Colorado Office of the State Auditor

Department of Corrections External Health Care Services Provided to Inmates

Performance Audit
April 2005

NAVIGANT CONSULTING

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Navigant Consulting, Inc.
Contract Auditor

175 W. Jackson Blvd., Suite 500
Chicago, Illinois 60604
312.583.5700 phone
312.212.6103 fax

April 15, 2005

Members of the Legislative Audit Committee:

This report includes the results of our performance audit of the Department of Corrections External Health Care Services Provided to Inmates, which Navigant Consulting, Inc. conducted on behalf of the Office of the State Auditor. The audit was conducted pursuant to Section 2-3-103, C.R.S., which authorizes the State Auditor to conduct audits of all departments, institutions, and agencies of state government. This report presents our findings, conclusions, and recommendations and the responses of the Department of Corrections.

Sincerely,

Paula Douglass
Director, Navigant Consulting, Inc.

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Report Summary
External Health Care Services Provided to Inmates
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Authority, Purpose, and Scope

This report presents the results of our performance audit of external health care services provided to Colorado inmates. The audit reviewed administrative services provided by the Department's external health care services contractor. The audit was conducted on behalf of the Office of the State Auditor under the authority of Section 2-3-102, C.R.S. We analyzed data from the Department and Access Correctional Care (the contractor) in three specific areas: (1) rates negotiated with external providers, (2) administration of the utilization management program, and (3) the Department's oversight of its external health care services contractor. Audit work was performed between August 2004 and March 2005.

We acknowledge the assistance and cooperation extended by management and staff at the Colorado Department of Corrections and at Access Correctional Care.

Overview

According to the 1976 United States Supreme Court ruling in *Estelle v. Gamble*, inmates have a constitutional right to health care. The Department of Corrections' Clinical Services Division is responsible for providing medical, optometry, and dental services to about 18,000 inmates in state- and privately-run correctional facilities at a cost of about $59 million per year.

Clinical staff who are employees of the Department or privately-run correctional facilities provide primary and emergency care in each correctional facility. External physicians, hospitals, and other health care facilities provide specialty physician services, outpatient tests and procedures, and inpatient hospital care to inmates. The Department contracts with Access Correctional Care (the contractor), one of Colorado Access's lines of business, to manage the external health care services for inmates. The administrative services provided by the contractor include: (1) establishing a provider network for external services, (2) maintaining a quality management and improvement program that identifies ways to improve care provided to inmates, (3) developing and implementing a utilization management program, (4) processing claims submitted by providers for external services and paying claims from a Department account, and (5) reporting statistics and trends related to utilization and costs of external services. The Department paid the contractor about $1.4 million in Fiscal Year 2004 for these administrative services.

Summary of Audit Comments

Provider Rates

We evaluated the rates negotiated with external health care providers for inpatient and outpatient hospital services provided to Colorado inmates and found:

- **The Department is not ensuring that the State is paying optimal rates for hospital services provided to inmates.** We found that the Department has provided minimal oversight of the contractor's rate-setting methodologies. We also found that the Department could have potentially saved $2.5 million if the contractor paid 120 percent of costs rather than using a percentage of charges system (e.g., for hospital charges of $1,000, the Department would pay $650 or 65 percent of charges) for outpatient and high-charge inpatient services at four hospitals between August 2003 and July 2004. Similarly, if the contractor paid 140 percent of costs, the Department could have potentially saved almost $1.9 million. Industry experts indicate that cost-based systems, rather than percentage of charges systems, protect against rapidly escalating hospital charges. Additionally, we found that rates negotiated for inmates' inpatient stays for a sample of diagnoses (e.g., chest pain) were, in most cases, higher than those established for Colorado Medicaid and Medicare patients at the same hospitals. If the Department were able to obtain rates similar to those paid by Medicaid and Medicare, the Department would have saved between $60,000 and $105,000, depending on whether savings are calculated based on Medicaid or Medicare rates. Although the State may not be able to obtain rates equivalent to those paid by Medicaid and Medicare, comparisons of rates established for inmates with those for the Medicaid and Medicare populations can be helpful in gauging whether the rates that the Department is paying for inpatient services are reasonable and beneficial to the State.

- **The Department paid almost $8,000 in duplicative security services for inmates receiving inpatient services at one hospital.** We identified 48 inpatient days in which the Department paid for security twice – once as part of the per diem rate paid to the hospital and a second time when it paid a private company for security services.

Utilization Management Program

Managed care companies establish utilization management programs as a way of controlling costs and improving quality. Three main types of utilization reviews are: (1) prior authorizations, which involve approving or denying requests for services before they are provided, (2) inpatient reviews, which are used during inpatient hospital stays to assess the appropriateness of care and to facilitate an inmate's transition from the hospital to a Department infirmary or correctional facility, and (3)

retrospective reviews, which are used to determine whether unplanned hospital admissions were medically necessary. We compared the utilization management program used by the contractor with contract requirements and found:

- **Both the Department and the contractor are performing prior authorization reviews; however, there are substantial differences between the contractor's and the Department's denial rates.** In particular, we found that the contractor denied about 2 percent of the referrals from Department staff and some participating specialists in Fiscal Year 2004. The Department began conducting its own reviews of referrals made by its physicians to external specialists in June 2004 due to concerns it had with low denial rates. Department data show that in November and December 2004 the Department denied 29 percent of the 525 requests it reviewed. The substantial discrepancy between these denial rates indicates a need for the Department to evaluate the contractor's prior authorization practices, determine the reason for differences, and establish controls to ensure adequate review.

- **The Department has not held the contractor accountable for providing effective inpatient review services.** We noted concerns with concurrent reviews and discharge planning. For example, we identified 9 out of 92 inpatient days (10 percent) in which the Department paid the Colorado Mental Health Institute at Pueblo (CMHIP) a higher per diem rate than medically necessary. The Department paid between $5,850 and $7,650 more than it should have for these inpatient days. In addition, we reviewed 38 inpatient records for inmates and found that none of the 38 files included documentation on how the inpatient care met the criteria for medical necessity or that the contractor communicated with the inmates' attending physicians to facilitate more timely discharge. The Department has assigned one of its own nurses to coordinate discharge planning for inmates. Although the Department's nurse needs to be involved in the discharge planning process to a certain extent, the level of involvement is greater than expected given the contract requirements and is duplicative because the Department is paying the contractor for this function.

- **The Department has not held the contractor accountable for performing retrospective reviews and providing sufficient documentation related to emergency visits.** Currently the contractor does not conduct retrospective reviews on emergency visits, as required by the contract. Further, the contractor has not provided the Department with the necessary documentation for the Department to determine whether emergency care provided to inmates in private prisons was appropriate. According to its contracts with private prisons, the Department should review this information to determine whether private prisons are responsible for emergency care provided to inmates housed in private facilities. Of the 184 emergency care claims submitted between August 2003 and July 2004 for inmates housed in private prisons, we identified 17 in which the diagnoses appeared to be inconsistent with an emergency room condition. The Department paid about $14,600 for these 17 claims.

Administration

We evaluated the Department's oversight and administration of its external services contract and found:

- **The Department has provided limited oversight of the contractor's claims adjudication process.** During the audit, we reviewed a sample of 34,400 inpatient, outpatient, and professional services claims transactions paid by the Department between August 2003 and July 2004 to determine whether the amounts paid were consistent with rates negotiated by the contractor. We identified about 1,710 transactions valued at approximately $760,000 that were questionable. These included 45 transactions with errors and 1,665 transactions with insufficient documentation to verify whether these transactions were paid appropriately. This represents an error rate of 5 percent which, although within the allowable range, is at the higher end of the contract requirement and industry norms and indicates a need for greater controls.

- **The Department has provided minimal oversight of the contractor's performance.** The Department has not performed any evaluations or audits of the contractor since January 2001. In addition, when the Department has noted deficiencies in the contractor's performance, the Department has either assigned its own staff to perform the functions or has taken minimal actions to ensure that the contractor corrects deficiencies.

The Department of Corrections agreed or partially agreed with all 9 recommendations in this report. The full texts of the Department's responses are contained in the body of this report.

RECOMMENDATION LOCATOR

Agency Addressed: Department of Corrections

Rec. No.	Page No.	Recommendation Summary	Agency Response	Implementation Date
1	20	Improve oversight of contractor activities related to rate negotiations for external health care services provided to Colorado inmates.	Agree	July 2006
2	22	Minimize the duplication of costs associated with security services by informing the external health care services contractor when hiring a private company to provide security services at hospitals and requiring the contractor to negotiate an intensive care unit per diem rate without security with hospitals	Agree	March 2006
3	27	Hold the external health care services contractor accountable for providing prior authorization services in accordance with the contract, specify the criteria the contractor must use for prior authorization services, and enforce the contract using remedial actions, as needed.	Agree	July 2006
4	32	Work with the external health care services contractor to improve concurrent reviews and discharge planning for inpatient cases, establish contract performance measures, monitor contractor performance, and follow-up to ensure deficiencies are corrected.	Agree	March 2006
5	35	Ensure that the external health care services contractor is complying with contract provisions related to retrospective reviews, including conducting risk-based retrospective reviews on emergency visits.	Agree	July 2006

RECOMMENDATION LOCATOR

Agency Addressed: Department of Corrections

Rec. No.	Page No.	Recommendation Summary	Agency Response	Implementation Date
6	36	Develop a process for reviewing emergency visit claims for inmates housed in private prisons and determine who is responsible for paying for these claims.	Partially Agree	July 2006
7	41	Ensure that claims submitted by providers to the external health care services contractor and paid by the Department are accurate.	Partially Agree	July 2006
8	43	Improve oversight of the external health care services contractor by monitoring the contractor's compliance with contract provisions, following up to ensure deficiencies are corrected, and using remedial actions to enforce the contract.	Agree	July 2006
9	45	Evaluate the costs and benefits of using a capitation rather than a fee-for-service payment system for purchasing external health care services	Partially Agree	March 2006

Description of Health Care Services Provided to Inmates

In 1976 the U.S. Supreme Court ruled in *Estelle v. Gamble* that inmates have a constitutional right to health care. This and other federal court decisions have held that inmates have the following three general rights related to medical care: the right to (1) access care, (2) receive care that is ordered, and (3) obtain a professional medical judgment.

The Department of Correction's Clinical Services Division is responsible for providing medical, optometry, and dental services to about 18,000 Colorado inmates (excludes offenders on parole or in community corrections) in state- and privately-run correctional facilities at a cost of about $59 million per year. Medical services in the Department are structured to function like other managed care organizations, providing a full range of health care services. Inmates receive basic medical care internally at Department-operated clinics located at each correctional facility. When needed, a physician may also refer an inmate for external diagnosis and/or treatment at a hospital or specialty clinic. We describe these two types of services in greater detail below.

Internal Health Care Services

Clinical staff who are employees of the Department (Department providers) or privately-run correctional facilities provide primary and emergency care in-house at each correctional facility. In-house services each facility provides to inmates include:

Evaluation upon reception into the Department of Corrections system. A team of clinicians staff the Denver Reception and Diagnostic Center (DRDC) and provide each incoming inmate with medical, mental, and substance abuse evaluations.

Clinic care. Most of the correctional facilities have a walk-in clinic that provides sick call care, limited emergency medical treatment, optometry, and dental services. The clinics provide care for inmates with episodic complaints (e.g., cold and flu symptoms, earaches, and back pain) as well as chronic illnesses (e.g., hypertension, coronary artery disease, and hepatitis C). All of the correctional facility clinics also provide emergency care for conditions such as a diabetic crisis, acute heart attack, a stabbing, or any other condition that requires immediate attention. The clinics are responsible for immediate intervention and stabilization, and if inmates require hospitalization, they are transported to an external hospital.

Infirmary care. The Department provides skilled nursing care at two infirmaries located at the DRDC and the Colorado Territorial Correctional Facility. Infirmary services are limited to post-hospital care, infectious disease isolation, special testing, pre-hospital admission preparation, post-accident/stroke/injury rehabilitation, and treatment of low resource-intensive acute and chronic conditions. Inmates who are discharged from external hospitals may be transferred to one of the two infirmaries before returning to their prison cells.

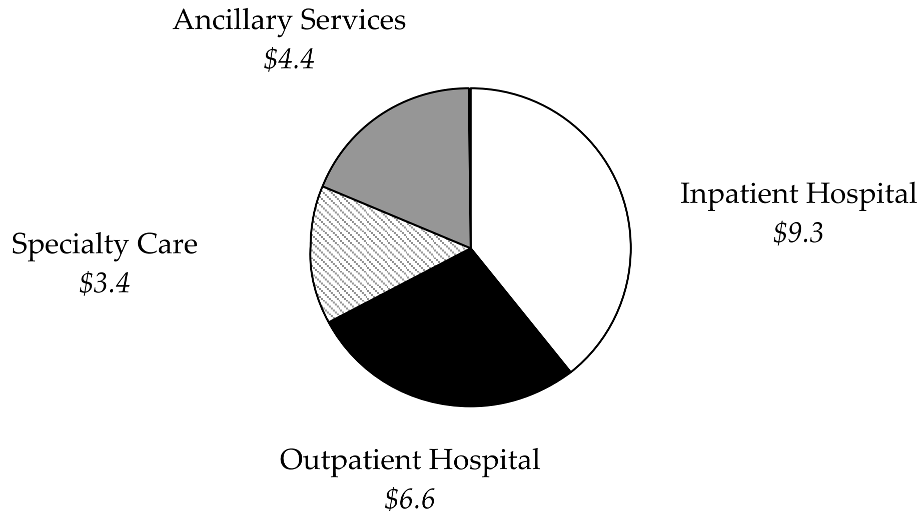
Ancillary services. A centralized pharmacy provides pharmacy services to all correctional facilities. Some clinics provide radiology services.

In Fiscal Year 2004, the Department was appropriated about 430 FTE and spent approximately $35 million on internal services, which represents close to 60 percent of total health care expenditures.

External Health Care Services

In general, external health care services provided to inmates include inpatient hospital services, outpatient tests and procedures, consultations with specialty physicians, and ancillary services (e.g., durable medical equipment and laboratory services). In Fiscal Year 2004, the Department paid just under $24 million for close to 900 inpatient hospital admissions, 10,400 outpatient encounters, 10,580 visits to specialists, and 58,990 ancillary services provided to inmates. The table below shows the amount and percentage of funds spent on the different types of external services in Fiscal Year 2004. The largest portion (66 percent) was for inpatient and outpatient hospital services.

Department Expenditures for External Health Care Services by Service Category in Fiscal Year 2004 (In Millions)



Source: Access Correctional Care, *Trend Reporting*
[1] These figures represent the payments made by the Department for services provided between July 1, 2003 and June 30, 2004 with an adjustment to account for services provided but not yet billed and paid at the time the report was prepared.

The Department contracts with Access Correctional Care, one of Colorado Access's lines of business, to manage all external services for inmates. The Department's contract with Access Correctional Care (the contractor) is similar to an administrative services only (ASO) contract that managed care organizations sometimes have with employers who self-insure for their employees' medical benefits. Under ASO contracts, the contractor is not "at risk" – that is, the contractor does not assume financial responsibility for the cost of providing care for the members covered by the insurance plan. Rather, the contractor performs administrative services associated with enrolling members, maintaining member eligibility files, authorizing services in advance, and adjudicating claims submitted by providers. The ASO contractor pays claims submitted by providers using the employer's, not its own, money.

The Department's contract differs from many ASO contracts in that the contractor's responsibilities are limited to externally-provided medical services. As discussed earlier, the Department's Clinical Services Division provides primary and initial emergency care services to inmates in the correctional facilities.

Under its contract with the Department, the contractor is responsible for the following:

- Establishing a provider network for external services, which includes (1) contracting with specialist physicians, hospitals, and other medical facilities and (2) credentialing external providers (i.e., making sure they are qualified and meet licensure requirements). Currently the contractor has about 1,100 external providers under contract to provide services to inmates, which include about 50 hospitals, 785 specialty care physicians (e.g., cardiologists and orthopedic surgeons), and 265 ancillary service providers (e.g., durable medical equipment and laboratory services).

- Maintaining a quality management and improvement program, which includes identifying opportunities to improve care provided to inmates.

- Developing and implementing a utilization management program, which includes (1) reviewing and approving or denying referrals for external health care services, (2) reviewing the medical condition of and services provided to hospitalized inmates to determine the medical necessity for continued stays, and (3) planning the discharge of a hospitalized inmate back to his or her correctional facility.

- Processing claims submitted by providers for external health care services and paying the claims from a Department account.

- Reporting statistics and trends related to utilization and costs of external health care services provided to inmates.

For these services, the Department pays the contractor $6.75 for each inmate for each month. In Fiscal Year 2004, the State paid the contractor about $1.4 million for the administrative services.

Health Care Costs

As stated previously, the Clinical Services Division spent a total of $59 million on inmate health care services during Fiscal Year 2004, which was an increase from $43.5 million spent in Fiscal Year 2001 (an increase of about 35 percent). The average cost per inmate (per capita costs) increased from $2,950 to about $3,400 between Fiscal Years 2001 and 2004 (an increase of 15 percent). In comparison, national per capita health care costs for the general population increased 23 percent during this time (from $5,020 in 2001 to $6,170 in 2004). Per capita health costs at the national level are higher than those for Colorado inmates. This can be explained, in part, to differences in the composition of the national and inmate populations. In particular, the national population may include a higher percentage of elderly individuals and women, who typically have higher utilization of hospital services than other populations.

Per capita costs for external services provided to inmates have risen at a faster rate than per capita costs for internal services. In particular, per capita costs for internal services increased by about 11 percent from Fiscal Years 2001 to 2004 while costs for external services increased by about 22 percent. Inpatient and outpatient hospital services, which comprise nearly 70 percent of the payments made for external services in Fiscal Year 2004, drive changes in external health care costs. The table below shows utilization and costs data for external inpatient and outpatient services between Fiscal Years 2001 and 2004.

Utilization and Expenditure Statistics for Inpatient and Outpatient Hospital Services Provided to Inmates From Fiscal Years 2001 to 2004

	Measure	FY 2001	FY 2002	FY 2003	FY 2004 [1]	% Change from FY 2001 to FY 2004
Inpatient	Inpatient annual per capita costs	$290	$340	$405	$545	86%
	Inpatient payments per encounter	$7,025	$7,025	$9,505	$10,420	48%
	Inpatient admissions per 1,000 inmates	40	50	40	50	25%
Outpatient	Outpatient annual per capita costs	$330	$390	$350	$380	15%
	Outpatient payments per encounter	$480	$520	$525	$630	31%
	Outpatient visits per 1,000 inmates	685	750	670	605	-12%
Total annual per capita costs for hospital services for Colorado inmates		**$620**	**$725**	**$755**	**$925**	**49%**
Total annual per capita costs for hospital services for the nation		**$1,570**	**$1,705**	**$1,800**	**$1,900**	**21%**

Source: Navigant Consulting Inc.'s analysis of Access Correctional Care's self-reported data included in *Trend Reporting* and of data in the Centers for Medicare and Medicaid Services' *National Health Care Expenditures Projections: 2003-2013.*

[1] The figures for Fiscal Year 2004 represent the payments made by the Department for services provided between July 1, 2003 and June 30, 2004, with an adjustment for services provided but not yet billed at the time the report was provided.

As shown in the table above, total per capita costs for all hospital services provided to inmates increased by about 50 percent, with costs for inpatient services increasing by more than 85 percent and costs for outpatient services increasing by 15 percent. These increases may be attributed, in part, to higher costs per encounter and to increases in utilization. As the table shows, the payments per encounter increased for both types of hospital services. In contrast,

utilization (i.e., admissions/visits per 1,000 inmates) rose for inpatient services but dropped for outpatient services.

There are a number of potential causes of increases in health care costs and utilization for inmates. Factors, such as an aging inmate population, a rise in inmates with communicable and chronic diseases and mental illnesses, a greater use of substance abuse treatment programs, and higher prescription costs, all contribute to increased utilization and higher costs. In addition, increases in the inmate population in Colorado as well as inflation have contributed to the rise in external health care costs.

Audit Scope

Our audit reviewed the administrative services provided by the contractor related to external health care services for Colorado inmates. We focused primarily on hospital services, which as stated previously, represent nearly 70 percent of external health care costs. In particular, we evaluated the processes used by the contractor to negotiate rates with external health care providers, ensure that claims paid by the Department are consistent with the negotiated rates, and administer the utilization management program. We also reviewed the contract oversight provided by the Department of Corrections in these areas. Our audit did not include a review of the processes used by the contractor to credential external health care providers, ensure that providers deliver high-quality services to inmates, and analyze the validity of claims submitted by providers (except the processes used by the contractor to ensure the proper payment of negotiated rates, as discussed above).

As part of the audit, we reviewed and analyzed information provided by the Department and the contractor, and analyzed data from other sources, such as the Colorado Department of Health Care Policy and Financing, which is responsible for Colorado's Medicaid Program, and the federal Centers for Medicare and Medicaid Services (CMS). We also interviewed Department and contractor staff and conducted medical record reviews of a sample of inmates who received services at selected hospitals. In addition, to assess rates negotiated with external providers, we reviewed a sample of 15 provider contracts (negotiated by the managed care contractor) that covered a total of 21 high-volume providers of health care services to inmates, which included:

- Six contracts covering 12 hospitals (multiple hospitals may be covered under a single contract). Our sample represented about 70 percent of the payments made to hospitals between August 2003 and July 2004.

- Five contracts for professional providers, which included three orthopedic surgeons, one internist, and one kidney specialist. Our sample represented almost 40 percent of the monies paid to professionals during the time period reviewed.

- Four contracts with ancillary service providers (e.g., laboratories and durable medical equipment suppliers). Our sample represented 6 percent of the funds paid to ancillary service providers during the time period reviewed.

Finally, we reviewed the contractor's paid claims data for the period between August 2003 and July 2004.

Provider Rates
Chapter 1

Background

As previously mentioned, inpatient and outpatient hospital costs have contributed significantly to the steady increase in per capita costs for external health care services provided to inmates. Health care costs for inmates will likely continue to rise due to projected increases in the inmate population, the increase in chronic and communicable diseases, and inflation. As a result, controlling costs for external health care services is an important Department of Corrections responsibility. Our review focused on the Department's cost containment efforts in two areas:

- Controls over rates paid for hospital services.
- Controls over hospital utilization.

In this chapter, we discuss controls over rates paid to hospitals. The second chapter discusses controls over hospital utilization.

Rate Negotiations

As part of the audit, we evaluated rates and discounts negotiated with external providers for inpatient and outpatient hospital services provided to inmates. Overall, we found that the Department is not ensuring that the State is paying optimal rates for these services. We used three indicators to assess the appropriateness of hospital (inpatient and outpatient) rates.

First, we compared increases in total hospital costs for Colorado inmates with those at the national level for the general population. We found that per capita costs for inmate hospital services increased at more than double the rate for the general population. In particular, inmate per capita hospital (inpatient and outpatient) costs increased nearly 50 percent between Fiscal Years 2001 to 2004 compared to an increase of approximately 20 percent for the general population. As discussed in the Description section, increases in costs for inmates may be due, in part, to factors such as an aging inmate population, a rise in inmates with communicable and chronic diseases and mental illnesses, a greater use of substance abuse treatment programs for inmates, and higher prescription costs. However, the significant increase for the inmate population does raise questions as to whether other factors, such as rates negotiated with

providers and utilization management functions used by the contractor and Department, contributed to the increase.

We also compared changes in inpatient hospital per diem rates negotiated for Colorado inmates with changes in the Medicare Inpatient Prospective Payment System Hospital Index (Hospital Price Index) from July 2000 to October 2004. The federal Centers for Medicare and Medicaid Services uses the Hospital Price Index as a basis for determining annual Medicare payment increases. We found that although increases in rates for the inmate population at some hospitals were consistent with the Hospital Price Index, we identified other instances in which increases were significantly higher. For example, for one hospital the per diem rates increased almost 40 percent compared to a 17 percent increase in the Hospital Price Index for the same time period. For another hospital, rates for certain major chest procedures (e.g., coronary bypass and cardiac valve procedures) increased between 57 and 114 percent, depending on the specific procedure, compared with an increase of 9 percent in the Hospital Price Index for the same time period. Although comparing changes in inmate hospital rates against national indices, such as the Hospital Price Index, does not consider whether rates were appropriate to begin with, these comparisons are useful for determining whether the Department should further scrutinize rates for reasonableness.

Second, we compared inpatient hospital rates for inmates with rates established for Medicaid and Medicare patients. We selected Medicaid and Medicare rates for comparison because they are public sector data and are readily available. We could not obtain private sector rates for our comparison because these rates are proprietary. Medicaid and Medicare pay for inpatient hospital services on a diagnosis-related group (DRG) basis. DRGs are used to classify related diagnoses into groups for purpose of payment. Under this system, hospitals are paid a set amount for treating patients in a particular category, regardless of the patient's length of stay or the number of services provided. In contrast, the Department pays a per diem rate for most inpatient hospital services for inmates, which involves paying a fixed amount for each day of an inmate's hospital stay, regardless of the services provided.

We selected three high-volume DRG categories for four hospital contracts in two regions in the State and compared inpatient hospital rates for inmates with those established for Colorado Medicaid and Medicare patients at the same hospitals. For these three DRGs, the Department paid nearly $225,000 to the hospitals from July 2003 to August 2004. We converted the amount paid by DRG to per diem rates for our comparison. The table below shows the results.

Comparison of Department, Medicaid, and Medicare's Inpatient Hospital Rates By DRG and Region in Fiscal Year 2004						
Diagnosis-Related Group (DRG)	**Region[1]**	**Average Dept. Per Diem Rates**	**Average Medicaid Per Diem Rates[2]**	**Average Medicare Per Diem Rates**	**Amount of Dept.'s Rates in Excess of Medicaid Rates**	**Amount of Dept.'s Rates in Excess of Medicare Rates**
143 Chest pain	A	$1,330	$1,320	$1,330	$10	$0
	B	$2,650	$1,170	$1,190	$1,480	$1,460
174 Gastrointestinal hemorrhage with complications and co-morbidities	A	$1,330	$1,160	$1,060	$170	$270
	B	$1,350	$720	$950	$630	$400
182 Esophagitis, gastroenteritis, and miscellaneous digestive disorders–Age greater than 17 with complications and co-morbidities	A	$1,330	$1,190	$950	$140	$380
	B	$1,350	$690	$850	$660	$500

Source: Navigant Consulting Inc.'s analysis of Access Correctional Care contracts with selected hospitals, claims data paid between July 2003 and August 2004 provided by Colorado Access, data from the Colorado Department of Health Care Policy and Financing, and data from the Center for Medicare and Medicare Services.

[1] Region A consists of hospitals located in the Denver-Metro Area, and Region B consists of hospitals located in the remainder of the State. There are fewer hospitals in Region B, and thus, competition is limited.

[2] Medicaid figures do not include some lump payments (e.g., graduate medical education payments and payments to hospitals with a disproportionately large share of low-income and uninsured patients), which the State makes to some hospitals. As a result, total Medicaid payments to some hospitals are higher than the per DRG rates, thereby reducing the difference between Medicaid rates and the Department's rates.

As shown in the table above, the Department is paying higher per diem rates than Medicaid and Medicare in all but one instance. In some cases, certain rates negotiated for inmates appeared unreasonably high. For example, we identified one $4,000 per diem rate negotiated for inmates with one hospital in Region B for DRG 143 (chest pain). This rate is significantly higher than the Department's average rates for the rest of the State ($1,710) and for the estimated Medicaid or Medicare per diem rates for Region B ($1,170 and $1,190, respectively). The per diem rate at this hospital covers 32 cardiac DRGs with a range of intensities and complexities (including chest pain). The $4,000 per diem rate may be appropriate for a resource-intensive, complex DRG (e.g., coronary bypass surgery) but it appears excessive for other types of cardiac medical cases that are typically less resource-intensive, such as those associated with DRG 143 (chest pain).

If the Department paid rates similar to those paid by Medicaid or Medicare for the sample of DRGs listed in the table above, the Department would have saved between $60,000 and $105,000, depending on whether the savings are calculated on Medicaid's or Medicare's rates. We recognize that the Department does not have the same buying power for its 18,000 inmates as the Federal Medicare Program has for its 500,000 beneficiaries in Colorado, who, in general, use health care services at a significantly higher rate than younger and non-disabled people, or the Department of Health Care Policy and Financing has for the 360,000 Medicaid beneficiaries served in Fiscal Year 2004. Although the State may not be able to obtain rates equivalent to those paid by Medicaid and Medicare, comparisons of rates established for inmates with those for the Medicaid and Medicare populations can be helpful in gauging whether the rates that the Department is paying for inpatient services are reasonable and beneficial to the State.

Finally, we assessed the total dollar savings, as calculated and reported by the contractor, resulting from rate negotiations for external health care services. The contractor reported that the rates negotiated for all external services provided to inmates in Fiscal Year 2002 saved the State about $16 million, or 50 percent of charges. These savings declined slightly to 48 percent between August 2003 and July 2004. If the contractor had continued to achieve a 50 percent discount from billed charges during the one-year period we reviewed, we estimate that the State would have saved an additional $1 million.

Oversight

Our review indicates a need to provide greater scrutiny over the rates paid for inpatient and outpatient hospital services. We found the Department is providing minimal oversight of the contractor's rate-setting methodologies and activities. First, we found that although the contract includes several provisions allowing the Department to gain access to rate information, prior to our audit the contractor had not provided the Department with rate data. As a result, the Department lacked key information to determine whether rates paid by the State were optimal or whether certain facilities could provide services to inmates at a lower cost than other facilities. For example, if the Department had known that one hospital in Region B had a negotiated rate almost double the rates it was paying at other hospitals, the Department may have chosen not to send inmates to this higher-cost hospital.

Second, the current contract contains no requirements that the contractor demonstrate that its rates have a reasonable basis and are cost-effective to the State. We identified two rate-setting methodologies that may not be in the State's best interest:

- **Percentage of charges rates.** The Department pays a discounted percentage of charges rate for most outpatient services and certain high-cost inpatient services (e.g., for hospital charges of $1,000, the Department would pay $650 or 65 percent of charges). Industry experts indicate that cost-based payment systems, rather than percentage of charges payment systems, provide a better basis for comparing payments across

providers and protecting against rapidly escalating hospital charges. Under a cost-based payment system, the Department would pay hospitals for outpatient services and high-cost inpatient stays based upon a percentage mark-up over costs. For example, if the negotiated mark-up is 20 percent, then 120 percent of the costs would be paid. Currently, 6 of the 12 hospitals in our sample use a cost-based payment system for outpatient services provided to inmates while the remaining 6 hospitals use the percentage of charges methodology. Further, 4 hospitals use the percentage of charges methodology rather than per diem rates for high-cost inpatient services. We compared payments the Department made for outpatient and high-cost inpatient cases using percentage of charges discounts with estimated payments under a cost-based system. We used data from hospital cost reports prepared annually by all hospitals for the federal Medicare Program to determine estimated payments. Because hospitals are unlikely to accept payment for inmate services at cost, we calculated potential savings based on a 20 percent and a 40 percent markup over costs. For the four hospitals in our sample with contracts that use the percentage of charges methodology and for which we were able to obtain cost data, we estimate that the Department potentially could have saved nearly $2.5 million if the contractor paid 120 percent of costs rather than using percentage of charges for all outpatient and high-charge inpatient services provided between August 2003 and July 2004. Similarly, if the contractor paid 140 percent of costs, the Department potentially could have saved almost $1.9 million.

- **Per diem rates.** The Department pays for most inpatient hospital services on a per diem basis (e.g., a flat rate per day, depending on the complexity of the illness and required level of care, such as intensive care versus routine medical/surgical care). Per diem rates may not offer the savings of other rate-setting methodologies. A DRG payment system, which is commonly used by Medicare and Medicaid, may be more beneficial to the State because the financial risks associated with long hospital stays are shifted from the State to the hospitals. According to the contractor, hospitals requested per diem rates for inmates rather than DRG payments because they could not control the length of an inmate's stay due to difficulties (e.g., transportation delays) encountered in discharging inmates. To be able to negotiate DRG payments with hospitals, the Department would need to better ensure that transportation is available when an inmate is ready to be discharged from the hospital and that concurrent reviews and discharge planning activities performed by the contractor are effective (discussed in Chapter 2).

Third, the contract requires the contractor to "negotiate all participating provider contracts in accordance with general guidelines and financial parameters/targets established by the Department." We found that the Department has not established guidelines and financial targets/parameters for negotiations of provider contracts, as required by contract provisions. Although the contractor provided us with guidelines and financial parameters for rate negotiation, we found that these guidelines were obsolete and did not reflect the types of rates currently used. The Department has neither requested nor reviewed these guidelines.

Overall, the Department needs to take steps to improve its oversight of the contractor's rate negotiations for external services. The Department should require the contractor to fully disclose all rates negotiated with providers. Such information is necessary for the Department to evaluate contract performance and to identify which providers offer the lowest rates. The Department may want to direct more inmates to these lower cost facilities when feasible. If the contractor fails to provide complete data on negotiated rates, the Department should use remedial provisions (e.g., denying payment) available in the contract to enforce this requirement, as discussed in Recommendation No. 8.

Additionally, the Department should modify the contract to require the contractor to demonstrate that the rates it has negotiated are appropriate for the current market conditions in different regions in the State. This should include periodic comparisons of rates established for inmates with the community standard (e.g., Medicaid and Medicare) and an analysis of each type of rate used (e.g., per diem rates, percentage of charges rates) to assess whether each rate is financially beneficial to the State. Further, the Department should work with the contractor in establishing guidelines and financial parameters/targets for rate negotiations, as required by the contract, and review the guidelines annually to ensure that they are appropriate for meeting the Department's needs. Finally, the Department should use the rate information, evaluations performed by the contractor, and the guidelines and parameters developed for rate negotiations to assess the contractor's performance and identify improvements.

Recommendation No. 1:

The Department of Corrections should improve its oversight of contractor activities related to rate negotiations for external health care services provided to Colorado inmates by:

a. Requiring the contractor to fully disclose to the Department all rates negotiated for services provided to Colorado inmates.

b. Working with the contractor to develop guidelines and financial parameters for negotiations of rates and discounts.

c. Modifying its contract to require the contractor to demonstrate to the Department annually that it is negotiating the most competitive rates on behalf of the Department in the different regions in the State.

d. Evaluating the contractor's performance related to rate negotiations on at least an annual basis. Using the results of the evaluation, the Department should notify the contractor of any deficiencies identified with rate negotiations and ensure they are corrected in a timely manner.

Department of Corrections Response:

Agree. Implementation date: July 2006. The Department realizes that there are issues with the rates Clinical Services pays external providers through the current Contractor. The Department also realizes that the current contract does not supply incentive to its Contractor to negotiate rates that are in the best interest of the DOC. The Department's current Managed Care Contractor gave the Department notice that it intends to terminate its contract effective June 30, 2005. The contract allows for a 90 day period after June 30, 2005 for transition to another Managed Care Contractor. The Department let a Request For Proposal (RFP) for Medical Care Management in April 2005 with anticipated award by the start of the next fiscal year (July 2005). The RFP addresses the above mentioned issues and requires the bidders to supply all rate information, negotiations, and renegotiations on an annual or as negotiated basis. The Department and the successful bidder will also work together to develop guidelines and financial parameters for negotiations of rates and discounts to ensure the best value for the Department's external medical expenditures and review and improve (if needed) this process annually. The Contractor will need to demonstrate "best value" negotiated rates to the Department annually. The Department will work with the successful bidder to develop annual review processes that will address rate issues and allow for new and more effective negotiations.

Security Rates

One of the hospitals that provides inpatient services to Colorado inmates maintains secured intensive care and medical/surgical units in its facility. The contractor has negotiated a per diem rate for intensive care services with security and two per diem rates for medical/surgical services – a higher rate that includes security and a lower one that does not. On occasion, an inmate may be placed in a non-secured unit of the hospital, particularly when no beds are available in the secured units. When this occurs, the Department must provide a security guard. Typically, the Department contracts for these security services through a private company.

During the audit, we reviewed all 16 claims submitted for intensive care unit services with hospital security and for which the Department paid about $130,000 from August 2003 to July 2004. We found that the Department actually provided security for 45 of the 57 days that were billed at the intensive care unit with security rate. For these 45 days, the Department paid for security twice – once as part of the per diem rate paid to the hospital and a second time when it paid a private company for security services. This occurred because there is no separate rate for intensive care services without security. If a rate had been established for intensive care unit

services without security, we estimate that the Department would have saved approximately $7,200 for these 45 days.

We also reviewed 20 of the 320 claims (6 percent) for medical/surgical services with security submitted by the hospital and paid by the Department between August 2003 and July 2004. We identified one claim where the inmate was placed in a non-secured unit but the hospital billed the Department for 3 of the 16 days of this claim at the higher rate that includes security. We estimate the overpayment to be approximately $500. Currently the Department does not inform the contractor when it provides security services for inmates receiving medical/surgical services. Such information is needed for the contractor to verify that security rates charged by the hospital are correct.

While the savings identified above are relatively small, they illustrate the problems associated with the lack of controls over payments. To minimize duplication of costs, the Department should notify the contractor when it hires a private company to provide security services at hospitals. The Department should ensure that the contractor uses this information to verify claims submitted by hospitals include the correct rates. Further, the Department should work with the contractor to renegotiate rates that include a non-security rate for inmates receiving intensive care services in a non-secured unit.

Recommendation No. 2:

The Department of Corrections should minimize the duplication of costs associated with security services by:

a. Informing its external health care services contractor when it hires a private company to provide security services at hospitals that also offer and charge for these same services. The Department should ensure that the contractor uses this information to verify that hospitals are billing the Department appropriately.

b. Requiring the contractor to negotiate an intensive care unit per diem rate without security to account for instances when hospitals with security provide care to inmates in non-secured units.

Department of Corrections Response:

Agree. Implementation date: March 2006. The Department realizes that there may have been instances where security was provided once but paid for twice. The Department will develop processes with the new Contractor to review claims with regard to security to ensure that if the DOC supplied security, the external heath provider was not also

charging for the service again. The Department will also need to work with facility personnel and/or the DOC Transportation Unit to develop the appropriate processes where external health providers and the new Contractor can be notified if DOC or the external security services will be used. The Department will work closely with the new Contractor to develop and implement contracts regarding intensive care rates that can be billed with or without the security component. The Department is currently developing a Quality Management Team that will develop the appropriate auditing processes to ensure that security is either supplied by DOC or by external hospitals.

Utilization Management Program
Chapter 2

Background

Managed care companies establish utilization management programs as a way of controlling costs and improving quality. These programs include various reviews to determine whether services provided, or to be provided, are medically necessary and whether they are at the appropriate level of care for the patient's condition. Three main types of utilization reviews are:

Prior authorizations. These reviews include approving or denying requests for services before they are provided. Prior authorizations are generally required for specialty services requested by the patient's primary care physician (e.g., a consultation with a cardiologist or orthopedic surgeon) and for diagnostic tests or treatments in an inpatient or outpatient setting (e.g., a cardiac catheterization or a knee surgery). In authorizing a procedure for an inpatient setting, managed care companies often specify a set number of days for which they will pay, and they may not pay providers if prior authorization is not obtained before the service is provided.

Inpatient reviews. These reviews occur during the course of inpatient hospital stays, and they include concurrent reviews and discharge planning. Managed care companies conduct concurrent reviews during a patient's hospital stay to be certain that the care and treatment a hospital provides are consistent with an inpatient setting and could not be provided in a less costly setting. Discharge planning is performed in conjunction with concurrent inpatient reviews and involves planning, coordinating, and facilitating a patient's discharge from the hospital to his or her home or another health care facility.

Retrospective reviews. These reviews involve evaluating services after they are rendered and are performed on unplanned hospital encounters and admissions (i.e., those under urgent or emergency circumstances) to verify they were medically necessary.

The Department's contractor is required to "establish, implement, and maintain Utilization Management (UM) policies and procedures to accomplish review and authorization of specialist referrals and treatment, inpatient concurrent review, discharge planning, and ancillary services." The contract further stipulates that the contractor must (1) develop processes to evaluate the effects of the utilization management program, (2) educate providers on how the program functions and determines medical necessity, and (3) maintain systems to

support utilization management activities and to generate reports for use in monitoring and managing covered services.

During the audit, we evaluated the utilization management program against contract requirements. We identified significant concerns related to authorizations of provider referrals, the concurrent review and discharge planning process, and the retrospective review process, which will be discussed in this chapter.

Prior Authorizations

The Department requires prior authorizations for referrals to (1) external specialists made by Department physicians, (2) external specialists made by another external specialist, and (3) outpatient tests or procedures made by external specialists. The Department does not subject inpatient admissions to the prior authorization process when they are for emergency care. The contract requires the contractor to use nationally standardized clinical criteria, such as InterQual or Milliman Care Guidelines®, for utilization management determinations. As part of the prior authorization process, the contractor uses InterQual criteria to assess whether a requested service is medically necessary. If the service is determined to be medically necessary, then the contractor will approve it and assign the case an authorization number. If the service is determined to not be medically necessary, then a provider can appeal the decision and submit additional documentation to substantiate the medical necessity of the referral.

As part of our audit, we evaluated the prior authorization process. We found that both the Department and the contractor are performing prior authorization reviews, and there are substantial differences between the contractor's and the Department's denial rates. In Fiscal Year 2004, the contractor reviewed about 3,140 referrals from Department staff and some participating specialists for external health care services for inmates and denied about 2 percent of these referrals. The Department began conducting its own reviews of referrals made by its physicians to external specialists in June 2004 due to concerns it had with the low denial rates. Department data show that in November and December 2004 the Department denied 155 of the 525 requests it reviewed, which represents a denial rate of 29 percent. Although the Department's and the contractor's denial rates were measured over different time periods, the substantial discrepancy between these denial rates indicates a need for the Department to evaluate the contractor's prior authorization practices to determine the reason for the discrepancy. According to the Department, the discrepancy may be due to the following reasons:

- **Standardized criteria.** The contractor uses InterQual criteria rather than Milliman criteria to evaluate whether a service is medically necessary, and therefore, should be authorized. According to the Department, InterQual criteria are less prescriptive than the Milliman criteria the Department prefers. Although the Department prefers

Milliman criteria, its contract allows the contractor to use either InterQual or Milliman criteria, and the Department has not modified the contract to clearly specify the criteria the contractor should use.

- **Criteria modifications.** Contract provisions allow for the Department and the contractor to collaboratively modify the standardized criteria (e.g., InterQual or Milliman) to "accommodate the inmate population, the Schedule of Covered Benefits, and limitations regarding elective procedures." In the past, the Department and the contractor worked together to develop in-house criteria to specifically address referrals to podiatry and physical therapy specialists and for durable medical equipment (e.g., hearing aids). The Department has not collaborated with the contractor since 2003 to alter additional criteria to meet the needs of the Department and the inmate population. The Department currently does not have a process in place to modify the criteria.

By establishing its own prior authorization process, the Department is duplicating work it is paying the contractor to perform. As a result, the State is paying for prior authorizations made by Department physicians to external specialists twice. The Department needs to hold the contractor accountable for providing the prior authorization services required by the contract. To enforce these requirements, the Department should use remedial actions available in the contract, such as denying payment or recovering payment for those services and deliverables which have not been performed or will be of no value to the Department, as discussed in Recommendation No. 8. The Department should also modify the contract to specify the standardized criteria that the contractor must use for prior authorization reviews. Further, the Department should collaborate with the contractor to modify criteria used for prior authorization reviews to meet the specific needs of the inmate population and the Department.

Recommendation No. 3:

The Department of Corrections should improve prior authorization services provided by its external health care services contractor by:

a. Holding the contractor accountable for providing high-quality prior authorization services required by the contract. This should include enforcing the contract using available remedial actions, as needed.

b. Modifying the contract to specify the standardized criteria it will require the contractor to use for prior authorization reviews.

c. Developing a process for collaborating with the contractor to modify the standardized criteria to meet the needs of the inmate population and the Department, as allowed by the contract.

Department of Corrections Response:

Agree. Implementation date: July 2006. Utilization Management is of paramount importance to the Department. The Department believes that utilization management plays a vital role in determining medical necessity and the provision of quality care. This will lead to efficient and effective management of our inpatient/outpatient appropriated funds. It is not the Department's intent to duplicate services that should be supplied by the Contractor. The Department realizes that intrinsic issues exist because our internal clinical providers are not part of the Contractor's external provider network. Currently, we have a two tiered process in place. In-house pre-authorizations are done by DOC while external pre-authorizations are performed by the Contractor. The Department believes that the best scenario is to conduct all utilization management by DOC personnel. Currently, this is not possible given limited resources but the Department will evaluate the resources needed to bring this capability in-house and if need be, develop a business case to request these resources through the State budget process. Through the RFP process, the Department will require the Contractor to use Milliman criteria. Additionally, as part of the RFP process the Department will communicate to bidders its expectations pertaining to the pre-authorization process, which will include informing bidders of the Department's two-tiered process. The RFP also requires the Contractor to develop financially-based, performance measures for utilization management.

Inpatient Reviews

According to its contract with the Department, the contractor is required to implement a utilization management program that includes inpatient concurrent reviews and discharge planning. These reviews are used to assess the appropriateness of care (e.g., whether a hospital stay is medically necessary and whether the severity of illness warrants the type of care provided) during an inmate's inpatient visit and to facilitate an inmate's transition from the hospital to one of the Department's infirmaries or correctional facilities. These reviews are particularly important for the inmate population because (1) an inmate may prefer to stay in the hospital longer than necessary because he or she does not want to return to a correctional facility and (2) arrangements must be made for transportation, security, and bed space before an inmate who no longer needs acute hospital care can be transferred to one of the Department's infirmaries.

During the audit, we evaluated the concurrent review and discharge planning processes used by the contractor for inpatient hospital cases. A registered nurse and a registered health information administrator from our consulting team reviewed medical records maintained by hospitals and case notes prepared by contractor staff for a sample of 38 inpatient hospital cases. As part of these

reviews, we applied the InterQual Criteria that the contractor used when it conducted utilization management reviews for all of the cases in our sample, except for services provided by the Colorado Mental Health Institute at Pueblo (CMHIP). CMHIP has a general hospital unit that provides medical and surgical care services to patients of the Colorado Mental Health Institutes of Pueblo and Fort Logan, Pueblo Regional Center, and to patients of the Departments of Human Services and Corrections. For services provided by CMHIP, the contractor used criteria that it developed jointly with the Department. In addition, we reviewed trends related to the length of inpatient hospital stays, and we compared inmates' average lengths of stay with average stays for the Medicaid and Medicare Programs. As we discuss in the following sections, we identified concerns with the concurrent reviews and discharge planning processes used.

Concurrent Reviews

In Fiscal Year 2003, the Department entered into an arrangement with CMHIP to provide 10 beds for inmate medical care. This arrangement was prompted by the General Assembly's decision to direct more of the Department's external health care services to CMHIP, essentially transferring funds from the Department to the State-owned hospital. The table below shows the types of services that CMHIP provides to inmates.

Inpatient Services Provided by the Colorado Mental Health Institute at Pueblo to Inmates

Type of Inpatient Service	Per Diem Amount Paid by the Department
Medical & surgical services - Short-term medical care and treatment for inmates who have an acute illness or injury or who have undergone a surgical procedure.	$1,350
Step-down services – Recuperative care following medical and surgical services for an acute illness or injury.	$700
Administrative services – Services designed for inmates who are awaiting transportation to the Department's infirmary and who do not need care at the medical/surgical or sub-acute levels.	$250

Source: Colorado Access's contract with the Colorado Mental Health Institute at Pueblo and rate information provided by the Department of Corrections.

As shown above, the most intensive services (i.e., medical and surgical services) receive a higher per diem rate than the less intensive services (i.e., step-down and administrative services).

We reviewed case records for 12 of the 286 inmates who received inpatient services from CMHIP between August 2003 and July 2004. We identified 9 out of 92 days (10 percent) in

which the contractor approved services at a higher level of care than necessary. Given the small size of the sample, this error rate is within reasonable industry norms. For these 9 days, the Department paid between $5,850 and $7,650 more than it should have for these services. In particular, we found:

- In one case, the inmate received only palliative care (care provided to patients who are dying, which includes pain management, emotional and spiritual support, and counseling) for the last five days of his stay. The Department paid for this stay at the medical/surgical rate when it should have paid the lower step-down rate. In total, the Department paid $3,250 more than it should have in this case.

- In another case, the inmate's medical condition supported either the step-down or administrative rate for his last two days in the hospital. Instead, the Department paid the higher medical/surgical rate, which resulted in the Department paying between $1,300 and $2,200 more than it should have paid.

- In two cases, inmates had unscheduled one-night stays for observation due to complications that developed following their procedures or due to transportation issues. The Department paid for these stays at the medical/surgical rates when it should have paid for them at the reduced step-down or administrative rates. The Department paid between $1,300 and $2,200 more than it should have in these cases.

Discharge Planning

As part of the audit, we evaluated two indicators of the quality of discharge planning: (1) changes in inmates' lengths of stay in hospitals and (2) inmates' lengths of stay for high-volume DRGs compared with those of Medicaid and Medicare patients. First, we reviewed changes in lengths of stays in recent years, and we found that from Fiscal Years 2003 to 2004 the average length of stay for all hospitals increased nearly 50 percent, from 4.2 days in Fiscal Year 2003 to 6.3 days in Fiscal Year 2004. This increase is due to a significant rise in the length of stay for inmates admitted to CMHIP. In particular, inmates' lengths of stay at CMHIP increased from 6.9 days in Fiscal Year 2003 to 10.7 days in Fiscal Year 2004, a 55 percent increase. The average length of stay for all other hospitals that provided services to at least one inmate in Fiscal Year 2004 was 4.3 days, which is about the same as the average stay in Fiscal Year 2003. CMHIP staff indicated the increased length of stay was due to two primary reasons. First, the Department's infirmaries did not have full-time physicians available to care for some inmates that were ready to be discharged from CMHIP for most of Fiscal Year 2004. As a result, these inmates remained at CMHIP until they could be adequately cared for at an infirmary. Second, CMHIP could not discharge inmates when they were ready due to transportation delays resulting from the Department shifting from a decentralized to a centralized transportation scheduling process.

Second, we compared inmates' average lengths of stay in hospitals with averages for the Colorado Medicaid and Medicare patients from July 2003 through August 2004. Our comparison included eight high-volume diagnosis-related groups (DRGs) and a sample of high-volume hospitals. We believe that Medicaid inpatient utilization provides a reasonable benchmark for comparison with inmates' utilization because, like inmates, Medicaid patients often have economic and social challenges that negatively affect their health status and health care needs. However, there are special circumstances involved in caring for inmates that are not present for Medicaid or other patients. For example, we would expect the length of stay to be less than or equal to those for Medicaid and Medicare patients since inmates typically are discharged to the Department's infirmary and not to their homes like Medicaid and Medicare patients. We found that inmates' lengths of stay were, in general, less than or equal to those of Medicaid and Medicare patients for six of the eight DRGs (i.e., chest pain, poisoning and toxic effects of drugs, certain circulatory disorders, vaginal delivery, major joint procedures and limb reattachment, and laparoscopic cholecystectomy). For the remaining two DRGs (DRG 277 for cellulitis and DRG 415 for operating room procedure for infectious and parasitic diseases), inmates' lengths of stay were substantially longer than those for Medicaid and Medicare patients. For example, for operating room procedures for infectious and parasitic diseases (DRG 415), the inmates' average length of stay was approximately 17 days compared with about 7 days for Medicaid patients and 14 days for Medicare patients.

Effectiveness of Inpatient Reviews

The Department needs to investigate concurrent reviews and discharge planning performed during inmates' inpatient hospital stays. During the audit, we reviewed the procedures for these utilization management functions and found that the contractor is not proactively managing inpatient hospital admissions to ensure that (1) services provided to inmates continue to be medically necessary, (2) the appropriate level of care is provided, and (3) timely and adequate discharge planning occurs.

We reviewed 38 inpatient records for inmates and found that none of the 38 files included documentation on how the care met the criteria for medical necessity. In addition, none of the 38 records included documentation showing that the contractor communicated with inmates' attending physicians to facilitate more timely discharge (e.g., switching the patient from intravenous to oral medication). The Department is aware of problems with inpatient reviews and has assigned one of its own nurses to coordinate discharge planning for inmates. The Department's nurse needs to be involved in the process to a certain extent, particularly to coordinate the transfer of inmates from a hospital to an infirmary. However, the level of involvement from the Department is greater than expected given the contract requirements and is duplicative because the Department is paying the contractor for this function.

Concurrent reviews and discharge planning are crucial functions for ensuring that inmates receive appropriate care and for controlling costs. To ensure the contractor is accountable for

performing these responsibilities under its contract, the Department should work with the contractor to identify key activities that should be included as part of inpatient reviews and to establish performance measures in the contract related to these reviews. In addition, the Department should regularly monitor the contractor's processes for conducting concurrent reviews and discharge planning. This should include reviewing a sample of case records to evaluate the quality of inpatient reviews. The Department should report any areas in need of improvement to the contractor and require management to submit a corrective action plan detailing how and when it will correct the deficiencies. The Department should perform follow-up reviews to ensure that deficiencies have been corrected in a timely manner. If the contractor fails to comply with contract requirements in this area, then the Department should use enforcement mechanisms available in the contract (e.g., withhold payments), as discussed in Recommendation No. 8.

Recommendation No. 4:

The Department of Corrections should work with its external health care services contractor to improve concurrent reviews and discharge planning for inpatient cases. This should include:

a. Working with the contractor to identify and define the key functions that should be included in inpatient reviews and to establish performance measures for evaluating inpatient reviews in the contract.

b. Monitoring the contractor's performance of inpatient reviews on regular basis.

c. Identifying areas in need of improvement and reporting them to the contractor. The Department should perform follow-up reviews to ensure that deficiencies have been corrected in a timely manner.

d. Using enforcement mechanisms available in its contract if the contractor fails to adequately perform concurrent reviews and discharge planning, as discussed in Recommendation No. 8.

e. Continue to work with the contractor to recover inappropriate payments made to the Colorado Mental Health Institute at Pueblo.

Department of Corrections Response:

Agree. Implementation date: March 2006. Inappropriate billings from CMHIP were brought to the attention of the Department by our Contractor. These potential inappropriate billings involved a sister State agency and a privately contracted

provider. The Contractor analyzed the charges and concluded that inappropriate billings did occur. The Department also expressed to the Contractor the concern that there may be others. The Contractor could not guarantee that others did not exist. The Contractor did assure the Department that where inappropriate billings were uncovered that the Contractor would recover the overcharges from the providers and return them to the Department prior to the end of the 2003-04 fiscal year. This did not take place. Because of this, the Department decided that it would be in the Department's best interest to negotiate a blended rate while maintaining the administrative rate. The Department negotiated directly with CMHIP for a blended rate of $900/day. The new rate went into effect March 1, 2005. The Department will continue to work with the contractor to recover inappropriate CMHIP payments with an expected recovery completion by January 2006.

We agree that the Contractor has not proactively managed inpatient hospital admissions. The Department has included, in the RFP, mechanisms that will allow it to work with the new Contractor to identify key criteria that will be used as part of inpatient reviews and to establish performance measures in the contract related to these reviews. The Department will also develop tools (through the Quality Management Team) to monitor the new Contractor's processes for conducting concurrent reviews and discharge planning. The Department will also work with the Contractor to review inpatient reviews monthly to ensure that deficiencies with the process have been corrected in a timely manner and to develop performance measures to ensure compliance or to impose enforcement mechanisms.

Retrospective Reviews

As mentioned earlier, retrospective reviews involve evaluating services after providers render them. These reviews are conducted on unplanned hospital encounters (i.e., those under urgent or emergency circumstances) to determine their appropriateness given a patient's condition. Between August 2003 and July 2004, Colorado inmates were involved in about 1,200 emergency visits. According to its contract with the Department, the contractor is required to perform retrospective reviews on all emergency visits. Specifically, the contract states that the contractor shall:

> *...require that all claims for Emergency Encounters be accompanied by sufficient documentation to determine the medical necessity and emergency nature of the services. Claims for emergent encounters from contract facilities [e.g., private prisons] must be reviewed by the [Department's] Chief Medical Officer.*

Retrospective reviews are particularly important for the inmate population because they can identify cases in which staff from the Department or private prisons inappropriately referred inmates for emergency care. In these cases, the Department can provide additional training to internal staff on the circumstances that warrant emergency visits. The Department can also use this information to determine whether private prisons are responsible for and should pay for emergency care provided to inmates housed at private facilities.

We found that the contractor is not complying with contract requirements related to retrospective reviews. In particular, the contractor has not enforced the contract requirement that hospitals submit documentation related to emergency visits, and it does not conduct retrospective reviews on these visits. Further, the contractor does not provide the Department with the necessary documentation (e.g., copies of claims and medical records) for the Department's Chief Medical Officer to determine whether hospital emergency room care provided to inmates housed in private prisons was appropriate. Of the 184 emergency care claims submitted between August 2003 and July 2004 for inmates housed in private prisons, we identified 17 in which the diagnoses appeared to be inconsistent with an emergency room condition. The Department paid about $14,600 for these 17 claims.

The Department has not held the contractor accountable for performing retrospective reviews and providing sufficient documentation related to emergency visits. The Department does not periodically monitor the contractor's retrospective review process. In addition, Clinical Services management was not aware of the contract provisions requiring the contractor to provide documentation on emergency care for inmates in private prisons and the Department's responsibility for using this information to assess who is financially responsible for the care. As a result, management has neither required the contractor to provide this documentation on the 184 emergency care cases we identified nor has it developed a process for reviewing the documentation to determine financial responsibility.

The Department should modify the contract to require the contractor to periodically evaluate trends related to emergency visits and to use this information to perform retrospective reviews on a sample of emergency visits using a risk-based approach. Currently the contract stipulates that the contractor is to perform these reviews on all emergency visits, which can be time- and resource-intensive for both the contractor and health care providers. Under a risk-based approach, the contractor could focus its retrospective reviews on emergency care claims in which the diagnoses are not consistent with emergency room conditions and on other high-risk indicators.

Additionally, the Department needs to improve its oversight of retrospective reviews performed by the contractor. This should include conducting periodic reviews of the process to ensure that it is effective. The Department should report any deficiencies identified to the contractor, ensure that they are corrected in a timely manner, and use remedial actions available in the contract if the contractor fails to correct them. The Department should also require the

contractor to report the results of its retrospective reviews regularly so that the Department can identify and correct any problems with emergency care referrals made by its staff. Further, the Department should ensure that the contractor provides all necessary documentation needed for reviews of emergency visits by inmates housed in private prisons. Finally, the Department should develop and implement a process for reviewing emergency visit claims for inmates in private prisons and determining who is financially responsible for the payments. This should include reviewing the 17 claims we identified during the audit.

Recommendation No. 5:

The Department of Corrections should ensure that its external health care services contractor is complying with contract provisions related to retrospective reviews. This should include:

a. Modifying its contract to require the contractor to periodically evaluate emergency visit trends and perform retrospective reviews on a risk basis.

b. Periodically reviewing documentation maintained by the contractor to ensure that retrospective reviews are occurring timely and are effective in identifying inappropriate emergency care referrals. The Department should report the results of these reviews to the contractor.

c. Requiring the contractor to submit a corrective action plan that specifies how and when the deficiencies will be corrected, if applicable.

d. Performing follow-up reviews to ensure that deficiencies are corrected in a timely manner.

e. Using enforcement mechanisms available in the contract if the contractor fails to correct deficiencies in a timely manner, as discussed in Recommendation No. 8.

Department of Corrections Response:

Agree. Implementation date: July 2006. The Department agrees that retrospective review is an important component of the contract to ensure appropriate utilization of services that are performed. The new Contractor will be required to provide these services as well as have financial performance measures in place to set the standards for the new contract. A component of the monthly Contractor/Department meeting will be ongoing audits in pre-certification, concurrent review as well as retrospective review. This process will provide the basis for the development of corrective action plans to continually look for new ways to improve the contractors operations with the

Department. The corrective action plan will need to include both time frames for the corrections as well as follow-up time lines. This will allow for a standardized approach that will address areas of concern and allow the Department to ask for the appropriate corrective action.

Recommendation No. 6:

The Department of Corrections should develop a process for reviewing emergency visit claims for inmates housed in private prisons and determine who is responsible for paying for these claims. The Department should use this process for the 17 claims identified by our audit and all future claims submitted for emergency care visits.

Department of Corrections Response:

Partially agree. Implementation date: July 2006. The Department does not believe it would be in our best interest, given our limited resources, to review the 17 claims identified by the audit. We do not have a valid mechanism currently in place that would allow us to recoup any potential inappropriate emergency visit claims. The Department will work with the Private Prison Monitoring Unit and our new Contractor to develop a process for reviewing these claims and a process that will allow for the reimbursement of costs if appropriate. The Department will develop a process for reviewing emergency visit claims for inmates housed in private prisons to determine who is responsible for paying these claims.

Auditor Addendum:

The Department's current private prison contracts provide a process for the Department's and the private prison's chief medical officers to review emergency visits for appropriateness and to recover payments made for inappropriate visits. The Department's private prison contracts state:

> ***Fiscal responsibility for Emergency Care, including ambulance or flight-for-life costs not resulting in a hospital admission, . . . will be mutually determined by the DOC [Department] and Contractor's [the private prison's] Chief Medical Officers on a case-by-case basis. Decision criteria will include, but not be limited to: discharge diagnosis, type and amount of care rendered, and initial presenting symptoms/complaint. The DOC shall retroactively bill the Contractor for emergency care billed to the DOC by the Third Party Administrator where fiscal responsibility is later determined to belong to the Contractor.***

The Department should use this existing process to review the 17 emergency visit claims identified in our audit and to recover funds from the private prisons, as appropriate.

Administration

Chapter 3

Background

The Department's Clinical Services Division oversees the performance of Access Correctional Care's contract. Effective monitoring and enforcement of the contract ensures that the State receives all defined services and that services are of high-quality. Section 24-50-503.5(1), C.R.S., stipulates that personal services contracts can be used only if it is determined that "accountability can be maintained by the government" based on factors such as the extent to which the agency has "sufficient resources and expertise to monitor, measure, and enforce performance of the contract."

As part of the audit, we evaluated the Department's oversight and administration of its contract with Access Correctional Care (the contractor). We identified several concerns with the administration of the contract, including oversight of claims processing and enforcement. We also suggest that the Department evaluate whether a capitation arrangement for its external health care services contract is feasible. We discuss these issues in greater detail in this chapter.

Provider Claims

Contract provisions require the contractor to adjudicate claims on behalf of the Department. Claims adjudication involves analyzing the validity of the claims submitted by providers and issuing payments for validated claims. According to the contract, the contractor must (1) maintain an automated claims processing system that effectively adjudicates all claims for covered inmates, (2) provide for a system of claims receipt, control, and internal distribution to ensure that all claims are entered into the automated system, and (3) maintain a quality assurance program to ensure accurate claims adjudication and to prevent fraud. As noted earlier, our review of the contractor's claims adjudication processes was limited to determining whether payments by the Department to external providers were consistent with the rates negotiated by the contractor.

During the audit, we reviewed a sample of 34,400 inpatient, outpatient, and professional services claims transactions paid by the Department between August 2003 and July 2004. We identified about 1,710 transactions valued at approximately $760,000 that were questionable, representing an error rate of 5 percent. The contract stipulates that the contractor is to have no

more than a 5 percent error rate in its claims processing, which is consistent with industry norms. Although the error rate is within the allowable range, it is at the higher end of the contract requirement and industry norms and indicates a need for greater controls. More specifically:

- **Payment errors.** We received sufficient documentation to identify payment errors for 45 transactions (valued at a total of $500,000). For these transactions, we identified about $24,000 in overpayments and $56,000 in underpayments to hospital providers. Incorrect payments were caused by data entry errors and application of the wrong contract terms or fees. The contractor informed us that it has taken steps to correct most of the errors we identified.

- **Insufficient documentation to verify payments.** For the remaining 1,665 transactions (valued at a total of $260,000), the documentation provided by the contractor was insufficient to verify whether these transactions were paid appropriately. We requested additional documentation for these transactions from the contractor, but the contractor did not respond.

We provided this information to Department management, which will need to follow up with the contractor to make sure the contractor investigates the claims we questioned, corrects underpayments, and recovers any overpayments.

We also found that the contractor does not compare a sample of claims submitted by providers with supporting medical records showing that the services were provided. A provider may have mistakenly or purposefully submitted a claim for services that it did not provide. Without a process for comparing a sample of inmate medical records with the submitted claims, the contractor has no mechanisms in place to discover these invalid claims.

The Department has provided limited oversight of the contractor's adjudication process in recent years. The contract states that "to ensure compliance, the Department shall periodically review the claims processing quality assurance program." The most recent review performed by the Department occurred in 1999. It is particularly important for the Department to conduct periodic evaluations of the contractor's claims adjudication processes because the contractor is not at risk for payments made to external providers. Rather, payments are made from Department funds.

Because of the risks involved with claims processing, the Department needs to evaluate the quality assurance processes used by the contractor to ensure payments made for services provided to inmates are accurate. These evaluations should be conducted on at least an annual basis, and they should include testing a sample of paid claims to verify the accuracy of payments. The Department should ensure that the contractor corrects any payment errors identified from these reviews in a timely manner, as required by the contract. If the contractor

fails to collect overpayments from providers, the Department should use enforcement actions available in the contract to enforce this requirement, as discussed in Recommendation No. 8. In addition, the Department should modify the contract to require the contractor to review medical records to ensure billed services were actually provided.

Recommendation No. 7:

The Department of Corrections should ensure that claims submitted by providers to its external health care services contractor and paid by the Department are accurate by:

a. Modifying the contract to require the contractor to review a sample of medical records to ensure that billed services were actually provided.

b. Evaluating the quality assurance measures used by the contractor to ensure the accuracy of claims submitted by providers and paid by the Department.

c. Ensuring that the contractor corrects any payment errors identified in a timely manner. If the contractor fails to meet such requirements, then the Department should withhold payments from the contractor until such errors are corrected.

Department of Corrections Response:

Partially agree. Implementation date: July 2006. The Department had performed an audit at the beginning of the contract with the Contractor comparing a target number of claims paid with the contracts and found no errors in payments at that time. The Department had been told that the Contractor had an auto audit program in place that would pay the claims according to the contracted rates. The Department had not checked if the claims were getting paid accurately. The Department is going out with a new managed care RFP and has incorporated this language into the bid and will also incorporate the language in the new contract to ensure that the contractor is only paying for the services that were provided and that the Contractor has a process in place to identify any billing errors. As part of the new Contractor's claims payment program, the Contractor will have to show the ability to "scrub" (electronically check) claims, to check for unbundling of services also. The Department has the ability to check controls but does not have the resources or expertise to audit the actual claims. The Department will also put in place a means to withhold payments from the Contractor until such errors are corrected; this will be included in the financially-based performance measures.

Contract Oversight

Throughout this report, we identified concerns with the Department's oversight of its external health care services contractor. We found that the Department has not ensured that (1) rates and discounts negotiated with external providers are optimal for the State, (2) utilization management functions adequately control costs and promote quality services, and (3) claims submitted by providers and paid by the Department accurately reflect actual services provided and the correct rates negotiated. Overall, we found that the Department has been ineffective in holding the contractor accountable for providing high-quality services required by the contract.

In recent years the Department has provided minimal oversight of the contractor's performance. The contract requires the Department to perform annual evaluations of service delivery (e.g., access to and timeliness of services) and the effectiveness of the utilization management program. The contract also requires the Department to conduct periodic reviews of the contractor's claims processing quality assurance system. Further, the contract states that the contractor shall be subject to an annual external review that examines the adequacy and effectiveness of the overall management plan and the provision of services to inmates. We found that the Department has not performed any evaluations or audits of the contractor since January 2001.

In addition, the contract stipulates that the contractor must maintain sufficient data systems to support utilization management activities and "to generate management reports to enable to the Department, with assistance of the contractor, to effectively monitor and manage covered services." The Department indicated that although the monthly management reports provided by the contractor include a large volume of data, the reports do not contain useful, actionable data to support decision making. In particular, some reports do not include analysis of the data and sufficient detail to explain the reasons for unfavorable trends or to recommend costs or utilization controls. Such information is essential to Department management in its decision making and in assessing outcomes and contract performance. Although the Department discussed problems with the reports at its monthly meetings with the contractor and notified the contractor in writing of its concerns, the Department did not take enforcement actions set forth in the contract. The Department needs to enforce the contract to ensure that it receives useful reports for managing utilization.

As discussed in this report, when the Department has noted deficiencies in the contractor's performance, the Department has either assigned its own staff to perform the functions or has taken minimal action to ensure that the contractor corrects the deficiencies. This has resulted in the Department duplicating services that it is paying the contractor to perform. Rather than addressing contract performance, the Department has allowed the contractor to continue its noncompliance with contract requirements.

As mentioned in Chapter 1, the contract contains remedial provisions that the Department can use to enforce the contract, which include: (1) requesting the removal of an employee who is justified as being incompetent, careless, insubordinate, unsuitable, or otherwise unacceptable; (2) denying payment or recovering reimbursement for those services and deliverables which have not been performed or will be of no value to the Department; and (3) terminating the contract. Since the Department began contracting with the contractor in 1997, it has never used the remedial actions available in its contract to enforce requirements.

The Department's oversight and monitoring of its external health care services contractor place state funds at risk of not being used effectively. As a result, it is imperative that the Department improve its oversight of the contractor's performance. As recommended throughout this report, the Department should regularly monitor the contractor against contract requirements. Further, the Department should communicate any deficiencies identified as part of its monitoring to the contractor and require it to submit a corrective action plan detailing how and when deficiencies will be corrected. The Department should perform a follow-up review to ensure that deficiencies are corrected within the prescribed time frames and use remedial actions described in the contract if the contractor fails to comply with the contract.

Recommendation No. 8:

The Department of Corrections should improve its oversight of its external health care services contractor by:

a. Regularly monitoring and auditing the contractor's compliance with contract provisions.

b. Ensuring that deficiencies noted during monitoring reviews and audits are corrected in a timely manner.

c. Using remedial actions to enforce contract requirements when deemed necessary.

Department of Corrections Response:

Agree. Implementation date: July 2006. The Department had made many attempts during the term of the contract to ensure contract compliance, although none were formally documented. A formal documented correction action letter went to the Contractor on August 31, 2004. The Contractor decided that rather than addressing the issues, it would terminate the contract. The Department did have discussions regarding the withholding of payment to the contractor for non-compliance. Before the decision could be made, the Contractor sent the Department a letter in January 2005 discussing

the possibility of not continuing the contract past the end of the fiscal year. The Department will have regular monitoring and auditing of the new managed care contract to ensure its compliance with contract provisions, noting deficiencies and using remedial actions to enforce contract requirements if necessary.

Capitation Arrangement

As described previously, the Department has an administrative services only (ASO) contract for management of external health care services provided to inmates. Under this arrangement, the contractor provides administrative services, such as establishing a provider network for external services, performing utilization management functions, and adjudicating claims. The contractor does not pay for external health care services using its own funds, but rather it pays for these services from an account maintained by the Department. One of the problems with this contractual relationship is that the contractor does not bear any of the financial risk for controlling costs for external health care services. Yet, the Department has delegated most of the responsibilities for managing costs and utilization to the contractor.

One alternative to the Department's ASO contract is to purchase external health care services on a capitated basis. Under a capitation arrangement, the Department would pay a managed care organization a set monthly payment for each eligible inmate, which would cover all external health care services received by Colorado inmates from the managed care organization. The managed care organization would be responsible for performing effective utilization management functions to ensure that services are only provided when medically necessary, the appropriate level of care is provided, and proper discharge planning occurs for inpatient hospital stays. This arrangement is often used by private insurance companies and state and federal government health care programs to control their financial risk.

National research indicates that 23 states use some form of a capitation arrangement to pay for health care services for inmates: 18 states contract out all inmate health care services on a capitated basis and 5 states provide routine care to inmates through their correctional departments and contract out inmate acute and emergency care on a capitated basis. Due to limitations within Colorado's state personnel system, a capitated system for all inmate health care services may not be feasible. There are about 430 Department employees who provide routine health care to inmates. A capitation system for only external health care services could possibly be used by the State.

The primary benefit of using a capitation system to pay for external health care services is the Department shifts its financial risks to the managed care organization. Under this arrangement, the managed care organization would bear the financial risk, which would be a motivator for controlling costs. However, one of the major drawbacks to implementing this system is that

managed care organizations may not be willing to contract with the Department because they would not have control over the primary care services that are currently provided by the Department or the coordination of transportation and security for inmates discharged from hospitals. If the primary care provided by the Department is not adequate, then inmates may need a greater number of or more intensive external services. Further, dilemmas in scheduling transportation or security could delay the discharge of inmates from hospitals. Such circumstances make it difficult for a managed care organization to control health care costs. As a result, the Department would need to develop and implement internal controls to assure that in-house services are of high-quality and transportation and security services are available when needed.

A capitation arrangement for external health care services provided to inmates may be a cost-effective alternative for the State. As a result, we believe the Department should evaluate the costs and benefits of purchasing external health services under a capitation system.

Recommendation No. 9:

The Department of Corrections should evaluate the costs and benefits of using a capitation rather than a fee-for-service payment system for purchasing external health care services for Colorado inmates.

Department of Corrections Response:

Partially agree. Implementation date: March 2006. In the new managed care RFP the Department has stated that the Department would be interested in reviewing alternative reimbursement mechanisms, to include but not be limited to: capitation mechanisms, DRG's for inpatient, etc. The Department may be in a position to negotiate DRG's or capitation upon the award of the RFP in July 2005. The Department will further investigate the ability of managed care contractor regarding capitation. Capitation would allow the Department to share the risk with the Contractor and capitation would also allow the Department to better manage its budgeting process.

Auditor Addendum:

A Request for Proposal (RFP) for an administrative services only contract is significantly different than a RFP for a capitation contract. We recognize that the Department needs to identify and select a new managed care contractor in a short time frame, and it makes sense for the Department to initially establish an administrative services only contract with the new contractor. However, upon selecting a new

managed care contractor, it would be beneficial to the State for the Department to evaluate the costs and benefits of using a capitation payment system in the future.

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