AGENDA

ASSEMBLY BUDGET SUBCOMMITTEE NO. 5 PUBLIC SAFETY

ASSEMBLYMEMBER REGINALD B. JONES-SAWYER SR., CHAIR

WEDNESDAY, APRIL 15, 2015
1:30 P.M. - STATE CAPITOL ROOM 437

ITEMS TO BE HEARD

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5225 CALIFORNIA DEPARTMENT OF CORRECTIONS AND REHABILITATION - CALIFORNIA CORRECTIONAL HEALTH CARE SERVICES

ISSUE 1: UPDATE ON PRISON HEALTHCARE AND THE RECEIVERSHIP

The issue before the subcommittee is an update on the status of the California Correctional Health Care Services Receivership.

PANELISTS

- California Department of Corrections and Rehabilitation – Receiver's Office
- Department of Finance
- Legislative Analyst's Office
- Public Comment

BACKGROUND

The California Department of Corrections and Rehabilitation's (CDCR) - California Correctional Health Care Services (CCHCS) receivership was established as a result of a class action lawsuit (Plata v. Brown) brought against the State of California over the quality of medical care in the state's 33 adult prisons. In its ruling, the federal court found that the care was in violation of the Eighth Amendment of the U.S. Constitution which forbids cruel and unusual punishment. The state settled the lawsuit and entered into a stipulated settlement in 2002, agreeing to a range of remedies that would bring prison medical care in line with constitutional standards. The state failed to comply with the stipulated settlement and on February 14, 2006, the federal court appointed a receiver to manage medical care operations in the prison system. The current receiver was appointed in January of 2008. The receivership continues to be unprecedented in size and scope nationwide.

The receiver is tasked with the responsibility of bringing the level of medical care in California's prisons to a standard which no longer violates the U.S. Constitution. The receiver oversees over 11,000 prison health care employees, including doctors, nurses, pharmacists, psychiatric technicians and administrative staff. Over the last ten years, healthcare costs have risen significantly. The estimated per inmate health care cost for 2015-16 is almost two and a half times the cost for 2005-06. The state spent $1.2 billion in 2005-06 to provide health care to 162,408 inmates. The state estimates that it will be spending over $2.4 billion in 2015-16 for 117,217 inmates.

CDCR's Historical Health Care Costs/ Per Inmate

Type of Care	2005-06	2007-08	2009-10	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16
Medical	$5,803	$9,721	$10,957	$10,439	$12,525	$12,280	$13,585	$13,845	$14,288
Mental Health	$1,463	$2,802	$2,420	$3,168	$2,621	$2,596	$3,214	$3,304	$3,190
Dental	$313	$916	$1,066	$1,088	$1,127	$1,163	$1,248	$1,266	$1,229
Total	$7,580	$13,349	$14,443	$14,695	$16,273	$16,039	$18,048	$18,415	$18,707

On June 30, 2005, the United States District Court ruled in the case of *Marciano Plata, et al v. Arnold Schwarzenegger, et al,* that it would establish a receivership and take control of the delivery of medical services to all California prisoners confined by CDCR. In a follow-up written ruling dated October 30, 2005, the court noted:

> *By all accounts, the California prison medical care system is broken beyond repair. The harm already done in this case to California's prison inmate population could not be more grave, and the threat of future injury and death is virtually guaranteed in the absence of drastic action. The Court has given defendants every reasonable opportunity to bring its prison medical system up to constitutional standards, and it is beyond reasonable dispute that the State has failed. Indeed, it is an uncontested fact that, on average, an inmate in one of California's prisons needlessly dies every six to seven days due to constitutional deficiencies in the CDCR's medical delivery system. This statistic, awful as it is, barely provides a window into the waste of human life occurring behind California's prison walls due to the gross failures of the medical delivery system.*

As discussed earlier, since the appointment of the receivership, spending on inmate health care has almost tripled. A new prison hospital has been built, new systems are being created for maintaining medical records and scheduling appointments, and new procedures are being created that are intended to improve health outcomes for inmates. According to the CCHCS, over 400,000 inmates per month have medical appointments and the rate of preventable deaths has dropped 46 percent since 2006.

Chief Executive Officers for Health Care. Each of California's 33 prisons has a chief executive officer (CEO) for health care who reports to the receiver. The CEO is the highest-ranking health care authority within a CDCR adult institution. A CEO is responsible for all aspects of delivering health care at their respective institution(s) and reports directly to the receiver's office.

The CEO is also responsible for planning, organizing, and coordinating health care programs at one or two institutions and delivering a health care system that features a range of medical, dental, mental health, specialized care, pharmacy and medication management, and clinic services.

Serving as the receiver's advisor for institution-specific health care policies and procedures, the CEO manages the institution's health care needs by ensuring that appropriate resources are requested to support health care functions, including adequate clinical staff, administrative support, procurement, staffing, and information systems support.

Regional CEOs. As part of transition activities, the receivership has been in discussions with CDCR regarding what would be the appropriate organizational model for oversight of institutional health care. Under CDCR, both dental and mental health had previously adopted, and had in place, a geographical, "regional" model for organizational oversight of their activities. As part of the movement toward transitioning medical care back to the state, the receiver felt that creation of cohesive, interdisciplinary regions that included medical leadership would lead to a more sustainable model for the future. As a result, the receiver took steps to hire four regional CEOs and worked with CDCR to align each region geographically so that medical, mental health, and dental consistently oversee the same institutions on a regional basis. The four regions are as follows:

1. Region I: Pelican Bay State Prison, High Desert State Prison, California Correctional Center, Folsom State Prison, California State Prison Sacramento, Mule Creek State Prison, California State Prison San Quentin, California Medical Facility, and California State Prison Solano.

2. Region II: California Health Care Facility, Stockton, Sierra Conservation Center, Deuel Vocational Institution, Central California Women's Facility, Valley State Prison, Correctional Training Facility, Salinas Valley State Prison, and California Men's Colony.

3. Region III: Pleasant Valley State Prison, Avenal State Prison, California State Prison Corcoran, Substance Abuse Treatment Facility, Kern Valley State Prison, North Kern State Prison, Wasco State Prison, California Correctional Institution, California State Prison Los Angeles County, and California City Prison.

4. Region IV: California Institution for Men, California Institution for Women, California Rehabilitation Center, Ironwood State Prison, Chuckawalla Valley State Prison, Calipatria State Prison, Centinela State Prison, and RJ Donovan Correctional Facility.

Each region consists of a regional health care executive, one staff services analyst/associate governmental program analyst, one office technician, and one health program specialist I. The cost for each of the regional offices is $565,000 per year, with a total budget for regional CEOs of almost $2.25 million per year. The funding and positions were created within CCHCS using existing resources.

Health Care Evaluations. In September 2012, the federal court requested that the court's medical experts conduct evaluations at each CDCR prison to determine whether an institution is in substantial compliance. The order defined substantial compliance and constitutional adequacy as receiving an overall OIG score of at least 75 percent and an

evaluation from at least two of the three court experts that the institution is providing adequate care.

In conducting the reviews, the medical experts evaluated essential components to an adequate health care system. These include organizational structure, health care infrastructure (e.g., clinical space, equipment, etc.), health care processes, and the quality of care.

To date, the medical experts have evaluated ten institutions. Of those ten, six were found to be providing inadequate medical care and the remaining four had specific procedural problems that needed to be addressed in order for their care to be deemed adequate.

Office of Inspector General (OIG) – Enhanced Medical Inspections. In 2007, the federal receiver, approached the Inspector General about developing an inspection and monitoring function for prison medical care. The receiver's goal was to have the OIG's inspection process provide a systematic approach to evaluating medical care. Using a court-approved medical inspection compliance-based tool, the OIG's Medical Inspection Unit (MIU) was established and conducted three cycles of medical inspections at CDCR's 33 adult institutions and issued periodic reports of their findings from 2008 through 2013.

In 2013, court-appointed medical experts began conducting follow-up evaluations of prisons scoring 85 percent or higher in the OIG's third cycle of medical inspections. (Those evaluations are discussed in more detail in a later item.) The expert panel found that six of the ten institutions evaluated had an inadequate level of medical care, despite scoring relatively high overall ratings in the OIG's evaluations. The difference between the two types of evaluations resulted in very different findings. The OIG's evaluations focused on the institutions' compliance with CDCR's written policies and procedures for medical care. The court experts, however, focused on an in-depth analysis of individual patients' medical treatment to determine the quality of care at each prison. After meeting with the receiver's office and the court medical experts, the Inspector General decided that his inspections should be modified to include the methodologies used by the medical experts in order to determine the quality of care being provided.

In the 2014 Budget Act, the OIG received a $1.262 million (General Fund) augmentation to establish four permanent positions in the Medical Inspections Unit of the OIG to evaluate medical care provided to inmates in state prison. In addition, the budget reduced the California Correctional Health Care Services (CCHCS) budget by $645,000 (General Fund) and two positions. The net cost of the proposal was $617,000.

The four positions consist of three physicians and one nurse who will provide medical expertise for the OIG to add clinical case reviews to the existing compliance-based monitoring system that is in place. The Inspector General will be providing a detailed update of his medical inspections at a subcommittee hearing later in the spring.

Transition Planning. On September 9, 2012, the federal court entered an order entitled *Receivership Transition Plan and Expert Evaluations*. As part of the transition from the

receivership, the court required the receiver to provide CDCR with an opportunity to demonstrate their ability to maintain a constitutionally adequate system of inmate medical care. The receiver was instructed to work with CDCR to determine a timeline for when CDCR would assume the responsibility for particular tasks.

As a result of the court's order, the receiver and CDCR began discussions in order to identify, negotiate, and implement the transition of specific areas of authority for specific operational aspects of the receiver's current responsibility—a practice that had already been used in the past (construction had previously been delegated to the state in September 2009). On October 26, 2012, the receiver and the state reached agreement and signed the first two revocable delegations of authority:

> ***Health Care Access Units*** are dedicated, institution-based units, comprised of correctional officers, which have responsibility for insuring that inmates are transported to medical appointments and treatment, both on prison grounds and off prison grounds. Each institution's success at insuring that inmates are transported to their medical appointments/treatment is tracked and published in monthly reports.
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> ***The Activation Unit*** is responsible for all of the activities related to activating new facilities, such as the California Health Care Facility at Stockton and the DeWitt Annex. Activation staff act as the managers for CDCR and coordinate activities such as the hiring of staff for the facility, insuring that the facility is ready for licensure, overseeing the ordering, delivery, and installation of all equipment necessary for the new facility, as well as a myriad of other activities. Activation activities, again, are tracked on monthly reports provided to the receiver's office.

In addition to the two delegations that have been executed and signed by the receiver and CDCR, the receiver has produced draft delegations of authority for other operational aspects of its responsibility which have been provided to the state. These operational aspects include:

- Quality Management
- Medical Services
- Healthcare Invoice, Data, and Provider Services
- Information Technology Services
- Legal Services
- Allied Health Services
- Nursing Services
- Fiscal Management
- Policy and Risk Management
- Medical Contracts
- Business Services
- Human Resources

***March 10, 2015 Order Modifying Receivership Transition Plan*.** Earlier this week, the federal court issued an order describing a process for ending the federal receivership. The order employs the OIG medication inspection reports to determine which institutions are providing a constitutional level of care. Once it is determined by the OIG and the receiver that an inspection shows that an institution is suitable for return to CDCR control, the authority for the healthcare at that institution will be delegated back to the state. Once the institution is returned to the state, the receiver will monitor the state's oversight for one year and at that time, if the quality of care is maintained, the institution will be removed from receivership. Finally, once healthcare in all 34 institutions has been returned to the state and the final year of monitoring is completed, the plaintiffs will have 120 days to file a motion with the court if they do not believe a constitutional level of care is being provided. In the absence of such a motion, the parties are ordered to promptly file a stipulation and proposed order terminating the receivership and the *Plata v. Brown* lawsuit.

It remains unknown, however, how long it will take to transition the responsibility for healthcare for all 34 prisons to the state.

Special Report from the Receiver. Along with the court order issued on March 10, the receiver issued a special report detailing the improvements that have been made over the last decade in the quality of healthcare provided to inmates. In the report, the receiver notes that significant improvement has been made in the quality and delivery of medical care. However, there also remains significant variation in the quality of care at the institution level.

The report found that competent and experienced leadership and staff are now in place at headquarters, in four regional offices, and in all of the institutions. The organizational structure that has been created provides a direct line of authority from headquarters to the individual Chief Executive Officers for Healthcare at the institutions.

The report further found that the state consistently meets, or is within five percent of meeting, statewide process implementation goals such as access to care, population health management, and medication management. The report also notes that there have been significant improvements in recruiting board-certified and appropriately credentialed medical providers.

However, despite progress, the report notes that there is remaining work to be done in for system-wide areas:

- Implementation of an electronic healthcare record that allows for information transferability and access to a patients complete medical history.
- Improvements in scheduling so that primary care physicians' are not overloaded, creating backlogs and delays.
- Addressing remaining shortcomings in chronic care, infection control, information management, and continuity of care.
- Continuing the facility improvements required under the Health Care Facility Improvement Plan (HCFIP).

In addition to system-wide improvements, the report notes that there are roughly three levels of institutions: early adopters that have made substantial improvements and maintain a higher quality of care, institutions that are following behind the early adopters and learning from their implementation and adopting best practices, and a third group that is lagging significantly behind in medical care improvements. The greatest remaining challenge will be improving the care at those lagging institutions.

The report speaks generally of these three categories of institutions but does not specify the number of institutions or which institutions fall into each category. The primary reason the report does not provide specific details is that it lays out a general framework for the transition and does not presume to predetermine what the Inspector General's inspections will find concerning the quality of care provided at each of the 34 state prisons. The Inspector General has scheduled the first 12 inspections:

1. Folsom State Prison (12/8/15)
2. Correctional Training Facility (1/5/15)
3. California Rehabilitation Center (1/26/15
4. California Correctional Center (2/16/15)
5. North Kern State Prison (3/9/15)
6. Chuckawalla Valley State Prison (3/30/15)
7. California State Prison - Solano (4/13/15)
8. Kern Valley State Prison (6/29/15)
9. California Correctional Institution (7/13/15)
10. Pelican Bay State Prison (8/3/15)
11. Valley State Prison (8/24/15)
12. Centinela State Prison (9/7/15)

These prisons were chosen by the receiver's office because their indicators suggest that they are among those institutions that will likely be determined to be early adopters and provide the highest level of care. This does not mean, however, that the receiver has presupposed what the Inspector General's medical inspections will find in terms of the constitutional level of care.

QUESTIONS FOR RECEIVER'S OFFICE

1) Will you please provide detail on California's plan for transitioning out of the Receivership?

ISSUE 2: CALIFORNIA HEALTH CARE FACILITY STAFFING

The issue before the subcommittee is a request for $76.4 million (General Fund) and 715 clinical positions to ensure adequate staffing upon full activation of the California Health Care Facility (CHCF) in Stockton.

This request also includes funding to cover partial-year employee costs for the current fiscal year.

PANELISTS

- California Department of Corrections and Rehabilitation – Receiver's Office
- Department of Finance
- Legislative Analyst's Office
- Public Comment

BACKGROUND

CHCF was designed and constructed to be a state-of-the-art medical facility that would provide care to inmates with high medical and mental health care needs. The construction of CHCF was completed in July 2013 and the receiver and CDCR began shifting inmates to the new hospital facility. The facility provides about 1,800 total beds including about 1,000 beds for inpatient medical treatment, about 600 beds for inpatient mental health treatment, and 100 general population beds. The CHCF cost close to $1 billion to construct and has an annual operating budget of almost $300 million.

Almost immediately after activation began, serious problems started to emerge. It was reported that there was a shortage of latex gloves, catheters, soap, clothing, and shoes for the prisoners. In addition, over a six-month period, CHCF went through nearly 40,000 towels and washcloths for a prison that was housing approximately 1,300 men. Investigations by officials at the facility found that the linens were being thrown away, rather than laundered and sanitized. In addition, the prison kitchen did not pass the initial health inspections, resulting in the requirement that prepared meals be shipped in from outside the institution. The problems were further compounded by staffing shortages and a lack of training. In addition, early this year, the prison suffered from an outbreak of scabies which the receiver's office attributes to the unsanitary conditions at the hospital.

Despite being aware of serious problems at the facility as early as September of 2013, it was not until February of 2014, that the receiver closed down intake at the facility and stopped admitting new prisoners. In addition, the receiver delayed the activation of the neighboring DeWitt-Nelson facility, which is designed to house inmate labor for CHCF, mentally ill prisoners, and prisoners with chronic medical conditions who need on-going care. The CHCF resumed admissions in July 2014, and currently houses about 1,900 inmates.

If the proposed augmentation to CHCF staffing is approved, total clinical staffing costs would increase from about $82 million annually to about $158 million annually, and staffing levels would increase from 810 positions to 1,525 positions.

LAO ASSESSMENT

Proposal Exceeds Independent Assessment Recommendations. In January 2014, the Receiver contracted with CPS HR Consulting for an independent assessment of the clinical staffing levels at CHCF. The assessment included a review of the current CHCF staffing levels and recommendations for ongoing clinical staffing levels. As part of the review, the consulting firm conducted on-site reviews of staff responsibilities and patient records. However, during the time of these visits, CHCF was less than half-filled. In July 2014, CPS HR released a report summarizing its findings and recommendations. Specifically, the report found that the current staffing levels at CHCF are inadequate and included recommendations to increase the number of staff positions by about 600. Such an increase would cost about $60 million annually.

As mentioned above, the Governor's proposal recommends increasing staffing by 714.7 positions, at a cost of $76.4 million. This is about 100 positions and $16 million more than recommended by CPS HR. According to the Receiver's office, this is due to several reasons. First, the Receiver's office notes that certain services were not included in the CPS HR analysis, such as mental health group treatment. Second, the office notes that the analysis did not account for supervisory and administrative staff, which the Receiver believes are necessary to provide adequate care. Finally, the Receiver notes that because CPS HR did not visit CHCF when it was at full capacity, the analysis did not account for issues that have arisen since the facility expanded its operations. For example, the analysis did not include staffing for a mental health unit that was not open at the time the consulting group visited CHCF.

While the overall staffing levels proposed by the Receiver for CHCF are higher than the CPS HR recommendations, we note that the Receiver's proposal excludes some positions recommended by CPS HR. For example, the Receiver's request includes fewer certified nursing assistants than recommended by CPS HR. According to the Receiver, this is because certified nursing assistants cannot perform certain tasks like other classifications, such as licensed vocational nurses. Given the unprecedented nature of CHCF, it is difficult to assess whether deviations from the CPS HR analysis are appropriate, or whether other changes to the analysis are needed.

LAO RECOMMENDATION

Given the deficiencies in care identified at CHCF, the LAO recommends the Legislature approve the additional clinical staffing and funding requested. However, in view of the above concerns, we recommend that only a portion of the staff be approved on an ongoing basis and the remainder on a limited-term basis. Specifically, we recommend that the Legislature approve the staffing recommended by the CPS HR staffing analysis—excluding those staff the Receiver found to be unnecessary—on an ongoing

basis. This amounts to about $52 million and 515 permanent positions. For the remaining positions not recommended by CPS HR, we recommend that the Legislature approve them on a one-year, limited-term basis because it is unclear whether all of these positions are necessary. This amounts to about $24 million and 200 limited-term positions.

In order to assess whether the above limited-term positions are necessary on an ongoing basis and whether care can be delivered in a more efficient manner than proposed by the Receiver, we further recommend that the Legislature require the Receiver to contract for an updated staffing analysis for CHCF. This staffing analysis, which would likely cost less than $100,000, should include (1) a review of all positions not recommended by the CPS HR analysis, and (2) whether adequate care can be delivered with fewer positions. As this analysis would be carried out after CHCF is fully activated, it would provide better information on what the ongoing staffing needs of CHCF are than the other reviews conducted to date. The results of the analysis should be provided to the Legislature in time for its consideration of the 2016-17 budget.

QUESTIONS FOR RECEIVER'S OFFICE

1) The budget proposal requests approximately 150 more positions than the CPS staffing analysis calls for (583 in the analysis and 714.7 in the budget proposal). Please explain the reason for the disparity and why the scope of the analysis did not include a comprehensive assessment of staffing needs for CHCF.

STAFF RECOMMENDATION

Approve proposal as budgeted.

ISSUE 3: WORKFORCE DEVELOPMENT – CLINICIAN RECRUITMENT AND RETENTION

The issue before the subcommittee is a request for $872,000 (General Fund) and 8 positions, to build an internal recruitment and retention program designed to recruit and retain clinicians and other medical personnel.

PANELISTS

- California Department of Corrections and Rehabilitation – Receiver's Office
- Department of Finance
- Legislative Analyst's Office
- Public Comment

BACKGROUND

In 2007, the Plata Workforce Development Unit was created in response to a court order requiring the receiver to develop a detailed plan designed to improve prison medical care. The unit consisted of 40 positions dedicated to the recruitment and retention of positions within the medical program deemed critical to providing a constitutional level of medical care. The goal was met in 2010 and the positions were shifted to other healthcare improvement priorities.

A subsequent federal court order on March 27, 2014 requires CHCS to report on recruitment and retention in their tri-annual reports in order to ensure that healthcare facilities do not dip below a 10 percent vacancy rate. The latest recruitment and retention report submitted in January 2015, show that 18 prisons currently have a vacancy rate of less than 10 percent, including remote prisons such as Pelican Bay in Crescent City and Ironwood and Chuckawalla Valley prisons in Blythe. Another 13 prisons have a vacancy rate for physicians between 10 and 30 percent. Finally, two prisons, North Kern Valley and Salinas Valley, have a physician vacancy rate in excess of 30 percent. Given the vacancy patterns and the fact that in several instances, there is a disparity in the ability to recruit and retain adequate staff between prisons that are in very close proximity. For example, North Kern State Prison has at least a 30 percent vacancy rate for physicians, while neighboring Wasco State Prison has a physician vacancy rate of less than 10 percent. Similar examples can be seen throughout the report. This would suggest that geography or remoteness of institutions is not the reason for high turnover or high vacancies, rather something in the working conditions, culture or the running of the institution itself may be causing the difficulties in recruiting or retaining clinicians.

QUESTIONS FOR RECEIVER'S OFFICE

1) Please provide information on current clinician staffing levels and existing recruitment and retention efforts.

2) Please provide the Receiver's assessment of why recruitment and retention is challenging.

STAFF RECOMMENDATION

Approve proposal as budgeted.

ISSUE 4: QUALITY MANAGEMENT PROPOSAL

The issue before the subcommittee is a request for $4.9 million (General Fund) and 30 positions, to expand the receiver's quality management efforts.

PANELISTS

- California Department of Corrections and Rehabilitation – Receiver's Office
- Department of Finance
- Legislative Analyst's Office
- Public Comment

BACKGROUND

In June 2008, the federal court approved the receiver's "Turnaround Plan of Action" to achieve a sustainable constitutional level of medical care. The plan identified six major goals for the state's inmate medical care program, including specific objectives and actions for each goal. One of the identified goals was to implement a quality assurance and continuous improvement program to (1) track prison performance on a variety of measures (such as access to care), (2) provide some training and remedial planning (for example, developing a plan to improve access to care at a prison that is struggling to meet that goal), and (3) share best practices across prisons, among other tasks.

Currently, the quality management section within the receiver's office has 32 positions and a budget of $3.9 million. In addition, there are also 170 staff statewide (5 positions at each prison) who are involved in quality management activities. These staff include psychologists, managers, and program specialists who perform quality management functions as well as other responsibilities. According to CHCS, about 90 percent of their time is devoted to quality management activities.

Of the additional staff being requested, 20 positions are for the development of quality management programs in the receiver's new regional offices. Regional staff would be responsible for overseeing prisons located within their geographic area of responsibility. Similar to existing quality management staff, these requested staff would be responsible for tracking prison performance, identifying areas where medical care is deficient, developing performance improvement plans, and sharing best practices across prisons.

LAO ASSESSMENT

Independent Review Raised Concerns About Receiver's Quality Management Section. In 2012, the Receiver contracted with Health Management Associates (HMA) for a review of the structure of the Receiver's office. In February 2013, HMA released its analysis and recommendations. The analysis recommended several changes to the Receiver's quality management section, including reassigning many of the staff to other activities. According to HMA, the size of the quality management section in the

Receiver's office far exceeded that in any other prison or health care system of a similar scale. At the time HMA found the quality management section to be overstaffed, it had 24 staff. Under the Governor's proposal, the section would have 62 staff. This does not include the 170 additional staff that spend a majority of their time on quality management activities at the state's 34 prisons.

Proposal Exceeds Community Standard. Private health insurance plans generally spend about 0.7 percent of their budget on quality management activities. Currently, the Receiver's office spends about 0.25 percent of their budget on the headquarters quality management section. However, including the prison-level quality management staff, the Receiver's office currently spends about 1.3 percent of their budget on quality management—more than double the spending of private health plans. If the Governor's proposal was approved, the Receiver's office would spend about 1.6 percent of its budget on quality management.

LAO RECOMMENDATION

Given that the Receiver's quality management section was found to be unnecessarily large in an independent assessment and is already larger than the community standard, we find no compelling reason at this time to expand the Receiver's quality management staff. Thus, we recommend the Legislature reject the Governor's proposal.

QUESTIONS FOR RECEIVER'S OFFICE

1) Please respond to the LAO's concerns about the size of your quality management staff in light of the findings of the Health Management Associates study released in 2013.

STAFF RECOMMENDATION

Approve proposal as budgeted.