implementation. The scope and frequency of audits and any resource needs to conduct them should be determined by joint agreement between the Receiver, CDCR and DCHCS.

- DCHCS

The Team recommends that DCHCS significantly enhance the resources devoted to contracting. A number of new functions are necessary to effectively carry out the program. In addition DCHCS needs to adopt a commitment to strong contract management including making this responsibility part of the performance assessment process. Medical professionals charged with the responsibility of planning for future contract needs, as well as those responsible for the day to day management of contracts; and managers responsible for the contract process must be held accountable to ensure sound business practices and public stewardship are maintained. The functions necessary to implement the Team's contract process recommendations include the following:

- Contract managers who manage the process of formulation, negotiation and execution of large health care contracts including the registries and hospital contracts. Contract managers retain responsibility for the ongoing operation of contracts with regard to any needed amendments for funds or change in scope.
- Establishment of Contract Managers who manage the process of formulation, negotiation and execution of large health care contracts including the registries and hospitals. The contract managers retain responsibility for the ongoing operation of the contracts with regard to any needed amendments for funds or change in scope.
- A health care rates function that performs rate analyses and establishes standard rates for health care services. The function supports contract project managers and institution contract analysts on all rate negotiations and related matters.
- A SOW and equipment standards and/or specifications function that develops and maintains health care services statements of work (SOW) for all of the types of health care services contracts, and health care equipment specifications and/or standards including any required standard terms and conditions related to these requirements. The function works through DCHCS health care professionals to develop and maintain SOWs and standards, and supports the contract project managers and institution contract analysts on all SOW and specification negotiations and related matters.
- A contract technical support function that manages the contract bid process, award process, protests (from unsuccessful contractors or the State Personnel Board); develops/maintains and improves CDCR contract standard terms; and, ensures "Best Practices" for the state. The function supports the contract project managers and contract analysts in carrying out the bid processes and on any proposed changes to standard contract terms. The function supports the contract project managers and institution contract analysts on any protests that are filled.
- A bidders development function that establishes bidder lists and works with health services providers to continuously improve the health care provider bidders pools. The function reviews the availability of health care providers by specialty and service, and by region and makes recommendations to the CDCR Director or designee regarding findings for bid or non-bid decisions. The function also ensures that health care provider proof of

insurance and licenses are provided, and licensure verification is performed; and performs periodic verification that these requirements remain in force.

- A training and institution support function that provides institution contract analysts technical support, training and assistance. The function also provides contract management training to health care professionals who manage institution contracts. The function provides institutional contract processing service back up in cases of large workload, staff shortages or other circumstances. The function facilitates institution (both contract analysts and health professional contract managers) coordination and support needs from headquarters.
- A contract planning and performance review function to maintain the contract information data base, master contract allocation utilization information, and carry out contract planning needs assessments. The function works with DCHCS management, regional health care directors and the institutions to plan for and ensure needed contracted health care services and equipment are provided. The function monitors the contract process information system to assess performance and recommend improvements. The function reviews institution contracts and master agreements to ensure they are providing useful healthcare services for the institutions and designs process revisions to improve the contract products.
- An IT systems function to support and improve the contract information system, depositories, data storage, and connectivity requirements of the program.
- Consolidated decision points to make the contracting decisions. An executive level position should be identified in headquarters and within the regional offices to execute health services contracts.
- A quality control/quality assurance function that provides assessments to DCHCS management/Receiver regarding the performance of the contracting program.

Institutions

The Team recommends that delegation be provided to the institutions to process exempt from bidding, and non-competitive bid agreements with dollar thresholds of $25,000.00 annually. This delegation will provide institutions more control and flexibility in obtaining needed health care services. This delegation is contingent upon no changes being made to the standard DCHCS contract terms (and DGS general terms), and standard SOW's; and that rates are within identified benchmarks.

The Team has been assessing the workload implications of various delegation decisions regarding institutional contracting authority. The Team initially decided that all master agreements (hospitals, statewide and regional) should be processed in headquarters whether they are bid or not bid and makes this recommendation here. Medical specialties have also been assessed to determine which types should be registry, master agreement or procured by the institutions. In addition, potential dollar ceilings on the contracts processed in the institutions was also considered. Table 3 provides an example of what the maximum number of contracts may be processed at each institution if no dollar cap is established. From this table it appears that the range of potential contracts that could be let by institutions with no established dollar limit is a high of 41 per year at California Mens Colony (CMC) to a low of 3 per year at California State Prison, Sacramento (SAC) with the average being 15 per year for all institutions.

Table 6 below breaks the same types of contracts down by dollar amount providing several ranges. The Team has established a dollar maximum of $25,000.00 per year as the basis for initial institution delegation. Based on this amount the total projected number of contracts that would be entered into by institutions is 1,263 for a five-year period or 252 per year. This number is slightly more than 50% of these types of contacts and if the workload adjusts proportionally, the projected number of contracts that will be let by each institution may also drop by approximately 50%. The Team will further refine this data as part of the personnel resource workload study to ensure that appropriate staff resources are located at institutions where this workload will occur.

TABLE 6
Exempt from Bidding and Sole Source Contracts by Dollar Amount

Total Contract Dollar Amount	Total 5 Year Contract Count
$0 - $14,999	253
$15,000 - $24,999	218
$25,000 - $49,999	428
$50,000 - $74,999	364
$75,000 – and above	1133

5 Yr Total Count Individual Exempt/Individual Sole Source Contracts	2396
1 Yr Average Individual Exempt/Individual Sole Source Contracts	479
Assuming all Contracts Above $25,000 Have 3 Yr Terms, Total For Contracts under $75,000	1,263
I Yr Average for Contracts Less than $75,000	252

C. New Contracting Processes

The Team proposes four new contract processes. The new processes make maximum use of the contract "tool" improvements and rely on IT to achieve a high level of contract processing efficiency. They rely on the new organization, the additional contracting functions and support, increased staff and contract manager training, and other improvements presented in this report and in previous reports to the Receiver. The processes generally meet the receiver's objectives to reduce processing times; eliminate unnecessary handling and management reviews; and, the processes reduce the number of people responsible for the contract decision process to an effective number. The processes are also dependent on the modified relationship with DGS. The four processes are described in flow charts that are enclosed with this report. However, as has been discussed in several Receiver meetings, without commitment to all of the recommendations for improvement, no process flow chart will lead to the improvements the Receiver has demanded.

Table 7 lists the basic processing times for each entity involved in the respective contract processes. This table shows the substantial process improvements proposed by the Team. All of the new processes are within the time frames suggested by the Receiver.

TABLE 7

Summary of Time by Organization and New Contract Process Type

All figures in Business Days

CONTRACT PROCESS TYPE	RAO.	INST	DCHCS/HQ.	CONT.	DGS BID AD	PROTESTS	(NON PROTEST)
MASTER BID	3	0	40.5*	16	13**	45	46
INDIVIDUAL BID	2	4	21	16	13**	45	40
NON BID MASTER							
AGREES TO STANDARDS	2	20	0	17	17	0	22
DOES NOT AGREE	2	6	22	17	0	0	30
NON BID INDIVIDUAL							
AGREES TO STANDARDS	2	23	0	21	0	0	25
DOES NOT AGREE	2	11	15	21	0	0	28

* Average Processing time

** DGS advertises bid

*** Total State Agency Process Time

D. New Tools

- The "Gray Box"
  DCHCS has often needed urgent health care services for inmate-patients in circumstances that are not a true emergency but where the services are needed in a very short time frame. These services may be for a single episode of care or are needed for an extended time. The urgent nature of the initial need makes the use of traditional contract methods difficult if not impossible to utilize before the services are rendered. This results in service providers billing for requested services while DCHCS does not have a legal way to pay for them. More effective contract health care service planning will eliminate this situation to a point. However, not all health care service needs can be anticipated.

  The Team recommends the "Gray Box" process as outlined below to provide mechanisms to pay for authorized, urgent care services while a contract is negotiated with the service provider. The "gray box" process will allow DCHCS to compensate service providers for a limited time period while one of the new contract processes is used to bring the provider under contract. The process consists of a method to compensate the provider at DCHCS's standard rate for up to 60 days of service. If the service provider believes they are entitled to a higher than baseline rate, they can pursue a claim at Victims Comp for the difference between the pre-set baseline rate, and their rate. During the 60-day period DCHCS will negotiate a contract with the service provider. If the provider is unwilling to enter into a contract, DCHCS will contract with another provider and cease use of the original provider.

- Master Agreement Changes
  The Team has identified changes that need to be made to master contracts that provide more than one provider for potential use at an institution. The current agreements are designed to provide a large number of eligible contractors to ensure there are sufficient alternatives if the primary awardees cannot perform. DCHCS has experienced increasing problems with this methodology, however, because frequently the primary, secondary and teritiary providers on down do not respond to requests for service, thereby requiring institutions to have to continue making calls off the list to obtain services. This process can take a long time and often – listed providers do not plan to provide services in all areas where they are listed. The Team recommends that the contract structure be changed to provide for the following. Before the contract is let providers will be cautioned to only list institutions where they intend to perform services. When the contract is let each institution will have access to a small list of eligible providers. If a provider declines to provide services more than twice they will be removed from the list at the institution's discretion. If both providers decline to provide services for a specific episode of care, the institution will use a non bid contract to provide services for that episode of care. If both providers decline to provide services twice the institution will have the option to: 1) use a sole source contract process using the SOW and rates agreed to in the initial contract to carry out services for the term of the master agreement; 2) request headquarters to certify additional providers from the original master contract process; or, 3) re bid the contract for the services at that location. If the sole source option is taken the contract term will run as long as the master agreement or until DCHCS determines that a pool of bidders exists and is interested in competing for the right to provide the needed services, which ever comes first.

- Insurance Licensure, and Permits
  Verifying that health care services providers contracting with CDCR have all of the necessary insurance, licensures, and permits can take a considerable amount of time and cause unnecessary delay in the contract process. Health care service providers who desire to contract with CDCR to provide services for inmate-patients must possess valid insurance, licensure(s), and necessary permits as a condition of having a contract. Licensure requirements are effectively managed in registry contracts. They are managed in accordance with the provisions of the Court's December 1, 2005 order.

  "The Court's Order is instructive on contract personnel credentialing and hiring:

  1. Paragraph 6.d: **"Verify the credentials and licensure of contract physicians and mid-level providers on a provisional basis within two business days of presentation...Complete the final verification of credentials and licensure within 5 business days of presentation..."**
  2. Paragraph 6.d: **"Verify the security clearance of contract physicians and mid-level providers on a provisional basis within two business days of presentation...Complete the final verification of security clearance within 5 business days of presentation."**
  3. Paragraph 6.e: **"Complete the hiring interview and make a provisional decision to hire or reject for 90% of all physicians and mid-level providers submitted for contract hire...within 4 business days of the submission."**

However, in contracting processes other than registry contracts, the process to obtain proof of insurance, licensure, and permits can cause delays. For example, an insurance carrier may not want to insure a provider treating inmate patients necessitating the service provider to obtain new insurance. As a condition of each contract, insurance, licensure, and permits must be maintained during the term of a contract or the contractor is in breach of contract. The contractor cannot perform services nor can the contractor be paid for services rendered. At this time, the DCHCS requires proof of these requirements before fully processing and executing a contract.

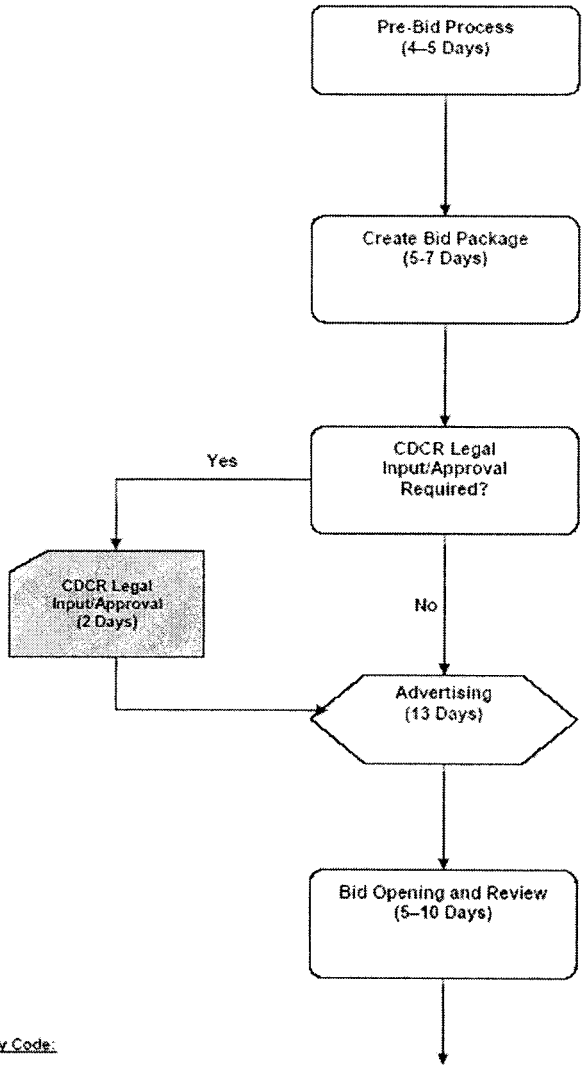
The Team recommends that DCHCS continue to initiate the process to secure required proofs of insurance, licensure and permits as early in the contract process as practical and strengthen the standard contract language to make it explicit that a contractor cannot begin work nor receive any compensation for work performed unless these requirements are in place. DCHCS should not stop the contract process while these documents are being obtained. DCHCS should award contracts where documentation of these requirements has not yet been received contingent upon the fact that the contractor will provide the documents within 10 business days from the date of the award. The provider **will not** be utilized in any capacity unless, and until all of the required insurance, licensure(s), and permits are received and verified.

The Team further recommends that a Contract Requirements Monitoring Function be added to DCHCS's contract management responsibility. This function would periodically review health care service providers to ensure that insurance, licensures and permits are current and in force. If the function finds a contractor out of compliance the contract should be suspended until the requirement(s) is satisfied; or, if in a reasonable time the requirement is not satisfied the contract should be terminated. In addition, the DCHCS should take appropriate action to withhold payment until the requirement(s) are met. DGS office of Risk Management performs a review of the insurance requirements and will have to be consulted regarding the change in policy.

IV. Next Steps

The critical unknown factor facing the Team at this point is the speed with which the IT solutions can be developed and implemented within CDCR. While progress can be made on developing the standard tools – SOWs, terms and conditions, and standard rates – a significant part of the process efficiency occurs when these documents are available instantly to all those involved in the process. The IT work group is pushing ahead to develop a detailed implementation plan and this document should be available within the next 30 days. Work is underway to refine a set of standard contract terms and conditions. This effort should be completed by the end of August. The work to develop standard SOWs is in the planning stage. The most recently developed SOWs are being collected and prioritized based on how soon they will be used and who in the organization will be making use of them. Review of the high priority SOWs by health care professionals will begin in August. The Standard Rate contractor is working and is expected to deliver the final product by the end of September. A workload analysis will be performed so that the needed contract functions can be established and staffed appropriately. Further process development regarding the new contract processes and other changes will result in policy and procedure development, which is planned for completion by the end of August 2006.

CDCR MEDICAL CONTRACTS
Formal Master Bid Process



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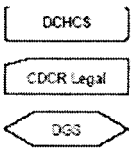


CDCR MEDICAL CONTRACTS
Proposed Formal Master Bid Process Matrix
(Long Term – Assumptions Met)

No.	PROCESS	DESCRIPTION	TIME FRAMES	RESPONSIBLE PARTY
1	Pre-bid Process	• DCHCS acquires contract information; enter request into database with any required changes, additions or alterations to boilerplates/SOW, etc. • Software alerts if there exists a pending request for a particular type of service and/or contracts already in effect. • Software generates request based on type of service, linking to appropriate boilerplates and bidder's list/bid proposal form. • Request to be forwarded to CDCR Legal, if applicable.	4 – 5 days	DCHCS
2	Create Bid Package	• Software alerts DCHCS of duplicates/similar requests and/or contracts already in effect. • Prepare Bid Package.	5-7 days	DCHCS
3	CDCR Legal Input/Approval	• Required only if significant changes are required to GTC only).	2 days	CDCR Legal
4	Advertising	• Advertise services a minimum of 10 business days (add 3 business days for posting) at the DGS Contracts Register website. • Provide Invitation for Bid documents and include STD 213s to allow for pre-signed contracts.	13 days	DGS
5	Bid Opening and Review	• Verify receipt of all bid packages. • Conduct Bid Opening with witness and declare apparent low bidder. • Review and evaluate bid packages document for possible alterations, completeness and required requested documents. • Perform analysis on Rate Sheets for accuracy. • Reject bids that exceed DCHCS benchmark rates. • Request missing documents from bidder or reject bid.	5-10 days	DCHCS
6	Award Process	• Eliminate 5 day period (Intent to Award letter for protest purposes) if awarding to the lowest bidder. • Insurance/license/permits will not be required, however, provider must meet insurance/license/permit requirements as stated in contract.	5 days	DCHCS
7	Contract Preparation	• Analyst prepares contract package for final approval.	5 – 10 days	DCHCS

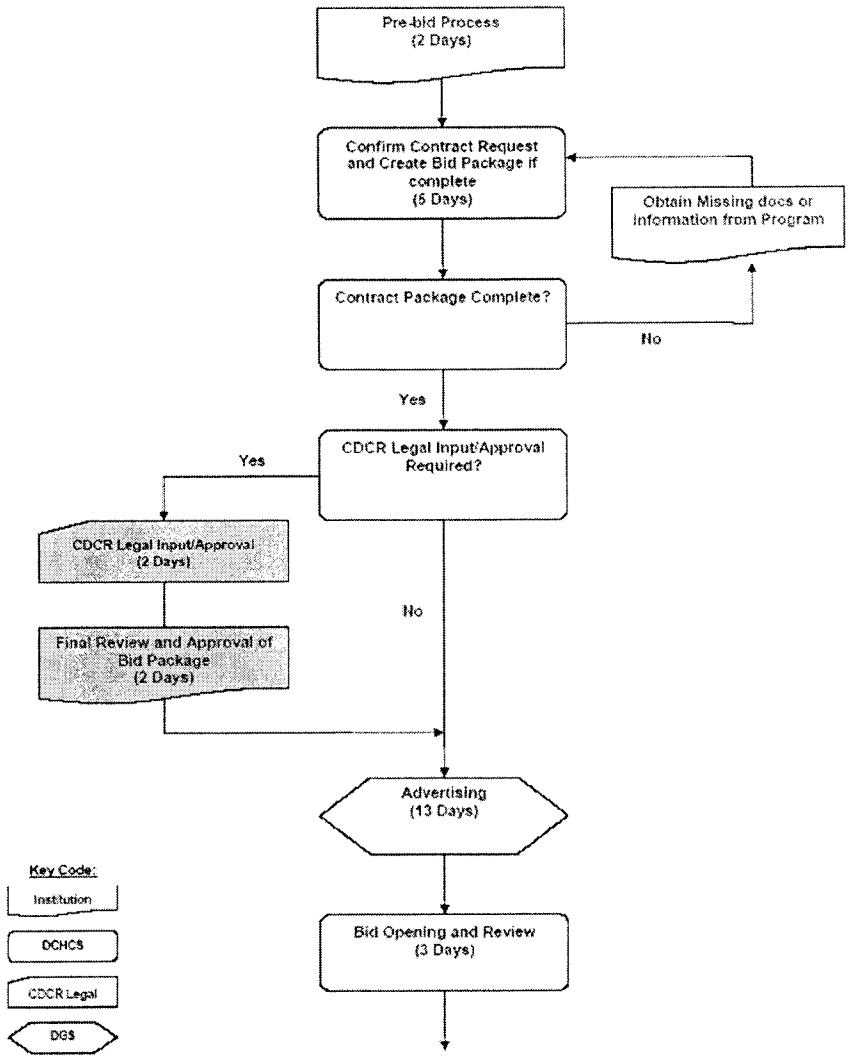
CDCR MEDICAL CONTRACTS
Proposed Formal Master Bid Process Matrix
(Long Term – Assumptions Met)

No.	PROCESS	DESCRIPTION	TIME FRAMES	
6	Accounting Encumbrance	• Master Contract encumbered by appropriate Accounting Office.	2 – 3 days	Accounting
9	Final Contract Approval	• DCHCS Manager final review for completeness, accuracy and approval of contract.	3 – 5 days	DCHCS
10	Distribution	• Update database to reflect approval date. • Scan contract into database. • Distribute executed contract via electronic notification.	2 days	DCHCS
		Total # of Days: (For Protests, add estimated 45 days). (For SPB Challenges, add estimated minimum 20 days for initial response).	• 39-55 days without items 3 & 6 • 45-62 days with items 3 & 6	

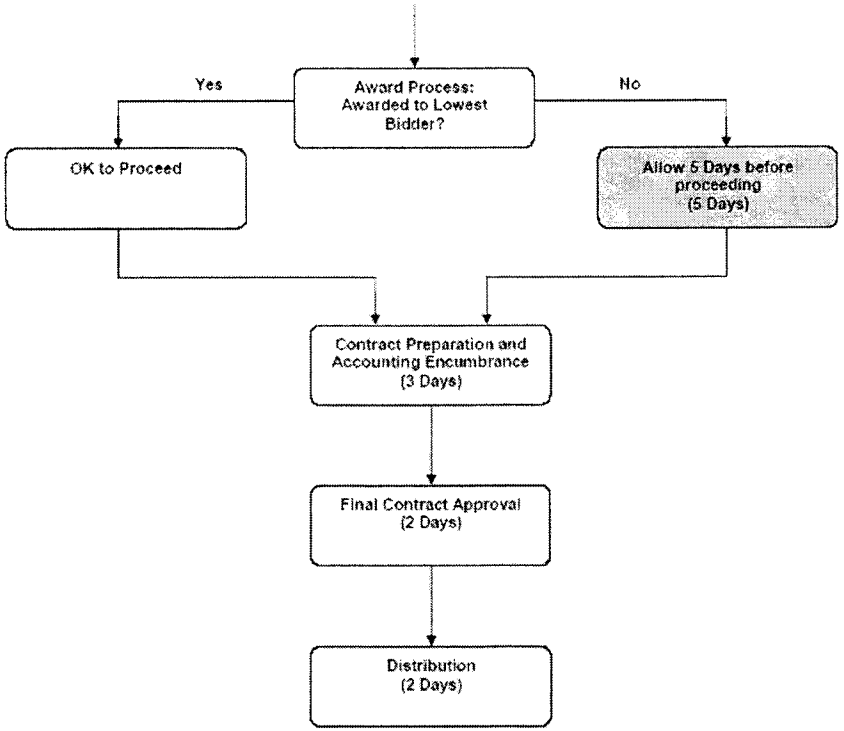
*Please note timeframes provided are based on an individual request and there is adequate staffing to perform the various functions timely. During heavy renewal cycles, the timeframes will need to be adjusted accordingly.

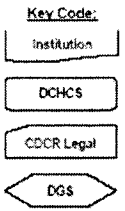
**Although DGS-Legal has been removed from this process, it is extremely critical that post auditing functions be performed throughout the process to ensure the dol/contract is processed in accordance with state laws, regulations and policies set forth. With the removal of DGS oversight/guidance, it is even more critical that CDCR maintain stewardship for the State and be in compliance with all internal and external audits.

CDCR MEDICAL CONTRACTS
Formal Individual Bid Process



CDCR MEDICAL CONTRACTS
Formal Individual Bid Process





CDCR MEDICAL CONTRACTS
Proposed Formal Individual Bid Process
(Long-Term – Assumptions Met)

No.	PROCESS	DESCRIPTION	TIME FRAMES	RESPONSIBLE PARTY
1	Pre-bid Process	• Institution acquires contract information; enter request into database with any required changes, additions or alterations to boilerplates/SOW, etc. • Software alerts institution of duplicate/similar requests and/or contracts already in effect for their institution. • Software generates request based on type of service, linking to appropriate boilerplates and bidder's list/bid proposal form. • Request to be forwarded to DCHCS & CDCR Legal, if applicable simultaneously.	2 days	Institution
2	Confirm Contract Request and Create Bid Package	• Retrieve "New" entered request, confirm if any changes need to be made to request; create electronic/paper file. • Software alerts DCHCS of duplicate/similar requests and/or contracts already in effect or available for that institution. DCHCS will combine similar pending requests from other institutions for same type services so a Master Bid can be performed opposed to an individual bid, if applicable. • Prepare Bid Package while awaiting Legal approval for changes, additions or alterations, if required.	5 days	DCHCS
3	CDCR Legal Input/Approval	• Required only if significant changes are required to GTC only.	2 days	CDCR Legal
4	Final Review and Approval of Bid Package	• Provide final review and approval of bid package (applies when changes are requested to the Scope of Work; Bid Proposal or GTC only).	2 days	Institution
5	Advertising	• Advertise services a minimum of 10 business days (add 3 business days for posting) at the DGS Contracts Register website. • Provide invitation for Bid documents and include STD 213s to allow for pre-signed contracts.	13 days	DGS
6	Bid Opening and Review	• Verify receipt of all bid packages. • Conduct Bid Opening with witness and declare apparent low bidder. • Review and evaluate bid packages document for possible alterations, completeness and required requested documents. • Perform analysis on Rate Sheets for accuracy. • Reject bids that exceed DCHCS benchmark rates. • Request missing documents from bidder or reject bid.	3 days	DCHCS

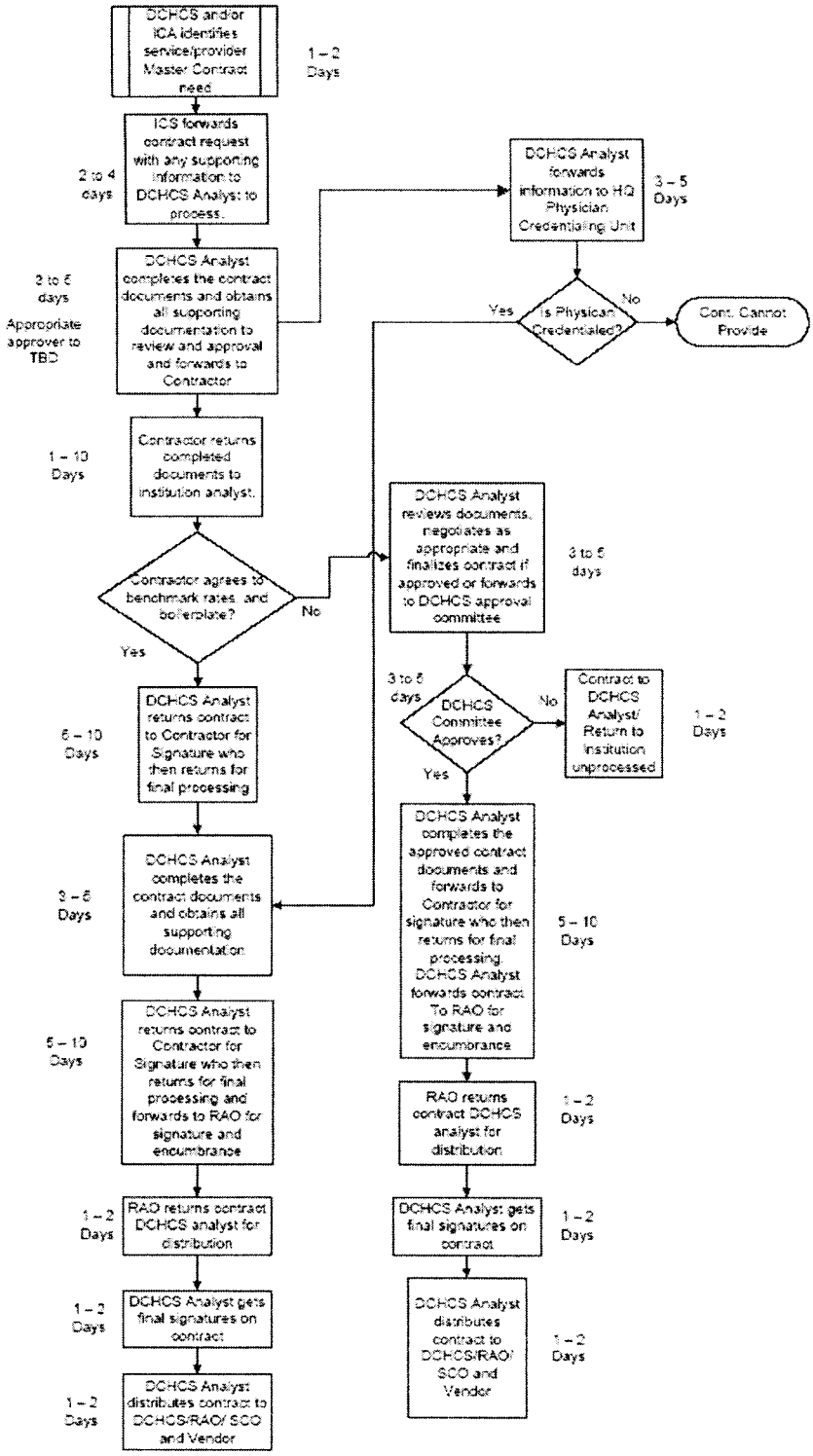
CDCR MEDICAL CONTRACTS
Proposed Formal Individual Bid Process
(Long-Term – Assumptions Met)

No.	PROCESS	DESCRIPTION	TIME FRAMES	RESPONSIBLE PARTY
7	**Award Process**	• Eliminate 5 day period (Intent to Award letter for protest purposes) if awarding to the lowest bidder. • Insurance/licenses/permits will not be required, however, provider must meet insurance/license/permit requirements as stated in contract.	5 days	DCHCS
8	Contract Preparation & Encumbrance	• Analyst prepares contract package for final approval. • Contract encumbered by appropriate Accounting Office.	3 days	DCHCS & Accounting
9	Final Contract Approval	• DCHCS Manager final review for completeness and accuracy; approval of contract.	2 days	DCHCS
10	Distribution	• Update database to reflect approval date. • Scan contract into database. • Distribute executed contract via electronic notification.	2 days	DCHCS
		Total # of Days: (For Protests, add estimated 45 days); (For SPB Challenges, add estimated minimum 20 days for initial response)	• 30 days without items 3, 4, & 7; • 39 days with items 3, 4, & 7	

*Please note timeframes provided are based on an individual request and there is adequate staffing to perform the various functions timely. During heavy renewal cycles, the timeframes will need to be adjusted accordingly.

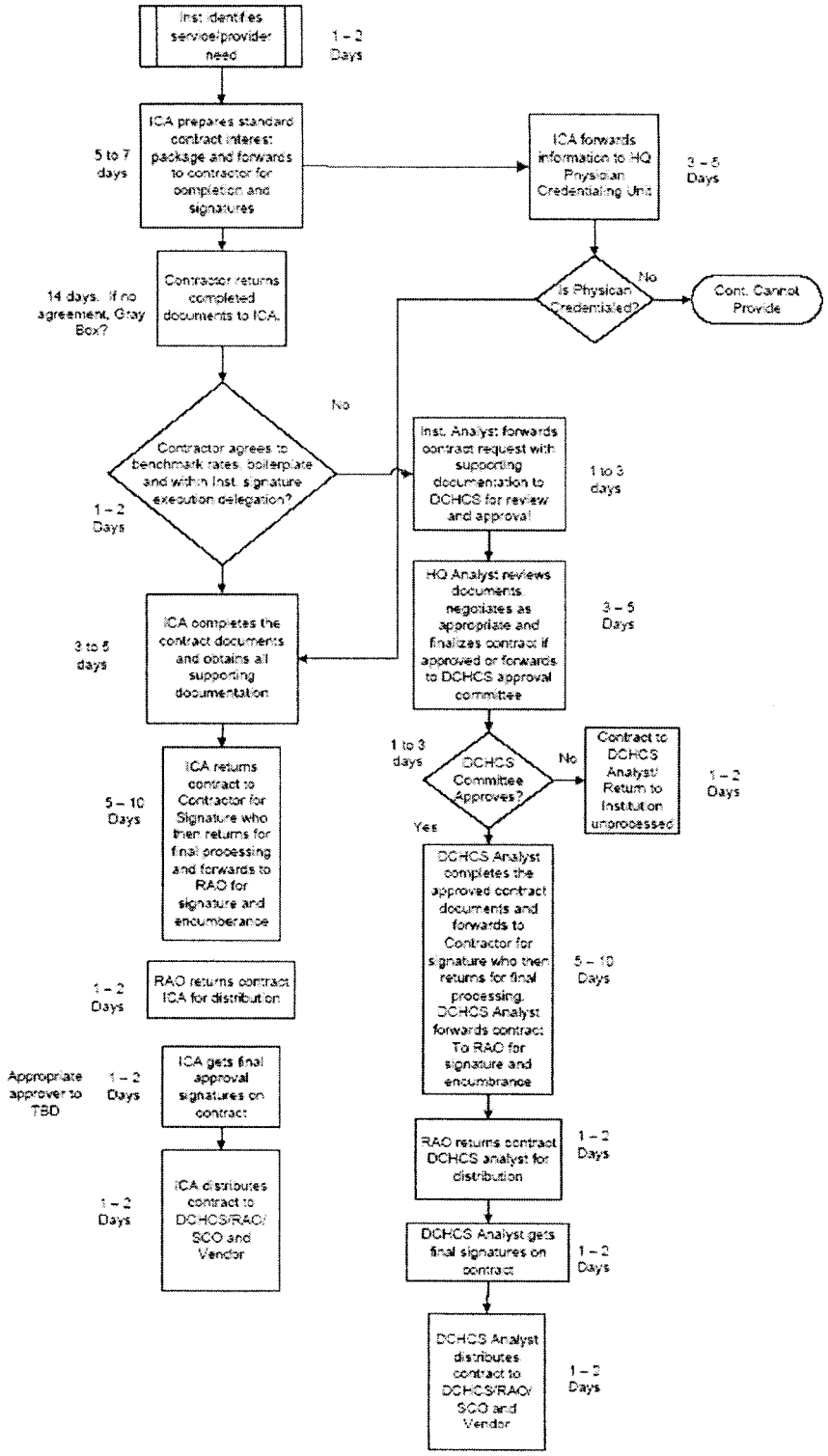
**Although DGS-Legal has been removed from this process, it is extremely critical that post auditing functions be performed throughout the process to ensure the bid/contract is processed in accordance with state laws, regulations and policies set forth. With the removal of DGS oversight/guidance, it is even more critical that CDCR maintain stewardship for the State and be in compliance with all internal and external audits.

Exempt and Informal Non Bid Contract Process – Master Contracts



7/24/2006

Exempt and Informal Non Bid Contract Process – Non Master Contracts



7/24/2008

EXHIBIT 6

CALIFORNIA PRISON HEALTH CARE RECEIVERSHIP CORPORATION
OFFICE OF THE RECEIVER

REQUEST FOR PROPOSAL
FOR HEALTH CARE CONTRACTS
DOCUMENT MANAGEMENT SYSTEM INTEGRATOR

SEPTEMBER 7, 2006

PROPOSALS DUE: FRIDAY, SEPTEMBER 15, 2006

CONTACT: JARED GOLDMAN, STAFF ATTORNEY
1731 Technology Drive, Suite 700
San Jose, CA 95110
jared.goldman@cprinc.org

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Attachments:

Agreement for System Integration Services

Cost Proposal Worksheet

REQUEST

The Receiver of the California Department of Corrections and Rehabilitation's (CDCR) prison medical system is requesting proposals for assisting the Receiver in the implementation of the CDCR's Health Care Contracts Document Management System (HCDMS). The awarded contract will be a service agreement with the Receiver through the California Prison Health Care Receivership Corporation (CPR).

BACKGROUND

As a result of the State of California's ongoing failure to provide medical care to prison inmates at constitutionally acceptable levels, the United States District Court for the Northern District of California has established a Receivership to assume the executive management of the California prison medical system and raise the level of care up to constitutional standards. On February 14, 2006, the Court appointed Robert Sillen to serve as the Receiver and granted him, among other powers, the authority to exercise all powers vested by law in the Secretary of the CDCR as they relate to the administration, control, management, operation, and financing of the California prison medical health care system.

The Court's actions stem from the case of *Plata v. Schwarzenegger*—a class action law suit brought on behalf of the CDCR's adult inmates. Applicants should refer to the Court's October 3, 2005 "Findings of Fact and Conclusions of Law Re Appointment of Receiver" and the Court's February 14, 2006 "Order Appointing Receiver" for further information regarding the conditions underlying the Receivership and the powers and responsibilities of the Receiver. These and other relevant documents can be found on the Court's website at:

> http://www.cand.uscourts.gov/
> (select the following links: "Judges"—"Henderson"—"Models and Examples"—"Henderson"—"Recent Orders"—"Plata v. Schwarzenegger")

Among other serious deficiencies in the CDCR health care system, the Court and the Receiver have identified the CDCR's failure to adequately management its contract system as one of the particularly grave problems threatening the health and lives of the CDCR's inmates. Major backlogs in contract invoice payments have lead to the delay or termination of specialty medical services, thereby placing inmate/patients' health in serious jeopardy. In addition, the mismanagement of the CDCR's health care contracting system has resulted in significant overpayments by the CDCR to its contractors.

It its March 30, 2006 "Order Re State Contracts and Contract Payments Relating to Service Providers for CDCR Inmate Patients," the Court ordered, among other remedies, that the State of California work, under the direction of the Receiver, to develop and institute new health care oriented policies and standards to govern CDCR medical contract management. The State assembled a project team, including the

CDCR, and various State control agencies ("Project Team"), for the purpose of preparing recommendations for improved medical contract management. A key recommendation of the Project Team was that the Receiver implement a Health Care Contract Document Management System (HCDMS). The Receiver has adopted the Project Team's recommendation and is issuing this Request for Proposal (RFP) for the purpose of identifying the vendor best suited for serving as the integrator of the HCDMS.

SCOPE OF WORK

The Receiver is seeking an integrator to implement Prodágio A/P and Prodágio Contracts, Documentum, Adobe Lifecycle, and Captiva's InputAccel at 33 California Department of Corrections and Rehabilitation (CDCR) prisons, eleven Regional Accounting Offices (RAOs) and two headquarters offices in Sacramento California. The project will include (a) piloting the system in four prisons, two RAOs and the headquarters offices by December 11, 2006, (b) statewide implementation at the remaining facilities and RAOs within nine months after acceptance and completion of the pilot, and (c) on going support services through the duration of the contract term.

The term of the contract will be approximately 15 months.

The complete Statement of Work is included in the Exhibit A of the Agreement for System Integration Services ("Agreement"), which is attached to this RFP.

INSTRUCTIONS FOR PROPOSALS

1. Point of Contact

All communications regarding this Request of Proposal (RFP) must be directed, in writing, to:

Jared Goldman, Staff Attorney
California Prison Health Care Receivership Corp.
1731 Technology Drive, Suite 700
San Jose, CA 95110
-or-
jared.goldman@cprinc.org

2. RFP Schedule

Event	Estimated Date
RFP Issued	Thursday, September 7, 2006
Bidder's Conference	Tuesday, September 12, 2006
Proposals due	Friday, September 15, 2006
Bidder Interviews Begin	Wednesday, September 20, 2006
Contract Award	Tuesday, September 26, 2006
Project start date	Monday, October 2, 2006

The bidder's conference will be held at by telephone conference call on Tuesday, September 12, 2006, at 1:30 P.M. The phone number for the conference call is (877) 322-9654, and the participant code number is 722147.

3. Format of Proposal

a. Submit one original proposal signed by the person or persons authorized to bind the applicant contractually.
b. Submit seven copies of the proposal.
c. All proposals must include required attachments, exhibits, etc. All attached materials should reference the applicant's name.
d. Oral, telephone, facsimile or electronic proposals will not be considered.
e. Proposals should be printed on 8-1/2" x 11" paper.

4. Content of Proposal

Proposals must provide complete responses to all the items in this section.

a. Cover Letter. Provide a cover letter, signed by the person or persons authorized to bind the applicant contractually, that includes a statement that the applicant, if selected, will agree to the contract terms and conditions set forth in the attached Agreement (except as provided in paragraph f below).
b. Executive Summary. Provide a summary of the principal advantages of contracting with your organization.
c. Company Data. Provide the following information:
   (1) Your company's name, business address and telephone numbers, including headquarters and local offices.
   (2) The name and email address of your contact person for the purpose of this proposal.
   (3) A description of your organization, including names of principals, number of employees, longevity, client base, and areas of specialization and expertise.
   (4) A disclosure of whether your company has defaulted in its performance on a contract in the last five years, which has led to the termination of a contract.

(5) A list of any lawsuits filed against your company, its subsidiaries, parent, other corporate affiliates, or subcontractors in the past five years and the outcome of those lawsuits.

(6) Copies of your company's last two audited annual financial statements, and/or other information that will assist in formulating an opinion about the stability and financial strength of your company.

(7) Three professional references and the references' contact information.

(8) A disclosure of any financial relationships with other vendors that may be a part of your proposal.

d. Qualifications. Provide the following:

(1) A description of your company's qualifications and ability to execute all of the goals, objective and timelines specified in the Statement of Work.

(2) A description of your company's prior experience related to implementing contract management systems.

(3) A description of the organization of the project team, identifying which members of the team will be responsible for accomplishing the specific deliverables in the Statement of Work.

(4) The names, resumes, and references for all key personnel and subcontractors associated with the proposal.

e. Cost. Provide a cost proposal for performing the Statement of Work, using the Cost Proposal Worksheet, which is attached to this RFP. All proposals must be on a fixed price basis.

5. Modification or Withdrawal of Proposal

Prior to the proposal due date, applicants may modify or withdraw a submitted proposal. Such modifications or withdrawals must be submitted to CPR in writing. Any modification must be clearly identified as such and must be submitted in the same manner as the original (e.g., appropriate copies, paper size, etc.). No modifications or withdrawals will be allowed after the proposal due date.

6. Public Opening

There will be no public opening of responses to this RFP. However, after a contract is awarded, all proposals may be available for public review. CPR makes no guarantee that any or all of a proposal will be kept confidential, even if the proposal is marked "confidential," "proprietary," etc.

7. General Rules

a. Only one proposal will be accepted from any one person, partnership, corporation or other entity.

b. Proposals received after the deadline will not be considered.

c. This is an RFP, not a work order. All costs associated with a response to this RFP, or negotiating a contract, shall be borne by the applicant.
d. CPR's failure to address errors or omissions in the proposals shall not constitute a waiver of any requirement of this RFP.
e. An applicant's proposal is an irrevocable offer for 60 days following the scheduled date for contract award.

8. Reservation of Rights

CPR reserves the right to do the following at any time, at CPR's discretion:

a. Reject any and all proposals, or cancel this RFP.
b. Waive or correct any minor or inadvertent defect, irregularity or technical error in any proposal.
c. Request that certain or all candidates supplement or modify all or certain aspects of their respective proposals or other materials submitted.
d. Procure any services specified in this RFP by other means.
e. Modify the specifications or requirements for services in this RFP, the contents or format of the proposals prior to the due date, or the contract terms or conditions prior to the contract award.
f. Extend the deadlines specified in this RFP, including the deadline for accepting proposals.
g. Negotiate with any or none of the candidates.
h. Terminate negotiations with an applicant without liability, and negotiate with other applicants.
i. Award a contract to any applicant.

9. RFP Evaluation and Contract Award

Each proposal submitted in response to this RFP will be evaluated by a selection committee appointed by the Receiver, which will make recommendations to the Receiver regarding the top applicants. The Receiver or his designee, taking the committee's recommendations into consideration, will, in his or her sole discretion, select the best applicant(s) for an interview. Interviews will be conducted by the Receiver and/or his designee and may include the further participation and advice of the selection committee. The Receiver or his designee, in his or her sole discretion, will select the candidate with whom CPR will enter a contract. If, for any reason, CPR is unable to finalize a contract with the selected applicant, the Receiver may select another applicant with whom CPR will enter a contract, or the Receiver may elect not to award the contract.

Unsuccessful applicants will be notified as soon as possible after the award of the contract.

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AGREEMENT BETWEEN
THE CALIFORNIA PRISON HEALTH CARE RECEIVERSHIP CORPORATION
AND _____
FOR SYSTEM INTEGRATION SERVICES

This Agreement ("Agreement") is made effective October 1, 2006, by and between the California Prison Health Care Receivership Corporation ("CPR") and _____ ("Contractor") to provide computer system integration services to CPR.

WHEREAS, CPR is responsible for the executive management of the California Department of Corrections and Rehabilitation, Division of Correctional Health Care Services (CDCR); and

WHEREAS, CPR desires to engage a system integrator to implement, within the CDCR, an electronic document creation, workflow, management and storage system for contract and invoice processing; and

WHEREAS, Contractor has experience and expertise necessary to provide such services;

THEREFORE, the parties agree as follows:

1. Nature of Services.

Contractor will provide to CPR the services described in Exhibit A, Statement of Work, which is attached hereto and incorporated herein by this reference.

2. Term of Agreement.

This Agreement is effective from October 1, 2006, to and including February 28, 2008, unless terminated earlier in accordance with Section 4. CPR will have the option to extend the term of this Agreement for up to 6 months to allow for unanticipated changes in the project schedule and to permit successful completion of deliverables.

3. Compensation.

A. Contractor will be compensated for services provided under this Agreement in accordance with the Rate Schedule included in Exhibit B.

B. Contractor will provide the CDCR Project Manager with invoices, no more than monthly, which shall identify the number and title (as provided in Exhibit B) of completed deliverables over the course of the preceding month. The CDCR Project Manager will forward approved invoices to CPR for payment. CPR will pay undisputed invoices within 45 days of

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Contractor's submission of the invoice to the CDCR Project Manager.

C. Compensation paid under this agreement shall not exceed _____ $ _____ for services. In addition, CPR shall reimburse Contractor for approved travel and overnight lodging as set forth in Exhibit B.

4. Termination.

A. Termination for Convenience.

(1) CPR may terminate performance of work under this Agreement at its convenience in whole or in part. CPR shall do so by delivering to Contractor a Notice of Termination specifying the extent of termination and the effective date thereof.

(2) After receipt of a the Notice of Termination, and except as directed by CPR, Contractor shall immediately proceed with the following obligations, regardless of any delay in determining or adjusting any amounts due under this clause. Contractor shall (i) stop work as specified in the Notice of Termination, (ii) place no further subcontracts except as necessary to complete the continuing portion of the Agreement, (iii) terminate all subcontracts to the extent they related to the work terminated, and (iv) settle all outstanding liabilities arising from the termination of subcontracts.

(3) If Contractor and CPR fail to agree on the amount to be paid because of the termination for convenience, CPR will pay Contractor the following amounts; provided that in no event will total payments exceed the amount payable to the Contractor if this Agreement had been fully performed: (i) The amount in the Rate Schedule for deliverables accepted by CPR and not previously paid for; and (ii) the total of the reasonable costs incurred in the performance of the work terminated and the reasonable cost of settling liabilities under terminated subcontracts that are properly chargeable to the terminated portion of the Agreement.

(4) Contractor will use generally accepted accounting principles and sound business practices in determining all costs claimed, agreed to, or determined under this clause.

B. Termination for Default.

(1) CPR may terminate this Agreement in whole or in part by written notice of default, if the Contractor fails to: (i) deliver the deliverables or perform the services within the time specified in the Agreement; (ii) make progress, so that the lack of progress endangers the performance of this Agreement; or (iii) perform any other provisions of this Agreement.

(2) CPR's right to terminate this Agreement under subsection (1) above, may be exercised if the failure constitutes a material breach of this Agreement and if Contractor does not cure such failure within the timeframe stated in CPR's cure notice, which in no event will be less than 15 days.

(3) If CPR terminates this Agreement in whole or in part pursuant to this Section, it may acquire, under terms and in the manner CPR deems appropriate, deliverables or services similar to those terminated, and Contractor will be liable to CPR for any excess costs for those deliverables and services. Contractor shall, however, continue the work not terminated. Contractor

shall not be liable for any excess costs if the failure to perform this Agreement arises from causes beyond the control and without the fault or negligence of Contractor and its subcontractors.

(4) CPR shall pay the amount set forth in the Rate Schedule for completed and accepted deliverables.

5. Conflicts of Interest.

In accepting this Agreement, Contractor covenants that it presently has no interest, and will not acquire any interest, direct or indirect, financial or otherwise, which would conflict in any manner or degree with the performance of the services provided under this Agreement. Contractor further covenants that, in the performance of this Agreement, it will not employ any contractor or person having such an interest.

6. Indemnification/Insurance.

Contractor's indemnification and insurance obligations with respect to this Agreement are set forth in Exhibit C, attached hereto and incorporated herein by this reference.

7. Information Technology Provisions.

The parties agree to the information technology provisions set forth in Exhibit D, which is attached hereto and incorporated herein by this reference.

8. Confidentiality of Information.

All financial, statistical, personal, technical and other data and information relating to State operations, which are designated confidential by the State and made available to carry out this Agreement, or which become available to Contractor in order to carry out this Agreement, shall be protected by Contractor from unauthorized use and disclosure. Contractor shall not be required under the provisions of this paragraph to keep confidential any data already rightfully in Contractor's possession that is independently developed by Contractor outside the scope of this Agreement or is rightfully obtained from third parties. No reports, information, inventions, improvements, discoveries, or data obtained, repaired, assembled, or developed by the contractor pursuant to this Agreement shall be released, published, or made available to any person in violation of any State or federal law.

Contractor agrees that all inmate/patient medical information is confidential. If the services provided under this Agreement involves the use of any inmate/patient medical information, Contractor agrees to comply with all applicable patient privacy laws, including, but not limited to, the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations (Code of Federal Regulations, Title 45, Sections 164.501 et seq.) ("HIPAA"), and California Civil Code Sections 56 et seq. If Contractor is a "Business Associate" (as that term is defined by

HIPAA) of the State, Contractor agrees to execute a separate Business Associate contract with the State.

9. Security.

A. Contractor agrees that if the provisions of this Agreement require Contractor to enter a prison facility, Contractor and any employee(s) and/or subcontractor(s) shall abide by applicable laws, rules and regulations governing conduct at prison facilities and in associating with prison inmates. This may include fingerprinting and/or obtaining security clearance through the Department of Justice, Bureau of Criminal Identification and Information (BCII). Contractor must notify the CDCR Project Manager or his or her designee, in writing, of the personnel, and subsequently any changes of those personnel, allowed access to State premises for the purpose of providing services under this Agreement. In addition, Contractor must recover and return any State-issued identification card provided to Contractor's employee(s) upon their departure or termination and upon the termination of this Agreement.

B. Gate Clearance. Contractor and Contractor's employee(s) and/or subcontractor(s) providing services a prison facility may be required by CDCR to obtain gate clearance prior to providing services at the facility. Contractor may be required by CDCR to complete a Request for Gate Clearance for all persons entering the facility a minimum of ten (10) working days prior to commencement of service at the facility. The Request for Gate Clearance must include the person's name, social security number, valid state driver's license number or state identification card number and date of birth. Information shall be submitted to the CDCR Project Manager or his/her designee. CDCR may use the Request for Gate Clearance to run a California Law Enforcement Telecommunications System (CLETS) check. The check may include Department of Motor Vehicles check, Wants and Warrants check, and Criminal History check. Gate clearance may be denied for the following reasons: the individual's presence in the institution presents a serious threat to security, the individual has been charged with a serious crime committed on institution property, inadequate information is available to establish positive identity of prospective individual, and/or the individual has deliberately falsified his/her identity. All persons entering the facilities must have a valid state driver's license or photo identification card on their person.

10. Limitation of Liability.

CPR, the State or their employees shall not be liable to Contractor or its staff for injuries inflicted by inmates of the State. CPR agrees to disclose to Contractor any statement(s) known to CPR staff made by any inmate which indicates violence may result in any specific situation.

11. Tuberculosis Testing

In the event that the services required under this Agreement will be performed within a CDCR institution, prior to the performance of contracted duties, Contractor's employees may be required to be examined or tested or medically evaluated for TB in an infectious or contagious

stage, and at least once a year thereafter or more often as directed by CDCR. Contractor's employees may be required to furnish to CDCR, at no cost to CDCR, a form CDCR 7336, "Employee Tuberculin Skin Test (TST) and Evaluation," prior to assuming their contracted duties and annually thereafter, showing that Contractor's employees have been examined and found free of TB in an infectious stage. The form CDCR 7336 will be provided by CDCR upon Contractor's request.

12. Compliance with Law.

Contractor shall, during the term of this Agreement, comply with all applicable federal, state, and local rules, regulations, and laws.

13. Accounting Principles.

The contractor will adhere to generally accepted accounting principles as outlined by the American Institute of Certified Public Accountants. Dual compensation is not allowed; a contractor cannot receive simultaneous compensation from two or more funding sources for the same services performed even though both funding sources could benefit.

14. Examination and Audit.

Contractor agrees that CPR, or its designated representative, shall have the right to review and copy any records and supporting documentation pertaining to the performance of this Agreement. Contractor agrees to maintain such records for possible audit for a minimum of 3 years after final payment, unless a longer period of retention is stipulated. Contractor agrees to allow the auditor(s) access to such records during normal business hours and to allow interviews of any employees or others who might reasonably have information related to such records. Further, Contractor agrees to include a similar right of CPR to audit records and interview staff in any subcontract related to performance of this Agreement.

15. Assignment.

Contractor has been selected to perform services under this Agreement based upon the qualifications and experience of Contractor's personnel. Contractor may not assign this Agreement or the rights and obligations hereunder without the specific written consent of CPR.

16. Subcontractors and Consultants.

Contractor is required to identify all subcontractors and consultants who will perform labor or render services in the performance of this Agreement. Additionally, the contractor shall notify CPR and the CDCR Project Manager, in writing, within ten (10) working days, of any changes to the subcontractor and/or consultant information.

17. Relationship of Parties; Independent Contractor.

Contractor will perform all work and services described herein as an independent contractor and not as an officer, agent, servant or employee of CPR. None of the provisions of this Agreement is intended to create, nor shall be deemed or construed to create, any relationship between the parties other than that of independent parties contracting with each other for purpose of effecting the provisions of this Agreement. The parties are not, and will not be construed to be in a relationship of joint venture, partnership or employer-employee. Neither party has the authority to make any statements, representations or commitments of any kind on behalf of the other party, or to use the name of the other party in any publications or advertisements, except with the written consent of the other party or as is explicitly provided herein. Contractor will be solely responsible for the acts and omissions of its officers, agents, employees, contractors, and subcontractors, if any.

18. Notices.

All notices required by this Agreement will be deemed given when in writing and delivered personally or deposited in the United States mail, postage prepaid, return receipt requested, addressed to the other party at the address set forth below or at such other address as the party may designate in writing in accordance with this section:

To Contractor: _____
_____
_____
_____

To the CPR: Receiver
California Prison Health Care Receivership Corporation
1731 Technology Dr., Suite 700
San Jose, CA 95110

19. Governing Law.

This Agreement has been executed and delivered in, and will be construed and enforced in accordance with, the laws of the State of California.

20. Entire Agreement.

This document represents the entire Agreement between the parties with respect to the subject matter hereof. All prior negotiations and written and/or oral agreements between the parties with respect to the subject matter of this Agreement are merged into this Agreement.

21. Amendments.

This Agreement may be amended only by an instrument signed by the parties.

22. Counterparts.

This Agreement may be executed in one or more counterparts, each of which shall be deemed to be an original, but all of which together shall constitute one and the same instrument.

23. Severability.

If any provision of this Agreement is found by a court of competent jurisdiction to be void, invalid or unenforceable, the same will either be reformed to comply with applicable law or stricken if not so conformable, so as not to affect the validity or enforceability of this Agreement.

24. Waiver.

No delay or failure to require performance of any provision of this Agreement shall constitute a waiver of that provision as to that or any other instance. Any waiver granted by a party must be in writing, and shall apply to the specific instance expressly stated.

IN WITNESS WHEREOF, CPR and Contractor have executed this Agreement as of the date above written.

CALIFORNIA PRISON HEALTH CARE RECEIVERSHIP CORP.	[Enter CONTRACTOR'S Name]
_____	_____
Robert Sillen Receiver Date:	By: Title: Date:

Exhibits to this Agreement:

Exhibit A	Statement of Work
Exhibit B	Rate Schedule
Exhibit C	Indemnification and Insurance
Exhibit D	Information Technology Provisions
Exhibit E	Facility List

EXHIBIT A

California Prison Health Care Receivership Corporation
Agreement for System Integration Services for the
CDCR Healthcare Contracts Document Management System

STATEMENT OF WORK

A. CONTRACT PURPOSE AND DESCRIPTION

Objectives

Improve the contracting processes for CDCR facilities by implementing electronic document creation, workflow, management and storage for contract and invoice payment systems.

Contractor will implement Prodágio A/P and Prodágio Contracts, Documentum, Adobe Lifecycle, and Captiva's InputAccel at 33 California Department of Corrections and Rehabilitation (CDCR) prisons, eleven Regional Accounting Offices (RAOs) and two headquarters offices in Sacramento California. The project will include (a) piloting the system in four prisons, two RAOs and the headquarters offices by December 11, 2006, (b) statewide implementation at the remaining facilities and RAOs within nine months after acceptance and completion of the pilot, and (c) on going support services through the duration of the contract term.

Contractor will pilot HCDMS at the following CDCR facilities:

- Pelican Bay State Prison, Crescent City, CA
- San Quentin State Prison, San Quentin, CA
- California Medical Facility, Vacaville, CA
- Central California Woman's Facility, Chowchilla, CA
- RAO – North Coast, CDCR headquarters, Sacramento, CA
- RAO - Corcoran, Corcoran, CA
- Health Care headquarters Sacramento, CA
- CDCR headquarters Contract Section, CDCR headquarters, Sacramento, CA

System Description

There will be four distinct components in the Health Care Contracts Document Management System (HCDMS). These key components will be:

- Standardized Medical Contract Templates
- Medical Contracts Process Management and Monitoring
- Medical Contracts Electronic Invoicing and Payment
- Medical Contracts Document Storage

EXHIBIT A

The following are descriptions and explanations of each of these components:

- ***Standardized Medical Contract Templates*** – Standardized medical contract templates for Statement of Works, Standard Rate Sheets, and Standard Contract Terms and Conditions will developed and made available to authorized staff. Each template will be formatted to limit changes, utilizing read only drop-down menus for modifications. A document-comparison feature will assure various contract elements have not been changed. A repository of vendors with their specialty\service information listed by local and or regional areas will also be included for the purpose of reducing the time needed to identify possible vendors for procurements.

- ***Medical Contracts Process Management and Monitoring*** –Once a contract is initiated, contracting and HCCUP staff will be able to monitor each contract's progress throughout the entire contract lifecycle. Medical Contracts documents will move through the system electronically, work progress reviews and approvals will also be accomplished electronically at various stages along the way. Additional flagging features will be used to identify when time limits by offices or staff are being exceeded; flags will be triggered when certain conditions are met\are not met. Document tracking features will also be built-in to ensure that staff know where all contracts are at all times.

- ***Medical Contracts Electronic Invoicing and Payment*** – All invoices related to medical contracts will be scanned and electronic copies of the documents will be stored for future usage or reference. As with Medical Contracts documents, Medical Contract Invoices will move through the system electronically, work progress reviews and approvals will also be accomplished electronically at various stages along the way. Specific flagging features will be used to identify when time limits by offices or staff are being exceeded; flags will be triggered when certain conditions are met\are not met. Additionally, a means for contractors to submit electronic bills for services that have been provided, as well as a means for electronic payment for services that have been received will be included. The capability to accommodate electronic signatures or the ability to sign documents and re-scan them into a *Medical Contracts Document Storage* System is also a requirement.

- ***Medical Contracts Document Storage*** – All contract and invoice documents will be scanned and electronically stored. Scanned documents will be linked to the specific contracts that they are associated with, allowing staff to easily track any contract through the entire process. Document search features will be required to enable staff to easily find documents within storage areas or archives.

Software Customization

HCDMS requires a combination of a commercial off the shelf ("COTS") document management package and customization and configuration to meet CDCR requirements.

Project Team

In addition to Contractor's team members necessary for successful implementation of HCDMS, the project team will include a Project Manager provided by CDCR (CDCR Project Manager), and technical team members from CDCR's Office of Enterprise Information Services. Staff from CDCR's Division of Correctional Health Services Accounts Payable and Contracts and Health Care Cost and Utilization Program will work through the CDCR Project Manager to provide input to the project.

B. CONTRACT DELIVERABLES AND ACCEPTANCE CRITERIA

Deliverable 1: Project Management Plan

Deliverable 1-1: Pilot Project Schedule

Contractor shall develop a project plan that will implement HCDMS at the pilot sites identified above by December 11, 2006. The plan shall include staffing requirements and operation of the pilot for 90 calendar days

Deliverable 1-2: Statewide Implementation Schedule

Contractor shall develop a statewide plan to implement the system at the remaining CDCR sites (see attached facility list (Exhibit E), which is incorporated herein) and complete the implementation within nine months after acceptance and completion of the pilot.

Deliverable 2: Business Process Analysis

Business forms, reports and processes have been posted on the CDCR internet site. Vendors can access the information by entering this site address directly in their browser: http://www.cdcr.ca.gov/ContractDocs/.

EXHIBIT A

Deliverable 2-1: Pre- installation analysis

Contractor shall complete a pre-installation analysis, which will include the following:

- Documentation of business roles and responsibilities as they relate to usage of the contracting system.
- Documentation of gaps between current CDCR processes and the processes to be utilized in the new system.
- Documentation of needed CDCR Contracting Process Re-engineering.
- Enterprise Resource Planning (ERP) mappings needed to configure Prodágio's ERP connection layer.
- Recommendations and plan for implementation of contracting system best practices in CDCR.
- Plan for integration of existing contracts into the new system.

Deliverable 2-2: External System Integration Plan

Contractor shall complete an external system integration plan, which includes the following:

- Documentation of external State accounting systems that exchange electronic contracting and accounting data with CDCR.
- Documentation of existing CDCR local databases and provision of a plan to incorporate functions from such databases.

Deliverable 2-3: Reporting

Contractor will identify and document the system generated reports required to meet CDCR business needs, and identify existing reports which meet such needs. Contractor will also identify gaps and document any new reports that will be necessary to meet CDCR business needs.

Deliverable 2-4: Data Conversion

The integrator will develop a data conversion plan for convert existing contract information from the CDCR contracts database into the new system. The plan will include data cleanup requirements and conversion processes.

Deliverable 2-5: Environment Validation

Contractor will validate whether CDCR's hardware and software infrastructure is sufficient to implement HCDMS, including the following:

- Validating Hardware configuration in CDCR and identifying gaps in hardware.
- Validating software configuration in CDCR and identifying gaps in software.
- Validating that all tools are in place for Acceptance Testing, implementation and ongoing support.

If CDCR's infrastructure is insufficient to implement HCDMS, CDCR will be responsible for performing infrastructure improvements necessary for the system, and CPR will make an equitable adjustment to the delivery schedule.

Deliverable 2-6: Training Plan

Contractor will develop a training plan, which includes the following:

- A plan for training CDCR pilot facility and Headquarters staff including end users and CDCR information technology staff. The plan shall provide for Contractor conducting training during the pilot period.
- A plan for "training the trainers." The plan shall provide for Contractor performing the "training the trainers" and for the trained CDCR staff to perform training for sites implemented during Deliverable 5.
- A plan for ongoing training.
- Assessment of the Contractor's training classes.

All training plans developed under this Deliverable must include a classroom component.

Deliverable 2-7: On-Going Support Plan

Contractor will develop an on-going support plan, which includes the following:

- Identify activities for integrator during project implementation.
- Identify activities for CDCR staff during implementation and on a on-going basis.

Deliverable 2-8: Remaining Site Implementation Plan

Contractor will update the statewide schedule developed for Deliverable 1-2 and provide a detailed plan that implements the system at the remaining CDCR sites within nine months of successful pilot completion. The plan will identify each site to be implemented and the activities required to implement the site.

Deliverable 3: User Acceptance Test

Contractor shall conduct a User Acceptance Test which will include the following:

- Training the testing team.
- Configuring the test environment.
- Developing an end user guide that includes agreed upon business processes that were developed in conjunction with this SOW to meet CDCR needs.
- Developing technical support documentation.
- Developing automated conversion of existing contract information from existing CDCR system.
- Conduct User Acceptance Test Sessions as needed.

Deliverable 4: Pilot Implementation

Contractor will implement the pilot sites identified above by December 11, 2006. The pilot duration will be 90 calendar days. During the pilot, the integrator will work with CDCR staff to validate and document that the system is functioning as required by the CDCR business processes. Contractor will also conduct training for pilot facility and Headquarters staff in accordance with the training plan developed under Deliverable 2-6.

Deliverable 5: Remaining CDCR Site Implementation

Contractor will implement the remaining CDCR sites as listed in the attached facilities list. Contractor will also "train the trainers" in accordance with the training plan developed under Deliverable 2-6. The order of implementation will be identified in the integrator's implementation plan in Deliverable 2-8. Each site will be a separate deliverable and can be invoiced separately upon successful implementation and acceptance by the CDCR Project Manager.

Deliverable 6: Ongoing support

Contractor will provide ongoing support for the installed sites through the life of this contract.

Acceptance Criteria

1. Deliverables shall be submitted for review both electronically using Microsoft Office products and on paper to the CDCR Project Manager. Contractor shall file all documents electronically on a file share area designated by CDCR Project Manager. All deliverables must be prepared with appropriate grammar and formatting in accordance to CDCR's Secretarial Handbook.

2. The CDCR Project Manager will notify Contractor and CPR of acceptance or rejection by the CDCR Project Manager of a deliverable within five (5) working days of receipt of the deliverable. Contractor will make any necessary changes, based on the CDCR Project Manager's findings, and resubmit the deliverable within five (5) working days. CPR shall retain the authority to determine, in its sole discretion, whether a deliverable has been successfully completed and is accepted.

C. STAFFING REQUIREMENTS

Contractor will provide a team of professionals aligned with the requirements defined by this Statement of Work. The core team will consist, at least, of the following roles:

Project Coordinator:
Guides the operational aspects of the project, including communicating project status, conducting status meetings, updating and monitoring the project plan, schedule and budget, organizing resources to complete project tasks, and resolving project issues. The Project Coordinator also provides best practices and serves as the primary point of contact for CDCR.

Business Analysts:
Gather the core business information requirements, including document management specific requirements, and assist in issue resolution and the creation of training materials.

Project Architect:
Direct the overall technical aspects of the project, including establishment of the technical environment and key implementation / configuration decisions as it pertains to Enterprise Resource Planning (ERP) Integration.

Configuration Consultant:
Provide expertise in the overall design, development, configuration, and deployment of the accounts payable system.

Training Specialist:
Develops training content specific to CDCR system and provides onsite training around the various processes & functionality of the contracts management system.

D. CONTRACTOR ROLES AND RESPONSIBILITIES

1. Contractor shall work cooperatively with CPR and CDCR staff and management. This includes interacting with CDCR Project Manager and project oversight consultants.

2. Contractor shall participate in all meetings and activities that are deemed necessary by the CPR or the CDCR Project Manager.

3. Contractor shall keep open and regular channels of communication to ensure the successful execution of this contract. Contractor shall communicate any potential problems or issues to the CDCR Project Manager and the CPR Contract Manager within 48 hours of becoming aware of said problem.

4. The Contractor's team lead must be available for on-site management of this contract at CPR's or the CDCR Project Manager's request.

E. CPR AND CDCR ROLES AND RESPONSIBILITIES

CPR will designate a CPR Contract Manager for the purpose of administering this Agreement. CPR will also ensure that the CDCR provides the following:

1. The CDCR shall provide cubicle accommodations at a CDCR location in Rancho Cordova, California and at 501 J. Street in Sacramento, California. Accommodations will include a desk, telephone, computer hardware, and software necessary for completion of the work of this Agreement. Contractor may be required to share cubicle space with other consultants working on different engagements for CDCR. No clerical support will be provided to Contractor by CPR or CDCR.

2. CDCR shall provide the Consultant with a copy of the CDCR's Secretarial Handbook.

3. CDCR shall provide resources for the following roles as needed:

   Project Sponsor:
   Responsible for key decisions related to project direction

   Project Manager:
   Provides direction to the CDCR and Contractor project team manager and facilitates operational aspects of the project on a daily basis, including issue resolution. Serves as primary point of contact for the project.

Technical Manager
Provides infrastructure details during technical workshops. Coordinates and assists in technical deployment activities and provides the integrator team access and technical information necessary for implementation and deployment.

IT ERP Resources (Legacy Systems):
Assist as necessary, in providing insight into CDCR ERP configurations and standards.

Accounts Payable Subject Matter Experts:
Accounts Payable and Finance team members that participate in workshops and issue resolution processes in order to define the direction of the business process and details of the required functionality at the facility and headquarter levels.

Contracts Processing Subject Matter Experts:
Contracts team members will participate in workshops and issue resolution processes in order to define the direction of the business processes and details of the required functionality at both the facility and headquarter levels.

E. ASSUMPTIONS AND CONSTRAINTS

1. Work hours for CDCR project staff are generally 8 am to 5 pm, Monday through Friday, except for State holidays, at 501 J Street, Sacramento, CA and 1920 Alabama Ave, Rancho Cordova, CA. Contractor staff should plan meeting with CDCR staff around these timeframes. Access to office space and equipment will be available to Contractor staff outside these hours.

2. Contractor will be given access to CDCR staff, meetings, and information to perform their duties. If Contractor is denied access to any of these, Contractor shall notify the CDCR Project Manager for resolution.

3. Any work on CDCR grounds is subject to the rules and procedures of the CDCR.

EXHIBIT B

RATE SCHEDULE

1. Contractor will be compensated for completed and accepted deliverables as set forth below:

[*T.B.D.*]

2. 50% of the cost of software and goods shall be apportioned equally between the system sites and invoiced on a per facility basis following successful installation and acceptance at the applicable facility by the CDCR Project Manager. The remaining 50% of the cost of software and goods shall be invoiced following the completion and acceptance of all deliverables.

3. In addition to the compensation for completed and accepted deliverables, CPR will reimburse Contractor for travel and overnight lodging expenses outside the Sacramento metropolitan area, but within California, which is necessary under this Agreement. Travel and overnight lodging must be authorized and approved in advance by the CDCR Project Manager. Travel and overnight lodging expenses and will be paid at the State Government Rate following submission of a claim, including requisite receipts. Receipts and documentation of travel are required to be submitted to the CDCR Project Manager for approval and will be forwarded to CPR for payment. No travel or parking for the Sacramento metropolitan area will be paid.

EXHIBIT C

INDEMNIFICATION AND INSURANCE

INDEMNIFICATION

Contractor shall indemnify, defend, and hold harmless CPR and the State of California, their officers, agents and employees from any claim, liability, loss, injury or damage that results from any act or omission or any negligent or willful misconduct by Contractor, its officers, agents, subcontractors or employees. Contractor shall reimburse CPR and/or the State for all costs, attorneys' fees, expenses and liabilities incurred with respect to any litigation in which Contractor is obligated to indemnify, defend and hold harmless the CPR and/or the State.

INSURANCE

Without limiting the Contractor's indemnification of CPR or the State of California, the Contractor shall provide and maintain at its own expense, during the term of this Agreement, or as may be further required herein, the following insurance coverages and provisions:

A. Evidence of Coverage. Prior to commencement of services, the Contractor shall provide a Certificate of Insurance certifying that coverage as required herein has been obtained. Individual endorsements executed by the insurance carrier shall accompany the certificate.

B. All coverage as required herein shall not be cancelled or changed so as to no longer meet the specified insurance requirements without 30 days' prior written notice of cancellation or change being delivered to CPR.

C. Insurance Required:

Commercial General Liability Insurance – for bodily injury (including death) and property damage which provides limits as follows:

- Each occurrence - $1,000,000
- General aggregate - $2,000,000

Workers' Compensation and Employer's Liability Insurance –

- Statutory California Workers' Compensation Coverage including broad form all-states coverage.
- Employer's Liability coverage for not less than $1,000,000 per occurrence.

D. General liability coverage shall include the following endorsement, a copy of which shall be provided to CPR:

"California Prison Health Care Receivership Corporation and the State of California, and their officers, agents, and employees, individually and

collectively as additional insured."

Insurance afforded by the additional insured endorsement shall apply as primary insurance, and other insurance maintained by CPR or the State, their officers, agents and employees shall be excess only and not contributing with insurance provided under this policy.

EXHIBIT D

INFORMATION TECHNOLOGY PROVISIONS

1. Definitions. Unless otherwise specified in the Statement of Work the following terms shall be given the meaning shown:

"Deliverables" means goods, software, information technology, telecommunications technology and other items (e.g., reports) to be delivered pursuant to this Agreement, including any such items furnished incident to the provision of services.

2. Contractor's Power and Authority.

Contractor warrants that it has full power and authority to grant the rights herein granted and will hold CPR and the State harmless from and against any loss, cost, liability, and expense (including reasonable attorney fees) arising out of any breach of this warranty. Further, Contractor avers that it will not enter into any arrangement with any third party which might abridge any rights of CPR or the State under this Agreement.

3. License Grant.

Contractor and its subcontractors hereby grant to CPR and the State, subject to the terms and conditions of this Agreement, a non-exclusive, non-transferable license to use the software products listed in the Statement of Work of this Agreement ("Software Products"). CPR and the State may use the Software Products in the conduct of their own business. The license granted above authorizes CPR and the State to use the Software Products on the computer systems located at the sites specified in the Statement of Work. By prior written notice, CPR or the State may relocate the authorized sites at which the Software Products are to be used.

4. Inspection, Acceptance and Rejection.

A. Contractor and its subcontractors will provide and maintain a quality assurance system acceptable to CPR covering Deliverables and services under this Agreement and will tender to CPR and the State only those Deliverables and services that have been found to conform to this Agreement's requirements. Contractor will keep records evidencing inspections and their result, and will make these records available to CPR during the performance of this Agreement and for 3 years after final payment. Contractor shall permit CPR to review procedures, practices, processes and related documents to determine the acceptability of Contractor's quality assurance system or other similar business practices related to the performance of the Agreement.

B. All Deliverables may be subject to inspection, test and acceptance by CPR or its authorized representatives. Contractor shall furnish to inspectors all information and data as may be reasonably required to perform their inspection.

C. CPR shall give written notice of rejection of Deliverables delivered or services performed hereunder within a reasonable time after receipt of such Deliverables or performance of such services. Such notice of rejection will state the respects in which the Deliverables do not substantially conform to their specifications. If CPR does not provide such notice of rejection within 45 days of delivery or completion, such Deliverables and services will be deemed to have been accepted. Acceptance by CPR will be final, except as it relates to latent defects, fraud, and gross mistakes amounting to fraud. Acceptance shall not be construed to waive any warranty rights that CPR might have at law or by express reservation in this Agreement with respect to any nonconformity.

5. Warranty.

A. The warranties in this subsection begin on the date of delivery or upon acceptance of the Deliverable or service in question and end 1 year thereafter. Contractor warrants that (1) Deliverables and services furnished hereunder will substantially conform to the requirements of this Agreement (including without limitation all descriptions and specifications identified in the Statement of Work), and (2) the Deliverables will be free from any material defects in materials and workmanship. Where the parties have agreed to design specifications and incorporated the same or equivalent in the Statement of Work directly or by reference, Contractor warrants that its Deliverables provide all material functionality required thereby. In addition to the other warranties set forth herein, where the Agreement call for the delivery of third party software, Contractor warrants that such software will perform in accordance with its license and accompanying documentation. CPR's approval of designs or specifications shall not relieve Contractor of its obligations under this warranty.

B. Contractor warrants that Deliverables furnished hereunder (1) will be free, at the time of delivery, of harmful code (i.e., computer viruses, worms, trap doors, time bombs, disabling code, or any similar malicious mechanism designed to interfere with the intended operation of, or cause damage to, computers, data or software); and (2) will not infringe or violate any intellectual property rights enforceable in the United States. Without limiting the generality of the foregoing, if CPR believes that harmful code may be present in any software delivered hereunder, Contractor will, upon CPR's request, provide a master copy of the software for comparison and correction.

C. (1) Contractor does not warrant that any software provided hereunder is error-free or that it will run without immaterial interruption.

(2) Contractor does not warrant and will have no responsibility for a claim to the extent that is arises directly from (i) a modification made by CPR or the State, unless such modification is approved or directed by Contractor, (ii) use of software in combination with products other than as specified by Contractor, or (iii) misuse by CPR or the State.

(3) Where Contractor resells hardware or software it purchased from a third party, and such third party offers additional or more advantageous warranties than those set forth herein, Contractor will pass through any such warranties to CPR and the State and will reasonably

cooperate in enforcing them. Such warranty pass-through will be supplemental to, and not relieve Contractor from, Contractor's warranty obligations set forth above.

D. All warranties, including special warranties specified elsewhere herein, shall inure to CPR and the State, their successors, assigns, customer agencies, and governmental users of the Deliverables or services.

E. Except as may be specifically provided in the Statement of Work or elsewhere in this Agreement, for any breach of the warranties provided in this section, CPR's and the State's exclusive remedy and Contractor's sole obligation will be limited to:

(1) re-performance, repair or replacement of the nonconforming Deliverable or service; or

(2) should CPR in its sole discretion consent, refund all amounts paid by CPR for the nonconforming Deliverable or service and payment to CPR of any additional amounts necessary to equal CPR's costs to cover (i.e., the cost, properly mitigated, of procuring Deliverables or services of equivalent capability, function, and performance). The payment obligation in Section E(2) above will not exceed the limits on Contractor's liability set forth in the Section "Limitation of Liability."

F. EXCEPT FOR THE EXPRESS WARRANTIES SPECIFIED IN THIS SECTION, CONTRACTOR MAKES NO WARRANTIES EITHER EXPRESS OR IMPLIED, INCLUDING WITHOUT LIMITATION ANY IMPLIED WARRANTIES OF MECHANTABILITY OR FITNESS FOR A PARTICULAR PURPOSE.

6. Limitation of Liability.

A. Contractor's liability for damages to CPR for any cause whatsoever, and regardless of the form of action, whether in contract or in tort, shall be limited to two times the Purchase Price. For purposes of this Section, "Purchase Price" will mean the aggregate compensation under this Agreement.

B. The foregoing limitation of liability shall not apply to (1) liability for infringement of third party intellectual property rights, (2) to claims arising under provisions herein calling for indemnification for third party claims against CPR or the State for bodily injury to persons or damage to real or tangible personal property caused by Contractor's negligence or willful misconduct, or (3) to costs or attorney's fees that CPR or the State become entitled to recover as a prevailing party in any action.

C. CPR's or the State's liability for damages for any cause whatsoever, and regardless of the form of action, whether in contract or in tort, shall be limited to the Purchase Price. Nothing herein shall be construed to waive or limit any immunity from suit that CPR or the State may be entitled to under law.

D. In no event will CPR, the State or Contractor be liable for consequential, incidental, indirect, special or punitive damages, even if notification has been given as to the possibility of such damages, except to the extent that Contractor's liability for such damages arises out of subsection B(1) or B(3) above.

7. Rights in Work Product.

A. All inventions, discoveries, intellectual property, technical communications and records originated or prepared by Contractor pursuant to this Agreement (collectively, the "Work Product") shall be Contractor's exclusive property.

B. CPR and the State will have Government Purpose Rights to the Work Product as Deliverable or delivered to CPR or the State hereunder. "Government Purpose Rights" are the unlimited, irrevocable, worldwide, perpetual, royalty, non-exclusive rights and licenses to use, modify, reproduce, perform, release, display, create derivative works from and disclose the Work Product. "Government Purpose Rights" also include the right to release or disclose the Work Product outside CPR or the State for any State government purpose and to authorize recipients to use, modify, reproduce, perform, release, display create derivative works from, and disclose the Work Product for any State government purpose. Such recipients of the Work Product may include, without limitation, State contractors and the U.S. federal government. "Government Purpose Rights" do not include any rights to use, modify, reproduce, perform, release, display create derivative works from, and disclose the Work Product for any commercial purpose.

8. Protection of Proprietary Software and Other Proprietary Data.

A. CPR agrees that all material appropriately marked or identified in writing as proprietary, and furnished hereunder are provided for the CPR's and the State's exclusive use for the purpose of this Agreement only. All such property shall remain the property of the Contractor. CPR agrees to take all reasonable steps to insure that such proprietary date is not disclosed to others, without prior written consent of the Contractor, subject to the California Public Records Act.

B. CPR will take all reasonable steps to insure that prior to disposing of any media, that any licensed materials contained thereon have been erased or otherwise destroyed.

C. CPR agrees that is will take appropriate action by instruction, agreement or otherwise with its employees or other persons permitted accessed to licensed software and other proprietary data to satisfy its obligations under this Agreement with respect to use, copying, modification, protection and security of proprietary software and other proprietary data.

9. Stop Work.

EXHIBIT D

A. CPR may, at any time, by written Stop Work Order to Contractor, require Contractor to stop all, or any part, of the work called for by this Agreement for a period of up to 90 days after the Stop Work Order is delivered to Contractor, and for any further period to which the parties agree. The Stop Work Order shall be specifically identified as such and shall indicate it is issued under this clause. Upon receipt of the Stop Work Order, Contractor shall immediately comply with its terms and take all reasonable steps to minimize the incurrence of costs allocable to the work covered by the Stop Work Order during the period of work stoppage. Within a period of 90 days after a Stop Work Order is delivered to the Contractor, or within any extension of that period to which the parties shall have agreed, CPR shall either (1) cancel the Stop Work Order, or (2) terminate the work covered by the Stop Work Order as provided in the termination clauses of this Agreement.

B. If a Stop Work Order issued under this clause is cancelled or the period of the Stop Work Order or any extension thereof expires, the Contractor shall resume work. CPR shall make an equitable adjustment in the delivery schedule, the Rate Schedule, or both, and the Agreement shall be modified, in writing accordingly, if: (1) the Stop Work Order results in an increase in the time required for, or in Contractor's cost properly allocable to, the performance of any part of this Agreement, and (2) Contractor asserts its rights to an equitable adjustment within 30 days after the end of the period of work stoppage.

C. CPR shall not be liable to Contractor for loss of profits because of a Stop Work Order issued under this clause.

EXHIBIT E

CDCR FACILITY LIST

Pilot Sites

Pelican Bay State Prison (PBSP)
California State Prison, San Quentin (SQ)
California Medical Facility (CMF)
Central California Women's Facility (CCWF)

Regional Accounting Office—NORTH COAST
1515 S Street, Room 516-S
Sacramento, CA 95814

Regional Accounting Office—CORCORAN
1020 North Chittenden Avenue
Corcoran, CA 93212

CDCR Headquarters
1515 S. Street
Sacramento, CA 95814

Health Care Services Headquarters
501 J. Street
Sacramento, CA

Remaining Implementation Sites

Adult Correctional Facilities:

Avenal State Prison (ASP)
Calipatria State Prison (CAL)
California Correctional Center (CCC)
California Correctional Institution (CCI)
Centinela State Prison (CEN)
California Institution for Men (CIM)
California Institution for Women (CIW)
California Men's Colony (CMC)
California State Prison, Corcoran (COR)
California Rehabilitation Center (CRC)
Correctional Training Facility (CTF)
Chuckawalla Valley State Prison (CVSP)
Deuel Vocational Institution (DVI)

EXHIBIT E

Folsom State Prison (FOL)
High Desert State Prison (HDSP)
Headquarters (HQ)
Ironwood State Prison (ISP)
California State Prison, Los Angeles County (LAC)
Mule Creek State Prison (MCSP)
North Kern State Prison (NKSP)
Pleasant Valley State Prison (PVSP)
Richard J. Donovan Correctional Facility (RJD)
California State Prison, Sacramento (SAC)
California Substance Abuse Treatment Facility and State Prison at Corcoran (SATF)
Sierra Conservation Center (SCC)
California State Prison, Solano (SOL)
Salinas Valley State Prison (SVSP)
Valley State Prison for Women (VSPW)
Wasco State Prison (WSP)

Regional Accounting Offices:

Regional Accounting Office—BAKERSFIELD
5016 California Avenue, Suite 200
Bakersfield, CA 93309

Regional Accounting Office—CENTRALCOAST
728 13th Street
Paso Robles, CA 93447

Regional Accounting Office—CENTRAL VALLEY
1550 W. Fremont Street, Suite 120
Stockton, CA 95203 (559) 992-7000

Regional Accounting Office—EL CENTRO
797 Main Street, Suite C
El Centro, CA 92243

Regional Accounting Office—SACRAMENTO
1900 Alabama Avenue
Rancho Cordova, CA 95742

Regional Accounting Office—SOUTHERN CALIFORNIA
10350 Commerce Center Drive, Suite 100

DRAFT

EXHIBIT E

Rancho Cucamonga, CA 91730

Regional Accounting Office—CENTRAL COAST
728 13TH Street
Paso Robles, CA. 93447-7021

Regional Accounting Office—BAKERSFIELD
5016 California Avenue, Ste. 200
Bakersfield, CA. 93309

Regional Accounting Office—SOUTH
10350 Commerce Center Drive, Ste. 100
Rancho Cucamonga, CA. 91730

DRAFT

EXHIBIT 7

CALIFORNIA PRISON HEALTH CARE RECEIVERSHIP CORPORATION
OFFICE OF THE RECEIVER

REQUEST FOR PROPOSAL
FOR THE IMPROVEMENT AND MANAGEMENT OF
THE CALIFORNIA DEPARTMENT OF CORRECTIONS AND REHABILIATION
ADULT PRISON PHARMACY SYSTEM

AUGUST 18, 2006

PROPOSALS DUE: MONDAY, SEPTEMBER 18, 2006

CONTACT: JARED GOLDMAN, STAFF ATTORNEY
1731 Technology Drive, Suite 700
San Jose, CA 95110
jared.goldman@cprinc.org

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Attachment: *An Analysis of the Crisis in the California Prison Pharmacy System Including a Road Map from Despair to Excellence*, Maxor National Pharmacy Services Corporation, June 2006

REQUEST

The Receiver of the California Department of Corrections and Rehabilitation's (CDCR) prison medical system is requesting proposals for assisting the Receiver in the improvement and management of the CDCR's adult prison pharmacy system. The awarded contract will be a service agreement with the Receiver through the California Prison Health Care Receivership Corporation (CPR).

BACKGROUND

As a result of the State of California's ongoing failure to provide medical care to prison inmates at constitutionally acceptable levels, the United States District Court for the Northern District of California has established a Receivership to assume the executive management of the California prison medical system and raise the level of care up to constitutional standards. On February 14, 2006, the Court appointed Robert Sillen to serve as the Receiver and granted him, among other powers, the authority to exercise all powers vested by law in the Secretary of the CDCR as they relate to the administration, control, management, operation, and financing of the California prison medical health care system.

The Court's actions stem from the case of *Plata v. Schwarzenegger*—a class action law suit brought on behalf of the CDCR's adult inmates. Applicants should refer to the Court's October 3, 2005 "Findings of Fact and Conclusions of Law Re Appointment of Receiver" and the Court's February 14, 2006 "Order Appointing Receiver" for further information regarding the conditions underlying the Receivership and the powers and responsibilities of the Receiver. These and other relevant documents can be found on the Court's website at:

> http://www.cand.uscourts.gov/
> (select the following links: "Judges"—"Henderson"—"Models and Examples"—"Henderson"—"Recent Orders"—"Plata v. Schwarzenegger")

While the problems identified by the Court and the Receiver reach into almost every element of the medical care system, numerous audits preceding the Receivership (including audits by the State Auditor, the Office of the Inspector General, and the Senate Advisory Commission on Cost Control in State Government), found particularly grave problems with the management and control of pharmacy services. As a result, among the Receiver's first actions was obtaining an evaluation of the present state of the CDCR's pharmacy services by the Maxor National Pharmacy Services Corporation (Maxor).

Maxor's audit titled *An Analysis of the Crisis in the California Prison Pharmacy System Including a Road Map from Despair to Excellence* ("Maxor Audit") (Attached) was formally presented in a hearing before the Court on July 26, 2006. In sum, the Maxor Audit found CDCR's pharmacy services to be costly, inefficient and unsafe, primarily due to:

> (1) lack of effective central oversight and leadership; (2) lack of an operational infrastructure of policies, processes, technology and human resources needed to support an effective program, (3) excessive costs and inefficiencies in the purchasing processes employed; and (4) ineffective systems for contracting, procurement, distribution and inventory control.

Maxor Audit, pg. 5.

In addition to identifying existing deficiencies in CDCR's pharmacy system, Maxor developed a "Road Map" designed to restructure and manage a constitutionally adequate pharmacy services delivery system. The primary focus of the Road Map is producing sustainable, patient centered, outcome driven processes, with the ultimate goal of creating a CDCR managed and operated "best practice" pharmacy system within three years. At the July 26 hearing, the Receiver announced his plan to engage a pharmacy management firm to implement the Road Map. The Court and the parties to the *Plata* litigation have endorsed the Receiver's plan.

SCOPE OF WORK

CPR is seeking a contractor for immediate implementation of the Road Map (Scope of Work) developed in the Maxor Audit. CPR will entertain suggested modifications to the Scope of Work proposed by applicants.

INSTRUCTIONS FOR PROPOSALS

1. Point of Contact

All communications regarding this Request of Proposal (RFP) must be directed to:

Jared Goldman, Staff Attorney
California Prison Health Care Receivership Corp.
1731 Technology Drive, Suite 700
San Jose, CA 95110
-or-
jared.goldman@cprinc.org

2. RFP Schedule

Event	Date
RFP Issued	Friday, August 18, 2006
Deadline for questions regarding RFP	Thursday, August 31, 2006
Responses to questions	Friday, September 8, 2006
Proposals due	Monday, September 18, 2006
Applicant interviews begin	Monday, September 25, 2006 (estimated)
Award announced	Tuesday, October 3, 2006 (estimated)
Estimated project start date	Monday, October 16, 2006 (estimated)

3. Addenda

Any questions regarding the RFP should be sent to CPR. CPR will, at its discretion, respond to questions in an addendum. Any necessary information not included in this RFP, which CPR deems necessary and relevant to responding to the RFP, will also be issued in an addendum. CPR makes no guarantee that any questions submitted will be answered.

Addenda will be sent to all known applicants. If you did not receive this RFP directly from CPR, and you wish to receive any RFP addenda, contact CPR by August 31, 2006.

4. Format of Proposal

a. Submit one original proposal signed by the person or persons authorized to bind the applicant.
b. Submit five copies of the proposal.
c. All proposals must include required attachments, exhibits, etc. All attached materials should reference the applicant's name.
d. Oral, telephone, facsimile or electronic proposals will not be considered.
e. Proposals should be printed on 8-1/2" x 11" paper.

5. Content of Proposal

Proposals must provide complete responses to all the items in this section.

a. Executive Summary. Provide a summary of the key aspects of your proposal and the principal advantages of contracting with your organization.
b. Company Data. Provide the following information:
   (1) Your company's name, business address and telephone numbers, including headquarters and local offices.
   (2) The name of your contact person for the purpose of this proposal.

(3) A description of your organization, including names of principals, number of employees, longevity, client base, and areas of specialization and expertise.

(4) A description of your company's prior experience related to pharmacy and correctional pharmacy systems.

(5) A description of your company's prior experience in the California.

(6) A disclosure of whether your company has defaulted in its performance on a contract in the last five years, which has led to the termination of a contract.

(7) A list of any lawsuits filed against your company, its subsidiaries, parent, other corporate affiliates, or subcontractors in the past five years and the outcome of those lawsuits.

(8) Copies of your company's last two audited annual financial statements, and/or other information that will assist in formulating an opinion about the stability and financial strength of your company.

(9) Three professional references and the references' contact information.

c. Scope of Work. Provide the following:

(1) A description of your company's qualifications and ability to execute all of the goals, objective and timelines specified in the Scope of Work.

(2) A description of the organization of the project team, identifying which members of the team will be responsible for accomplishing the specific objectives of the Scope of Work.

(3) The names, resumes, and references for all key personnel and subcontractors associated with the proposal.

(4) A disclosure of any financial relationships with other vendors that may be a part of your proposal.

(5) Your company's assessment which Road Map objectives are mission critical and your anticipated milestones and timelines for those objectives.

(6) Any proposed modifications to the goals, objectives and timelines identified in the Scope of Work.

(7) A transition plan to return pharmacy management to the State.

d. Cost. Provide a cost proposal for performing the Scope of Work, including a methodology for payment based on the successful completion of contract deliverables. Cost proposals should assume that local facilities will be staffed by CDCR personnel. Cost proposals must include the anticipated costs to the applicant in providing the proposed services, including the compensation for each member of the applicant's team providing services under the proposal. Cost proposals must also include the profit margin the applicant anticipates realizing in performing the project.

6. Modification or Withdrawal of Proposal

Prior to the proposal due date, applicants may modify or withdraw a submitted proposal. Such modifications or withdrawals must be submitted to CPR in writing. Any modification must be clearly identified as such and must be submitted in the same manner as the original (e.g., appropriate copies, paper size, etc.). No modifications or withdrawals will be allowed after the proposal due date.

7. Public Opening

There will be no public opening of responses to this RFP. However, after a contract is awarded, all proposals may be available for public review. CPR makes no guarantee that any or all of a proposal will be kept confidential, even if the proposal is marked "confidential," "proprietary," etc.

8. General Rules

a. Only one proposal will be accepted from any one person, partnership, corporation or other entity.
b. Proposals received after the deadline will not be considered.
c. This is an RFP, not a work order. All costs associated with a response to this RFP, or negotiating a contract, shall be borne by the applicant.
d. CPR's failure to address errors or omissions in the proposals shall not constitute a waiver of any requirement of this RFP.

9. Reservation of Rights

CPR reserves the right to do the following at any time, at CPR's discretion:

a. Reject any and all proposals, or cancel this RFP.
b. Waive or correct any minor or inadvertent defect, irregularity or technical error in any proposal.
c. Request that certain or all candidates supplement or modify all or certain aspects of their respective proposals or other materials submitted.
d. Procure any services specified in this RFP by other means.
e. Modify the specifications or requirements for services in this RFP, or the contents or format of the proposals prior to the due date.
f. Extend the deadlines specified in this RFP, including the deadline for accepting proposals.
g. Negotiate with any or none of the candidates.
h. Terminate negotiations with an applicant without liability, and negotiate with other applicants.
i. Award a contract to any applicant.

10. RFP Evaluation and Contract Award

Each proposal submitted in response to this RFP will be evaluated by a selection committee appointed by the Receiver, which will make recommendations to the Receiver regarding the top applicants. The Receiver, taking the committee's recommendations into consideration, will, in his sole discretion, select the best applicant(s) for an interview. Interviews will be conducted by the Receiver and may include the further participation and advice of the selection committee. The Receiver, in his sole discretion, will select the candidate with whom CPR will begin negotiations for a contract. If CPR is unable to negotiate a contract with the selected applicant, the Receiver may select another applicant with whom CPR will begin contract negotiations, or the Receiver may elect not to award the contract.

Unsuccessful applicants will be notified as soon as possible after the award of the contract.

EXHIBIT 8

California Prison Health Care Receivership
Office of the Receiver

August 11, 2006

SENT VIA EMAIL

Todd Jerue
Program Budget Manager
Department of Finance
915 L Street
Sacramento, CA 95814

Dear Mr. Jerue:

The Receiver would like to establish a routine, quarterly mechanism for replenishing the operating fund of the California Prison Health Care Receivership from Schedule (5) of the CDCR Division of Correctional Health Care Services Budget. It is my understanding that you are our contact for the purpose of assisting our office with requests for routine funding. For the first quarter of Fiscal Year 2006-2007, we will require a transfer of $1.2 million.

Please contact me at your earliest convenience to make the appropriate arrangements. I can be reached at (408) 436-6862 or (408) 306-7820 (cell).

Best Regards,

Jared Goldman
Staff Attorney

c: John Hagar
Molly Arnold

EXHIBIT 9

California Prison Health Care Receivership Corp.

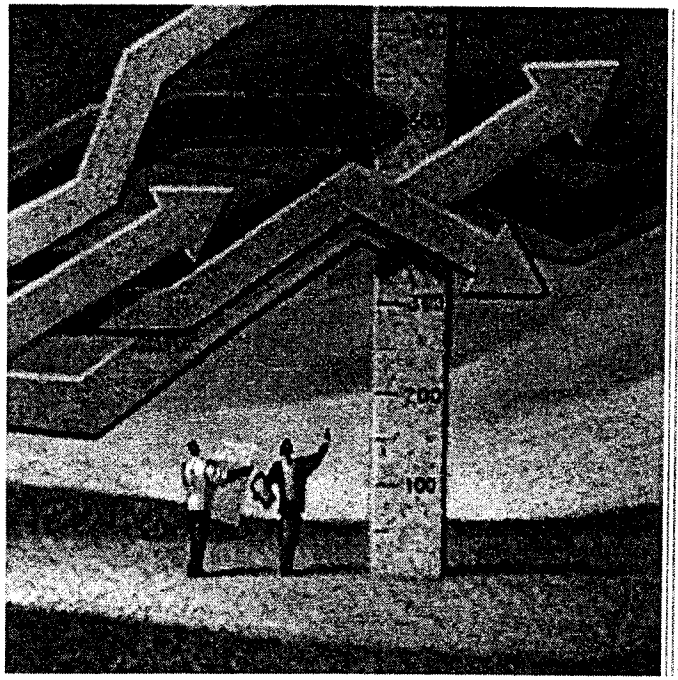
Statement of Expenses

For the two months ending August 31, 2006

Operating Expenses	Actual
Salaries & Wages & Related	$462,552
Consulting, & Other Professional Fees	$207,210
Office Expenses	$4,075
Rent	$22,106
Insurance	$7,498
Telephone	$5,519
Travel	$31,383
Miscellaneous	$0
Total Operating Expenses	**$740,343**
Other Income	
Interest Earned	$12,064
Total Other Income	$12,064
Net Expenses	**$728,279**

EXHIBIT 10

MERCER
Health & Benefits



August 29, 2006

California Prison System

Assessment of Organizational Structures

MMC Marsh & McLennan Companies

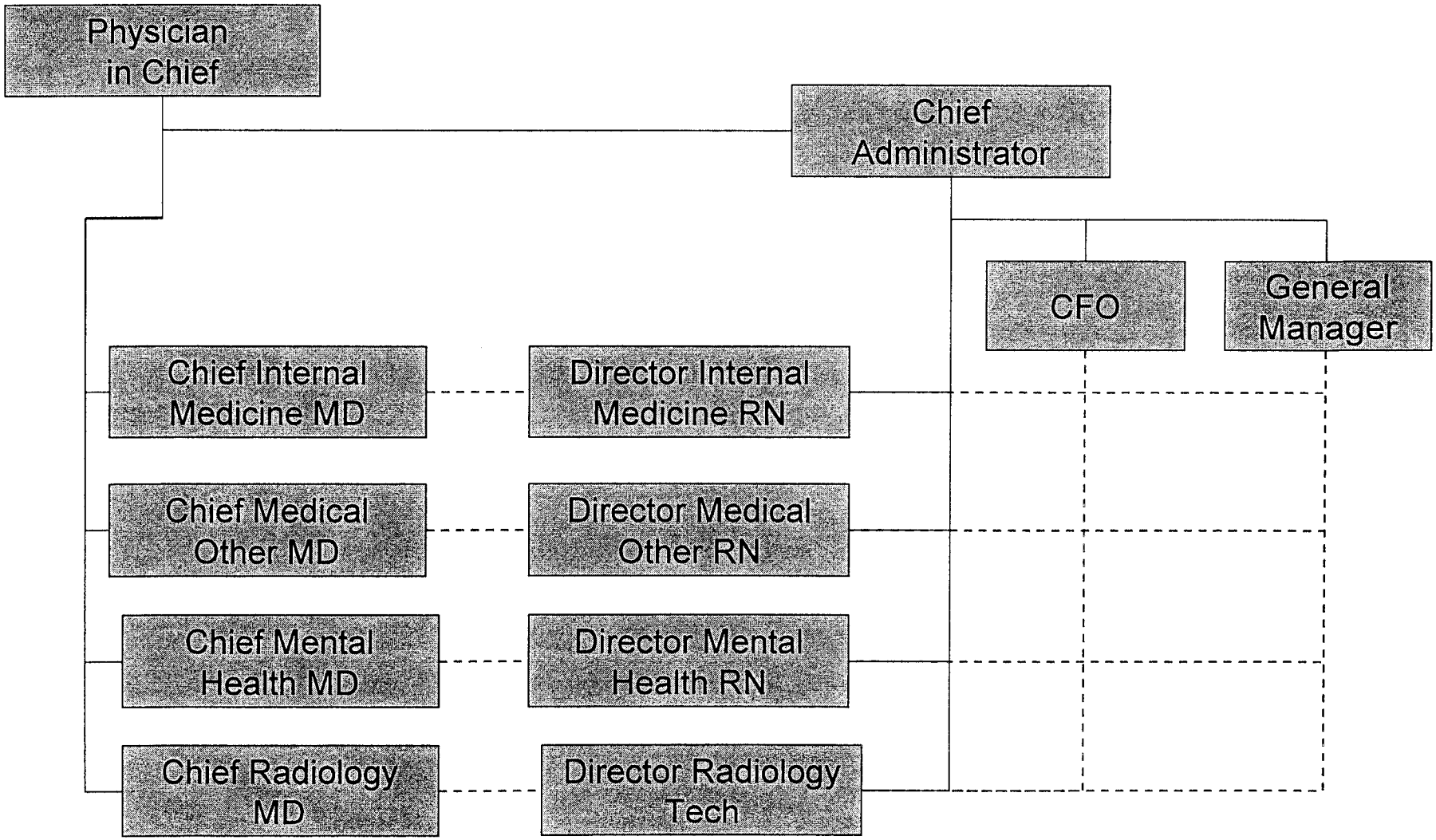
Organizational Design Principles

- Foster administrative decision-making accountability by ensuring that one individual maintains overall responsibility for health care
- Create checks and balances and teamwork with three equal lieutenants reporting to the chief administrative officer
- Standardize and coordinate care by having one senior physician with ultimate responsibility for all clinical decisions
- Promote teamwork and leverage of shared resources with paired physician-nurse leadership at the clinic level, while maintaining individual reporting relationships
- Provide career advancement opportunities with structure that provides opportunities for growth

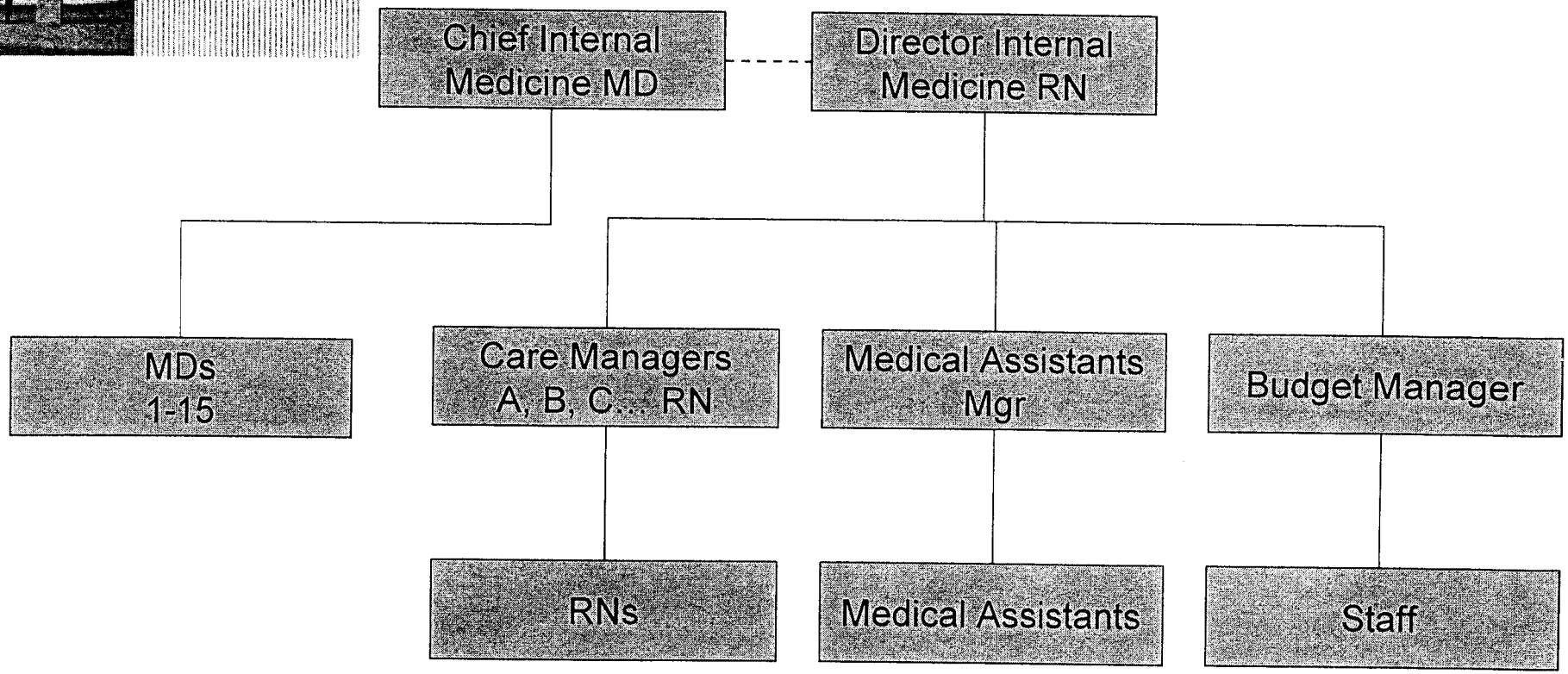
Common Themes from Other Organizations

- Top level administrator is not a physician except in physician run organizations, like TPMG
- There are generally three positions at the second level. They are:
  - Chief MD, Chief RN and Assistant Administrator
  - In some structures, the Chief RN reports to the Assistant Administrator
- A single physician oversees all other physicians
- There is a nurse-physician pair that runs each specialty clinic
- Support/ancillary functions report to the Assistant Administrator

1. TPMG, Top Three Levels TPMG



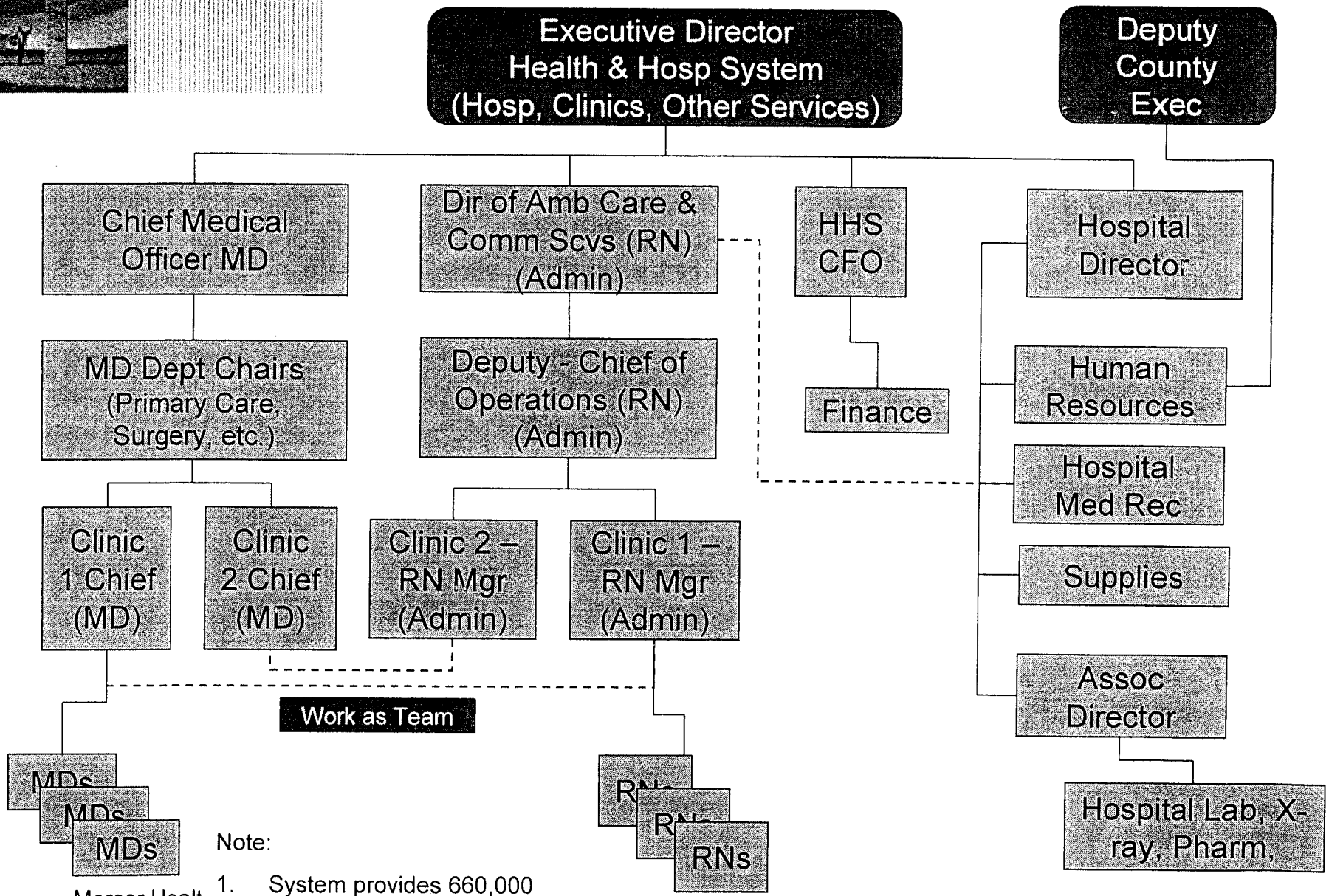
1. TPMG, Levels 4-5 TPMG



Notes:

1. MD dominated organization: everyone reports to Chief Physician.
2. Care Managers do NCQA
3. Director does most negotiations re budget, etc.
4. Physicians chiefs are usually 50% clinical, 50% administrative
5. Structure varies slightly from site to site.

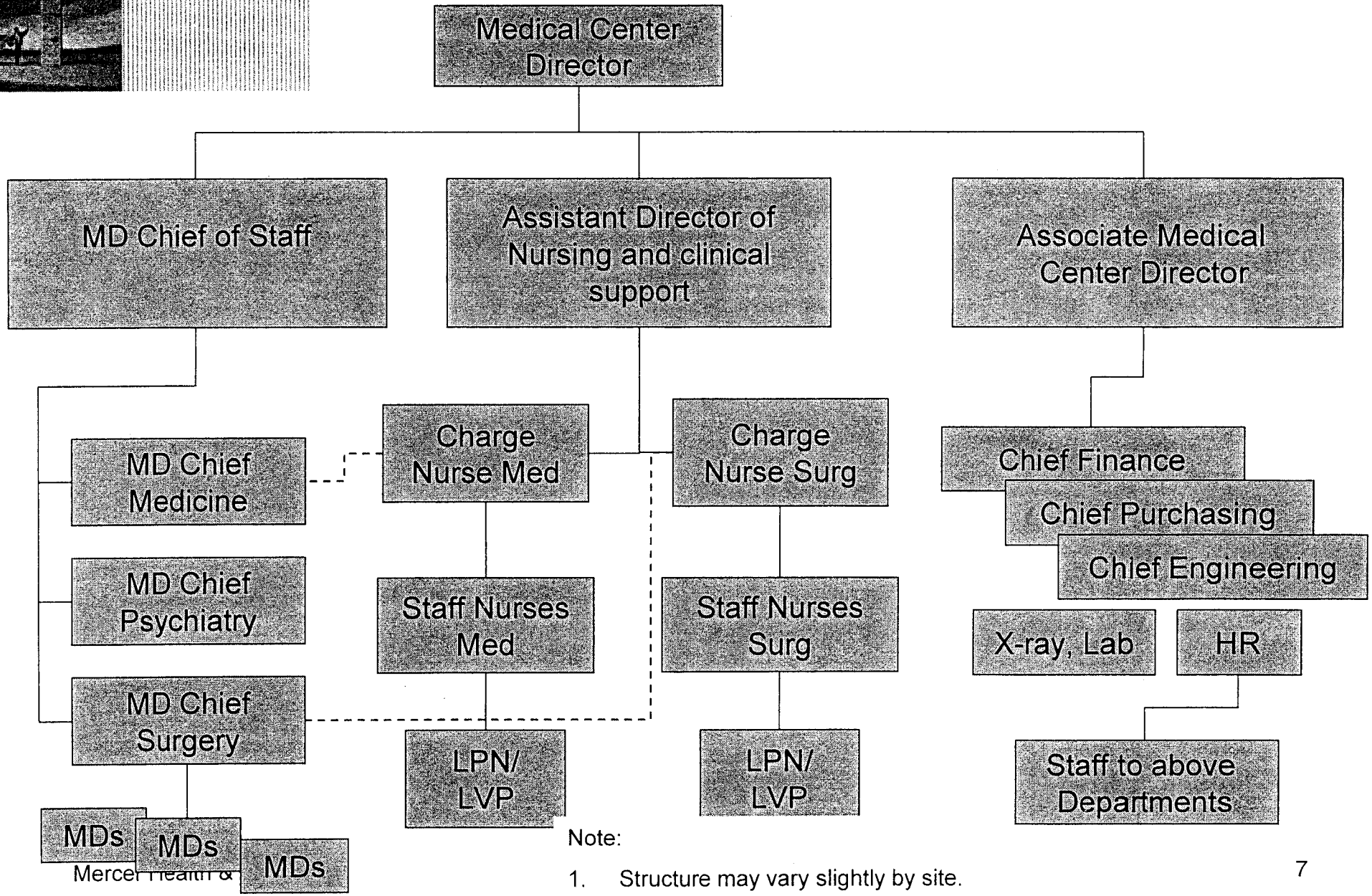
2. Santa Clara County, 5 Levels



Note:

1. System provides 660,000 patient visits/yr at 10 locations.

3. VA Medical Center, 4 Levels



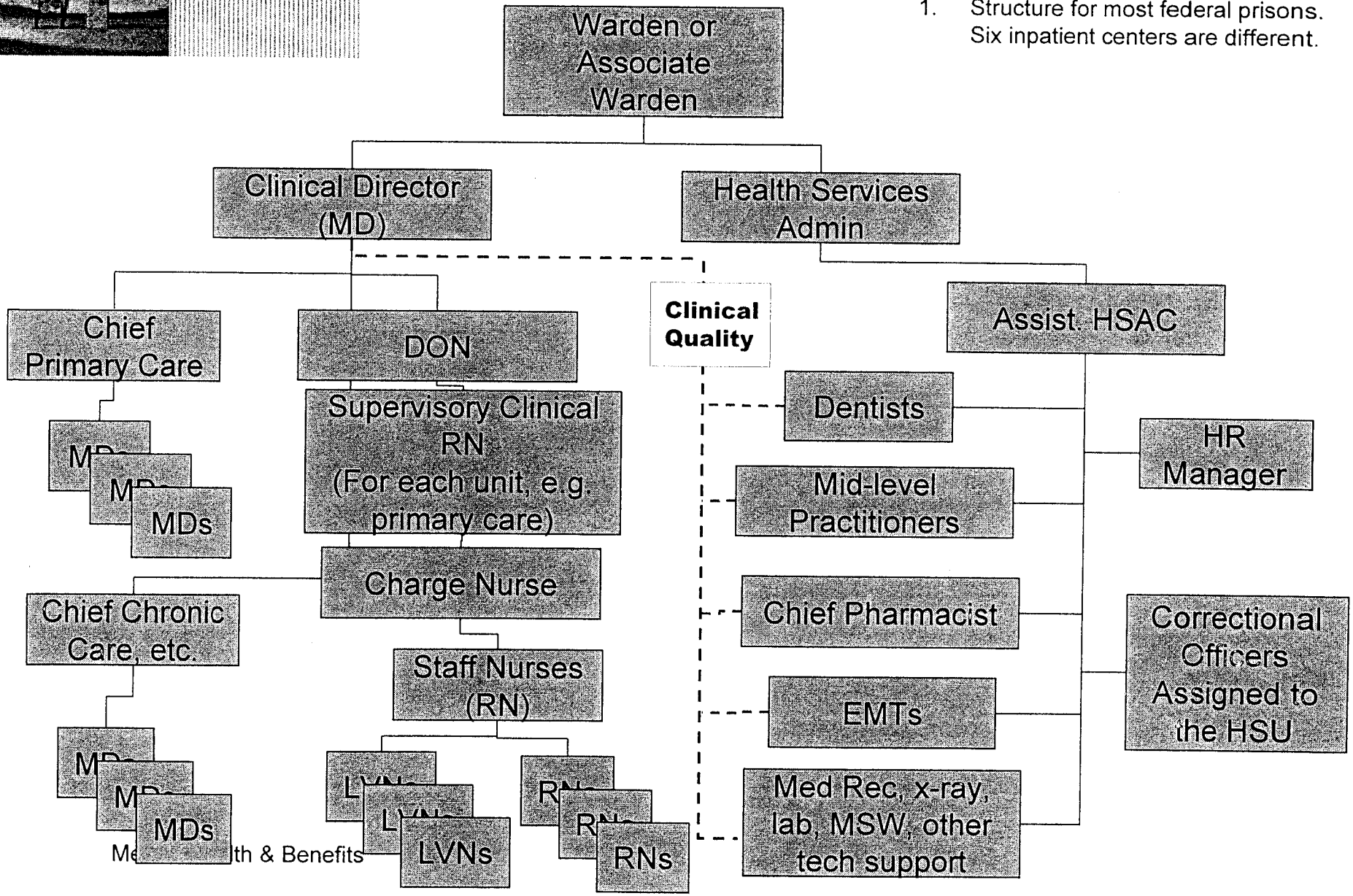
Note:

1. Structure may vary slightly by site.

4. Federal Prison System

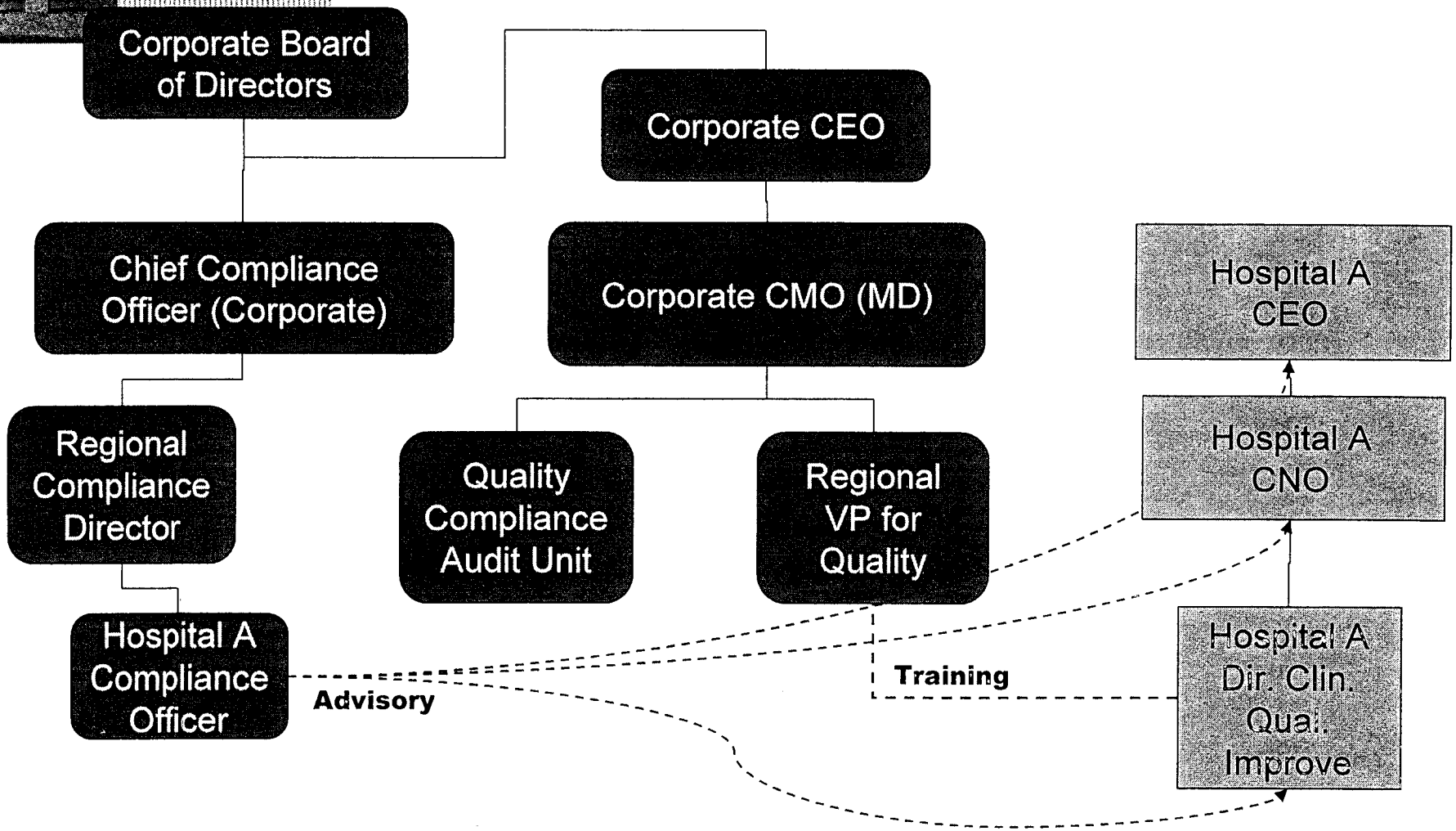
Note:

1. Structure for most federal prisons. Six inpatient centers are different.



NS6

5. Tenet HealthSystem Medical, Inc. Quality Improvement & Compliance



Note:

1. Quality Compliance Audit Unit audits in all regions.
2. Hospital Compliance Officer may oversee more than one hospital

Slide 9

NS6 Jennifer,

I don't understand relation between hospital leaders and DCQI. I don't think the leaders have a dotted line reporting to them.

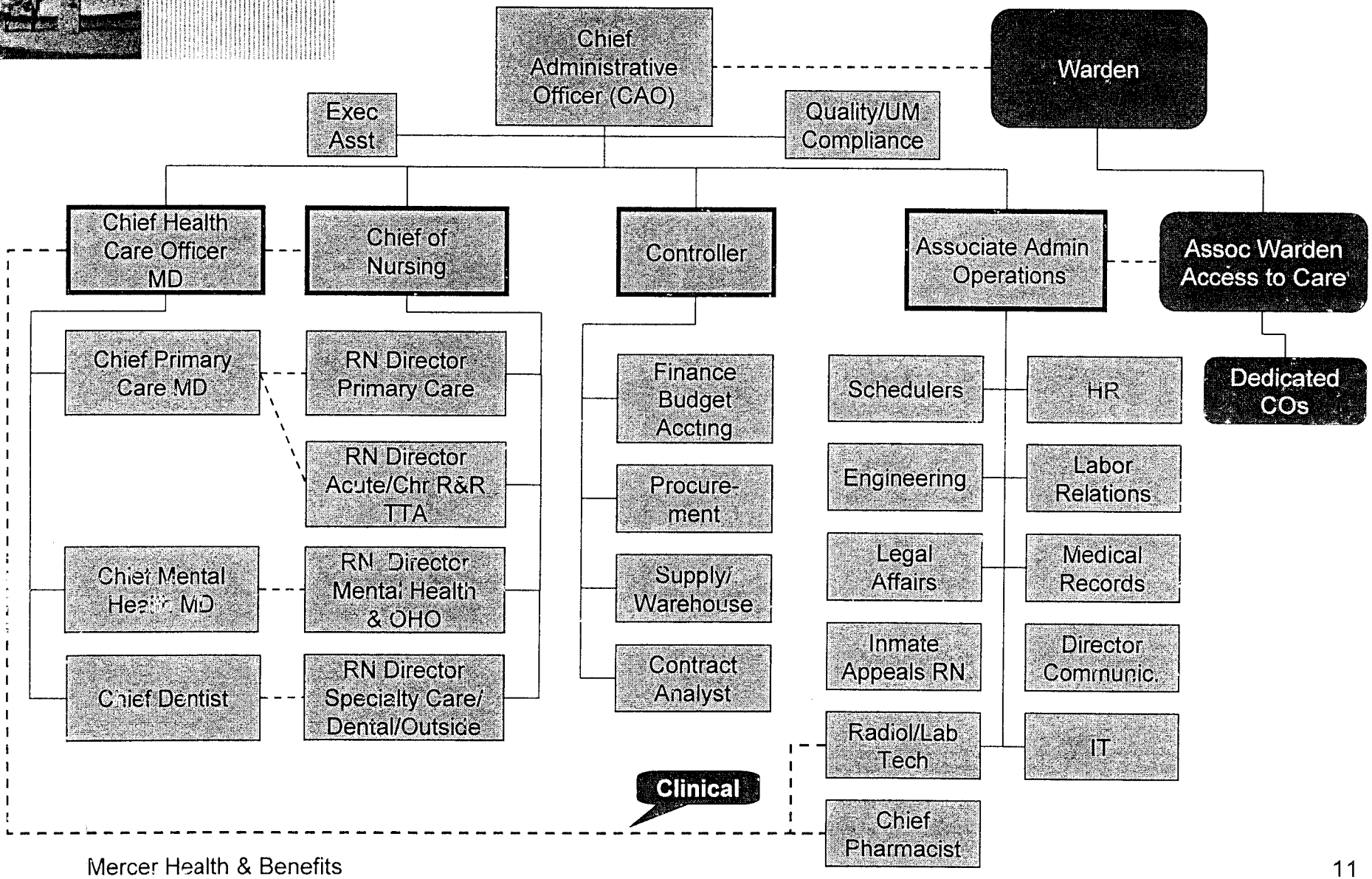
Also, you need another slide showing relationship between DCQI (corporate) and quality/compliance folks at hospital. This is the key point we want to show w Tenet.

Neil Smithline, 8/11/2006

Organizational Comparison

	Kaiser	Santa Clara	VA	Federal Prison	Tenet	Comments
Non-MD top level	No	Yes	Yes	Yes	Yes	Kaiser model is unique
Main Branches	3	4	3	2	3	Federal Prison DON reports to MD Clinical Director
Single MD over all others	Yes	Yes	Yes	Yes	Yes	Standard throughout
RN-MD Pairs at clinic level	Yes	Yes	Yes	?	N/A	Very common
Ancillary reports to Asst/ Assoc Admin	Yes	Some	Yes	Yes	Yes	Very common

Recommended Organizational Structure



PROOF OF SERVICE BY MAIL

I, Kristina Hector, declare:

I am a resident of the County of Alameda, California; that I am over the age of eighteen (18) years of age and not a party to the within titled cause of action. I am employed as the Inmate Patient Relations Manager to the Receiver in Plata v. Schwarzenegger.

On September 19, 2006 I arranged for the service of a copy of the attached documents described as APPENDIX OF EXHIBITS IN SUPPORT OF RECEIVER'S SECOND BI-MONTHLY REPORT on the parties of record in said cause by sending a true and correct copy thereof by pdf and by United States Mail and addressed as follows:

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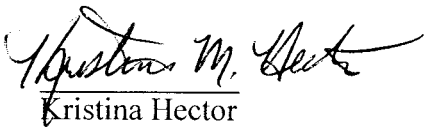
I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct. Executed on September 19, 2006 at San Francisco, California.



Kristina Hector