The Case for Reorganization of the California Department of Corrections and Rehabilitation: Prison Health Care

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Introduction

Good afternoon, Commissioners and staff of the Little Hoover Commission. I am pleased to once again appear before this Commission to discuss important issues involving the most cost-effective approaches to organizing and operating state government.

Over the course of the last twenty years, I have been involved in a series of government reorganization and accountability reforms. I spent most of the 1990s working with the Judicial Branch to reorganize the trial courts and strengthen governance mechanisms within the courts. Because of Chief Justice Ronald M. George's extraordinary leadership, those efforts have been successful. The unification of the trial courts led to dramatic improvements in productivity and local trial court governance, and the adoption of state-level funding of the trial courts led to a more equitable allocation of funds to local courts as well as greater transparency and accountability for court spending.

During my almost six years earlier this decade as the State's Chief Information Officer, we focused on consolidation of the data centers, which created ongoing savings approaching $100 million annually, and we established a foundation for enterprise-wide governance over information technology resources, including creating the State CIO's office as a real member of the Governor's cabinet. Although the CDCR reorganization has received a great deal more attention, that reorganization was actually the Governor's second reorganization. In my role as State CIO, I championed and then led the first reorganization of the state's two largest data centers, and that reorganization has been a success both in terms of budget savings and governance. The State CIO for the last two years, Teri Takai, has pushed forward with an additional consolidation of responsibility for IT resources which will serve the state very well over the next several decades.

During the first year of the Schwarzenegger Administration, I served as a Director on the California Performance Review and directly participated in the Performance Review's deliberations and reports. Most of the Performance Review's recommendations in the area of information technology have actually been implemented, saving the state millions of dollars and setting the groundwork for restoring California's information technology program as a national leader.

Finally, since my appointment in January of 2008 as the federal receiver responsible for prison medical care, I have been working to improve the quality of prison medical care to constitutionally acceptable levels with ongoing operational costs that the state will be able to afford. In this role, I have seen up close the effects of the reorganization of the California Department of Corrections and Rehabilitation (CDCR), and I have developed a pretty strong sense of why that reorganization continues to struggle and what needs to happen to put corrections on a better pathway.

The goals of a reorganization should be to reduce expenditures while improving performance. These two goals are *not* incompatible because improving performance in corrections should result in fewer inmates returning to prison after parole or release, more efficient and cost-effective operations, and a healthier prison population that requires less expensive health care. In my judgment, the State can reasonably expect a reorganization to produce hundreds of millions in savings as a result of decreases in the recidivism rate because of improved rehabilitation and vocational programs (resulting in lower prison population), savings from realigning responsibility for parole from the state to local law enforcement (resulting both in immediate savings from the realignment and additional savings from reduced recidivism from the parole population), and savings from improved mental health and medical care to parolees whose risk of recidivism is tied to their mental health and/or medical conditions.

Too Big, Too Political, Too Focused on Confinement

The Governor's reorganization of CDCR in 2005 was supposed to achieve the following:

> Restructuring will [1] establish clear lines of reporting, accountability and responsibility and performance assessment that will [2] improve services, [3] reduce the likelihood of repeat offenses, and [4] eliminate abuses within the current system. [5] It will centralize services and activities to remove duplication and [6] leverage the scale of the Department's $6 billion spending authority, thus reducing the cost of operations. [7] The reorganization will deliver a safer society at less cost to the people of California. ("A Government for the People for a Change: Governor's Reorganization Plan 2," p. 2).

Unfortunately, it appears that *none* of these goals has been achieved. First, lines of reporting and accountability are anything but clear within CDCR. About the only clear message externally is that the Secretary is apparently accountable for *everything* within CDCR. That is an unrealistic expectation. The organization is simply too large for any one person to shoulder all responsibility for operational successes or failures. Moreover, there has been so much turnover and churning within CDCR's executive staff for reasons apparently unrelated to job performance, that accountability for actual results simply does not exist as a practical matter. A significant problem in this regard is the large number of appointments within CDCR (including all of the wardens) that are made by the Governor instead of by the Secretary. Once a Governor has appointed someone, it is very difficult

to remove that person. If the Secretary is going to be held accountable for performance, then the Governor's office needs to give the Secretary the full freedom to hire *and* fire most of the executive staff as well as all of the wardens. Employees and wardens who feel they are protected by a gubernatorial appointment are inevitably not as responsive to the Secretary as they should be.

Second, services not only did not improve, but they substantially deteriorated. In the case of medical care, the deterioration was so bad that the federal court decided to take prison medical care into receivership in 2006. Other services have suffered as well, however. At the time of the reorganization in 2005, much was made of adding the word "rehabilitation" to the department's title. Unfortunately, the "R" in CDCR has been reduced to virtual irrelevance as decisions were made to cut education, vocational training and other programs related to recidivism-reduction. Internally, administrative services are in a state of chaos and disrepair. For example, trying to find out how much CDCR has actually spent during the year is like a visit to the house of mirrors. Nothing is what it seems.

Third, as for reducing the likelihood of repeat offenses, the most recent recidivism report released by CDCR shows that very little to no progress has been made there at all. The body of the report properly indicates that "for in-depth analysis, the focus of this report is on the three-year rates of returns to prison for inmates released during FY 2005-06." ("2010 Adult Institutions Outcome Evaluation Report," p. 2 (October 2010)). Appendix A in the report shows there has been no improvement at all in the three-year rates of return. In fact, the rate of return is slightly higher than in prior years (66.2% for 2002-03, 65.6% for 2003-04, 66.8% for 2004-05, and 67.5% for 2005-06). Appendix A also shows that the one-year recidivism rates have fluctuated through the decade and are still higher than the one-year recidivism rates in the two years immediately preceding the reorganization (48.0% for 2002-03, 45.9% for 2003-04, 46.5% for 2004-05, 49.1% for 2005-06, 47.4% for 2006-07, and 47.5% for 2007-08). When CDCR released this report, it seized upon the 1.6% reduction in the one-year recidivism rate from 2005-06 to 2007-08 as "very encouraging." I don't believe the data supports that hopeful characterization given that the rate is still worse than one-year recidivism rates immediately prior to the year of the reorganization. Moreover, from 2006 to 2009, the state has seen a 12.5% reduction in the violent crime rate and an 18% reduction in the property crime rate. Yet the one-year recidivism rate is essentially flat. With such a dramatic reduction in the crime rate, one might have thought that we would see significant improvements in recidivism reduction. Instead, it appears that prison remains a training ground for criminal activity notwithstanding substantial reductions in the overall crime rate. Finally, the Governor's Reorganization Plan 2 said the following about recidivism:

> [E]vidence of the current structure's failure can be found in the rate at which adult inmates re-offend after being released from prison. Forty-three percent are likely to be back in prison within one year of their release and more than 60% will be back within three years. This is 3 in every 5 prisoners and speaks to a failure of the system to take responsibility and

> accountability for the rehabilitation of offenders and provide the training, counseling and support needed to prevent re-offending. (Governor's Reorganization Plan 2, p. 6)

Judged by the standard set by the Governor's Reorganization Plan 2, the reorganization has failed to meet its goal of solving CDCR's revolving door problem.

From my observations over the last three years, the reorganization's failure may be traced to several root problems which were actually exacerbated by the reorganization itself. First, the department is simply too big and has too broad a portfolio of very different functions for it to be managed as a single organizational entity. As a result, there is very little focus within CDCR. There is too much to do, and not enough time to focus. As anticipated by the reorganization proposal, the Secretary is indeed closer to the line worker in terms of the Secretary's personal accountability for operational performance, but it turns out there are too many lines spread over too many institutions, and it simply is not possible for any one Secretary to manage the whole enterprise. For example, health care is obviously a major function within CDCR, and yet Secretary Cate often would be able to think about health care issues for only five or ten minutes out of the day. This was not because of any misallocation of time by Secretary Cate, but simply the reality that other issues within CDCR take precedence. I submit that if an organizational function representing one-quarter of the organization's budget routinely is neglected because of other organizational priorities, that function no longer belongs within the organization. It needs to be separated out and given its own organizational leadership.

Second, in addition to having operational responsibility for CDCR, the Secretary is also a member of the Governor's cabinet. This creates an especially bad situation where the Secretary must split his or her time between the demands of organizational operations and the more political demands of working with the Governor and Governor's staff, legislators and legislative staff, and other external stakeholders in the large law enforcement community. Particularly given the highly politicized nature of corrections and corrections policy in California, and the pressure put on the Governor's office by the modern 24-hour news cycle, the time the Secretary has to improve organizational performance and effectiveness is further eroded responding to or anticipating the next bad headline.

Third, in light of the chronic overcrowding in California prisons, which are operating at around 180% of design capacity, the primary focus within CDCR is on confinement. That is CDCR's *de facto* organizational mission, and that overriding mission tends to overwhelm CDCR's many other functions. The operational obstacles raised by overcrowding have been well chronicled elsewhere and subject to judicial review, so I will not rehearse them here again. Suffice it to say that the degree of overcrowding makes it very difficult, if not impossible, to provide inmates with access to *any* programs at all, and overcrowding puts inmates and custody staff on a hair-trigger for violence and resulting custody-based decisions to put part or all of a prison on a "lockdown" status where inmates are kept in their cells for up to 23 hours a day. Although the numbers vary

substantially from prison to prison, it appears overall that inmates are in lockdown as much as 40% of the time, and one-third of the prisons are in lockdown more than two-thirds of the time. With this much cell time, it is perhaps no wonder that there is very little rehabilitation going on. CDCR needs to return to the basics of how to run a prison to facilitate rehabilitation and other programs.

Fourth, given the evident chaos within CDCR, it has unfortunately developed a reputation within the Executive Branch as a department to avoid. I have personally seen at the top of CDCR some of the most gifted and talented executives I have ever worked with. However, CDCR's reputation throughout the branch is not positive, in part because of a general recognition that the reorganization has made CDCR virtually ungovernable, and the inability to attract the best and brightest to join CDCR's ranks creates additional organizational challenges.

Fifth, because of the reorganization, the Secretary is personally accountable for the performance of the parole system. In a parole system that releases more than 100,000 persons a year, there are always going to be cases where a parolee commits one or more especially heinous crimes, and there are always going to be mistakes made in the system. Unfortunately, every one of those mistakes is now visited personally upon the Secretary, who must spend an inordinate amount of time focused on responding to the inevitable mistakes and failures and the extensive media coverage which follows those errors. It is not the best use of the Secretary's time.

Sixth, the Secretary's ability to hold employees and wardens accountable for performance is undermined by the excessive number of employees who are appointed directly by the Governor. The reorganization made a slight improvement in this situation by removing wardens from the Senate confirmation process. But the reorganization did not go nearly far enough because it retained gubernatorial appointment of wardens as well as appointment of literally scores of employees within CDCR headquarters. Every one of these appointments becomes an obstacle to organizational performance and accountability because the Secretary has no real power to discipline or remove an employee without essentially challenging the Governor's appointment, a challenge that comes at great political cost.

General Recommendations

Based on the above, I believe CDCR should be reorganized pursuant to the following general principles:

- CDCR should be restructured so that it has a traditional cabinet level secretary and agency with a number of departments and other organizational entities below that agency;

- Organizational entities within the new corrections agency should be aligned with the major lines of business within CDCR so that each entity can focus on improving its organizational effectiveness;

- There should be a significant reduction in the number of employees within corrections who are appointed by the Governor since gubernatorial appointments interfere with real accountability in managing operations within corrections.

There are of course many ways in which CDCR could be reorganized. I offer the following as one possible approach:

Corrections Agency

A typical agency, known as the Corrections Agency, should be reestablished with the usual small staff to support the Secretary's external, policy-making and oversight roles. The Secretary will be responsible for making sure that the correctional entities within the agency work together collaboratively to achieve each of their goals. The Secretary will of course remain a member of the Governor's Cabinet.

Department of Adult Prisons

Custody operations for CDCR's adult prisons should be transferred to a Department of Adult Prisons led by a director appointed by the Governor subject to Senate confirmation. The large number of exempt appointments should be significantly reduced so that staff within the Department of Adult Prisons will be accountable to the Director for their performance. For similar reasons, all wardens should be appointed by the Director. The Office of the Inspector General should continue to review applicants for the position of warden and make recommendations to the Secretary.

The Department of Adult Prisons needs to be given a focused charge to improve the way in which prisons are run on a day-to-day basis. Secretary Cate is already moving towards national accreditation of the prisons as one strategy to secure improvements, and that is a positive development. The Department of Adult Prisons should focus a great deal of attention on reducing the amount of time spent in lockdowns and modified programs. Lockdowns interfere with all rehabilitation and health care activities.

Department of Rehabilitation Services

The Department of Rehabilitation Services would be responsible for operating all education, vocations and offender programs. This department would also have responsibility for establishing, maintaining and expanding cooperative agreements with local law enforcement and community-based organizations and other entities that can aid in the rehabilitation and reintegration of inmate and parolees. The Prison Industry Authority and its board should probably remain with this department for coordination and administrative purposes.

Board of Parole Hearings

The Board of Parole Hearings should not be changed.

Department of Parole Operations

This department will supervise inmates who are released on parole and will help parolees successfully reintegrate into their communities. However, as part of the reorganization, that should be a realignment of responsibilities that shifts lower level parole supervision from state parole to county probation. The Legislative Analyst has repeatedly recommended this shift in supervision, which would affect over 70,000 parolees with current convictions for non-serious, nonviolent drug and property crimes. This realignment of responsibility is likely to produce savings of approximately $50 million

Corrections Standards Authority

The Corrections Standards Authority should not be changed.

Division of Youth Operations

Juvenile justice at the state level should be abolished in its entirety. Juvenile justice at the state level has performed poorly and is wildly expensive on a per ward basis. There has been about a 90% reduction in the number of wards over the last decade, and we should finish the job by realigning the juvenile program to local law enforcement agencies. This realignment will result in millions of dollars of savings, and the state simply cannot afford the juvenile justice program at the state level.

California Health Care Authority

As discussed in detail below, responsibility for prison health care should be transferred to a separate California Health Care Authority that will contract with the Department of Adult Prisons and Department of Parole Operations to provide necessary health care services.

The Special Case for a California Healthcare Authority

There are two key organizational questions with respect to prison health care: First, should prison health care be permanently spun off into a separate organizational entity, or should it return to being a division within CDCR upon the termination of the Receivership? Second, if prison health care should be spun off, what type of organizational entity will mostly likely lead to that entity meeting its organizational purpose and goals?

Even if no other reorganization of CDCR takes place, there is a compelling reason for spinning off health care. The simple truth is that the Receivership has been operating as a *de facto* separate department for about five years and that separate organizational status has been a major contributor to the quick progress made by the Receivership in improving prison medical care. In my judgment, the end of the Receivership and termination of the multiple federal cases related to prison healthcare will be advanced by spinning off healthcare into its own organization. Simply put, given the twenty-year history of these cases, the federal courts are not in a position to trust state management of prison healthcare so long as primary management responsibility is placed in the hands of corrections and custody officials, instead of in the hands of healthcare leaders.

Prison healthcare could conceivably be spun off into its own Department of Prison Healthcare that would have a director who reports to the new corrections agency. In my view, this is not the best organizational approach, although it would at least give prison healthcare a measure of independence from custody leadership and would makes its operations and budget more visible to the Legislature. Instead, I believe prison health should be transferred to an organizational service entity that has more of an entrepreneurial structure and focus. The structure best aligned with entrepreneurship and service is an "authority" governed by a board, to be known as the California Health Care Authority. This structure will maximize prison healthcare's independence, transparency and organizational performance.

The Authority would be staffed initially by transferring to the Authority all of the existing health-care-related staff (both clinical and non-clinical) from the CDCR. There is adequate executive leadership within CDCR's Division of Correctional Health Care Services and the Receivership to manage an authority, and because of the extensive reporting responsibilities to the courts, the staffing infrastructure to support a board already exists. Thus, creating the Authority would not add any new layers of bureaucracy to California's Executive Branch or health care programs. In fact, creating the Authority will substantially contribute to reducing the costs of prison health care since, as discussed below, it will facilitate drawing down federal money in support of some health care costs and will help us qualify us for especially favorable federal pharmaceutical pricing.

More broadly, with respect to the State's safety net health care programs, the State can no longer afford the vertical and horizontal silos that pit levels of government and health care disciplines against each other in providing basic health care services to persons who intersect with the criminal justice system. Instead, we need to pull together and collaboratively align our now separate resources to serve patient interests. This will maximize the value of our existing collective resources, provide better care and position the State for maximum federal support in 2014 if key federal mandates and revenues for health care become effective.

Finally, by extending mental health care and substance abuse services to certain parolees or to individuals who may be diverted from parole or prison under special court

supervision because of mental health or substance abuse conditions, we should be able to reduce the prison population by reducing recidivism.

Statewide Infrastructure

The implementation of the Receivership's 2008 Turnaround Plan of Action is intended to bring medical care within California's prisons up to constitutional standards. Similar improvement efforts are underway with respect to the dental and medical programs managed by CDCR's Division of Correctional Health Care Services. In so doing, we are establishing a statewide health care system consistent with community standards of practice that serves a very large population of patients, many of whom have serious pre-existing medical, mental health and dental conditions when they enter the system, who move in and out of the system regularly and are geographically dispersed throughout the state.

We already have in place substantial clinical resources to accomplish our primary goal of providing appropriate health care in the prisons, including primary care physicians, psychiatrists and psychologists, dentists, nursing staff, pharmacy staff, and allied health professionals. With respect to care outside the prison walls, we have entered into a multi-year contract with Health Net to provide us with access to a cost-effective, statewide provider network. This contract is a good example of how to implement public-private partnerships to serve public goals. We also already have in place the basic infrastructure of a standard health maintenance organization, including utilization management, a drug formulary, central fill pharmacy, a patient appeal process, and third party administration of health contract payments.

With the budget support we are receiving from the Administration and Legislature, we will be able to complete over the next several years a series of foundational information technology projects that, once finished, will give us a statewide telecommunications network – much of it in rural areas in California – over which we will provide to our clinicians and affiliated providers basic digital health care records, medical information technologies, clinical decision support tools and a framework for specialty care. In addition, we are making a substantial investment in telemedicine technologies as a cost-effective model for projecting our primary care providers and outside specialty care providers to patients in areas where our staffing is short-handed. All of our technology systems are scalable to handle more patients and are being implemented consistent with national standards for health information exchange.

In short, by the time the Turnaround Plan of Action is fully implemented, we will have established a basic safety net health care system with a statewide scope of operations mostly in rural California and the capacity to grow that system to other populations in addition to adult prisoners (such as local custody populations, community mental health resources and the safety net public populations in communities that support CDCR facilities).

Health Care to Parolees

A first and very natural extension of health care services would be to begin the planning for how to provide services to parolees. Under the recently enacted medical parole bill, SB 1399, the Authority could assume responsibility for providing care to these medical parolees in the community. This may in fact be the most cost effective way of implementing SB 1399 (in part because the Authority could manage care consistent with its own utilization management standards) and is likely to help us generate the greatest reduction in expenditures of the costly care provided to these patients.

Working with county public health and mental health officials to provide care collaboratively to non-medical parolees also has some significant potential positive consequences. First, continuity of care has been a problem when an inmate with chronic medical or mental health conditions is released on parole. If the Authority provides care to inmates and is responsible for managing care provided to parolees in the community, continuity of care is likely to be substantially improved. This integration of care should result in more stable medical and mental health for parolees, translating to a better ability to remain compliant with parole conditions. That should reduce the costs of care that is provided (by reducing the likelihood that a lack of continuity results in a patient degenerating into conditions that are more costly to treat).

Second, particularly with respect to mental health problems, improving continuity of care is likely to reduce parole violations and recidivism that results from breaks in treatment. Reducing the number of persons who cycle back from parole into the corrections system has very positive budget consequences.

Third, pursuant to the new federal health care reforms, parolees will ultimately be covered with substantial federal participation for health care costs. If the authority has already expanded its patient pool to include persons on parole, the state will be optimally positioned to secure maximum federal participation for these costs.

A Path to Reducing Mental Health and Substance Abuse Recidivism

The overlap between persons with mental health and substance abuse problems and the population of adults within our prison system is quite extraordinary. Recent estimates are that 75-80% of the adult prison population suffers from substance abuse, serious mental health problems, or both. Unfortunately, because our treatment approaches are so siloed and fragmented, CDCR has become a revolving door for this population. It is time to break that revolving door.

A collaborative, fully integrated approach to treatment inside of prison and outside will improve care and outcomes. The same can be said about parolees with serious substance abuse problems.

In addition, there is a subset of this population who should have been diverted from prison at time of sentencing to treatment programs and, at time of parole, should be diverted from traditional parole to a clinical treatment program. The state already has experience with this population, both through the implementation of *Laura's Law*, Welf. & Inst. Code §§ 5345-5349.5, and through the good work being done by California's "mental health courts." *See* http://www.courtinfo.ca.gov/programs/collab/mental.htm. Successful programs in other States, such as Hawaii's HOPE Probation program (*see* www.hopeprobation.org), should be considered for adoption here in California as part of this diversion program.

By providing coordinated, collaborative care to this population – much of which would still be provided by community health, mental health and substance abuse programs through contracts with the Authority – we can improve the performance of these programs and subject them to more rigorous evaluation, assessment and improvement. The budget and social implications for the State are again quite substantial, both in making care more cost-effective and in reducing the prison and parole population.

Health Care Beyond the State Criminal Justice System

The Authority could also become a partner with local criminal justice systems and jails as a primary or secondary provider of care, or as a provider of certain services, such as pharmaceuticals through our central fill pharmacy. In addition to promoting greater continuity of care, there are economies of scale that could be provided to local jails. At its broadest, it is conceivable that the Authority could become a safety net health care provider, particularly in those rural counties where the resources for providing full health care services are absent, although this would certainly not be an initial focus of Authority planning or activities. However, the federal overhaul of health care presents the State with a perfect opportunity for collaboratively realigning how safety net health care services are delivered in the State, particularly to that population which intersects with the State and local criminal justice systems. This would serve effectively to leverage the necessary costs and capacity for delivering health services to CDCR and to diversify the product lines so as to reduce the costs for all clients of the Authority.

The remainder of this paper describes the structure and operations of the Authority. The appendix contains statutory language which could be adopted by the Legislature or form the basis for a Governor's Reorganization Proposal.

Structure and Operations of the California Health Care Authority

In organizational terms, the proposal is to spin off prison health care (and perhaps CDCR's substance abuse treatment programs) to a statutorily-established "authority," the California Health Care Authority ("CHCA"), which would have exclusive responsibility for providing health care services to adults held in California's prisons and would be authorized to provide health care services to certain other groups including persons on medical parole pursuant to SB 1399 (Leno), persons on non-medical parole, persons

subject to a civil mental health treatment order in lieu of parole (if such a program were to be established), persons subject to a civil mental health treatment order issued by a superior court as part of a mental health court program, persons held in local jails, and other underserved children, adults and seniors who otherwise qualify for state or federal health care assistance.

The CHCA would be governed by a seven-person board to oversee budget development and operations of the authority, subject of course to the usual state budget processes. The board would set the rates to be charged for providing care to its various populations of patients. In the case of care provided to inmates, CDCR would be obligated to pay pursuant to the rates set by the board.

There is precedent for creating precisely this type of "authority" in California government. For example, the "California Earthquake Authority," governed by a five-person board (3 voting and 2 ex officio, non-voting), provides residential earthquake insurance to California homeowners at rates set by the board. It essentially is a government-managed entity that provides a service to the public in the form of residential earthquake insurance. Another example is the "Technology Services Board" which governs the budget and operations of the "Office of Technology Services." The Office of Technology Services provides information technology services to all Executive Branch agencies, charging rates for those services set by the Technology Services Board.

Composition of the Board

The CHCA should be governed by a seven-person board, all appointed by the Governor, as follows:

(a) Governor's Designee, Chair;
(b) Director of Department of Finance, or his or her designee;
(c) Secretary of CDCR, or his or her designee;
(d) Director of a County Public Health program;
(e) Director of a County Mental Health program;
(f) Two public members (perhaps someone with statewide prominence in California health care discussions, and a second person with experience leading private sector health care providers).

Because of the Board's power to set rates for services (discussed below), it is important for the Department of Finance to be represented on the Board. Because of the need to have very close collaboration between the CHCA and CDCR, and because CDCR will be one of the primary purchasers of CHCA's services, it is important for the Secretary of CDCR to be represented on the Board. Because one of the Authority's purposes is to marshal state and local health care resources collaboratively, it is important to have representation from county public health and mental health programs. The board's two public member positions give the Governor the opportunity to round out membership

with a leading policy analyst or thinker as well as someone from the private sector with experience managing large healthcare organizations.

The Board's Powers

The Board would have the power to appoint the CEO of the CHCA (subject, initially, to conversations with the four federal courts regarding the relationship between the CHCA Board and the Receivership).

The Board's primary functions would be:

(a) Selection, evaluation and retention of the CHCA's CEO;

(b) Consideration and approval of a plan of operations for the CHCA to be submitted by the CEO on an annual basis; and,

(c) Consideration and approval of an annual budget and of rates to be charged for services.

The CHCA's Authority and Operations

The Authority's CEO would have all powers to manage the affairs of the CHCA, including hiring/firing, contracting, and so on. The CHCA would operate under the general statutes and procedures of the Executive Branch. All existing CDCR health care and health care related employees (i.e., clinical and non-clinical) would be transferred to the CHCA as civil service employees.

With respect to health care services for inmates, the CHCA and CDCR would be required to enter into a contract by which CHCA provides all prison health care services to adult inmates pursuant to rates set by the Board of the CHCA. The CHCA would assume the role currently performed by CDCR relative to the existing contract between CDCR and the Department of Mental Health for specified mental health services. In order to provide services, the CHCA would be authorized to have its own employees provide health care services.

In addition, it would be authorized to contract with other entities, both public and private and at both state and local levels, to secure additional health care and health care related services (e.g., interagency agreements with other state and local entities that provide health care services, contracts with individual providers, and contracts with health maintenance organizations or other provider networks to establish statewide network coverage of health care services). At the State level, cooperative engagement with the Department of Health Care Services (DHCS) and/or contractual arrangements with the Managed Risk Medical Insurance Board ("MRMIB") would put the Authority in the best position to maximize federal support. It is through this network of interagency agreements and contracts that the CHCA would be able to marshal state and local health

care resources, both public and private, to provide cost-effective, managed care to its patient populations.

Appendix

SECTION 1. Article 14.5 (commencing with Section 12840) is added to Chapter 1 of Part 2.5 of Division 3 of Title 2 of the Government Code, to read:

ARTICLE 14.5. CALIFORNIA HEALTH CARE AUTHORITY

12840. This article shall be known and may be cited as the California Health Care Authority Act of 2010.

12840.1. For purposes of this article, the following terms shall have the following meanings, unless the context requires otherwise:

(a) "Authority" means the California Health Care Authority established by this article.

(b) "Health Care Authority Board" or "board" means the board created pursuant to Section 12840.3.

(c) “Health care services" means all reasonably necessary medical, mental health, dental, and substance use disorder services, as well as all allied health services that support these services

(d) “Underserved children, adults and seniors” are children, adults and seniors who qualify for public assistance for health care services pursuant to Medi-Cal or Medicare, or any similar state or federal health care services assistance program, or mental health treatment or other services pursuant to Proposition 63, the Mental Health Services Act.

12840.2. (a) There is in state government the California Health Care Authority.

(b) The purpose of this article is to establish an authority that will collaboratively marshal and coordinate state and local health care resources to provide the most cost-effective health care services to underserved populations, particularly persons involved with the criminal justice system, including but not limited to, (1) the adult population held in prisons managed by the California Department of Corrections and Rehabilitation, (2) persons on medical parole pursuant to Section 3550 of the Penal Code, (3) persons on parole, (4) persons subject to a civil mental health treatment plan and judicial supervision pursuant to orders issued as part of a mental health court program, and (5) other underserved children, adults or seniors.

(c) In fulfilling the purpose set forth in subdivision (b), the authority shall seek to develop and maximize the value of revenue streams other than the State’s General Fund, including but not limited to funds available through Medi-Cal, Medicare, Proposition 63, the Mental Health Services Act, and any other federal, state or private grant programs that support health care services. The authority shall also use its status and the status of its patient population, or any reasonable affiliations with other public or private health care providers, to maximize cost savings, including reducing the cost of pharmaceuticals through the use of Section 340B pricing. The authority shall work with the Managed Risk Medical Insurance Board and the Department of Health Care Services

to coordinate the authority's activities with the State's implementation of federal health care reform.

12840.3. (a) The Authority shall be governed by a California Health Care Authority Board.

(b) The board shall consist of seven members, as follows:

(1) A designee of the Governor, who shall serve as the chair of the board.

(2) The Director of Finance, who shall serve as vice-chair of the board, or his or her designee;

(3) The Secretary of the Department of Corrections and Rehabilitation, or his or her designee;

(4) A county public health director appointed by the Governor;

(5) A county public mental health director appointed by the Governor; and,

(6) Two public members appointed by the Governor.

(c) Until such time as the federal court in *Plata v. Schwarzenegger* shall have terminated the receiver the court has appointed to manage prison medical care, the receiver shall exercise the board's powers with respect to matters within the jurisdiction of the receivership, except the receiver shall consult with the board on all such matters.

12840.4. (a) The board shall meet not less than once each quarter.

(b) A quorum shall consist of four members of the board. All decisions of the board shall be made by a majority vote of the voting membership of the full board.

(c) Members of the board shall be required to file financial disclosure statements with the Fair Political Practices Commission.

(d) The Bagley-Keene Open Meeting Act (Article 9 (commencing with Section 11120) of Chapter 1 of Part 1 of Division 3 of Title 2 of the Government Code) applies to meetings of the board.

12840.5. (a) The board shall engage an independent firm of certified public accountants to conduct an annual financial audit of all accounts and transactions of the Authority. The audit shall be conducted in accordance with Generally Accepted Government Auditing Standards.

(b) The board may arrange for other audits as are necessary or prudent to ensure proper oversight and management of the department.

12840.6. The chief executive officer of the authority shall be appointed by, and serve at the pleasure of, the board. The chief executive officer shall act as executive officer of the board. The chief executive officer may be a member of the state civil service, or the authority may contract for the services of a chief executive officer, and this contract shall not be subject to otherwise applicable provisions of the Government Code and the Public Contract Code, and for those limited purposes, the authority shall not be considered a state agency or other public entity. The chief executive officer shall be required to file financial disclosure statements with the Fair Political Practices Commission.

Until such time as the federal court in *Plata v. Schwarzenegger* shall have terminated the receiver the court has appointed to manage prison medical care, the receiver shall exercise the chief executive officer's powers with respect to matters within the jurisdiction of the receivership.

12840.7. The chief executive officer shall be responsible for managing the affairs of the Authority and shall perform all duties, exercise all powers and jurisdiction, assume and discharge all responsibilities necessary to carry out all purposes of this article. The chief executive officer shall employ such professional, clerical, technical, and administrative personnel as necessary to carry out the provisions of this chapter, all of whom shall be subject to civil service provisions. The Authority shall have the power to establish and fill "RCEA" positions as currently authorized by the State Personnel Board.

12840.8. (a) The chief executive officer shall administer the Authority pursuant to a written plan of operations developed in consultation with the board. The plan of operations shall establish in detail the policies, procedures and organization of the Authority, including, but not limited to, financial and administrative operations, financial disclosure requirements, performance measurements, methods of collection, procedures consistent with constitutional, statutory, and common law requirements for dispute resolution, and procedures by which the department enters into all agreements and contracts, including, but not limited to, purchases, sales, leases, licenses, memorandums of understanding, and interagency agreements. Except as provided in this chapter, the authority shall be subject to otherwise applicable provisions of the Government Code and the Public Contract Code which govern other executive branch agencies.

(b) The chief executive officer shall propose for board consideration and approval an annual budget for the operations of the Authority. At least ninety days before submitting the proposed budget to the board, the chief executive officer will submit the proposed budget to the Department of Finance. The Department of Finance will prepare a report to the board evaluating the reasonableness of the proposed budget.

(c) The chief executive officer shall propose for board consideration rates for services based on a formal rate methodology approved by the board. At least ninety days before submitting proposed rates to the board, the chief executive officer will submit the proposed rates to the Department of Finance. The Department of Finance will prepare a report to the board evaluating the reasonableness of the proposed rates.

12840.9. (a) The prison health care functions of the Division of Health Care Services of the California Department of Corrections and Rehabilitation are transferred to the Authority.

(b) Except as expressly provided otherwise in this chapter, the Authority is the successor to, and is vested with, all of the duties, powers, purposes, responsibilities, and jurisdiction of the Division of Health Care Services of the California Department of Corrections and Rehabilitation. Any reference in statute, regulation, or contract to that entity with respect to the transferred functions shall be construed to refer to the Authority unless the context clearly requires otherwise.

(d) No contract, lease, license, or any other agreement to which the California Department of Corrections and Rehabilitation or its Division of Health Care Services, with respect to health care services, is a party shall be void or voidable by reason of this article, but shall continue in full force and effect, with the Authority assuming all of the rights, obligations, and duties of the Division of Health Care Services, with respect to health care services functions.

(e) On and after the effective date of this chapter, the balance of all money available for expenditure by the Division of the Health Care Services of the California Department of Corrections and Rehabilitation, with respect to carrying out any functions transferred to the Authority by this article, shall be transferred to the California Public Health Care Authority Revolving Fund created by Section 12840.11, and shall be made available for the support and maintenance of the Authority. The Controller shall continue to make all payments in the same manner and subject to the same processes as before the implementation of this chapter.

(f) All books, documents, records, and property of the Division of Health Care Services of the California Department of Corrections and Rehabilitation, with respect to providing health care services, shall be transferred to the Authority.

(g) All officers and employees of the former Division of Health Care Services of the California Department of Corrections and Rehabilitation, and of the California Prison Health Care Services, are transferred to the Authority. The status, position, and rights of any employee of the Division of Health Care Services of the California Department of Corrections and Rehabilitation, and of the California Prison Health Care Services, shall not be affected by the transfer of the functions of that officer or employee to the Authority.

12840.10. (a) The chief executive officer shall confer as frequently as necessary or desirable, but not less than once every quarter, with the board, on the operation and administration of the Authority. The chief executive officer shall make available for inspection by the board or any board member, upon request, all books, records, files, and other information and documents of the Authority and recommend any matters as he or she deems necessary and advisable to improve the operation and administration of the Authority.

(b) The chief executive officer shall make and keep books and records to permit preparation of financial statements in conformity with generally accepted government accounting principles and any state policy requirements.

12840.11. (a) The "California Health Care Authority Revolving Fund", hereafter known as the fund, is hereby created within the State Treasury. Notwithstanding Section 13340, the fund is continuously appropriated and available for encumbrance without regard to fiscal years for the purposes of this chapter. The fund shall be administered by the Chief Executive Officer, pursuant to the authority’s plan of operations, to receive all revenues from providing health care services pursuant to this chapter and all other moneys properly credited to the board and authority from any other source, and to pay all costs arising from this chapter including, but not limited to, operating and other expenses of the board and authority and to establish reserves. At the

discretion of the Chief Executive Officer, segregated, dedicated accounts within the fund may be established.

(b) The fund shall consist of the following:

(1) Moneys appropriated and made available by the Legislature for the purpose of this article.

(2) Any other moneys that may be made available to the authority for the purpose of this article from any other source, including the return from investments of moneys by the Treasurer.

(c) The authority may collect payments from state or local agencies for providing services to those agencies that the client agency has contracted with the authority to provide. The authority may require monthly payments by client agencies for the services the client agency has contracted the authority to provide. Pursuant to Section 11255, the Controller shall transfer any amounts so authorized by the authority, consistent with the annual budget of each client agency, to the fund. The authority shall notify each affected state agency upon requesting the Controller to make the transfer.

(d) If the balance remaining in the fund at the end of any fiscal year exceeds 10 percent of the authority's current fiscal year budget, the excess amount shall be used to reduce the billing rates for services rendered during the following fiscal year.