Performance Audit Report

Inmate Healthcare

Reported Contractor Staffing Levels Could Not Be Verified

Contract Monitoring Procedures Were Inadequate

Contractor Patient Health Data Were Not Reliable

February 2007

OFFICE OF LEGISLATIVE AUDITS
DEPARTMENT OF LEGISLATIVE SERVICES
MARYLAND GENERAL ASSEMBLY

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DEPARTMENT OF LEGISLATIVE SERVICES
OFFICE OF LEGISLATIVE AUDITS
MARYLAND GENERAL ASSEMBLY

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February 21, 2007

Delegate Charles E. Barkley, Co-Chair, Joint Audit Committee
Senator Nathaniel J. McFadden, Co-Chair, Joint Audit Committee
Members of Joint Audit Committee
Annapolis, Maryland

Ladies and Gentlemen:

We conducted a performance audit of certain aspects of the Department of Public Safety and Correctional Services' (DPSCS) current inmate healthcare system, which began in fiscal year 2006. The current system consists of six different contracts covering such areas as medical, pharmaceutical, dental, and mental health services. During that year, contractor costs totaled $110 million. The audit objectives included (1) the review of healthcare contractors' staffing levels, (2) DPSCS contract monitoring procedures to ensure the delivery of appropriate medical services, and (3) coordination among the contractors in rendering medical services to the inmate population. This audit was requested by the chairmen of the Joint Audit Committee.

For our first objective, we focused on the medical, dental, and mental health contractors and found that, although DPSCS did monitor staffing levels, the required levels were not being provided by all three contactors. For example, DPSCS identified a shortage of approximately 11 percent for May 2006 (the equivalent of 66 full-time positions for the medical services contractor). Furthermore, DPSCS did not verify the accuracy of the underlying contractor timekeeping records. Our tests found the dental and mental health time records to be generally reliable, but the medical contractor's time records were not always adequately supported. Also, medical contractor employees often worked schedules that deviated from those approved by DPSCS. DPSCS also had not formally assessed agreed-upon contractor staffing levels—which were based on contractors' estimates developed as part of the procurement process—to determine whether these staffing levels were sufficient for providing inmate healthcare.

For our second objective, we focused on the medical contract, which we deemed the most critical since it relates to the primary provider of care to inmates. We found inconsistent monitoring by DPSCS. Specifically, DPSCS had not required the contractor to develop a formal corrective action plan to address known healthcare service deficiencies, which included inmates not receiving initial medical exams (on booking or incarceration). In addition, we identified problems previously unknown to DPSCS because of its failure to verify the accuracy of

contractor records and reports used by DPSCS for monitoring purposes. For example, based on available records, inmates did not always receive routine check-ups for chronic health conditions and timely examinations for illnesses requested during sick calls. Contractor reports of inmates with infectious diseases, which were used by DPSCS to monitor treatment, were found by OLA to be understated. Also, a required inmate methadone detoxification program had not been implemented, although work appeared to be progressing in that area.

With respect to objective three, our audit disclosed that the development of the Electronic Patient Health Records (EPHR) computer system—which is intended to provide a comprehensive database of each inmate's medical history and to aid in the coordination of service delivery—was still ongoing. Although partially operational, the EPHR system contained incomplete and inaccurate patient health records and could not yet be used to effectively monitor inmate healthcare contractors and services. We also found issues that indicate the need for better coordination between contractors, including missing medical records.

On January 16, 2007, the State reached a settlement agreement with the United States Department of Justice to resolve numerous previously identified health and safety violations at the Baltimore City Detention Center. Many of those health violations are similar to the findings in this report.

DPSCS also recently entered into agreements requiring the medical services contractor and the mental health services contractor to pay liquidated damages of $1.75 million and $130,000, respectively, for the period from July 1, 2005 through January 17, 2007. These negotiated agreements specify that DPSCS will hold these contractors harmless from any further claims for liquidated damages or costs relating to contractor billings for this period. As a result, DPSCS does not have any further financial recourse against these contractors for deficiencies occurring during that period, including those identified by our audit.

We wish to acknowledge the cooperation extended to us by DPSCS staff during this audit, especially the Office of Inmate Health Services.

Respectfully submitted,

Bruce A. Myers, CPA
Legislative Auditor

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Executive Summary

The Office of Legislative Audits conducted a performance audit of certain aspects of the Department of Public Safety and Correctional Services' (DPSCS) inmate healthcare system.[1] In June 2005, DPSCS entered into six inmate healthcare contracts with five contractors to provide healthcare services to approximately 26,000 inmates in DPSCS custody. During fiscal year 2006, the total cost of these service contracts was approximately $110 million. The audit had three stated objectives, the results of which are summarized in the following three sections.

Unlike the previous fixed-price contracts for inmate healthcare services, the current contracts for medical, mental health, and dental services generally use a time and materials delivery and payment model. Payments for services provided under these contracts are based on work hours reported by the contractors at hourly rates established in the contracts for the various positions (such as physicians and nurses). The contracts for pharmaceutical services, utilization management services, and the Electronic Patient Health Records (EPHR) computer system are fixed-price contracts with respect to services performed directly by the contractors' employees. In addition, DPSCS pays the costs for medicines dispensed to inmates and specialty care provided by hospitals and outpatient providers.

Many of these findings relate directly or indirectly to monitoring by DPSCS staff within the Office of Inmate Health Services (OIHS). OIHS has a staff of approximately 30 employees and is responsible for providing oversight of the inmate healthcare system by monitoring healthcare operations throughout Maryland. This is essentially the same staff as was used to monitor the previous fixed-price inmate health service contracts. OIHS meets routinely with contractor management and on-site personnel and conducts audits to verify compliance with contract requirements.

Sufficiency of Contractor Staffing (pages 21 to 28)

Our first objective was to determine whether DPSCS had adequate procedures to ensure that the contractors hired sufficient staff with the requisite

[1] For the purposes of this report, we generally did not differentiate between arrestees (persons awaiting booking or trial) and inmates (parties found guilty in a court of law and assigned to the custody of DPSCS). Unless "arrestee" is specifically used, the term "inmates" as used in this report applies equally to both.

qualifications as stipulated by the inmate healthcare contracts and directives of DPSCS. Our audit disclosed that, although there was a process in place to ensure that contractor staff possessed the requisite qualifications, the process was not designed to ensure that staff for the medical, dental, and mental health contractors worked the scheduled hours. Our review of the processes and related tests disclosed in the following deficiencies:

- Procedures were not established to ensure that reported contractor hours worked were supported. Our tests of contractor timekeeping records concluded that the reported work hours of employees of the medical contractor could not always be verified to DPSCS facility sign-in/sign-out logs or to other documentation of work performed during those periods (such as patient records evidencing procedures performed). We were able to verify the reported work hours tested for the mental health and dental contractors. (Finding 1)

- Procedures were not established to verify that contractor employees were physically present at their work stations. During a visit to various facilities in the Baltimore Region, we were unable to sight all medical contractor employees scheduled to work. We attempted to physically sight 37 medical contractor employees scheduled to work on November 17, 2006, but OIHS and medical contractor staff could not locate 8 employees, including 6 employees scheduled to perform intake medical exams in the Baltimore Central Booking and Intake Center (BCBIC). (Finding 1)

- OIHS had not enforced work schedules under the medical services contract, which generally indicated that contractor employees would work 8 hours per day, as we found that more than 10 percent of the shifts analyzed exceeded 8 hours. The medical contractor's timekeeping records for May and June 2006 identified 2,418 individual work shifts (out of 21,644) in which contractor employees worked at least 12 hours per day, with 1,029 of those shifts of at least 16 hours per day duration. (Finding 2)

- The medical, dental and mental health contractors had not provided approximately 11 percent of the respective required staffing, and the OIHS process for monitoring that deliverable, while providing a reasonable estimate, could be improved. Furthermore, DPSCS had not conducted an analysis to determine the adequacy of the contractually-required staffing levels. (Finding 3)

Monitoring of Medical Services Contractor (pages 29 to 37)

Our second objective was to determine whether DPSCS had implemented the necessary contractor monitoring procedures to ensure compliance with significant service delivery and reporting provisions of the medical contract. We found several significant areas of noncompliance impacting the medical services provided to inmates. Although a specific assessment of the quality of medical services rendered was beyond the scope of this audit, the failure to provide certain required medical services could impact inmate health and, therefore, could be considered linked to the overall quality of care. From our review of OIHS and medical contractor procedures and records, we found the following deficiencies:

- As of November 13, 2006, OIHS had not required the medical contractor to provide documentation that 416 inmates, held at BCBIC since at least August 2006, had received the required initial medical screenings. (Finding 4)

- OIHS did not ensure that inmates with chronic medical conditions (such as heart disease, diabetes and infectious diseases) received required quarterly medical examinations. For example, as of October 31, 2006, the medical contractor's records indicated that approximately 800 of 8,200 inmates with chronic medical conditions had not been seen by a healthcare professional within the 90 days subsequent to their scheduled quarterly follow-up appointment dates; effectively, this means at least 180 days had passed since their last examinations. (Finding 5)

- There was a lack of documentation that appropriate corrective actions had been put in place for known medical service delivery issues. For example, OIHS audits found that 39 percent of the inmates tested during September 2006 had not received requested treatment within established timeframes (either 48 or 72 hours). Also, a September 1, 2006 report from the medical contractor disclosed that 70 percent of medication dosages were not documented for the 20 records tested. Finally, at regularly held treatment meetings with contractors, deficiencies in service delivery were repeatedly discussed, including the aforementioned medication administration recordkeeping; however, we could not find any documentation of formal corrective action plans and follow-up of established plans. (Finding 6)

- As of November 2006, an inmate methadone detoxification program had not been implemented as required by the contract and by State law. We were advised that, potentially, at least 10 percent of the 100,000 persons annually processed through BCBIC exhibit symptoms of addiction to controlled substances and could possibly benefit from such treatment. (Finding 7)

- OIHS had not established adequate procedures to verify the completeness and accuracy of contractor reports intended to aid OIHS in monitoring for compliance with the healthcare contracts. We found contractor-prepared treatment monitoring reports that disclosed numerous errors in the administration of medication and thousands of medical appointments cancelled by the medical staff; however, there was no OIHS process to verify the reliability of the data. Also, monthly contractor reports of inmates with infectious diseases were not comprehensive, and were not always consistent with other reports submitted by the contractor. For example, over 800 and 400 inmates, respectively, were omitted from the July and August 2006 reports, which was not detected by OIHS. (Finding 8)

- OIHS did not ensure that an independent physician timely reviewed the medical records of deceased inmates to assess the adequacy of the treatment provided. We found that, as of September 30, 2006, 25 of 67 inmate deaths in fiscal year 2006 had not been reviewed. (Finding 9)

Several of the above issues indicate deficiencies in contractors' performance that would likely qualify for recovery of significant liquidated damages by DPSCS. We noted that, although OIHS had negotiated a liquidated damages amount from the medical contractor for significant contract violations during the July 1, 2005 to January 17, 2007 period, OIHS had not determined the potential amount of liquidated damages available based on the actual violations and the specific contract provisions. (Finding 10)

Coordination Among Contractors (pages 39 to 43)

Our third audit objective was to determine whether DPSCS had implemented procedures to ensure effective coordination among the five inmate healthcare contractors in rendering inmate healthcare services. These services include medical, dental, pharmaceutical, mental health, and secondary care (such as

outpatient specialty care and hospitalization). A key element in the eventual success of that coordination is the development of the Electronic Patient Health Records (EPHR) computer system, designed to provide an electronic medical record for each inmate accessible from DPSCS computer terminals throughout the State. Implementation of the EPHR system would allow OIHS to more effectively monitor contractor performance in several areas discussed in our audit findings under Objective 2 (such as timeliness of medical exams, inmate sick call responses, and visits to inmates with chronic medical conditions).

We found that EPHR was not fully operational as of December 31, 2006, which was 18 months into the two-year contract. Our tests disclosed that EPHR contained incomplete inmate medical records as well as multiple medical records for many inmates, which has delayed the implementation of the medication administration module of EPHR for use in tracking each inmate's prescription drug history. In addition, medical contractor employees did not consistently enter lab test results in EPHR. Furthermore, as of October 31, 2006, there was a backlog of 60 employees awaiting access to the EPHR system to perform their job duties. (Finding 11)

Besides the deficiencies in EPHR, we found administrative issues affecting the coordination between contractors, which could potentially impact patient care. For example, the mental health contractor had reported that over 500 patient charts could not be found by the medical services contractor, potentially hampering the delivery of mental health services. Required peer reviews of providers of secondary care (specialty care and hospitalization services) had not been conducted for fiscal year 2006 by the utilization management services contractor as of November 30, 2006. Finally, the medical services contractor did not always submit the required physician referrals to the utilization management contractor to support visits to hospital emergency rooms. During the period from October 1, 2005 to June 30, 2006, the utilization management services contractor reported that referrals were lacking for 209 of the 1,084 such visits. (Finding 12)

Background Information

Healthcare Contracts Overview

In fiscal year 2006, the Department of Public Safety and Correctional Services (DPSCS) entered into six new inmate healthcare service contracts with five vendors. These contracts were to provide for inmate healthcare services in the following six areas: (1) medical, (2) dental, (3) mental health, (4) pharmaceutical, (5) utilization management, and (6) electronic patient health records.[2]

The medical services contractor is the primary provider of healthcare services to inmates and notifies the other contractors when additional services are required (such as dental care, mental health counseling, prescription medication, and specialty care). In general, the medical and mental health contractors are to perform an immediate cursory exam of inmates upon arrival at a DPSCS facility to determine whether hospitalization or infirmary care is necessary. The medical contractor is responsible for performing a more detailed medical exam of each inmate within seven days of arrival at a DPSCS facility to determine whether each inmate requires routine follow-up care, specialty care, or no additional treatment. The medical contractor is also responsible for responding to inmate sick call requests within 48 hours during weekdays and within 72 hours on weekends.

The utilization management services contractor (UM contractor) is responsible for controlling the costs of outside care (such as from hospitals or specialists) by establishing a network of secondary care providers and by authorizing and making all payments for usage of such providers. The UM contractor is also responsible for conducting periodic peer reviews of all providers of healthcare services, which includes employees of the other contractors and secondary care providers.

The contractor for the electronic patient health records (EPHR) is responsible for implementing a computer system that provides a full medical history, in an electronic format, for each inmate that could be accessed from any EPHR system terminal in DPSCS facilities and offices to allow users to readily determine whether appropriate healthcare services were provided.

[2] The vendor selected for the medical services contract was also selected to implement a computer system for electronic patient health records.

The contractors began work on June 1, 2005 to provide a one-month transition period between the new and old contracts (the old contracts terminated on June 30, 2005). The new contracts are for a term of two years and one month, with the State having the sole option to exercise up to three additional one-year renewals. If all three renewals are exercised, the contracts will terminate on June 30, 2010. The contract amounts are to be evaluated annually and adjusted based on the consumer price index. The total cost for these six contracts during fiscal year 2006 was approximately $110 million, according to DPSCS records, and is summarized in the following table:

Table 1
Inmate Healthcare Contract Costs

Contract	Fiscal Year 2006 Contract Amounts	Fiscal Year 2006 Actual Expenditures
Medical Services	$ 62,351,829	$ 49,169,351
Mental Health Services	11,163,827	9,323,978
Dental Services	8,605,578	6,764,469
Pharmaceutical Services	15,860,277	19,336,516
Utilization Management	10,901,741	23,320,505
Electronic Patient Health Records (EPHR)	1,782,082	1,782,082
Total	**$110,665,334**	**$109,696,901**

The initial DPSCS budgeted amount for these contracts during fiscal year 2006 totaled approximately $85 million, which was subsequently amended to approximately $109 million. The increase was primarily due to higher than anticipated costs for (1) prescription medicines and (2) secondary care services for inmate hospitalizations and specialty care, which are paid under the utilization management contract.

Under the previous inmate medical services fixed-price contracts, two vendors provided all services at a cost of approximately $69 million during fiscal year 2005. The significant increase in costs under the new contract model (from $69 million to $85 million) was primarily due to increasing healthcare costs (in particular, the rising costs to treat HIV, AIDS, and Hepatitis C), a statutory requirement to provide methadone detoxification, the conversion from paper

to electronic medical records, and generally making medical services more readily available to the inmates (thereby increasing opportunities for use). According to DPSCS records, the healthcare contractors provided healthcare services to an average daily population of approximately 26,200 inmates in State correctional facilities during fiscal year 2006.

Historic Problems With Inmate Healthcare

In the past, numerous complaints had been made about deficiencies in Maryland's inmate healthcare program, particularly in the Baltimore jail system, and some have resulted in investigations and lawsuits. For example, in August 2002, the Federal Department of Justice (DOJ) cited the Baltimore City Detention Center for 107 different violations of health and safety, including 45 violations related to medical care and mental health patient treatment. In January 2007, the State reached an agreement with DOJ to resolve these violations by January 2011. The aforementioned DOJ investigation was conducted to determine whether the State had complied with provisions of the 1993 federal consent decree regarding health and safety conditions in the Baltimore jail system that had not sufficiently improved since the initial lawsuit was filed in 1971.

Under this 1993 consent decree, the health and safety conditions at the Baltimore City Detention Center and Baltimore Central Booking and Intake Center must be accredited annually by the National Commission on Correctional Healthcare. Although these facilities received provisional accreditation as of June 30, 2006, the related accreditation report listed numerous consent decree requirements that were not in full compliance, a number of which are also included as audit findings in this report (such as staffing shortages and poor recordkeeping related to dispensing of medication, intake medical screenings, and treatment for the chronically ill).

These types of issues do not appear isolated to Maryland. Inmate healthcare deficiencies in California, Florida, Michigan, and Missouri have been the subject of various lawsuits and investigations in recent years. Available literature and reports from other state auditors also point to similar problems:

- Tennessee state auditors, in a September 2003 report, found that their state's inmate medical contractor did not adequately monitor inmates with chronic medical conditions, did not perform intake exams in a timely manner, and did not comply with physician staffing requirements.

- New York state auditors, in an August 2002 report, found that Nassau County's inmate medical contractor did not provide sufficient medical staffing and did not adequately use the infirmary in the County's correctional facility to reduce hospitalization costs.

- South Carolina state auditors, in a March 2000 report, found that their state's inmate medical contractor did not administer medication in a timely manner. This report also indicated that South Carolina corrections officials did not properly monitor medical services provided or contractor staffing levels.

Intended Benefits of New Healthcare Contract Format

An underlying issue in the delivery of quality healthcare under fixed-price contracts is that services rendered potentially impact the contractor's profits. We were advised by DPSCS management personnel that an inherent problem with a fixed-price contract is the possibility that inmate's medical services are being weighed against the related costs. Another consideration is the inability or unwillingness of contractors to hire a sufficient number of qualified medical personnel.

In an effort to reform inmate healthcare services, DPSCS selected a time and materials service delivery and payment model for the medical, dental, and mental health contracts. The contracts established the following four service delivery areas (SDA) in Maryland: Baltimore, Jessup, Eastern, and Western. DPSCS payments for services provided under the medical, mental health, and dental contracts are based on work hours reported by the contractors at hourly rates established in the contracts in each SDA and for each position (such as physician and nurse). The contracts with the medical services, dental, and mental health providers contain staffing requirements expressed as Full Time Equivalent (FTE) positions for each position (for example, physician, registered nurse). The number of contractor positions budgeted for the medical services, dental, and mental health contractors were 609 FTEs, 63 FTEs, and 87 FTEs, respectively. These staffing levels were basically established by the winning contractors as part of the bid process based on staffing levels under the previous contract.

The contracts for pharmaceutical services, UM services, and EPHR are fixed-price contracts with respect to services performed directly by the contractors.

For each of these contracts, DPSCS pays monthly amounts that are one-twelfth of the annual administrative and payroll-related costs specified in the contracts, except that a portion of the amount paid to the UM contractor is withheld as an incentive reserve and is to be subsequently paid based on certain benchmarks. The three contracts also allow the contractors to receive reimbursement for allowable and approved expenditures, such as for the purchase of equipment and materials. The costs for secondary healthcare services (such as hospitalizations and outpatient specialty care) provided to inmates are paid to the outside providers by the UM contractor and the UM contractor is then reimbursed by DPSCS. Pharmaceuticals for inmates are obtained at fixed prices for each medication, with no limits on total quantities purchased to meet inmates' prescribed needs.

The Office of Inmate Health Services (OIHS), within the DPSCS Office of Treatment Services, is responsible for monitoring the five inmate healthcare contractors to ensure that services are provided in accordance with the related contracts. Approximately 30 OIHS employees[3] located in Baltimore and throughout the State have been assigned to monitor the inmate healthcare contracts. The responsibilities of OIHS include determining whether contractors adhered to contract requirements to provide sufficient qualified staffing and timely healthcare treatment services (such as healthcare for inmates with infectious diseases or chronic health conditions). For example, the medical, dental, and mental health contracts require each contractor to submit work schedules, for OIHS approval, detailing the daily working hours for all employees during each month. OIHS employees also participate in investigations of inmate healthcare-related complaints received from inmates, DPSCS corrections personnel, and contractor employees. All contractors are required to attend monthly quality improvement meetings held in each SDA as well as quarterly statewide meetings held at OIHS headquarters in Baltimore.

Invoice processing for contractor billings is handled by the DPSCS Office of the Secretary. Specifically, OIHS is responsible for advising the Office to pay the invoices after comparing the invoice totals to monthly budgeted amounts. Subsequently, OIHS is responsible for verifying hours billed, billing rates, and the mathematical accuracy of the invoices. These responsibilities are addressed in our fiscal compliance audits of the Office of the Secretary.

[3] This is essentially the same staff assigned in OIHS to monitor the previous fixed-price contracts. Our audit did not undertake an evaluation of OIHS staffing levels; however, the new time and materials contract model would be expected to require much more monitoring (due to the open-ended cost structure) than was necessary under the fixed-price model.

Liquidated Damages and Settlement

The contracts permit DPSCS to assess liquidated damages against any contractor that fails to perform in a manner consistent with the contract provisions and limits the extent of damages from any one incident to $150,000. The liquidated damages calculations in the contracts consider several factors, including the nature and severity of the contract violations and the estimated time required by OIHS staff to determine the impact and remedy.

Subsequent to our fieldwork, DPSCS entered into agreements requiring the medical services contractor and the mental health services contractor to pay liquidated damages, totaling $1.75 million and $130,000, respectively. DPSCS management personnel advised that the terms and amounts of these agreements were negotiated to settle all claims and potential damages for the period from July 1, 2005 through January 17, 2007, and also to create a "clean slate" for the new Secretary of DPSCS, going forward from January 17, 2007. These negotiated agreements specify that DPSCS will hold these contractors harmless from any further claims for liquidated damages or costs relating to contractor services and billings for this period.

Although details of the basis for the settlement amounts were not readily available from DPSCS, we were advised by DPSCS that, prior to the settlements, the contractors had made known their intentions to seek monetary remuneration from DPSCS for certain issues under dispute. We were also advised that the settlements were reached after consideration of the potential claims and the likelihood that DPSCS would ultimately prevail on its positions.

These agreements also specify that these contractors are entitled to the compensation—as provided for in their respective contracts—for their services during this period *as invoiced by the contractors,* without regard to OIHS pre-approved work schedules. This is significant since the OIHS audit unit was in the process of reviewing the inmate medical services contractor's invoices and reported work hours for compliance with the OIHS-approved work schedules and had planned to assess penalties (which are different from liquidated damages) to the medical services contractor for failure to comply with those schedules. Even though OIHS had only reviewed a portion of the medical services contractor invoice and reported work hours for one month (November 2005), the OIHS preliminary findings resulted in a proposed $219,805 penalty for work hours deemed not in compliance with the

contract. This proposed penalty was about 8 percent of the total costs reviewed of approximately $2.6 million; this review excluded approximately $1.2 million invoiced for the Baltimore SDA, which was still under a grace period.[4]

No liquidated damages have been assessed for the dental, pharmaceutical services, UM services, and EPHR system contracts; however, there are no time limitations specified in the contracts for assessment of liquidated damages.

[4] The grace period was to allow the new contractors time to ramp up staffing without adherence to definite staffing schedules. The general grace period was 90 days, ending on September 30, 2005 and, for the Baltimore area, was 180 days ending on December 31, 2005. Although the contractors would not be penalized for not adhering to the staffing schedules during the grace period, contractors could still be penalized for staffing services that were not provided or for incorrect billing rates.

Audit Scope, Objectives, and Methodology

Scope

We conducted a performance audit of the process used by the Department of Public Safety and Correctional Services (DPSCS) to monitor certain aspects of the inmate healthcare services program administered by contractors. This audit was conducted in response to a request made in June 2006 by the Joint Audit Committee. The committee was concerned as to whether intended improvements had been made in the delivery of inmate healthcare services during fiscal year 2006, which was the initial year of the new inmate healthcare contracts. We conducted the audit under the authority of the State Government Article, Section 2-1221 of the Annotated Code of Maryland, and performed it in accordance with generally accepted government auditing standards.

Objectives

We had three specific audit objectives:

1. To determine whether DPSCS established procedures to ensure that the contractors hired sufficient staff with the requisite qualifications as stipulated by contracts and other directives of DPSCS

2. To determine whether DPSCS implemented the necessary contractor monitoring procedures to ensure compliance with significant reporting provisions of the medical services contracts

3. To determine whether DPSCS implemented adequate procedures to ensure effective coordination among contractors in rendering services to the inmate population

The focus of our audit was on determining the level of services and work hours provided; generally, we did not attempt to calculate the potential

financial impact of any contractor noncompliance.[5] We also did not attempt to assess the quality of care provided to individual inmates.

Methodology

To conduct this audit, we obtained and reviewed relevant current inmate healthcare services contract documents and conducted interviews of the contractors' staff and employees of the DPSCS Office of Inmate Health Services (OIHS) and certain DPSCS facilities to obtain an understanding of the service delivery process and expectations.

To address our first objective, we reviewed existing DPSCS – OIHS reports detailing actual staffing levels for the medical, dental, and mental health contracts during fiscal year 2006, which were derived from the contractors' monthly payroll expenditure data, and compared the staffing levels to contract requirements. Contract employee work hours are recorded either in the contractors' electronic time keeping system or, for a small group of medical contractor employees and temporary agency employees, on manual time sheets.

To assess the reliability of contractor timekeeping records, we conducted statistical and non-statistical testing of the three contractors' time records, and we

- compared the hours invoiced for employees to hours worked as reported on time records, and

- verified whether these employees did indeed work at the designated institutions by sighting evidence at the facilities, such as sign-in/sign-out logs or patient record entries.

In addition, to determine whether employees had the requisite qualifications to perform their job duties, for these selected employees, we reviewed qualifications and credentials.

For our second objective, after identifying and evaluating certain reports prepared by OIHS for consistency with the underlying data provided by contractors, we determined the extent to which OIHS used these reports to monitor contractor compliance with significant contract provisions and for

[5] The Office of Legislative Audits has recently completed a fiscal compliance audit of the DPSCS Office of Secretary, and the resulting report, which was recently issued, contains several comments addressing financial matters related to certain healthcare contract monitoring issues.

decision-making purposes impacting the adequacy of inmate healthcare. We also reviewed OIHS procedures designed to ensure it received certain critical contractually-required data regarding inmate healthcare service delivery (such as reports of medication errors, missed appointments, missing patient medical records, and hospital emergency room admissions) and OIHS procedures to verify the reliability of that data.

To address our third objective, we reviewed the OIHS and the utilization management services contractor (UM contractor) processes and procedures for compiling treatment monitoring reports, which demonstrated whether the various contractors effectively coordinated their responsibilities under the new contracts. We determined whether related reports were in accordance with contractual provisions. We also determined the reliability of certain critical UM contractor-supplied data used by OIHS for decision-making purposes. In addition, we determined whether OIHS had implemented corrective actions as recommended in UM contractor reports and in the minutes of periodic meetings with all the contractors to resolve treatment issues.

As part of our third objective, we also determined the progress of the implementation of the Electronic Patient Health Records (EPHR) system. The primary function of EPHR is to provide a consolidated record of all patient health information to allow OIHS medical staff to readily determine whether appropriate healthcare services were provided. While the EPHR modules for medical, dental, and medication records have been developed, the system is not fully operational due to some outstanding implementation issues (for example, consolidation of multiple health records for individuals). Before we began our fieldwork, we were advised by OIHS that many contractor employees were not consistently entering treatment records into EPHR due to a lack of training or staffing shortages; accordingly, we reviewed existing EPHR reports and attempted to determine the extent to which the EPHR system is being used by contractor employees. We also attempted to assess the completeness of the patient records included in the EPHR system during our testing of the source records for various treatment monitoring reports as previously mentioned in objectives 2 and 3.

Fieldwork and DPSCS Response

We conducted our fieldwork from July 2006 to December 2006. The response from DPSCS to our findings and recommendations is included as an appendix to this report.

Findings and Recommendations

Objective 1
Sufficiency of Contractor Staffing

Conclusion

Our first objective was to determine whether the contractors had hired sufficient staff with the requisite qualifications as stipulated by the inmate[6] healthcare contracts and directives of the Department of Public Safety and Correctional Services (DPSCS). Our testing identified three staffing issues, two of which impacted the medical contractor exclusively, and the third which applied to the medical, dental, and mental health contractors equally. Our review of the DPSCS Office of Inmate Health Services (OIHS) licensing verification process found that it was generally adequate to ensure that licensed health professionals were employed by the three contractors.

Staffing

Assessing contractor staffing levels requires reliance on the underlying employee time reports. Since OIHS did not have a formal process for verifying this information, we conducted statistical and non-statistical testing of the three contractors' time records for one week in May 2006. We were able to verify the employee work hours reported by the mental health and dental contractors; however, we concluded that the reported hours for the medical contractor were unreliable because, for certain medical contractor employees tested, there was no evidence that the employees signed in or out of DPSCS facilities, as required. The contractor could also not provide documentation of work performed (such as patients visited or procedures performed) on the days tested to verify that the specific contractor employees in question (7 of the 29 employees in our May 2006 test) were otherwise physically present as reported on the

[6] As used in this report, the term "inmate" collectively refers to both arrestees processed by the Baltimore Central Booking and Intake Center awaiting arraignment or trial and inmates consigned to the care of DPSCS facilities after being found guilty of associated charges.

contractor's timekeeping records. Most of these 7 employees were assigned to the Baltimore Region.

On November 17, 2006, we visited various facilities in the Baltimore Region in an attempt to sight contractor medical staff. Eight of the 37 medical contractor employees scheduled to work that day could not be found, including 6 employees scheduled to perform intake medical exams at the BCBIC (see Finding 4 for the potential impact of understaffing of these positions). Our test results ultimately impact the effectiveness of assessing the adequacy of staffing.

We also found that, although OIHS was aware that the medical contractor permitted some employees to work a schedule of more than 8 hours a day, it was unaware of the frequency this was occurring, at least in part because the contractor had not submitted required schedule modifications to OIHS for prior approval. The medical contractor's timekeeping records for May and June 2006 indicated 2,418 daily individual work shifts (11 percent of the total shifts for the period) in which contractor employees worked at least 12 hours per day. We then reviewed the records for the Baltimore Pretrial region (which includes the Central Booking and Intake Facility, and the Baltimore City Detention Center) during the six-month period ending September 2006. We found that the medical contractor's records indicated that employees worked a total of 3,054 daily individual work shifts of at least 12 hours per day. The original reason OIHS intended to limit daily shifts to 8 hours was to help ensure a high quality of care rendered to inmates.

Finally, for all three contractors, we found that required staffing levels based on Full Time Equivalent (FTE) positions were not being supplied. For example, during the month of May 2006, OLA calculations placed the FTE shortages between 8 and 14 percent of the required levels.[7] Reported understaffing has continued, yet a formal plan to reach full staffing has not been implemented.

These required staffing levels were developed by the three contractors as part of their respective bids, yet no subsequent formal assessment has been conducted to determine what the necessary levels should be to provide comprehensive services now that the contracts have been in force for over a year and a half.

[7] Note that the methodology used by OIHS and OLA differed. OIHS based its calculations on a conversion of contractor-billed salary expenditures into FTEs, while the OLA based its calculations on a conversion of reported hours worked, a more precise method. The OIHS results, in this case, were reasonably close to the OLA results.

Licensing

In accordance with Objective 1, we also conducted a review of the OIHS monitoring process to ensure appropriate licensing of the healthcare professionals employed by the medical services, dental, and mental health contractors. Contract terms specified that certain healthcare professionals employed by the medical, dental, and mental health contractors should be licensed. Although our testing found one instance of a two-month lapse between license expiration and renewal for one nurse employed by the medical services contractor, we found that OIHS appeared to have an adequate process in place to ensure that licensed staff provided healthcare services to inmates. Specifically, OIHS reviews the licenses of all new contractor healthcare personnel and then conducts quarterly reviews of all employees for changes in licensing status.

Findings

Background

DPSCS entered into multi-year contracts at the beginning of fiscal year 2006 with several corporations to provide healthcare services to inmates in DPSCS correctional facilities. To help ensure that services are effectively provided at the various facilities in each region, three of the contracts required the contractors to provide minimum staffing levels for various types of healthcare professionals. The number of contractor positions budgeted for the medical services, dental, and mental health contractors were 609 FTEs, 63 FTEs, and 87 FTEs, respectively.

DPSCS' OIHS is responsible for monitoring the medical services, dental, and mental health contractors' staffing level for compliance with these staffing requirements. For each month, the contractors submit invoices detailing the hours worked by their employees, according to work hours reported in the contractors' timekeeping systems. In addition to the contractors' timekeeping records, DPSCS policy requires each contractor employee to record his or her name in a sign-in/sign-out log upon entering and leaving a correctional facility, which serves as an independent source in determining the reliability of hours billed.

The three contracts also require each contractor to submit a work schedule, for OIHS approval, detailing the daily working hours for all employees during each month; adjustments to the work schedule are required to be approved in advance. In the vast majority of cases, the approved daily work schedules consist of eight-hour work days. The contract allows OIHS to recover any payments for unapproved hours.

1. **Staffing levels provided, as reported by the medical contractor, should be periodically verified to supporting documentation.** – We found that OIHS compared hours billed to scheduled work hours and then used billed hours to monitor staffing schedules. However, this process was not effective because it did not include a verification that employees actually worked the hours billed. This verification should include, on a test basis, a review of the supporting sign-in/sign-out logs and a procedure to physically sight employees on scheduled work days.

   We conducted tests of billed hours and the facility log books, and found that the billed work hours of dental and mental health contractor employees tested were reliable. However, we could not reach a similar conclusion for the much larger medical services contractor. In addition to possibly paying for services that were not documented, since these billed work hours are used by OIHS personnel to monitor required contractor staffing levels, there is no assurance that the intended staffing and the anticipated level of service are being provided. Our test results for the medical services contractor were as follows:

   - A statistical sample of 29 medical contractor employees disclosed that, for 7 of these employees, the required sign-in/sign-out logs at DPSCS facilities were not completed to substantiate 293 hours invoiced during one week tested in May 2006. These undocumented hours represented approximately 23 percent of the total 1,262 hours billed during the week for the 29 employees in our sample. After repeated inquiries, the contractor was unable to provide any other documentation (such as notations on patient medical records) to substantiate that these 7 employees were physically at work on the days in question. Based on our statistical sampling, we are 95 percent confident that supporting documentation for reported work hours would not be available for at least 11 percent of all the contractor's employees reported as working during our test period (the week of May 21 to May 27, 2006).[8] For the month of May 2006, the medical contractor reported that it employed 713 employees.

     Based on these results, OIHS issued memos, on September 8, 2006, to the medical contractor and to the wardens in the Baltimore Region—where 6 of the 7 employees were assigned—reinforcing the policy that contractor employees sign in and out of DPSCS facilities. We conducted a follow-up test during two weeks in October 2006 at

[8] Our statistical sampling results cannot be projected beyond that period.

the Baltimore Region for 10 medical contractor employees and found that the required sign-in/sign-out logs were not always completed for 5 employees.

- Since our original test showed incomplete sign-in/sign-out logs, we chose to conduct an unannounced visit to sight medical contractor employees at their workplaces. During a November 17, 2006 site visit to the Baltimore Region, we could not physically sight 8 of 37 medical contractor employees who should have been working that day, according to OIHS approved work schedules (which OIHS uses to verify billed hours). During our visit, neither the contractor's representative nor the OIHS official who accompanied us could provide an explanation for the employees that were not located. Of those 8 employees, 6 were scheduled to work on intake screenings in BCBIC. We found that, at the time of our visit, only 5 employees were working on intake screenings.[9]

  Subsequent to our fieldwork, we reviewed the medical services contractor's invoice for services provided during November 2006, and the related time records, and determined that the contractor billed DPSCS for 23.5 work hours for 3 of the aforementioned 8 employees that could not be located at BCBIC during our site visit on November 17, 2006.

- From our November 2006 site visit, we also found that the medical contractor was not regularly submitting adjustments to employee work schedules to the OIHS regional contract manager, as required. Twelve of the 29 contractor employees physically sighted during our visit were not listed on the OIHS approved work schedule, but were replacing other scheduled employees.

2. **OIHS should closely monitor contractor compliance with pre-approved work schedules. –** OIHS did not require employees of the medical contractor to adhere to pre-approved work schedules required in the related service contract, which usually anticipated an 8 hour work day per employee. Although the practice of working a fewer number of longer shifts seems to be common in the private sector, we were advised by OIHS that this scheduling was intended to positively impact the quality of healthcare services provided, by limiting employee fatigue that could result from long

[9] We also noted, in Finding 4, that intake screenings at BCBIC were not being completed in a timely manner. These screenings form one of the primary methods for assessing medical conditions and are required to be completed on inmates within 7 days of arrival at BCBIC. Although we were not definitively able to determine the cause for the untimely screenings, a lack of staffing would impact that service delivery.

shifts. However, the contractor reported that many of its employees consistently worked shifts of 12 hours or more per day.

According to the medical contractor's electronic timekeeping records for May and June 2006, there were 2,418 (11 percent of 21,644) daily individual work shifts in which contractor employees worked at least 12 hours per day, including 1,029 (5 percent) work shifts in which contractor employees worked at least 16 hours per day. As seen in Table 2 below, statewide, 48 percent of the employees who reportedly worked during those months had shifts of 12 hours or more (344 out of 713 employees). The majority of the employees working long shifts were nursing staff at the Baltimore Region's facilities. Although OIHS management was aware that, due to understaffing, the medical contractor allowed its employees to work longer hours during evenings and weekends, OIHS did not formally monitor the situation as it was unaware of the reported frequency. As noted in Finding 1, there is no assurance that all work hours reported by the medical contractor were actually worked; nevertheless, OIHS should have taken action based on any reported instance of noncompliance.

Table 2
Count of Daily Work Shifts in May and June 2006 in Which Medical Contractor Employees Reportedly Worked Excessive Hours

Region	Number of Employees in June 2006	May and June 2006 Combined Totals			
		Count of Employees With Daily Shifts Of 12 to 15 Hours		Count of Employees With Daily Shifts Of At Least 16 Hours	
		Employees	Shifts	Employees	Shifts
Baltimore Pretrial[1]	177	43	620	61	373
Baltimore - Other	125	29	335	31	251
Baltimore Region	**302**	**72**	**955**	**92**	**624**
Jessup Region	202	30	177	52	206
Western Region	142	28	203	50	192
Eastern Region	67	16	54	4	7
Statewide Totals	**713**	**146**	**1,389**	**198**	**1,029**

Source: Electronic timekeeping records of inmate medical contractor

[1] Baltimore Pretrial includes the Central Booking and Intake Facility, and the Baltimore City Detention Center.

Longer shifts, however, were not just confined to nursing staff. For example, the medical contractor reported that one physician in the Eastern

Region worked at least 12 hours per day for 29 days in June 2006. We subsequently expanded our review of these records and found that, during the six-month period from April to September 2006, contractor employees in one Baltimore Region facility were reported to have worked a total of 3,054 shifts of at least 12 hours per day, which included 1,198 shifts of at least 16 hours per day. Again, OIHS should have investigated any reported instances of noncompliance.

3. **OIHS should determine the appropriate contractor staffing levels needed to provide all required services to inmates. –** OIHS had no assurance that adequate staffing levels were being provided for medical, dental, and mental health services. As previously noted, the contracts contained required staffing levels (expressed as Full Time Equivalent positions, or FTEs) for specific categories of healthcare professionals; however, there has not been a formal assessment or study to determine if these Statewide and regional FTE totals are appropriate or adequate. DPSCS acknowledged that the contractual staffing levels were developed by the current contractors as part of the bidding process, and may not necessarily reflect the staffing levels needed to provide all required services to all inmates.

   Furthermore, OIHS monitoring has shown that actual staffing levels were not meeting the contractual FTE requirements, but OIHS had not taken any specific actions to require the contractors to reach full staffing. For example, OIHS estimated that, for the medical, dental, and mental health services, 11, 12, and 10 percent, respectively, of the contractually required FTEs were not provided for May 2006. For the medical services contract, the 11 percent shortage equates to approximately 66 full-time positions.

   Finally, while the monitoring methodology used by OIHS provided reasonable estimates of FTEs, we found that it could be enhanced to further improve reliability. Monthly, OIHS tallied the actual payroll expenditures and compared them to budgeted expenditures[10] to estimate the FTEs being provided in relation to the contracts' requirements. The use of actual hours provided as the basis for determining staffing percentages would more realistically equate to FTE positions. Our calculations of the FTEs based on reported actual hours of service provided resulted in slightly different percentages. We calculated the medical, dental, and mental

[10] Budgeted expenditures are essentially annual estimated contract costs divided by 12 months.

health FTEs that were not provided for May 2006, to be 8, 14, and 9 percent, respectively, of the contractually required FTEs.

Recommendations

1. We recommend that OIHS establish a process to monitor the medical contractor's adherence to the contractual time reporting requirements. Specifically, contractor employees should be required to complete sign-in/sign-out logs and the contractor should submit employee work schedule adjustments to the OIHS for approval. We also recommend that OIHS establish a process to periodically verify contractor time records and contractor employees' presence at work, at least on a test basis.

2. We recommend that the OIHS establish procedures to closely monitor the medical contractor's compliance with pre-approved contractor employee work schedules. OIHS should recover any future payments to the contractor for employee work hours that exceed the approved work schedules.

3. We recommend that OIHS enhance its process to capture and record Full Time Equivalent (FTE) positions actually delivered and use this information to enforce contractor compliance with established staffing requirements. We also recommend that OIHS determine the appropriate contractor staffing levels needed to provide all required services to inmates.

Objective 2
Monitoring of Service Delivery Requirements in Medical Services Contract

Conclusion

Our second objective was to determine whether DPSCS had implemented monitoring procedures to ensure contractor compliance with significant provisions of the medical services contract (other than required staffing levels, which were reviewed in Objective 1). This objective was limited to the medical services contract, which is the largest contract and the most important in terms of overall patient care. This contractor is to provide various levels of patient care (such as chronic healthcare checkups) and acts as a gatekeeper, authorizing patient access to more expensive specialty care and inpatient hospital services. We found a number of areas in which inadequate OIHS monitoring appeared to lead to potential lapses in required medical coverage and certain required medical treatments.

- As of November 13, 2006, OIHS had not ensured that 416 inmates, held at BCBIC since prior to September 2006, had received medical screenings that are required to be performed within seven days of booking. Because of inadequate records, it was unclear whether these screenings were ever performed.

- OIHS did not ensure that inmates with chronic medical conditions (such as infectious diseases, diabetes, and heart disease) received required quarterly follow-up visits from medical contractor employees. For example, contractor records indicated that approximately 800 inmates in chronic care as of October 31, 2006 had not been visited by the medical contractor within 90 days of their scheduled quarterly follow-up appointment date.

- A methadone detoxification program for inmates of State correctional facilities addicted to controlled substances had not yet been implemented, even though it was required by the contract and State law. We were advised by an OIHS management employee that there is likely a significant unmet demand for this treatment.

- OIHS did not ensure that independent physician reviews of the medical records of inmates who passed away in DPSCS custody

were performed within 30 days. OIHS records indicated that timely reviews were not performed for 25 of 67 inmate deaths during fiscal year 2006.

We also noted deficiencies with the OIHS process for monitoring reported service delivery problems and for developing appropriate corrective action plans. There are various mechanisms in place to identify medical service delivery issues, including periodic audits by OIHS and contractor staff, routinely scheduled meetings between the contractor and OIHS, and monthly contractor reports. Our review of these communicative processes, disclosed a number of deficiencies for which there was no related corrective action plan or formal OIHS follow-up to ensure that the issues were satisfactorily addressed. The following are examples of the types of issues noted:

- Inmates were not receiving timely treatment in response to sick call requests. OIHS auditors noted this condition for 45 percent and 39 percent of those tested by OIHS during September 2005 and 2006, respectively.

- According to a September 1, 2006 audit report prepared by the medical contractor, there were documentation problems in the administration of medication to 70 percent of the inmates tested (representing 14 of 20 records tested) at BCBIC.

- During the period from March to August 2006, the medical contractor reported 109 medication dispensing errors and 2,717 appointment cancellations by its staff.

As part of the monitoring process, OIHS often relied on contractor reports. Although OIHS had processes in place to determine the reliability of certain contractor reported data, these processes were often not effective, and some critical data were not subject to verification to supporting documentation, such as inmate medical records,. For example, our testing of certain medical contractor reports of inmates with infectious diseases found that they did not include all service regions, thereby underreporting the extent of the problem by several hundred cases.

Several of the above issues are of a nature that would likely allow for recovery of significant liquidated damages by DPSCS. We noted that, although OIHS had negotiated a liquidated damages amount from the medical contractor for significant contract violations during the July 1,

2005 to January 17, 2007 period, OIHS had not previously determined the potential amount of liquidated damages available based on the actual violations and the applicable contract terms.

Findings

Background

The inmate medical services contract requires the medical contractor to provide medical services (including medical exams, routine chronic care visits, and inmate sick call visits) within specified timeframes. The contractor is required to complete medical exams of inmates within seven days of their arrival at DPSCS facilities. The majority of such medical exams are conducted at the BCBIC. The exams are performed to detect infectious diseases and serious medical conditions before arrestees are released into the general inmate population. The contractor is also required

- to maintain unique programs for chronic care patients which ensures that these health conditions are appropriately diagnosed, treated, and controlled, including visits at least every three months, and

- to respond to inmate sick call requests within 48 hours during weekdays and within 72 hours on weekends.

OIHS and the medical contractor periodically conduct audits of the medical contractor's records to ensure compliance with these contract requirements. OIHS regional and headquarters staff also conduct treatment monitoring meetings individually with contractors at least monthly, and all of the contractors attend quarterly meetings at OIHS headquarters. OIHS management asserted that these routine contractor meetings, during fiscal year 2006, led to quicker and easier identification of inmate healthcare problems and solutions.

4. Medical exams of arrestees should be completed within seven days of arrest as required. – We were advised, in August 2006, by OIHS management that it had become aware of hundreds of arrestees at BCBIC who had not received medical exams within seven days of arrest, as required. In September 2006, OIHS staff began to monitor this situation, going forward, using DPSCS records of all arrestees processed by BCBIC and by comparing these records to the medical contractor's records of

inmates who had received medical exams or who had been released. This comparison enabled OIHS to quantify and identify inmates requiring medical exams.

We used the same documents to quantify the number of current inmates booked, prior to September 1, 2006, who had not received the required medical exams. Our comparison identified 561 inmates, arrested prior to September 2006 and still incarcerated at BCBIC, for which there was no documentation that medical screenings had been received as required. These 561 inmates represented 63 percent of the BCBIC population as of September 7, 2006, and included 537 inmates who apparently still had not received an exam at least one month after arrest and 151 inmates who had not received exams at least 3 months after arrest. While we did not verify the accuracy of the contractor and DPSCS records, our results indicate that a significant problem may exist that OIHS should have addressed.

OIHS monitoring records, as of November 13, 2006, indicated that medical exams appeared to have been conducted, as required, for arrestees processed after August 31, 2006; however, these records did not indicate, and OIHS staff was unsure, whether medical exams had subsequently been performed for 416 of the aforementioned 561 inmates.

5. **A process should be put in place to ensure that inmates with chronic medical conditions receive appropriate treatment as required.** – OIHS did not have a process to ensure that inmates with chronic medical conditions (such as infectious diseases, diabetes, and heart disease) were enrolled in chronic care clinics, as required, and that those enrolled received required periodic visits from medical staff. OIHS also had not reviewed chronic care reports received from the medical contractor and had not taken appropriate corrective action to resolve reported deficiencies in chronic care services. In addition, as commented upon in Finding 8, OIHS had not established procedures to verify the accuracy and completeness of certain contractor reports (including chronic care). Nevertheless, OIHS should have taken steps to address these reported deficiencies:

   - Four of the 10 inmates diagnosed with Hepatitis C by the medical contractor in July 2006 were not included in the contractor's chronic care clinic database as of October 31, 2006. Consequently, OIHS had no assurance that those inmates were receiving appropriate treatment.

- The medical contractor's records indicated that 1,917 of 8,247 inmates in chronic care as of October 31, 2006 (23 percent) had not been seen by a healthcare professional within 30 days of their scheduled quarterly follow-up appointment dates. This included 797 inmates for whom at least 180 days had passed since their last examinations.

- The medical contractor's reports disclosed that 144 inmates in chronic care as of October 31, 2006 had gaps between scheduled appointments of 4 to 12 months. The contract requires 3-month intervals between follow-up visits.

6. **Corrective actions should be taken to address reported healthcare deficiencies. –** OIHS did not take sufficient corrective action to follow up on service delivery deficiencies noted in audits conducted by OIHS staff and the medical contractor and those discussed in meetings between OIHS and the contractors. We also noted that the OIHS audit coverage was limited to certain regions.

   OIHS staff performed audits of the response time for inmate sick call requests for treatment and concluded that it was generally beyond the contractually-required 48 to 72 hours. Specifically, OIHS audits in September 2005 and September 2006 at certain DPSCS facilities disclosed that, for 45 percent and 39 percent of the requests, respectively, responses were untimely. The September 2005 audit also disclosed that, for half of sick call requests tested, in which follow-up treatment was necessary, there was no documentation that follow-up treatment was provided. Furthermore, the September 2006 audit did not include the correctional facilities in the Baltimore Region, which comprised 7,336 (28 percent) of the 26,200 inmates in the average daily inmate population of DPSCS facilities as of June 30, 2006.

   In addition, a September 1, 2006 audit report prepared by the medical contractor, addressing BCBIC inmate medication administration recordkeeping practices, disclosed that all medication dosages were not documented for 14 of the 20 records tested (representing 70 percent).

   Yet we found no evidence that OIHS had required the medical contractor to provide formal corrective action plans for these OIHS and medical contractor audits and no evidence that OIHS staff had followed up to ensure that all audit weaknesses were resolved.

Furthermore, OIHS did not ensure that corrective actions recommended during its meetings with the medical contractor were actually implemented. Our review of the minutes of OIHS meetings with the contractor disclosed that several weaknesses in inmate medical services were discussed repeatedly with no indication that corrective actions were implemented. For example, medication administration recordkeeping deficiencies had been discussed at each quarterly meeting during the period from September 22, 2005 to July 28, 2006; however, OIHS could not provide documentation that it was regularly tracking the recommended corrective actions or taking measure to ensure implementation of corrective actions.

7. **A methadone detoxification program should be implemented as required.** – A methadone detoxification program for inmates of State correctional facilities addicted to controlled substances had not been implemented as of November 2006, as required by the medical services contract.[11] The contract, however, did not specify an effective date for the establishment of such a program. We were advised by OIHS management that the primary reason for the delay was that staff from DPSCS and the medical contractor had underestimated the challenges in implementing a methadone treatment program, which must be certified by federal and State health agencies prior to its operation.

   As of December 31, 2006, we were advised by OIHS management that the medical contractor had developed the requisite program operation manuals, had purchased required equipment (such as safes to store the methadone), and had submitted program operation applications to federal and State agencies, but that the contractor was still awaiting approval to begin the program. Since the costs of implementing the program were factored into the rates charged for services provided by the medical services contractor, we were unable to readily determine the extent to which costs associated with this program were included in the approximately $49 million in payments made by DPSCS to the medical services contractor during fiscal year 2006.

   The issue of providing substance abuse treatment services to inmates as a method of reducing recidivism has been a primary focus of DPSCS as evidenced by initiatives, such as the RESTART program (Reentry Enforcement Services Targeting Addiction, Rehabilitation and Treatment).

[11] In addition to the contract, there has been a longstanding requirement in State law, Correctional Services Article, Section 9-603 of the Annotated Code of Maryland, requiring DPSCS to provide and pay for inmate methadone detoxification treatment.

An OIHS management employee advised us that at least 10 percent of the approximately 100,000 inmates per year at BCBIC exhibit symptoms of addiction to controlled substances and could be eligible for treatment once a methadone detoxification program is implemented.

8. **Action should be taken to address identified service delivery problems and medical contractor reports should be verified for reliability.** –OIHS had not established procedures to verify contractor-reported service delivery statistics for accuracy and completeness, even on a test basis, and had not taken action to correct the reported problems. Reports from the medical contractor, for the period from March 1, 2006 to August 31, 2006, disclosed that 109 errors were made by its staff in dispensing prescription medication to inmates and that its staff had cancelled 2,717 inmate medical appointments. For two months during this period (May and June 2006), we tested the medical contractor reports of medication administration errors in the Jessup Region and of cancelled appointments in the Western Maryland Region; these were regions where these problems appeared prevalent. Our tests disclosed that the medical contractor could not provide any documentation to support the accuracy of its reported figures (such as a list of the respective inmates for each category). We also noted that OIHS had not established procedures to verify other contractor reports, such as chronic care reports.

   OIHS also did not verify the accuracy and completeness of various infectious disease reports received from the medical contractor to ensure the reports agreed to the underlying medical records. OIHS uses the contractor's infectious disease reports to track the spread of these diseases within the inmate population and to identify significant fluctuations in the number of infected inmates which may require further investigation by OIHS staff and corrective action. When we reviewed these monthly reports, we found reliability problems. For example, our comparison of the July, August, and September 2006 monthly reports with the underlying medical records found that

   - the July and August 2006 reports omitted 400 inmates in facilities in the Baltimore Region that were infected with the Hepatitis C virus, and

   - the July 2006 report omitted another 400 similarly infected inmates from Jessup Region facilities.

9. **A timely independent review should be conducted of the adequacy of care rendered subsequent to each inmate death. –** OIHS did not ensure that an independent physician performed a review of inmate deaths in a timely manner. OIHS informal policy is that an independent physician should review each inmate death within 30 days, to verify the cause of death as reported by the medical contractor, and to conduct a comprehensive review of the adequacy of the medical treatment provided to the inmate. However, OIHS records of 67 inmate deaths during fiscal year 2006 indicated that, as of September 30, 2006, there was no evidence that the independent reviews had been performed for 25 inmate deaths, including 13 inmates who had been deceased for at least six months. We were advised by OIHS management that the delay in conducting the independent death reviews was due to staffing shortages.

10. **OIHS should ensure that all significant healthcare violations and performance deficiencies are identified and documented timely and that full liquidated damages are assessed as soon as practical. –** As indicated on page 15 of this report, OIHS had negotiated liquidated damages agreements with the medical services contractor and the mental health contractor for the July 1, 2005 through January 17, 2007 period. However, OIHS did not have a definitive basis for the negotiated amounts.

    We were advised by a management official that OIHS was tracking contractor non-performance issues and wanted to build a compelling case with several violations before assessing any damages; however, OIHS could not provide documentation to show that all significant violations during the period had been identified and documented, and that the value of damages had been calculated in accordance with the contract terms.

    According to the contract documents, OIHS may deduct liquidated damages (reduce subsequent payments) for cases in which any of the five contractors fails to perform in a satisfactory and timely manner, with a limit of $150,000 in damages for any one incident. Liquidated damages serve as an incentive for contractors to perform their responsibilities fully and timely, and to mitigate any additional costs incurred by DPSCS as a result of the contractor(s) deficiencies.

    Following are some examples of major contractor deficiencies identified during our audit:

    - Failure to provide required care to inmates with chronic medical conditions (Finding 5)

- Delayed response time for inmate sick calls (Finding 6)
- Failure to implement a methadone detoxification clinic (Finding 7)
- Lack of peer reviews of providers of secondary care medical services, such as specialists and hospitals (Finding 12)

Recommendations

4. We recommend that OIHS ensure that medical exams are completed within seven days for all arrestees, as required in the inmate medical contract.

5. We recommend that OIHS establish a process to ensure that all inmates with chronic care conditions receive required services from the contractor's medical staff.

6. We recommend that OIHS require corrective action plans from contractors to address service delivery deficiencies identified in audits conducted by OIHS and by the contractors, as well as service delivery weaknesses discussed in the periodic meetings with the contractors. We also recommend that OIHS establish procedures to ensure that the corrective action plans are implemented, and retain documentation that establishes corrective actions have been fully implemented.

7. We recommend that OIHS ensure the required methadone detoxification program is implemented as soon as possible.

8. We recommend that OIHS ensure that contractor service delivery reports contain all required information, that OIHS periodically review the underlying medical records for contractor reports to ensure reliability, at least on a test basis and that OIHS investigate and resolve any discrepancies. Finally, we recommend that OIHS take action to address any identified service delivery deficiencies.

9. We recommend that OIHS establish a process to ensure that an independent physician reviews each inmate death in a timely manner to evaluate the adequacy of medical care provided to the inmate.

10. We recommend that OIHS ensure that all significant contractor performance deficiencies are identified and documented timely, and that related liquidated damages are fully recovered as soon as practical.

Objective 3
Coordination Among Contractors

Conclusion

Our third audit objective was to determine whether DPSCS implemented procedures to ensure effective coordination among the five inmate healthcare contractors in rendering inmate healthcare services. The medical services contractor is the primary provider of healthcare services to inmates and acts as the gatekeeper to an inmate's access to additional services. These services include dental care, mental health counseling, and prescription medication, plus specialty care, and hospitalization. Additionally, there are other matters requiring coordination among the contractors which could potentially impact the quality of healthcare being provided, such as maintenance of reliable patient records.

Our audit disclosed that the Electronic Patient Health Records (EPHR) computer system was not fully operational as of December 31, 2006, which was 18 months into the two year contract. The EPHR system is intended to provide an electronic medical record for each inmate, accessible from DPSCS computer terminals throughout the State, and therefore, is a critical tool for properly coordinating the care provided to inmates. A fully implemented EPHR system would also allow OIHS to more effectively monitor contractor performance in several areas discussed in our audit findings under our audit objective 2 (such as timeliness of medical exams, inmate sick call responses, and visits to inmates with chronic medical conditions).

Our audit also disclosed that inmate health records were not readily available to mental health service providers, that the UM contractor did not complete required peer reviews of secondary care providers (such as outpatient specialty providers and hospitals), and that the medical services contactor did not always provide documentation to the UM contractor for hospital emergency room visits.

Findings

Electronic Patient Health Records Computer System Implementation

Background

In June 2005, DPSCS executed a contract for the development and implementation of a computer system to electronically track patient health records. The EPHR contract requires that the patient health records include each inmate's health history while in DPSCS custody, including all medical exams, diagnoses, laboratory test results, medications administered, and secondary care services (such as visits to hospitals or specialists). As of December 2006, the EPHR contract had been in effect for 18 months and DPSCS payments to the contractor totaled approximately $2.7 million of the estimated $3.2 million two year contract cost to implement the system.

11. Outstanding issues delaying the implementation of the electronic patient records computer system need to be resolved.

— The EPHR system is not fully operational and contains inaccurate and incomplete patient health records. As a result, OIHS has been unable to use EPHR to analyze electronic patient health data which could help address contract monitoring deficiencies, such as those discussed in four of our audit findings (see Findings 5 through Finding 8). For example, a patient's electronic record is required to include a history of medical exams, infectious diseases, chronic care visits, and sick call visits. Specifically, our audit of the implementation of the EPHR system disclosed the following conditions:

- The EPHR system contains multiple medical records for individual inmates due to its inability to share inmate population data effectively with other DPSCS computer systems that track inmates during their incarcerations. One problem noted by DPSCS results from the use of different numbers, among various DPSCS computer systems, to identify individuals in its custody. EPHR uses the State Identifier (SID) number, which was deemed by DPSCS to be the best method of tracking an inmate throughout his or her incarceration. However, the SID number is not assigned to arrestees until seven days after their intake. Since the vast majority of arrestees are released within three days without being assigned an SID number,

most arrestees who have been arrested repeatedly and released within seven days do not have a comprehensive medical history; rather, these inmates have several medical records in EPHR. (This situation is exacerbated when the individuals arrested use alias names.) We were advised by OIHS management that it was working with the DPSCS Information Technology and Communications Division and the EPHR contractor to research the feasibility of developing a computer program to merge multiple records and to purge duplicate records without losing critical inmate medical histories.

- The medication administration module of EPHR cannot be successfully implemented to track medicine dosages for inmates until a solution is developed for the aforementioned problem regarding duplicate inmate records. As a result, OIHS cannot use this vital component of the EPHR system to monitor prescription trends and treatment success rates because of the risk of prescribing the same medications repeatedly for a particular inmate who has multiple medical records.

- Contractor employees were not always timely in entering lab test results into the EPHR system. Specifically, our test of 49 inmate laboratory tests, for inmates suspected of contracting Hepatitis C or MRSA (Methicillin-Resistant Staphylococcus Aureus, which is another very contagious disease) in the Jessup and Western Maryland SDAs, disclosed that 48 of the laboratory results were not reported on the respective inmates' medical records in EPHR for periods ranging from three to four months after the related lab tests. Thirty-five of these 48 results indicated that the related inmates had tested positive for these infectious diseases.

- According to an OIHS report, as of October 26, 2006, there was a backlog of 60 employees, of both OIHS and the contractors, who were awaiting EPHR access to perform their job duties, including 21 employees who had requested such access at least 90 days prior to the report date. According to OIHS records, there were 891 users with access to EPHR as of October 30, 2006.

Indicators on Adequacy of Coordination

12. Actions should be taken to address contractor-reported weaknesses in coordination. – As of November 30, 2006, OIHS had not taken adequate corrective actions to investigate and resolve potential weaknesses in the coordination among contractors. Contractor-prepared treatment monitoring reports for March 1, 2006 through August 31, 2006 disclosed the following weaknesses for which no action had been taken:

- The mental health services contractor reported that 558 patient charts could not be located by the medical services contractor and, as a result, the mental health services contractor did not have these inmate medical histories readily available when providing mental health services. The number of missing patient charts generally remained constant from March to August 2006, with no definitive action by OIHS to have this problem corrected. An employee of the mental health services contractor advised us that a fully implemented EPHR system would help to alleviate this problem (see Finding 11).

- As of November 30, 2006, the UM contractor had not conducted any required peer reviews of providers of secondary care (specialty care and hospitalization services) for fiscal year 2006. Such peer reviews can assist the contracted healthcare providers in directing needed outpatient services to the most effective, prompt, and least costly secondary providers. The UM contractor is required to establish a network of secondary care providers and to conduct a peer review once every other month of each provider to assess the quality of the care provided. These requirements are specified in the UM service contract and the related costs are included in the fees to administer the contract, payments for which totaled $1.1 million during fiscal year 2006. OIHS had taken no documented actions to have the peer reviews performed as required by the contract.

- Under the inmate medical services contract, documentation signed by the referring physician is required to support visits to hospital emergency rooms. This documentation is a vital tool used by the UM contractor to determine whether emergency room visits were preventable, and could result in the medical services contractor, rather than DPSCS, being required to cover the cost of certain hospitalizations, According to UM contractor reports, the medical

services contractor did not submit the required documentation to the UM contractor for 209 (19 percent) of 1,084 visits to hospital emergency rooms during the period from October 1, 2005 to June 30, 2006. In addition, the UM contractor reported that the percentage of emergency room admissions without required supporting documentation increased from 8 percent of all such visits during October 2005 to 31 percent of all such visits during June 2006. OIHS had taken no formal actions to ensure that complete documentation was provided to the UM contractor.

Recommendations

11. We recommend that OIHS take appropriate actions to ensure the full implementation of the EPHR, including the medication administration module, as soon as possible. We also recommend that OIHS establish procedures to ensure that contractor employees are promptly and accurately recording all laboratory testing results and other medical records into the EPHR system, and in establishing access to EPHR for authorized individuals. We further recommend that OIHS use the EPHR patient health data to monitor contractors' performance.

12. We recommend that OIHS ensure that identified deficiencies in coordination among contractors are resolved as soon as possible, and document the measures taken to resolve the deficiencies and the results achieved. In particular, OIHS should ensure that inmate health records are readily available to providers of mental health services, require the UM contractor to perform the required peer reviews of secondary care providers, and ensure that the medical services contractor submits required documentation to support emergency room admissions.

APPENDIX

Department of Public Safety and Correctional Services

Office of the Secretary
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February 16, 2007

Mr. Bruce A. Myers, CPA
Legislative Auditor
Office of Legislative Audits
301 West Preston Street – Room 1202
Baltimore, Maryland 21201

Dear Mr. Myers:

The Department of Public Safety and Correctional Services has reviewed the draft performance audit report dated February 5, 2007, for **Inmate Healthcare** covering the fiscal year 2006 period. The Office of Inmate Health Services (OIHS), as well as the Department, appreciates the effort of the Legislative Auditors to understand the Department's inmate healthcare delivery system and the various complexities and challenges that exist in providing healthcare services within a prison environment.

As the Department continues to enhance its inmate healthcare delivery system, we acknowledge the importance of each of the findings and value the constructive recommendations made as a result of this performance audit. This report will greatly assist the Department's ongoing management of the inmate healthcare contracts.

Attached are Assistant Secretary Richard Rosenblatt's itemized responses to the audit report, with which I concur. Be assured that appropriate corrective action has been or will be implemented for all the agreed upon recommendations noted in the audit report.

I trust that these responses adequately address the findings and recommendations reflected in the audit report. If you have any questions regarding the Department's responses, please contact me.

Sincerely,

Gary D. Maynard
Acting Secretary

c: G. Lawrence Franklin, Deputy Secretary for Administration
Mary L. Livers, Ph.D., Deputy Secretary/Chief of Staff
Richard B. Rosenblatt, Assistant Secretary for Treatment Services
Barbara Y. Alunans, Deputy Chief of Staff
Susan D. Dooley, Director of Financial Services
Walt Wirsching, Director of the Office of Inmate Health Services
Joseph M. Perry, Inspector General

Department of Public Safety and Correctional Services

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CORRECTIONAL TRAINING COMMISSION

POLICE TRAINING COMMISSION

MARYLAND PAROLE COMMISSION

CRIMINAL INJURIES COMPENSATION BOARD

EMERGENCY NUMBER SYSTEMS BOARD

SUNDRY CLAIMS BOARD

INMATE GRIEVANCE OFFICE

February 14, 2007

Mr. Gary D. Maynard, Acting Secretary
Department of Public Safety and Correctional Services
Suite 1000
300 East Joppa Road
Towson, Maryland 21286

Re: Performance Audit Report – Inmate Healthcare

Dear Acting Secretary Maynard:

Below are the responses to the draft Performance Audit Report for Inmate Healthcare. This Report reflects an analysis of the current inmate healthcare delivery system, which went into effect on July 1, 2005. It does not compare this system to that which was in place previously. Indeed, had such an assessment been performed, the Report would have reflected:

- substantially increased staffing levels for the delivery of care (particularly within the Division of Pre-trial Detention and Services), both with respect to the required staffing levels and the percentage of the required staffing delivered;

- inmates receiving medications and consultations more often and on a more timely basis as a result of eliminating profit for the denial of care as a result of a reimbursement system; and

- a greater responsiveness to issues raised by the Department as a result of each functional unit (mental health, dentistry, pharmacy, and primary medical) having distinct corporate identity that alleviates the need of a single provider to balance and prioritize issues requiring attention.

No healthcare delivery system is perfect and, as the report indicates, the Department's inmate healthcare system is no exception. The issues identified in the Report with which we agree require corrective action. That said, two points remain to be made. First, one of the objectives of the Audit Report was to assess coordination between the contractors in rendering services to the inmate population. The Department could not be prouder of the professional manner in which our contractors have worked together in a coordinated fashion under the

leadership of the Office of Inmate Health Services (OIHS). The issues cited under this section of the Analysis in the Report are important, but are not unique to a multi-vendor delivery structure. If anything, our experience to date is that the separate corporate entities responsible to the Department establish a system of checks and balances more inclined toward exposing and resolving issues, rather than a subcontractor situation under a single vendor where difficulties in delivery and cooperation may be hidden from the Department.

The second point relates to the OIHS itself. As the Audit Report reflects, the number of personnel within the Office has not increased concomitant to the increase in responsibility under this delivery methodology and system of remuneration. In order to appropriately address the audit issues, and to maximize return on investment in health services, personnel enhancement is essential. With the staffing resources available, the OIHS will have to prioritize its attention to those issues likely to have the greatest impact on patient health outcomes (e.g. required examinations, sick call, medication administration, follow-up care, chronic care) and those issues required in the Department of Justice (DOJ) settlement agreement. To the extent that the findings and recommendations of the Legislative Auditors are congruent with these priorities, corrective action will be taken as delineated below.

Finding #1 - Staffing levels provided, as reported by the medical contractor, should be periodically verified to supporting documentation.

We agree. The Department will continue to develop its monitoring process of the medical contractors' adherence to the contractual time reporting requirements. The Department will insist that sign-in/sign out logs are completed, and will periodically verify contractor time records and contractor employees' presence at work, at least on a test basis. The Department will also ensure that the contractor submit employee work schedule adjustments for approval, though this aspect of the recommendation relates to deployment more than confirmation of staffing levels at a facility.

Finding #2 - OIHS should closely monitor contractor compliance with pre-approved work schedules.

We agree. As a means to ensure that the contractor is deploying staff in accordance with agreed upon need, the Department will establish procedures to monitor the medical contractor's compliance with pre-approved contractor

employee work schedules. To the extent that more staff is deployed than approved, the Department will seek to recover payments made relative to these additional hours. However, nothing herein should be construed as an indication that the Department will limit an individual employee to a single work shift on the approved staffing schedule on a given day, or that the Department will not approve splitting work shifts to attain coverage.

Finding #3 - OIHS should determine the appropriate contractor staffing levels needed to provide all required services to inmates.

We agree in part, disagree in part. The Department will continue in its effort to enhance its process of capturing and recording FTE positions actually delivered, and will continue to encourage the contractors to work toward achieving full staffing levels. The Department will also continue to evaluate, on an on-going basis, the demand for services against the staffing levels to ensure that the staffing levels currently established are appropriate to provide all required services to inmates. While the Department acknowledges that there may be situations from time to time where staffing levels do not conform to service demands, it disagrees that there is not currently a generally acceptable correlation between staffing levels and service needs.

Finding #4 - Medical exams of arrestees should be completed within seven days of arrest as required.

We agree. The Department will ensure that medical exams are completed within seven days for all arrestees who are not released within that time, as required in the medical contract.

Finding #5 - A process should be put in place to ensure that inmates with chronic medical conditions receive appropriate treatment as required.

We agree. The Department will develop a process to ensure that all inmates with chronic care conditions receive required services from the contractor's medical staff.

Finding #6 - Corrective actions should be taken to address reported healthcare deficiencies.

We agree. The Department will require formal corrective action plans from contractors to address service delivery deficiencies identified in audits conducted

by the Department. Further, the Department will require such formal corrective action plans, where appropriate, upon contractor self-disclosure or in furtherance of issues discussed in the periodic meetings with contractors recognizing that informal resolution may be appropriate in some instances. The Department will establish procedures to ensure that where corrective action plans are developed, they are implemented, and will retain documentation to such effect.

Finding #7 - A methadone detoxification program should be implemented as required.

We agree. The Department will ensure that the required methadone detoxification program is implemented as soon as possible in conformance with all required licensing provisions.

Finding #8 - Action should be taken to address identified service delivery problems and medical contractor reports should be verified for reliability.

We agree. The Department will ensure that contractor service delivery reports contain all required information, will establish procedures to review the underlying medical records to ensure reliability, at least on a test basis, and will investigate and resolve discrepancies. Where such reports identify a service delivery deficiency, the Department will take whatever action is appropriate to ensure that the deficiency is addressed.

Finding #9 - A timely independent review should be conducted of the adequacy of care rendered subsequent to each inmate death.

We agree. However, the Department contends that a timely independent review of the adequacy of care is currently conducted subsequent to each inmate death in the form of a Mortality and Morbidity Review. The issue identified for lack of timeliness is the subsequent independent assessment of the cause of death by the Department's Medical Director. The Medical Director has been unable to conduct such reviews within the thirty days required by the Department's own policy due, in part, to delays in completion of autopsies in some cases, and, in part, to prioritization of cases with questionable issues related to a death. The Department will continue to ensure that a timely independent review is conducted subsequent to every inmate death and will re-examine and modify, as appropriate, its policies.

Finding #10 - OIHS should ensure that all significant healthcare violations and performance deficiencies are identified and documented timely and that full liquidated damages are assessed as soon as practical.

We agree in part, disagree in part. The Department will ensure that all significant contractor healthcare performance deficiencies are identified and documented timely. However, it will continue to maintain discretion with respect to the imposition of liquidated damages in the absence of "unjust enrichment." Unlike prior contracts, liquidated damages are not a means of recovering monies paid for staffing that was not provided. In this contract, remuneration is based on hours actually worked. Thus, the liquidated damages provisions in the contracts reflect a measurement of compensation for injury sustained that otherwise is not susceptible to calculation. Assessment of liquidated damages is not an end to itself; it is a means to insist on improved performance and to obtain that performance. Just as a Judge does not impose a maximum punishment for a first offense, and may withhold judgment for a time to monitor improvement in performance, the Department must utilize the liquidated damages provision of the contract in a way that will best obtain the services it requires. Moreover, there are many situations where the Department and the contractor agree on the facts but disagree on whether the facts constitute a deficiency of performance under the contract. In such instances, compromise may be appropriate to obtain any recovery at all. [1]

[1] An example of these concepts lies in the compromise settlement between the Department and the medical provider referenced in the Background section of the Report. The auditors referred to a single month where $219,805 worth of services was not in compliance with the contract. There was no dispute between the Department and the medical provider that the State received this value of services. It was only that the services provided were above and beyond the scheduled hours in the staffing schedule. Still, even with these additional hours worked, the contractor fell below the available allocation based on 100% staffing. Thus, the Department was not in a position to reclaim the full dollars paid. Additionally, the contractor filed a claim to contest the Department's interpretation of the contract with respect to whether it was appropriate to withhold payment for hours that were actually worked so long as the total value fell below the "not to exceed amount" for wages. Thus, in an effort both to entice conformance to the procedures for modifying work schedules, while at the same time paying for value received and avoiding a claim, the Department folded this issue into the overall settlement. If deviation continues, the Department can seek a more substantial remedy in the future.

Finding #11 - Outstanding issues delaying the implementation of the electronic patient records computer system need to be resolved.

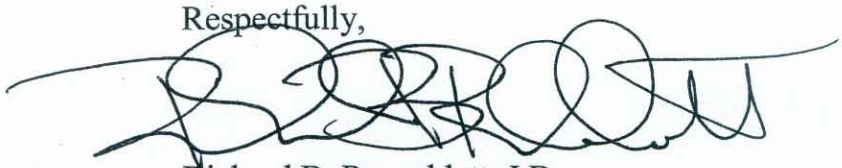
We agree. The Department will take appropriate action to ensure the full implementation of the EPHR, including the medication administration module, as soon as possible. The Department will also establish procedures to ensure that contractor employees are promptly and accurately recording all laboratory testing results and other medical records into the EPHR system, and in establishing access to the EPHR for authorized individuals. Once the EPHR system is fully functional, populated with data, and reliable, the Department will use the EPHR patient health data to monitor contractors' performance.

Finding #12 - Actions should be taken to address contractor-reported weaknesses in coordination.

We agree. The Department will, and does, ensure that identified deficiencies in coordination among contractors are resolved as soon as possible, and will document the measures taken to resolve the deficiencies and the results achieved. Even under a single contractual provider, access to medical records by mental health professionals was problematic in the past leading to separate medical and mental health files. Those files have now been consolidated for purposes of ensuring quality of treatment and in preparing for the movement toward the EPHR. However, the problem of access to written medical files by mental health providers has re-emerged. Nevertheless, the Department will take steps to eliminate this problem until it is finally resolved by the EPHR system. The Department will also ensure that the primary care provider submits required documentation to support emergency room admissions in order to facilitate the retroactive approval for payment upon determination of necessity. Although peer reviews of secondary care providers are required under the contract, such reviews are not a reflection of coordination between vendors and, in fact, have minimal

utility in this health care system. If a specialist who is part of the UM provider's network fails to perform appropriately in a given case or on a regular basis, the UM provider will obtain the services of a new provider and terminate its relationship with the unsatisfactorily performing provider.

Respectfully,



Richard B. Rosenblatt, J.D.
Assistant Secretary – Treatment Services

cc: G. Lawrence Franklin, Deputy Secretary
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