Report of the Vermont State Auditor

October 24, 2013

CORRECTIONAL HEALTH CARE

Annual Cost Overruns, but Contract Oversight Has Improved

Douglas R. Hoffer
Vermont State Auditor
Rpt. No. 13-06

Mission Statement

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Douglas R. Hoffer
STATE AUDITOR

STATE OF VERMONT
OFFICE OF THE STATE AUDITOR

October 24, 2013

Addressees (see last page of letter)

Dear Colleagues,

Attached is our audit report on Correctional Health Care. The Department of Corrections (DOC) contracts with Correct Care Solutions (CCS) to operate a comprehensive health care program for inmates housed in-state. Because of the importance and expense of this contract, the State Auditor's Office (SAO) decided to review the State's oversight of this contract. Specifically, our two objectives were to determine whether DOC monitors the CCS contract in a manner that 1) provides assurance that the State's costs are minimized and 2) ensures that the contractor meets the contract's performance requirements.

First, DOC's choice of a cost-plus-management fee contract places the financial risk on the State. As a result, the contractor lacks incentive to minimize costs. Although the CCS contract was recently extended for two years, DOC has engaged consultants to help review various health care delivery options for the future.

Second, DOC's monitoring of the costs of the CCS contract has not ensured that costs are minimized, and the State paid $4.2 million more than the $49.1 million that was budgeted in the first three years of the contract. DOC's cost monitoring was not robust during the earlier years of the contract but has improved since late 2012. Moreover, DOC provided evidence that it expressed concerns to CCS about cost overruns during the course of the contract and has explored ways with the contractor to control costs.

In addition, DOC policy states that inmate resources, such as insurance coverage, will be used to meet medical expenses incurred for care of the offender beyond services provided by employees and contractors of the department. Accordingly, for complex cases, the contract requires CCS to ascertain whether the inmate has health insurance and to pursue collection on the State's behalf, including from Medicaid if applicable. However, testing identified one instance in which Medicaid was not billed for an inmate who was hospitalized at a cost to DOC of $84,000.

Third, DOC's monitoring of CCS's performance against the contract requirements has been mixed. DOC employed various mechanisms to oversee CCS's activities, but the department did not apply allowed penalties to prompt timelier contractor performance improvements until late 2012, even though CCS had not fulfilled certain contractual requirements from many months earlier.

For example, in early 2013, DOC applied penalties for the performance periods August 2010 – December 2011. In taking so much time to apply penalties for performance deficiencies, DOC lost the opportunity to offer a monetary incentive for CCS to correct its deficiencies in a timely manner.

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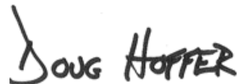
The lack of timely application of all allowable penalties appears to be due, at least in part, to significant personnel and operational changes at the Department during the first three years of the contract's performance period. However, DOC hired a new contract monitor in October 2012, who implemented a process to systematically track contractor performance against the contract's guarantees. Since December 2012, the contract monitor has been reducing payments to CCS for assessed penalties, when applicable.

DOC has made substantial improvements to both their cost and performance monitoring processes in the past year. However, more needs to be done to help ensure that the State is not paying excessive amounts for the services that it is purchasing. Accordingly, we have offered various recommendations to help reduce its current costs and improve internal controls, and to reduce its risks in the implementation of health care delivery models under current consideration.

I would like to thank the management and staff at the Department of Corrections for their cooperation and professionalism during the course of the audit.

Sincerely,



Doug Hoffer
Vermont State Auditor

ADDRESSEES

The Honorable Shap Smith
Speaker of the House of Representatives

The Honorable John Campbell
President Pro Tempore of the Senate

The Honorable Peter Shumlin
Governor

Mr. Douglas Racine
Secretary
Agency of Human Services

Mr. Andrew Pallito
Commissioner
Department of Corrections

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Introduction

Adequate health care services are essential to the success and well-being of inmates committed to correctional facilities. Moreover, Vermont is constitutionally[1] required to provide the basic necessities for persons in its correctional facilities, including health care. Providing adequate care has proven to be costly. The fiscal year 2014 budget for the Agency of Human Services Department of Corrections (DOC) includes about $19 million for health care services, which is funded from the State's general fund.

DOC contracts with Correct Care Solutions (CCS) to operate a comprehensive health care program for inmates that are housed in-state. This contract requires that CCS operate the health program in a cost-effective, fiscally responsible manner and in accordance with National Commission on Correctional Health Care (NCCHC) standards.[2] Because of the importance and expense of this contract, the State Auditor's Office (SAO) decided to review the State's oversight of this contract. Specifically, our two objectives were to determine whether DOC monitors the CCS contract in a manner that 1) provides assurance that the State's costs are minimized and 2) ensures that the contractor meets the contract's performance requirements.

Appendix I contains the scope and methodology we used to address these objectives. With respect to the cost and performance of CCS, the scope of our audit covers the performance period of the first three years of the contract (February 1, 2010 to January 31, 2013). However, we also considered DOC monitoring processes that were added after January 2013. Appendix II contains a list of abbreviations used in this report.

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[1] This is largely due to the U.S. Constitution's eighth amendment prohibition against "cruel and unusual punishment" as well as the due process clauses in the fifth and fourteenth amendments.

[2] NCCHC is an independent organization that, through an accreditation process, renders a professional judgment on the effectiveness of a correction facility's health services delivery system. In 2012, NCCHC re-accredited the health care services at DOC's facilities.

Highlights: Report of the Vermont State Auditor

Correctional Health Care: Annual Cost Overruns, but Contract Oversight Has Improved

(October 2013, Rpt. No. 13-06)

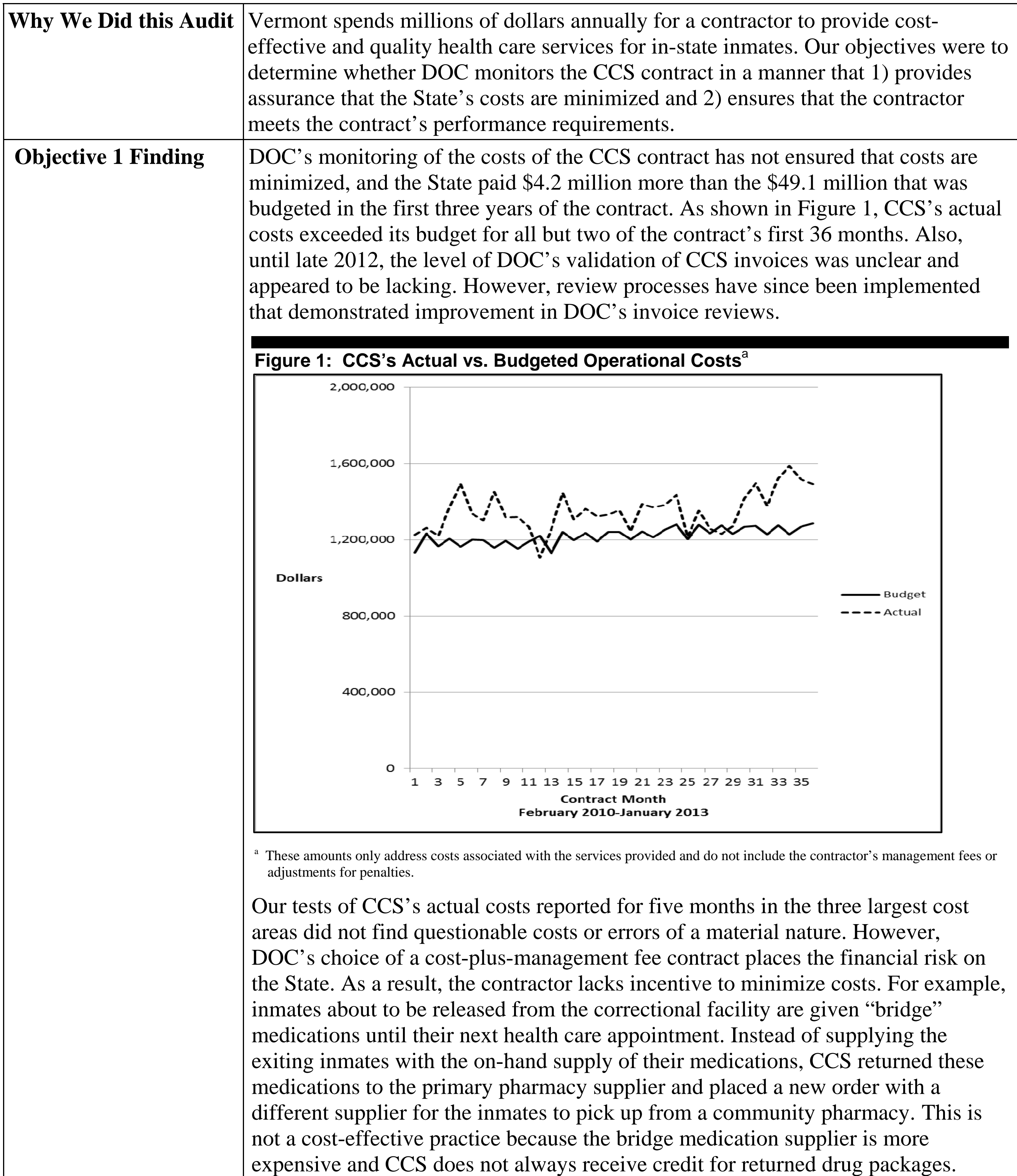
Why We Did this Audit

Vermont spends millions of dollars annually for a contractor to provide cost-effective and quality health care services for in-state inmates. Our objectives were to determine whether DOC monitors the CCS contract in a manner that 1) provides assurance that the State's costs are minimized and 2) ensures that the contractor meets the contract's performance requirements.

Objective 1 Finding

DOC's monitoring of the costs of the CCS contract has not ensured that costs are minimized, and the State paid $4.2 million more than the $49.1 million that was budgeted in the first three years of the contract. As shown in Figure 1, CCS's actual costs exceeded its budget for all but two of the contract's first 36 months. Also, until late 2012, the level of DOC's validation of CCS invoices was unclear and appeared to be lacking. However, review processes have since been implemented that demonstrated improvement in DOC's invoice reviews.

Figure 1: CCS's Actual vs. Budgeted Operational Costs[a]



[a] These amounts only address costs associated with the services provided and do not include the contractor's management fees or adjustments for penalties.

Our tests of CCS's actual costs reported for five months in the three largest cost areas did not find questionable costs or errors of a material nature. However, DOC's choice of a cost-plus-management fee contract places the financial risk on the State. As a result, the contractor lacks incentive to minimize costs. For example, inmates about to be released from the correctional facility are given "bridge" medications until their next health care appointment. Instead of supplying the exiting inmates with the on-hand supply of their medications, CCS returned these medications to the primary pharmacy supplier and placed a new order with a different supplier for the inmates to pick up from a community pharmacy. This is not a cost-effective practice because the bridge medication supplier is more expensive and CCS does not always receive credit for returned drug packages.

Objective 2 Finding	DOC's monitoring of CCS's performance against the contract requirements has been mixed. DOC employed various mechanisms to oversee CCS's activities, including meetings at the executive and facility levels that are focused on health care quality, and quarterly quality assurance audits by an independent contractor. However, the department did not apply allowed (but not required) penalties to prompt more timely contractor performance improvements until late 2012, even though CCS had not fulfilled certain contractual requirements from many months earlier. For example, DOC applied penalties for the performance periods August, 2010 – December 2011 in early 2013. In taking so much time to apply penalties for performance deficiencies, DOC lost the opportunity to offer a monetary incentive for CCS to correct its deficiencies in a timely manner. Some of these deficiencies related to the submission of required operational reports for the evaluation of CCS's performance. According to DOC documentation, between 2010 and mid-2012 CCS did not provide all required operational reports or provided reports that were inaccurate or incomplete. For example, in May 2012 DOC sent CCS a letter stating that it "requests the submission of all outstanding reports related to performance guarantees some of which are 18+ months overdue despite multiple DOC requests and CCS promises to deliver." The lack of timely application of all allowable penalties appears to be due, at least in part, to significant personnel and operational changes at DOC. In particular, from November 2010 to January 2012, DOC had a vacancy in the health services director position. During this timeframe, the chief nursing officer served a dual role filling in as the interim health services director. Further, the contract monitor changed and Tropical Storm Irene caused DOC's central office to relocate. Since the health services division only has five staff positions (another DOC staff member in the business office helps monitor the contract), such significant changes can be more difficult to absorb than in a larger organization. DOC hired a new contract monitor in October 2012, who implemented a process to systematically track contractor performance against the contract's guarantees. Since December 2012, the contract monitor has been reducing payments to CCS for assessed penalties, when applicable.
What We Recommend	We recommend short-term cost-containment and monitoring improvements related to medications and insurance as well as longer-term recommendations, including using a more cost-effective contracting type than cost-plus-management fee.

Background

DOC's Health Services Division oversees the provision of all medical services (physical and mental health) for inmates housed in-state. There are five positions in this division,[3] including a director and chief nursing officer. DOC operates eight in-state correctional facilities, two of which are work camps. In fiscal year 2012, DOC housed an average daily population of in-state inmates of 1,583,[4] which included both sentenced offenders and detainees.[5]

According to the Public Consulting Group (PCG),[6] the unique structure of Vermont's correctional system makes it difficult to make comparisons to the health care expenditures in other states' correctional systems. In particular, Vermont correctional facilities perform both prison and jail functions,[7] and the State has a small population of in-state inmates in a relatively large number of in-state facilities.[8] According to PCG, these attributes contribute to the high cost of Vermont's inmate health care because they 1) increase staffing needs and 2) do not take advantage of economies of scale available to larger facilities.

In January 2010, DOC entered into a contract with CCS for a three-year period, beginning on February 1, 2010, to provide comprehensive healthcare services for Vermont inmates. CCS, in turn, subcontracts for some services, such as pharmacy and off-site services (off-site services include, for example, dialysis procedures and emergency room visits). In February 2013, DOC and CCS agreed to extend this contract two years and it is now scheduled to end in January 2015.

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[3] There is also a staff member in DOC's business office that provides contract monitoring support to the Health Services Division.

[4] The fiscal year 2012 average daily population of all DOC inmates, including those housed in out-of-state correctional facilities, was 2,103.

[5] Also known as a detentioner, this is a person committed to the Commissioner of Corrections by the court or other authorized person or entity, who is confined in a correctional facility until he/she is sentenced or released.

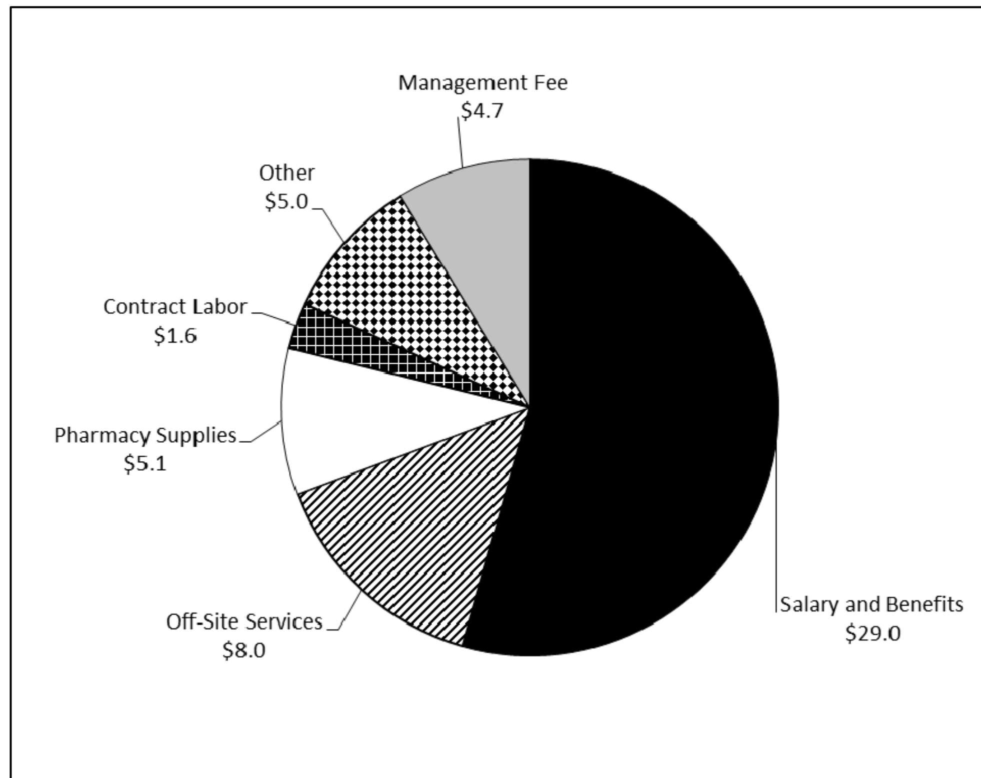
[6] In October 2011, DOC hired PCG to perform an analysis of its health care delivery system and provide recommendations.

[7] A jail houses inmates for less than a year.

[8] PCG found that only North Dakota had a smaller number of in-state inmates.

DOC paid CCS $53.3 million for the first three years of the contract. As shown in Figure 2, a little over half of these costs were for salaries and benefits and about 9 percent was for CCS's management fee.

Figure 2: Breakout of Major CCS Costs for First Three Years of Contract, in Millions[a]



[a] Numbers do not add to $53.3 million due to rounding.

Objective 1: DOC's Monitoring of Health Care Costs Has Not Ensured that Costs Are Minimized, but Improvements Have Been Made

DOC's monitoring of CCS's health care costs has not ensured that these costs are minimized since the contractor spent $4.2 million more than was budgeted in the first three years of the contract. Since DOC signed a cost-reimbursement contract, the department is responsible for (and has paid) this overage. Cost-reimbursement contracts carry a risk of wasteful spending, since entities pay for expenses as incurred instead of agreeing upfront on a fair and reasonable fixed price for the delivery of a service, and so it is prudent to implement robust monitoring processes. DOC's cost monitoring was not robust during the earlier years of the contract but has improved since

late 2012. Moreover, DOC provided evidence that it expressed concerns to CCS about cost overruns during the course of the contract and has explored ways with the contractor to control costs. Nevertheless, we found that CCS had not implemented a cost-effective approach to medications provided to released inmates. A consultant (PCG) reported that it does not recommend that the State continue with its cost-reimbursement model in the long-term, and DOC is exploring new delivery models for providing inmate health care.

CCS Costs

DOC's agreement with CCS is a cost-plus-management fee contract.[9] Under a cost-reimbursement contract, contractors are paid based on the incurrence of allowable costs, as opposed to the delivery of a completed product or service. DOC's choice of a cost-plus-management fee contract means that the State generally absorbs cost overruns because this type of contract places the financial risk on the State rather than the contractor. As a result, this type of contract lacks incentive for the contractor to minimize costs.

The maximum amount payable on the original three-year contract was $49,094,656, split between a budgeted amount for the annual cost to provide health care services and an annual fixed management fee. Taken together, these costs were the contractor's base compensation. Table 1 provides a schedule of the estimated costs outlined in the contract versus what was paid in the first three years of the contract. During this timeframe, the State paid CCS $4.2 million more than what was budgeted in the contract—8.5 percent more than the contracted price.

Table 1: Schedule of Budgeted and Actual Costs[a]

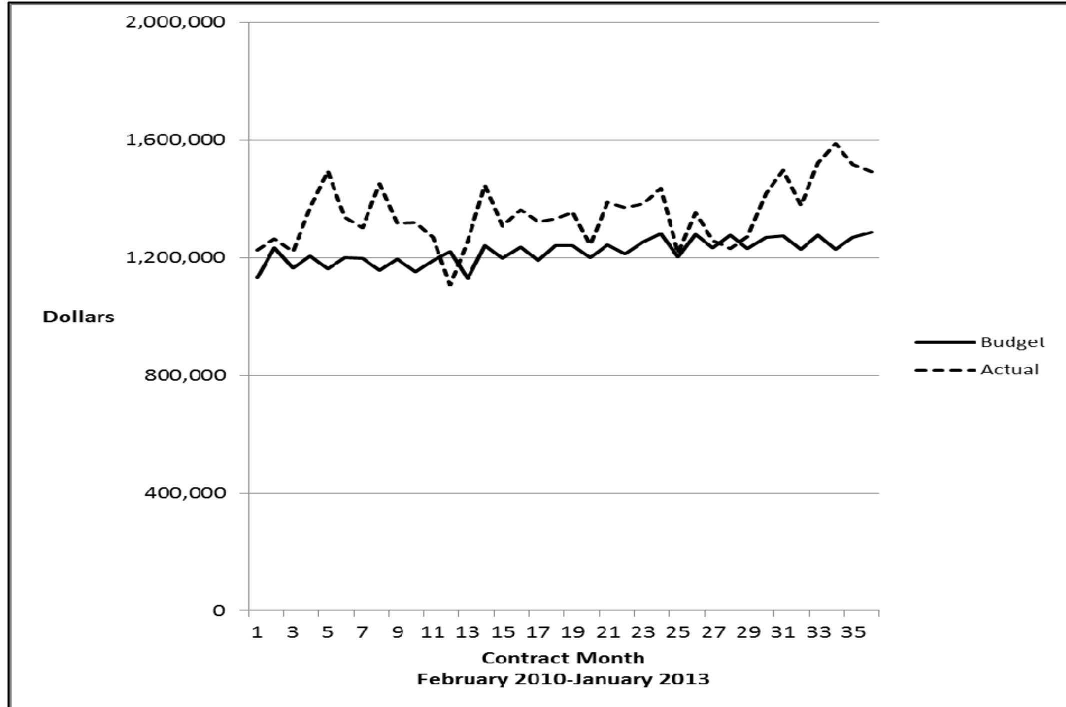
	Year 1	Year 2	Year 3	Total
Budgeted costs for health care services	$14,219,581	$14,671,912	$15,053,163	$43,944,656
Fixed management fee	1,700,000	1,700,000	1,750,000	5,150,000
Total base compensation	$15,919,581	$16,371,912	$16,803,163	$49,094,656
Actual costs for health care services	$15,677,276	$16,204,264	$16,742,118	$48,623,659
Actual management fee[b]	1,643,333	1,586,667	1,437,450	4,667,450
Total, actual cost and management fee	$17,320,610	$17,790,931	$18,179,568	$53,291,109
Amount actual costs exceeded budget	$1,401,029	$1,419,019	$1,376,405	$4,196,453

[a] Amounts may not add due to rounding.
[b] We subtracted from this line item: 1) a management fee reduction DOC assessed in years one and two and 2) penalties DOC assessed in year three.

[9] A cost-plus-management fee contract is a type of a cost-reimbursement contract.

CCS has consistently exceeded its budget throughout the course of the first three years of the contract. Figure 3 illustrates that CCS was over budget in the cost of providing health care services (i.e., not including the management fee) for all but two of the first 36 months of the contract.

Figure 3: Comparison of CCS's Actual and Budgeted Health Care Services Costs[a] by Contract Month



[a] These amounts only address costs associated with the health care services provided and do not include the contractor's management fees or adjustments for penalties.

DOC Cost Monitoring

Cost reimbursement contracts carry significant risk of overspending taxpayer resources, so it is important that the contracting entity have appropriate monitoring in place to provide reasonable assurance that the contractor is applying efficient methods and effective cost controls.

Invoices

According to state and federal internal control best practices, invoices should be reviewed for accuracy.[10] Invoice reviews ensure that services were actually received, the amounts billed are allowable, and the government is not incurring claimed costs that are inadequately supported. Every quarter, CCS is required to submit an invoice that includes a summary of its actual costs (called the quarterly true-up).[11] To support their invoices, CCS sends DOC a monthly budget-to-actual financial report that delineates the costs for specific line items, such as salaries, benefits, pharmacy supplies, and off-site expenses. This report can then be validated using underlying support, such as third-party invoices.

Until late 2012, however, the level of validation that was occurring was unclear and appeared to be lacking. The records that DOC provided related to cost performance in the first two years of the contract showed limited evidence of invoice reviews. Turnover of the DOC contract monitors may account for these limitations. The first contract monitor retired in December 2011. While the second contract monitor took over in this same month, she was only in this position until April 2012.[12] The position then remained vacant until the current contract monitor was hired in October 2012. According to DOC's financial director, although they searched for records related to financial documentation from the earlier time periods of the contract, they did not find many.

Since late 2012, DOC has implemented improved invoice review procedures including:

- Obtaining explanations and support for variances in the budget-to-actual financial report;

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[10] *Purchasing: Internal Control – Best Practices* (Vermont Department of Finance and Management, April 2007) and *Contract Management: Extent of Federal Spending under Cost-Reimbursement Contracts Unclear and Key Controls Not Always Used* (U.S. Government Accountability Office, GAO-09-921, September 30, 2009).

[11] The CCS contract requires the contractor to bill the state monthly for 1/12 of the annual base compensation (budgeted costs and management fee). Every quarter CCS submits an invoice that summarizes the actual costs for the prior three months and reconciles this amount to that which had been previously billed. If the reconciliation shows that actual costs were greater than what had been paid, DOC pays the difference (DOC would receive a credit if the actuals were less than what was paid).

[12] According to the DOC financial director, the second contract monitor continued to provide part-time monitoring assistance on the CCS contract until the next contractor monitor was hired even though she had taken a new position.

- Questioning the allowability and accuracy of the amounts that are shown on the monthly budget-to-actual financial report;
- Obtaining actual invoices for two of the largest expenditures—pharmacy and off-site expenses—which are provided by CCS subcontractors; and
- Reconciling anomalies with the contractor through explanations from the CCS financial office or obtaining contractor-prepared reconciliations when the invoices do not match the financial statement detail.

We conducted tests of CCS's actual costs reported for September 2010, April 2011, July 2011, November 2012, and January 2013,[13] in the three largest cost activities (salaries and benefits, off-site services, and pharmacy supplies) and did not find material questionable costs or errors.

Financial System and Internal Controls

According to the U.S. Government Accountability Office, cost-reimbursement contracts involve significantly more government oversight than do fixed-price contracts.[14] Accordingly, the federal government requires that the contractor's accounting system be adequate for determining costs related to the contract and that government monitoring provide reasonable assurance that efficient methods and effective cost controls are used.[15]

DOC relies on the accuracy and completeness of CCS's financial reports in its monitoring of the contractor's costs. However, DOC has not substantiated that it can rely on CCS's financial systems and internal controls to ensure that the reported costs are accurate and complete.

The importance of understanding how a contractor accounts for its financial activities related to the contract is demonstrated by CCS's approach to available discounts in its former and current pharmacy supplier subcontracts. These subcontracts allowed CCS to take a 1 percent discount for prompt payment. A CCS financial official told us that CCS generally takes these

[13] These tests were generally focused on three facilities—Southern State Correctional Facility, Northern State Correctional Facility, and Chittenden Regional Correctional Facility.

[14] *Contract Management: Extent of Federal Spending under Cost-Reimbursement Contracts Unclear and Key Controls Not Always Used* (U.S. Government Accountability Office, GAO-09-921, September 30, 2009).

[15] We used criteria from the federal government because the state does not have requirements or guidance pertaining to the monitoring of cost-reimbursement contracts.

discounts. The official informed us that DOC and CCS have an "informal" agreement for the current subcontract such that the discount will be passed on to DOC if Vermont pays its monthly invoices within the payment terms. CCS provided a spreadsheet showing that CCS passed on $8,331 in discounts for the January-June 2013 timeframe. However, CCS did not pass on any of the discounts that it took under the pharmacy supply subcontract that was in place from February 2010 to October 2012 (estimated at $1,300 a month). According to the CCS official, the discounts under the prior subcontractor were not passed through to Vermont because there was no agreement in place for this to be done. However, the contract defines an actual cost as those costs that are incurred as recorded in the books and records of the contractor, so we believe that any discounts taken by CCS should have been passed through to DOC. Although these amounts are not large in the context of the total contract, they demonstrate the risk taken under a cost-reimbursement contract when the contractor's financial methods are not understood and monitored carefully.

DOC's approach also entails a risk that it could be relying on financial reports that are generated by systems or internal control processes that have weaknesses. For example, during our walkthroughs of controls related to pharmacy supplies at three correctional facilities, we found a weakness in how CCS controls their unused and expired medications. At all three facilities, at least once a month unused and expired medications were returned to the primary pharmacy subcontractor[16] (see Figure 4 for a picture of a box of medications to be returned to the pharmacy subcontractor). This process reduces DOC's costs because in certain circumstances, the pharmacy subcontractor will credit CCS invoices for returns.[17]

Figure 4: Box of Medication in Blister Packs at the Chittenden Regional Correctional Facility To Be Returned to Pharmacy Subcontractor

CCS's policy states that medications placed in the box for return to the pharmacy subcontractor should be documented on a return form. CCS health service administrators (HSAs) noted that the return form was created when the box was full and ready to be returned. However, none of the facilities tracked what went into the box while awaiting return. As a result of this control weakness, we could not validate that all unused and expired medications were returned as intended, which indicates that there is a risk that DOC's costs were not being adequately reduced by the subcontractor's return process. Moreover, there is a risk that medications could be diverted.

[16] This process does not apply to controlled substances (e.g., narcotics), which are sent to a subcontractor for disposal.

[17] Under the current pharmacy supply subcontract, credit is issued for returned pharmacy items that are reusable under applicable federal and state laws and regulations. For example, credit is issued on full, unopened manufacturer's unit-dose packaged medications and full, unopened commercially pre-packaged bulk containers.

According to DOC's health services director, the department did not have a "how to" manual on how to monitor a cost-reimbursement contract, but since January 2012 it has implemented cost validation and monitoring processes to more fully understand what is being charged. We agree that DOC's recent documentation shows evidence of more rigorous monitoring of costs. This more rigorous monitoring, coupled with the limited length of time remaining until the contract ends, partially mitigates the risk associated with not doing a full evaluation of CCS's financial systems and internal controls.

Opportunities for Cost Savings

According to the federal Office of Management and Budget, there is a risk of wasteful spending when entities pay for expenses as incurred instead of agreeing on a fair and reasonable fixed price upfront for the delivery of a service. DOC's documentation (e.g., correspondence, emails, and meeting minutes) indicates that it expressed concerns to CCS about cost overruns and explored ways with the contractor to control costs. For example, in an April 2013 meeting between DOC and CCS executive staff, there was a discussion about staffing cost overruns, and the DOC health services director requested that CCS provide options to lower these costs. Nevertheless, during the course of our audit, we identified changes in CCS's approach that could reduce the State's costs related to inmate health care.

Bridge Medications

NCCHC standards state that for planned discharges, health staff should arrange for a sufficient supply of current medications—called bridge medications—to last until the inmate can be seen by a community health care professional. The DOC contract with CCS and CCS's policy are consistent with this standard (we did not identify a DOC policy that specifically addresses bridge medications). Both the contract and the CCS policy indicate that medication supply would be for a period of 7-30 days. The CCS policy allows the facility to provide inmates with their available blister package(s) of medication upon release if the quantity is less than or equal to the quantity being provided to the inmate upon release.

Instead of providing the inmate with the existing supply of his or her medication, CCS local health care officials return those drugs to the supplier and order a new prescription for the inmate to pick up at an community pharmacy. This is not a cost-effective practice because the bridge medication supplier is more expensive and CCS does not always receive credit for returned drug packages.

For example, using their January 2013 invoices, we identified 28 medications from the primary pharmacy subcontractor and the bridge medication

pharmacy subcontractor that had common National Drug Codes.[18] The bridge medication subcontractor's price was more expensive in every case.[19] To illustrate, for two inmates who were released from the Chittenden Regional Correctional Facility in January 2013, one received four bridge medications and the other three bridge medications for which CCS returned unused stock. The cost of these bridge medications was $1,329, and CCS returned the unused stock to the primary pharmacy subcontractor for a credit of $97. We estimate that DOC paid about $1,100 more than it would have if CCS had used their supply of the medications for the two inmates rather than ordering from the bridge medication supplier.[20]

The CCS health staff at the three facilities we visited stated that they were told not to provide on-hand medications to inmates upon release. Concerns cited were related to offenders that later denied receiving the medications and the lack of child-proof containers. However, CCS's written policy states that an inmate's existing medicine supply could be provided to the released inmate. Moreover, offenders used to sign a CCS form (including witness signature) acknowledging receipt of the medication and their responsibility for keeping the medication away from children. The CCS regional manager stated that the changes in how bridge medications were to be handled were discussed during a CCS monthly operational meeting but that the written policy had not changed.

Although there was documentation indicating that DOC was aware of this practice change, we found no evidence of DOC's approval of the change. The CCS contract requires DOC approval of the contractor's policies and procedures and states that they are subordinate to DOC policies and procedures. DOC's health services director stated that she has been communicating with CCS about this issue and has asked for support for CCS's position that medications that have already been purchased and are on-site at the correctional facility cannot be given to the exiting inmate.

It also appears that some inmates are given a greater quantity of bridge medications than may be required. For example, of the 524 prescriptions for

[18] The National Drug Code is a unique, three-segment number that serves as the universal product identifier for drugs.

[19] For example, for a 30-day supply, 1) Abilify® 20 MG tablets (used as an add-on treatment with anti-depressants) cost $826.15 from the primary pharmacy supplier and $965.49 from the bridge medication supplier and 2) Humulin® R U-100 insulin solution (used to treat diabetes) cost $73.11 from the primary pharmacy supplier and $87.44 from the bridge medication supplier.

[20] We included in our estimate the amount of medication that would have to be ordered from the bridge medication supplier to address those cases in which DOC returned a partial package of drugs to the primary pharmacy supplier.

bridge medications billed in November 2012 and January 2013, 447 (85 percent) were for a 30-day supply. In one of the three facilities that we visited, the HSA stated that the practice at that facility was to automatically place an order for a 30-day supply of bridge medications without consideration as to the inmate's next medical appointment.

Finally, inmates that are in a correctional facility for only a few days may receive bridge medications, even though they could have valid prescriptions at their pharmacies or at home. We found no DOC or CCS policy that distinguishes between short- and long-term inmates with respect to supplying bridge medications and, according to the CCS regional manager, there is no difference in the process for supplying bridge medications. One HSA told us that short-term inmates are provided with a 30-day supply of medications upon release although she noted that she will sometimes direct the applicable nurse not to submit the order if she becomes aware that the inmate has a supply at home.

Providing release medications to short-term inmates is significant because, according to DOC data, in almost 70 percent of the 7,479 releases from incarceration in fiscal year 2013, the inmate's length of stay was between 1-30 days.[21] Also, many offenders are on medication when they enter a DOC facility. For example, according to PCG, in September and October 2011, about 56 percent of all inmates processed into DOC were on at least one medication. Providing medications to inmates that may already have filled prescriptions at home not only increases DOC's costs, but it also adds to the risk that these extra medications could be misused in the community. According to the federal Drug Enforcement Administration, the abuse of prescription drugs is a serious social and health problem in the United States.

Insurance

DOC policy states that inmate resources, such as insurance coverage, will be used to meet medical expenses incurred for care of the offender beyond services provided by employees and contractors of the department. Accordingly, for complex cases, the contract requires CCS to ascertain whether the inmate has health insurance and to pursue collection on the State's behalf. In addition, CCS is responsible for helping inmates complete a Medicaid application.

[21] The length of stay was between 1-3 days for 2,963 releases, 4-7 days for 811 releases, 8-15 days for 731 releases, and 16-30 days for 698 releases.

We tested whether off-site services for inmates that were enrolled in Medicaid 1) had claims submitted to Medicaid for applicable services[22] and 2) did not result in payments by DOC and Medicaid for the same services. We identified no cases in which DOC and Medicaid both paid for the same service. However, we identified one instance in which Medicaid was not billed for an inmate who was hospitalized at a cost to DOC of $84,000. We traced the inmate referenced to the Medicaid Management Information System and found that the inmate was enrolled in Medicaid and that no Medicaid claim had been filed for the period in which he received services. According to the DOC contract monitor, this occurred because the claim was incorrectly coded and it was bypassed as being eligible for Medicaid.

With respect to other types of insurance, we saw evidence in one of the months used for our tests that CCS had established a receivable associated with workers' compensation insurance for an inmate who had been injured prior to being incarcerated. However, we did not see evidence in the test months of other types of private insurance being billed for inmate health care. A CCS senior vice president reported that the contractor seeks to collect this information. We asked the senior vice president to provide documentation illustrating that private insurance had been billed, when applicable. On August 22, 2013, he reported that CCS had no record that they had billed a third-party insurer other than Medicaid nor had the subcontractor that CCS uses to process claims for off-site services. The senior vice president also stated that the claims processing subcontractor for off-site services has not received any refunds from other insurers. Considering that CCS and its off-site services claims subcontractor have been in place since February 2010, the lack of any billings to a third-party insurer indicates that an effective process to identify other payers that could reduce DOC's costs is not in place.

Implementing an effective process to bill insurance companies is becoming increasingly important. According to legal advice sought by the health services director, under the Affordable Care Act, beginning in January 2014, a detainee may enroll in a qualified health plan prior to conviction and this plan can be billed to cover the inmate's health care costs. Accordingly, it would behoove DOC to ensure that CCS is collecting insurance information and billing for appropriate claims.

Potential New DOC Approach

Act 41 (2011) required the Agency of Administration, in conjunction with the Joint Fiscal Office, to conduct a study of how the State can best provide

[22] Medicaid does not pay for inmates' health care except for certain off-site care (e.g., inpatient hospitalization or nursing home care).

quality health care to persons incarcerated in Vermont at a cost savings to the State. In response to this requirement, DOC hired PCG in October 2011 to provide 1) a comprehensive and detailed analysis of all aspects of the correctional health care system, 2) recommendations to reduce costs and maintain a clinically appropriate level of care that can be implemented under the current DOC model, and 3) a long-term plan for a healthcare delivery system. PCG completed its work in January 2012.

As part of its analysis, PCG stated that it would not recommend that the State continue with its cost-reimbursement model over the long-term. PCG found that this approach does not allow for the contractor to develop new or innovative approaches. In addition, the PCG study outlined multiple operational models and various strategies for DOC to consider for reducing costs without sacrificing quality.

As part of the next phase in its Act 41 study, in March 2013, DOC contracted with Community Oriented Correctional Health Services to conduct analyses identifying strengths, weaknesses, opportunities, and threats in eight areas for five potential health care delivery models.[23] The eight areas are: 1) staffing; 2) continuity of care; 3) care planning; 4) capacity for data sharing; 5) procedures for prior approval, quality assurance, and utilization management, 6) data collection and metrics; 7) governance; and 8) finance. This contract's deliverables are expected to be completed by March 2014.

Objective 2: DOC's Monitoring of Contractor Performance Was Mixed, but Has Improved Recently

DOC's monitoring of contractor performance was mixed because although DOC employed various mechanisms to oversee CCS's activities, the department did not apply allowable penalties to prompt timelier contractor performance improvements. With respect to DOC's monitoring, the contract required CCS to submit regularly scheduled operational and financial reports, hold multidisciplinary inter-organizational meetings, and establish a quality assurance process. In addition, the contract includes performance guarantees that allow DOC to apply penalties if this monitoring determines that the

[23] The five models are the use of 1) OneCare, a joint venture between Fletcher Allen Health Care and Dartmouth-Hitchcock Medical center as the contractor, 2) Bi-State Primary Care Association of Federally Qualified Health Centers in Vermont and New Hampshire as the contractor, 3) a new non-profit or limited liability corporation that distributes services between local providers near each jail, 4) state employees hired by DOC, and 5) the Green Mountain Care Board as the organizational entity for correctional health care rather than DOC.

contractor did not meet certain performance expectations. DOC did not begin to reduce payments to CCS for penalties until December 2012, even though CCS had not fulfilled certain contractual requirements from many months earlier. Moreover, the penalties that were assessed did not cover all of the deficiencies. Accordingly, DOC did not effectively use one of the tools that it had available to prompt performance in accordance with contract requirements. Since DOC began assessing penalties, it has continued to apply them to monthly performance periods, when applicable.

DOC's Performance Monitoring Process

DOC's contract with CCS requires that the contractor provide a series of operational and financial reports. These reports are intended to provide DOC with basic information regarding health services activity in the facilities and a means to evaluate performance. Examples of these reports include those that address staffing levels at the facilities, how long it took for CCS to administer prescribed drugs or complete required health assessments, and how quickly CCS responded to inmates' requests for health care services.

CCS did not always provide required operational reports or the reports did not contain all required information. DOC provided evidence that they brought reporting deficiencies to the attention of CCS and attempted to resolve these deficiencies during the course of the contract. For example, in December 2010, DOC sent CCS a summary of the first year of the contract in which it stated that "there are a number of inaccuracies in both CCS financial and statistical reports and this is not acceptable. Data parameters that were agreed upon … have not been reported. As a result, data that would greatly assist in delivery management are not available." (Further discussion of this issue is contained in the subsection labeled Assessment of Performance Guarantees.)

DOC also regularly held a variety of meetings with CCS. According to the contract, these multidisciplinary, inter-organizational meetings are intended to identify inmate problems and opportunities for improvement, as well as to communicate quality improvement findings and to describe actions taken to resolve problems that are specific to health services. For example, since the inception of the contract, DOC and CCS have held monthly meetings at the executive level (called the Executive Health Committee) and quarterly meetings at the facility level (called the Medical Administration Committee) that are focused on health care quality. On the financial side, DOC and CCS hold executive business meetings. Other ad hoc meetings were also held to address specific operational issues.

Another critical monitoring piece is quality assurance. Since August 2010, DOC has used a contractor to perform quarterly independent audits of specific health-related indicators. The Vermont Program for Quality in Health Care

(VPQHC) conducted audits at the eight correctional facilities and provided DOC with quarterly and biannual reports. Examples of the health-related indicators reviewed by VPQHC include whether: 1) health assessments are completed within seven days of an inmate's intake, 2) the medical administration record matches the doctor's orders, and 3) sick call requests are triaged within the timeframes outlined by the contract. In addition, the CCS contract requires that the contractor maintain a continuous quality improvement program, which entails having the eight facilities conduct self-audits every month of samples of medical records for adherence to requirements. DOC's Health Services Division's quality assurance administrator checks the validity of the facility self-audit reports.

Assessment of Performance Guarantees

According to Vermont's contracting policy,[24] penalties should be considered for failure to meet standards or deliver products. The policy goes on to state that penalties should generally be assessed and reflected in the next invoice payment. Performance guarantee penalties were included in the CCS contract for times when the contractor failed to meet certain requirements, but assessment of penalties was at the discretion of DOC.

For the first three years of the contract period, DOC assessed a total of $331,100 in performance guaranty penalties and reduced the payments to CCS in the same amount. However, the first time DOC reduced payments to CCS as a result of assessed penalties was in the December 2012 quarterly true-up invoice. These penalties encompassed the performance period of January-June 2012. DOC sent CCS a letter announcing these penalties on July 31, 2012[25]—about two years after the performance guaranty clauses came into effect.[26] DOC applied additional penalties for the performance periods August, 2010 – December 2011 and July 2012 – December 2012 in the next quarterly true-up invoice.[27]

This is not the timely assessment of penalties as called for in Vermont's contracting policy. Moreover, the significant delay in assessing penalties may

[24] Vermont Agency of Administration's Bulletin 3.5, *Contracting Procedures* (July 15, 2008).

[25] CCS disputed some of these penalties and requested that they be reconsidered. DOC later agreed to abate some of the penalties.

[26] The contract did not allow penalties to be assessed in the first six months of the performance period, which was considered to be a breaking-in period.

[27] This quarterly true-up invoice encompassed the performance period November 2012 – January 2013. It was submitted and paid in March 2013.

account for CCS not addressing some of DOC's concerns. For example, in a September 2012 email, the DOC health services director observed:

> "It seems that the whole notion of creating reports for the purpose of documenting care and services and assessing performance were [sic] not taken seriously by CCS. There was no expectation that they would be paying penalties."

In taking so much time to apply penalties for performance deficiencies that had occurred many months earlier (in some cases about two years earlier), DOC lost the opportunity to offer a monetary incentive for CCS to correct its deficiencies in a timely manner.

DOC also did not assess all of the penalties allowed under the contract. To the extent data was available, we recalculated the penalties that could have been applied for CCS's performance at three facilities for five months. Our results, summarized in Table 2, demonstrate that DOC could have applied an additional $11,371 in penalties in these limited circumstances alone.

Table 2: DOC and SAO Calculations of Penalties for CCS Performance At Three Facilities[a] During Five Months[b]

Performance Guaranty	Amount Assessed by DOC	Amount Calculated by SAO	Difference	DOC's Rationale
No more than 100 inmate trips statewide for medical purposes of a non-emergent nature in any month. (Penalty = twice the actual costs for trips over 100)	0	$9,271	$9,271	The DOC health services director reviewed and determined the trips were medically necessary and that no penalties would be assessed.
Provide/administer pharmaceutical drugs for routine administration of on-going care within two hours of scheduled time. (Penalty = $500 per occurrence)	0	$1,500	$1,500	DOC abated the penalties based on subsequent explanatory information provided by CCS.
Provide/administer medications ordered stat[c] within 1 hour of the provider's order for medications immediately accessible onsite. (Penalty = $500 per occurrence)	0	0	0	
Provide/administer medications for which a prompt administration order has been given within two hours of the provider's order if stock supply is not available and a backup pharmacy must be used. (Penalty = $500 per occurrence)	0	0	0	
Pharmacy must deliver newly ordered prescriptions within 48 hours Monday-Friday; 72 hours Saturday and Sunday. (Penalty = $500 per occurrence)	0	0	0	

Performance Guaranty	Amount Assessed by DOC	Amount Calculated by SAO	Difference	DOC's Rationale
Failure to achieve a passing score (90 percent) in the quarterly independent quality assurance audit. (Penalty = $100 per failed indicator; maximum of $2,500 per quarter)	$17,500	$17,400	($100)	
Maintain NCCHC accreditation for every current and future facility in the state system. (Penalty = $500 per day per non-accredited facility)	0	0	0	
Meet dental staffing requirements or adequately control the size of the waiting list. (Penalty not to exceed $500/day for not providing adequate access to dental services)	0[d]	0[d]	0	
Qualified health care professionals to be hired to fill all posts in accordance with staffing standards and coverage schedules. (Penalty not to exceed $500 for each uncovered shift)	Neither DOC nor SAO could calculate whether penalties on this measure should have been assessed as CCS did not provide reports that would support such a calculation			
Provide timely response to inmate requests for health care services. (Penalty = $50 per request outstanding 48 hours Monday-Friday; 72 hours Saturday and Sunday)	$50	$750	$700	DOC did not calculate penalties on exceptions it determined to be reasonable.
Provide specialty services in a timely fashion (agreed-upon target date). (Penalty = $500 per day until services commence or $2,500 per incident if no resolution)	0	0	0	
Meet mortality documentation submission timelines and other mortality review requirements. (Penalty = $2,500 per occurrence)	0	0	0	
Develop an individualized treatment plan for each inmate diagnosed with serious mental illness. (Penalty = $250 per occurrence)	$1,750	$1,750	0	
Provide prescription drugs and/or other services in accordance with the mental health treatment plan. (Penalty = $250 per occurrence)	0	0	0	
Provide required operational and financial reports within prescribed time periods. (Penalty = $500 per report per month)	Not applicable to test. Penalties for reports are issued on a DOC-wide basis, not for individual facilities. See the following paragraph for information on penalties associated with reports.			

[a] The three facilities were Southern State Correctional Facility, Northern State Correctional Facility, and Chittenden Regional Correctional Facility.
[b] The five months were September 2010, April 2011, July 2011, November 2012, and January 2013.
[c] According to the contract, stat generally confers the presence of an emergent or urgent situation.
[d] In the earliest three test months, CCS did not provide documentation to DOC that would allow a determination of whether this standard was met.

Since DOC was relying on the contractually required operational reports as part of its performance monitoring of the contract, we also evaluated the penalties assessed on the timeliness of the required reports for all correctional facilities between September 2010 and January 2013. However, we could not perform a calculation of the amount of penalties that could have been applied because DOC's records would not support such an analysis. According to DOC documentation, between 2010 and mid-2012 CCS did not provide all

required operational reports or provided reports that were inaccurate or incomplete. In May 2012 DOC sent CCS a letter stating that it "requests the submission of all outstanding reports related to performance guarantees some of which are 18+ months overdue despite multiple DOC requests and CCS promises to deliver." Subsequent to this letter, CCS submitted all but four required reports dating from August 2010 to December 2011. DOC penalized CCS $105,000 for the four missing operational reports. We could not determine what the penalty amount should have been because DOC's records were insufficient to determine which reports were not provided in a timely fashion or which reports DOC did not consider usable for each month of the contract—the information needed to calculate potential penalty amounts.

According to the health services director, DOC management decided not to implement the full penalty amount because of turmoil between DOC and CCS surrounding the format and submission of operational reports that are used to assess contract performance. The director went on to state that animosity surrounding the report requirements and objections by CCS over penalties were beginning to taint negotiations for a contract extension, which were occurring at the same time. In addition, according to the health services director, DOC management forgave penalties for report delinquencies in exchange for a reduction in management fees in the last two years of the amended contract and a waiver of inflationary increases in future years (although this waiver only pertains to the CCS budget and not to actual costs that are reimbursable).

In addition, the contractor lacked an incentive to provide some reports where the penalty for not meeting the standard was likely greater than the penalty for not providing the report. The penalty for not submitting a report is $500 a month. However,

- CCS can incur a penalty of $500 per occurrence if it does not administer pharmaceutical drugs for routine administration of on-going care within two hours of the scheduled time. For a single month—September 2012—CCS incurred a $2,500 penalty.

- CCS can incur a penalty of $250 per occurrence if it does not develop an individualized treatment plan for each inmate diagnosed with serious mental illness. In March 2012 CCS incurred a $3,500 penalty.

- CCS is supposed to meet a minimum staffing requirement or else it can incur a penalty of up to $500 for each uncovered shift. This is significant because the agreed-upon staffing levels at each facility are based on the clinical needs of the inmate patients and the volume of care and nature of services to be provided. According to the DOC contract monitor, January 2013 was the first time that CCS provided a

usable report to DOC that allows the department to determine whether this requirement is being met.

The lack of timely application of all allowable penalties appears to be due, at least in part, to significant personnel and operational changes. In particular, from November 2010 to January 2012, DOC had a vacancy in the health services director position. During this timeframe, the chief nursing officer served a dual role filling in as the interim health services director. Further, there were also changes in the contract monitor and Tropical Storm Irene caused DOC's central office to relocate. Since the health services division only has five staff positions (another DOC staff member in the business office helps monitor the contract), such significant changes can be more difficult to absorb than in a larger organization. According to the interim health services director/chief nursing officer, her primary focus was on the clinical delivery and critical health care needs of the inmates.

DOC hired a new contract monitor in October 2012, who implemented a process to systematically track contractor performance against the contract's guaranties. Since December 2012, the cost monitor has been reducing payments to CCS for penalties associated with monthly performance periods, when applicable.

Conclusions

Cost-plus-management fee contracts are high risk contracting mechanisms for the State and require strong oversight to ensure that the State's objectives are met and its resources are used wisely. DOC did not initially implement an effective cost monitoring process and the first three years of the contract produced a cost overrun of $4.2 million. Moreover, CCS changed its practice for supplying bridge medications to one that is more expensive—passing those costs onto DOC. With respect to performance monitoring, DOC established a process that relied on CCS reports, meetings, and independent quality assurance audits. Nevertheless, monitoring was lacking because CCS did not provide complete and accurate reports in a timely manner and DOC did not assess penalties until many months after the performance period in which the deficiency occurred.

DOC has made substantial improvements to both their cost and performance monitoring processes in the past year. Nevertheless, to ensure that the State is not paying excessive amounts for the services that it is purchasing, DOC can take short-term actions to reduce its current costs and improve internal controls as well as long-term actions to reduce its risks in the implementation of health care delivery models under current consideration.

Recommendations

Short-Term Recommendations

We recommend that the Commissioner of the Department of Corrections:

1. Evaluate CCS's process for controlling unused and expired medications and ensure that controls are in place to provide safeguards that medications designated for return to the pharmacy subcontractor are accounted for and returned.

2. Develop a policy that minimizes the cost of bridge medications and directs CCS to ensure that this policy is consistently followed at all of the correctional facilities. This policy should include, at a minimum: 1) providing inmates with their on-hand medications upon release, where possible; 2) limiting the amount of bridge medication provided to the inmate to no more than that which is needed until a scheduled appointment date with an outside provider; and 3) establishing guidelines for when it is, and is not, appropriate to provide bridge medications to short-term inmates.

3. Ensure that CCS is collecting inmates' insurance information and billing their insurance for appropriate claims.

Long-Term Recommendations

As part of evaluating a new service delivery model for providing health care services to inmates, we recommend that the Commissioner of the Department of Corrections:

1. Select a more cost-effective contracting type than cost-plus-management fee.

2. Include a plan for a monitoring process at the outset of any new contract to provide reasonable assurance that effective cost and performance controls are in place as soon as the contract is enacted and that applicable penalties are assessed in a timely manner.

Management's Comments

On October 15, 2013, the Commissioner of the Department of Corrections provided a letter commenting on a draft of this report. Appendix III contains a reprint of the letter and our evaluation of one of the department's comments.

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In accordance with 32 VSA §163, we are also providing copies of this report to the secretary of the Agency of Administration, commissioner of the Department of Finance and Management, and the Department of Libraries. In addition, the report will be made available at no charge on the state auditor's website, http://auditor.vermont.gov/

Appendix I
Scope and Methodology

In addressing both of our objectives, we reviewed 1) DOC's contract with CCS, which included the request for proposal and CCS's best and final offer; 2) the State's contracting requirements and internal control guidance; and 3) monitoring requirements or guidance for cost reimbursement contracts issued by others. We also reviewed DOC directives that address inmate health care services.

Regarding the DOC's monitoring of CCS's costs, we obtained, reviewed, and summarized the contractor's invoices and monthly budget-to-actual financial reports for the first three years of the contract (February 1, 2010 to January 31, 2013). We discussed the DOC monitoring process with the health services director and current and former contract monitors and reviewed emails and other correspondence between DOC and CCS regarding cost issues.

We focused our review on three major cost areas: salaries and benefits, off-site services, and pharmacy supplies, which in total accounted for about 78 percent of the contract's costs in the first three years of the contract. We discussed how CCS tracks these costs with CCS central office officials. We also reviewed applicable CCS policies and performed walkthroughs of the time reporting process and off-site service and pharmacy supply invoice review process with CCS officials at three correctional facilities—Southern State Correctional Facility, Northern State Correctional Facility, and Chittenden Regional Correctional Facility. We chose these facilities because they had incurred the highest costs in the first three years of the contract.

We also performed testing related to costs associated at these three facilities for five of the 36 months of the original contract period, focusing on the three major cost categories. The months for which we performed tests were September 2010, April 2011, July 2011, November 2012, and January 2013. The following are examples of the tests that we performed:

- Confirmed that CCS's invoices were based on their reported costs.
- Confirmed that CCS had documentation that supported the facility-specific budget-to-actual financial reports.
- Compared the CCS staff members for the site listed in the payroll system used by CCS to the timekeeping system and confirmed that the timekeeping system provided support for the staff members and number of hours worked at the site.
- Confirmed that inmates listed on the pharmacy subcontractors' invoices were incarcerated at the facility at the time and that the CCS

medical records system supported that the drug on the invoice was prescribed and administered for 75 transactions.

- Confirmed that charges for off-site services were for patients who were in fact incarcerated at the time and that their medical records confirmed that off-site services were provided for 75 transactions.
- Compared the invoices from the off-site services subcontractor to recipient eligibility data in the Medicaid Management Information System to confirm that DOC was not charged for Medicaid claims.

With respect to our performance monitoring objective, we identified the various performance requirements in the contract and determined which had penalties that could be applied for non-conformance. For those requirements that included potential penalties, we obtained DOC documents pertaining to penalty calculations that they had performed and assessed. Based on documents provided by DOC, we independently calculated the penalties that could have been assessed and 1) verified DOCs calculations or 2) obtained an explanation for those penalties that were not assessed.

We also discussed the DOC performance monitoring process with the health services director, chief nursing officer, contract monitor, and quality assurance administrator. We obtained and reviewed the minutes of meetings held with CCS throughout the course of the contract period and reviewed the results of reviews of specific health-related indicators by DOC's independent quality assurance contractor, the Vermont Program for Quality in Health Care.

Our audit work was performed between January and early September 2013 at DOC headquarters in Williston, CCS's regional office in Waterbury, Southern State Correctional Facility in Springfield, Northern State Correctional Facility in Newport, and Chittenden Regional Correctional Facility in South Burlington. We conducted this performance audit in accordance with generally accepted government auditing standards, which require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Appendix II
Abbreviations

CCS	Correct Care Solutions
DOC	Department of Corrections
HSA	Health Service Administrator
NCCHC	National Commission on Correctional Health Care
PCG	Public Consulting Group
SAO	State Auditor’s Office
VPQHC	Vermont Program for Quality in Health Care

Appendix III
Reprint of the Commissioner of the Department of Corrections' Management Response and Our Evaluation

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Agency of Human Services

October 15, 2013

Douglas Hoffer, Vermont State Auditor
132 State Street
Montpelier, Vermont 05633-5101

Dear Doug,

I would like to offer up our sincere appreciation on behalf of the Department of Corrections and specifically the Health Services Division for the immense amount of effort put forth by your auditing team of June Sweeney, Linda Lambert and Hugh Pritchard. The team was extremely diligent, professional and organized. They attempted to allow a reasonable amount of time for our staff to respond.

I would also like to use this time to express my appreciation and gratitude to my staff that performed admirably. Dr. Burroughs-Biron feels that all of her staff and CCS' staff in the Regional and Corporate Offices were cooperative and forthcoming in their responses. Dr. Burroughs-Biron would in particular like to thank Ms. Debra Kobus, a fairly new employee, at the start of the audit for the tremendous effort displayed in providing reports and other documents to you that were not immediately in her possession or tenaciously seeking out those that were not. Dr. Burroughs-Biron is certain that without Ms. Kobus the audit would not have gone as smoothly as it did.

The Health Services staff agree that this was in fact a worthwhile learning experience which will be extremely valuable as they move forward toward an extensive change in DOC inmate health services that of potentially implementing a new model of care.

We have attached our management comments along with additional documentation noted as Attachments A, B, C, D, E.

Many thanks again to you and your staff. We will await your response.

Sincerely,

Andrew Pallito
Commissioner, VT Department of Corrections

CC: Sarah Clark, Financial Director, VT Department of Corrections
Delores Burroughs-Biron, MD, Health Services Director, VT Department of Corrections
Debra Kobus, Contract Monitor, VT Department of Corrections

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Agency of Human Services

REPORT OF THE VERMONT STATE AUDITOR – CORECTIONAL HEALTH CARE ANNUAL COST OVERRUNS, BUT CONTRACT OVERSIGHT HAS IMPROVED

Management Comments

Objective 1: DOC's Monitoring of Health Care Costs Has Not Ensured that Costs Are Minimized, But Improvements Made
Finding: "DOC's monitoring of CCS's health care costs has not ensured that these costs are minimized since the contractor spent $4.2 million more than was budgeted in the first three years of the contract."

DOC acknowledges that the costs of this contract have not been minimized but would add that the causes have been multifactorial and not completely within our control. We do feel that we have acted in a fiscally responsible manner in our efforts to minimize costs. We agree with the State Auditor's office regarding the nature of a cost plus fixed fee (a type of cost reimbursement contract) and offer up additional elaboration with the following quote from a U.S. Government contract document Air Force Materiel Command: Contract Types Module Lead))-ALC/PKCA, August 2007. "Cost reimbursement contracts are appropriate when there are technical and cost uncertainties that do not permit costs to be estimated sufficiently accurately and… This contract type permits contracting for efforts that might otherwise present too great a risk to contractors, but it provides the contractor only a minimum incentive to control costs". Cost plus fixed fee contract are based only on an estimate of actual costs. "Cost uncertainties and risk to contractors" echo from DOC's past.

An examination of the history of corrections healthcare contracts provides insight into the State's choice of this contract type dating from 2006. The State first engaged in the use of for profit correctional health care providers in about 1996. The first contracts used a capitated model with varying reports on the quality of services and care provided. Over a decade later (2006) this contract model gave way to the cost plus fixed fee model when the contractor gave 3 months' notice to terminate the contract declaring "We have chosen to give notice of termination to the Vermont Department of Corrections because the cost of providing healthcare to inmates has risen beyond the contract's ability to cover that cost." (The Vermont Guardian November 2006). The rising costs of providing Nursing services was specifically cited.

This type of contract has an inherent weakness (low incentive for cost control by contractor) however it makes a good effort in attempting to address the sometimes enormous "cost uncertainties and risks to contractors" inherent in the task of providing what is to some extent an insurance product to inmates, a relatively high risk category of beneficiaries. Even best estimates at predicting cost and best efforts at controlling costs will inevitably fall short. Cost drivers can be grossly divided into those over which DOC has had little if any control category (1) and others over which DOC has had a degree of control, category (2)

Cost drivers that contribute to cost overruns

Category (1)

1. Unpredictability of illness, disease and catastrophic events in the population (see Attachment A)
2. Corrections patients are by definition a population with high disease burden requiring higher level of intensive, and expensive staff resources
3. Corrections patients are by definition a population with high needs for mental health care and treatment (see Attachment A)
4. Constitutional requirements (eighth and fourteenth amendments) to provide health (medical and mental) care that by necessity have grown beyond provision of 'basic necessities' in keeping with bio-technological improvements in the diagnosis and treatment of diseases
5. Provision of care that is consistent with Vermont's standard of equitable care for all citizens

Appendix III
Reprint of the Commissioner of the Department of Corrections' Management Response and Our Evaluation

6. Vermont's unique (about one of 6 states) unified system (facilities, house, jail, prison and detainee populations) which creates conditions for rapid turnover and requires higher levels of staffing than one would expect for a relatively small population (see Attachment A)
7. Vermont's limited capacity to house all inmates in state results in the need for additional contractor staff to regularly process inmates for transfers out of state and back in upon their return
8. Vermont's limited corrections' willing and available workforce of nurses and other healthcare professionals requiring salaries beyond prevailing community parameters as inducement to work (See Auditor's report figure 2)
9. Vermont's limited workforce leads to high use of agency and contract staff at 1.5 to 2xs the usual cost of 'employed' workers
10. Vermont's inherent lack of economy of scale based on use of 8 facilities to house 1600 inmates increases cost due to need to have redundant systems
11. Use of contract model that successfully provides for a good quality of inmate services but which also has inherent cost risks to the State and is additionally not Vermont specific and that has not received adequate expert attention to the design of payment and oversight systems to manage the risk (lack of specific guidelines and adequate DOC staff resources)
12. Multiple changes in key staff over the course of the first 2.5 years of the initial 3 year contract (two turnovers each in Health Service Director (HSD), Contract Monitor (CM) and Quality Assurance Administrator (QAA).
13. Tropical Storm Irene- with significant disruption in DOC Central Office staff operations including initial loss of access to essential records and later difficulty locating documentation relocated during the move which could have provided additional support to work performed during this period
14. First time in Vermont Health Services contractor who was enthusiastic, but naïve, as to the implications of challenges (availability of and cost of work force, use of pharmaceuticals) inherent in providing services to inmates within Vermont's unique correctional system

Category (2)

1. The rigorousness with which DOC's Contract Monitor and Health Services staff engaged in cost monitoring activities although significant during the latter part of year one (the start of the penalty period) and year two was less than the threshold required to produce an effect upon CCS in the area of penalty assessment.
2. DOC Health Services Division should have assessed late penalties from the first overdue day on all reports delayed by CCS from August 2010 forward
3. More aggressive cost tracking and trending should have begun in the first month of the contract with requirement for CCS to develop more effective processes for monitoring and reporting costs. The Contract monitor developed a spreadsheet in the seventh month of the contract which demonstrated the upward trend which the Health Services Division used to develop a potential plan for limiting and attempting to control these cost including a reduction in Management Fee by CCS and cuts in staff positions.

Objective 2: DOC's monitoring of Contractor performance was mixed but has improved recently*
Finding: "DOC's monitoring of contractor performance was mixed because although DOC employed various mechanisms to oversee CCS' activities, the Department did not apply allowable penalties to prompt timelier contractor performance improvements"

DOC agrees that the penalties from the first 2 years of the contract were not assessed in a timely fashion. The major reason for this was the failure of CCS to uphold their responsibility to provide reports in a timely fashion which coupled with the loss of a key leadership figure, Health Services Director (HSD) in October of year one leading to a serious and significant reduction in an already small contract management team set the course. This small reduction of an already small team translated into a large loss. The Chief Nursing Officer served as Interim HSD with no backfill of her position. The Interim was not able to provide support to the Contract Monitor along with full oversight of both clinical operations (which place inmate care and life safety as high priorities) and financial operations which place cost control as a top priority. The application of late fees to the missing reports could have been used to motivate CCS to begin to provide the reports. Improvements in contractor monitoring were all clearly related to the return of the Health Services Division to fully staffed status in January 2012 and long-term stability of the team was achieved in October of 2012 with a new full-time CM. (see Attachment B). The Health Services Division team of year 1 and 2 performed admirably given the extent of disruptions in service and operations (TSI) and essential staff in that period.

1. Year one highlights in September 2010 the Contract Monitor analyzed all costs associated with the contract and developed three detailed spreadsheets Healthcare Contract Deficit Reduction Plan dated 10/12/10; Summary of Impact of proposed cost reductions dated 10/14/10 and Detail of proposed Cost reduction dated 1/13/11 rev (2). These outlined reductions in several areas including management fee, staffing, merit raises and inventories of supplies and prescriptions.
2. Intense discussions ensued with CCS ending with their agreement to take a reduction in management fees spread out over three months. The reduction totaled close to $170,000. Staffing saw a small reduction through attrition.

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Appendix III
Reprint of the Commissioner of the Department of Corrections' Management Response and Our Evaluation

Report of the Vermont State Auditor Correctional Health Care: Annual Cost Overruns, but Contract Oversight has Improved
Management Comments

3. Year two brought continued challenges despite which Health Services staff persisted in their efforts at bringing reports up to the DOC's standard multiple meetings and communications between the Interim Health Services Director, Contract Monitor, and CCS Regional Office Staff and Corporate staff related to contract cost and operational issues.
4. An MD consultant was hired to assist the Interim Health Services Director in managing the needs of the more complex patients and to review utilization patterns in off-site visits, formulary and other areas.
5. The Interim Health Services Director provided input and data to the PCG consultants and oversaw the Quality Contract with VPQHC and Medical Records audits.
6. The Interim Health Services Director's work and efforts in bringing CCS into contract compliance was hampered in large extent by an unexpected illness and lengthy medical leave (months) of a key CCS Manager as well as the resignation of the CCS Regional Medical Director in the same period of time (June 2011).
7. No permanent replacement was found for the CCS Vermont Regional Medical Director for approximately 6 months, coinciding with the return of the previous Health Services Director to DOC.
8. *Year 3 January 2012* saw the return of the previous Health Services Director and immediate implementation of more extensive cost monitoring including review of invoices, request for more detailed documentation regarding the highest costs line items-pharmacy, staffing including the use of contract and agency staff, off-site costs and requests for additional reports (see Attachment B)
9. Year 3 the Chief Nursing Officer was able to resume her regular duties which included the essential tasks of monitoring quality of services in conjunction with the QAA and oversight of inmate care involving skilled nursing components
10. Year 3 saw the hiring of a new CM who worked closely with the HSD in implementing cost controls and bringing the problem with outstanding reports to a satisfactory closure so that allowable discretionary penalties could be applied; this process took place over several months (see Attachment B)
11. Following additional discussion and pressure CCS began to provide DOC with operational and Financial reports upon which appropriate penalties and/or late fees have been assessed as determined by the CM; the contractor is allowed a period of review and requests for abatement on penalties which can take place over a period of time and may appear as a delay in assessment particularly given that DOC applies the penalties at the time of the quarterly true-up (referred to as reduced payments to… or applied to a period of time)
12. Contract negotiations began in June of 2012 during which the HSD and CM implemented additional reporting requirements as well as requested more detail on financial and operational report (see Attachment B)
13. DOC persevered through contract negotiations using late reports and their potential penalties ('virtual dollars') from a 14 month period as exchange for 'actual dollars' resulting in CCS' accepting a reduction in management fee of $268,000. CCS however was assessed a late fee on those abated fee reports. No further abatements will be given.
14. October the arrival of a new Contract Monitor (CM) essentially helped to bring the contract fully back on track so that all reports and penalty assessments are nearly current. The new CM has spent an exhaustive amount of time on developing a process for assessing penalties on the staffing reports including those which have been delayed in coming to DOC.

Short Term Recommendations

We recommend that the Commissioner of the Department of Corrections:

1. Evaluate CCS's process for controlling unused and expired medications and ensure that controls are in place to provide safeguards that medications designated for return to the pharmacy subcontractor are accounted for and returned.

DOC is in agreement with the Auditors and we requested that CCS provide a system of controls. Please see *Attachment C.*

2. Develop a policy that minimizes the cost of bridge medications and directs CCS to ensure that this policy is consistently followed at all of the correctional facilities. This policy should include, at a minimum: 1) providing inmates with their on-hand medications upon release, where possible; 2) limiting the amount of bridge medication provided to the inmate to no more than that which is needed until a scheduled appointment date with an outside provider; and 3) establishing guidelines for when it is, and is not, appropriate to provide bridge medications to short-term inmates.

DOC agrees that there may be a savings to be found in applying tighter controls and taking an alternative approach which was actually used in our previous contracts, to release medications. DOC began discussions with CCS prior to the audit and had already requested an analysis of the cost of bridge medications provided through blister pack versus using InMedRX. The analysis has shown a clear cost advantage with use of blister packs and use of on-hand medications, it is just as clear however that InMedRX also has advantages as well. The InMedRX system has great utility in our fast paced, high turnover prison jail (detainee) system. Supplying on hand blister-pack medications is possible and worked to a degree in our past contract and would meet the needs of some of our population. Providing a reduced supply of medications would not impose a risk to some releases; however, there may be a substantial number of releasees who would not have enough medications until they were able to arrange an appointment but even more importantly until they were actually able to keep that appointment. There is yet

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another group who without a secondary system would have no medications upon release. It is not unusual for inmates to attend a court hearing and to be released from jail following that hearing. They typically do not have their medications with them and therefore would be completely without. Vermont lacks a Mass transportation system, and many releasees lack other means of transportation by which they could return to the facility to pick up medications. The current process allows the inmate to notify medical who can then transmit the prescription to the releasee's local pharmacy. Poor medical and mental health follow up including lack of medications particularly for individuals with mental illness is linked to recidivism. The risk of medical or psychological decompensation in many of our patients seems to outweigh the cost of providing medications in adequate quantities and in a manner that offers options to accessibility. DOC is working with CCS on a more cost effective solution to release medications using a combination of on-hand blister packs and InMedRX or similar system as we attempt to ensure the physical and emotional stability of some of our most vulnerable citizens and indeed in some cases decrease the risk in our communities.

DOC is in the process of developing a more complete policy with CCS which will incorporate best correctional and community practices, patient needs and cost efficiencies in a manner that will consider the complex issues of Vermont's unique correctional system. See Attachment D interim policy guidance

3. Ensure that CCS is collecting inmate insurance information and billing their insurance for appropriate claims.

See Attachment E. DOC began plans for engaging in Vermont's Health Care Reform initiatives some time ago and recently we began working with Blueprint for Health and Navigators in Health Connect to enroll inmates in Health Benefit Exchange and where appropriate Health Benefit Plans.

Long Term recommendations

As part of evaluating a new service delivery model for providing health care services to inmates, we recommend that the Commissioner of the Department of Corrections:

1. Select a more cost-effective contracting type than cost-plus management fee.
DOC agrees with this long-term recommendation and we began to move in that direction with PCG report in 2011 and now in 2013 in Phase II of creating a Vermont specific inmate health services model anticipate that our Community Oriented Correctional Health Services (COCHS) consultants will provide us with information with which we may make informed decision that incorporate both quality of care and improved management of cost

2. Include a plan for a monitoring process at the outset of any new contract to provide reasonable assurance that effective cost and performance controls are in place as soon as the contract is enacted and that applicable penalties are assessed in a timely manner.

DOC agrees with the need for such controls to be in place as soon as possible and for penalties to be assessed in a timely fashion should these apply to a new contract. DOC's Commissioner and the Health Services Division were impressed with the auditor's expertise, professionalism, knowledge base in general and specifically as it now relates to corrections. With this in mind we feel that it will be to the State's advantage that we make a formal request for non-audit service relative to best practices and technical assistance as we develop our next contract model.

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Agency of Human Services

REPORT OF THE VERMONT STATE AUDITOR – CORRECTIONAL HEALTH CARE ANNUAL COST OVERRUNS, BUT CONTRACT OVERSIGHT IMPROVED
ATTACHMENT A

Management Comments

The contract is performance based and of moderate size with multiple areas (financial, operational, clinical, Quality Assurance and Improvement and performance guarantees) requiring oversight and monitoring The FY 2014 budgeted Cost ~$20, 000,000 for the provision of full non-copay medical and mental health services to each person incarcerated in DOC includes; on-site management of chronic disease, wellness, preventative care, health education, obstetrical and gynecological, urgent and emergent services, full pharmaceutical, dental, optometric, mental health individual and group counseling augmented by a Certified Recreational Therapist at some sites, psychiatric consultation, medication prescription and monitoring. 24/7 nursing (RNs, LPNs and LNAs) care is provided with on-site physicians, psychiatrists, dentists and midlevel providers by schedule. Off-site services as noted below. DOC operates 2 infirmaries and 1 Medical Housing unit for care of persons who may be terminally ill or otherwise too sick or frail to be allowed in general population. Incapacitated persons (~ 1,300/year) not considered incarcerated receive modified intake assessments and any necessary urgent or emergent services.

Population over the past decade (2001-2012) the population overall has grown with the peak in 2008 trending down from 2007-2011 with a slight increase from 2011-2012. On average inmates have grown older, are admitted with more medically complex conditions, co-occurring disorders and the number serving life or effective life sentences has increased; all of these are factors which impact the cost of care.

Facts and Figures 2012; Flow in full DOC Population was 6,696 (not including 1,300 INCAPS)
Unique Annual flow of Males 5,682 and females 1,014
ADP 2012; 2,102 with ~ 518 or 40% housed out of state population growth has outstripped housing capacity
Note *FY 2002 the ADP was 1,750; a 20% growth in a decade (now trending down 1.3% from 2011)
Detainees ADP 398 growth of 10.6% in one year
Unified System 55% of the population will come and go in < 1 year and 33% will come and go in < 1 month
Aging population-persons equal to and above age 50 increased by 14.6% from 2000 and 12.9% from 2010 to 2012
40.9% of all inmates were age 50 and over; 4.6% > age 60
Lifers- grew from 58 in 2001 to 146 in 2012

2012 Health Stats in brief (a little of what we track and monitor):
Nurses received and reviewed 34,921 sick slips of which;
Mental Health received 4, 973 sick slips
Dental received 2, 671 and
Medical received 22,233
Chronic diseases seen as visits =14,079
Mental Health Caseload- 40.7% of all males and 76.6% of all females
Medications ~ 5,000 prescriptions are written per month = 60,000/year about 38% are for mental health medications (also one of the most expensive groups)
FY 2013 Off site visits totaled = 2,648 (63% increase from 2012)
Diagnostic tests =542 (66% increase from 2012) includes MRI, PET scans, CT scans etc.
Specialty appointments = 1345 (60% increase from 2012) includes oncology, kidney dialysis, Neurology, Ophthalmology, Surgery etc.
ER visits = 340 (27% increase from 2012)
In-patient hospital days = 365 and (142% increase from 2012) includes treatment for cancer, cardiac bypass surgery, embolism, births, etc.
Out-patient surgery = 56 (a 56% increase from 2012)

Six State of Vermont employees monitor the entire in-state contract which includes care and services provided by the 122 FTE CCS employees in 8 Vermont facilities, DOC Health Services Division interfaces with the nine CCS Waterbury Regional Office management staff. The DOC inmate population is scattered throughout the state in 8 facilities (2 are work camps). The facilities are spread out in as many counties. The 6 State of Vermont employee's duties also include oversight of the health and mental health services provided by Corrections Corporation of America (CCA) to the 400+ inmates housed in Kentucky and other states on Interstate Compact. Each inmate housed out of state has originated from and received services in Vermont prior to transfer. The 6 State of Vermont employees are as follows:

1. Health Services Director (HSD) –on call for VT and CCA 24/7 365 days of year with vacations covered by CNO
2. Chief Nursing Officer (CNO)
3. Chief of Mental Health Services
4. Contract Monitor (Business Office Employee)
5. Quality Assurance Administrator (QAA)
6. Administrative Assistant

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REPORT OF THE VERMONT STATE AUDITOR – CORRECTIONAL HEALTH CARE ANNUAL COST OVERRUNS, BUT CONTRACT OVERSIGHT HAS IMPROVED
ATTACHMENT B

Management Comments

Auditor comment ***"DOC's cost monitoring of the contract was not robust during the earlier years of the contract but improved since late 2012"***

DOC respectfully offers the following corrections to the underlined portions of the above sentence.

See comment 1 in the table after DOC's response.

The reassembling of the full Health Services Division team and the resultant ability to focus more specifically on all aspects of the contract began in January 2012 not as noted in late 2012. This can be demonstrated through substantial documentation found in email, meeting minutes, written documents, detailed plans, notes and other forms of communication. The following briefly describes the highlights of only a portion of the activities:

1. The Health Services Division team officially began their work as a full team in late December 2011 the Interim Health Services Director (HSD) and Contract Monitor (CM) (1) communicated with the incoming HSD to determine a strategy for transfer of duties.
2. The HSD began work on January 9, 2012 as the Chief Nursing Officer (CNO/Interim HSD) provided a thorough handoff of the outstanding issues and problems needing attention.
3. The CNO who had doubled as HSD bridging clinical, operational and financial areas was able to return to her duties full time
4. The HSD requested and was provided a copy of the most recent financials in the month prior to her return these were reviewed in preparation for assuming the role.
5. The Health Services Division team met with Correct Care Solutions (CCS) in early January 2012 to discuss outstanding issues as focused on information provided by the Interim including staffing matrix, release medications, physician staffing reorganization and other operational and financial concerns.
6. On 1/18/12 the HSD and the Health Services Division team received a report out from the PCG on ACT 41 report (Feasibility Study) which set forth short and long term recommendations; on 1/18/12 the HSD determined a plan and course of action relative to those recommendations.
7. On 1/24/12 the Health Services Division held another meeting with CCS regarding "telepsych and medications and staffing".
8. The HSD and new CM(2) met and determined that they would undertake a more detailed review of all costs based on the preceding year's financials.
9. The HSD and team arranged multiple meetings with CCS on multiple topics having to do with all aspects of the contract.
10. Early February discussions were underway with the Regional Medical Director at CCS regarding the control of costs of various classes of medications.
11. The HSD in anticipation of Community Health Centers (CHC) potential involvement in correctional health care began exploring alternative possibilities for an interested CHC to provide pharmacy services this discussion took place over several months and involved a detailed cost analysis and comparison between the CCS pharmacy and CHC pharmacy.
12. 2/27/12 the HSD sent the following to email request to a CCS Corporate office official "*I am in the process of reviewing our current contract budge and financial data from CCS retrospectively and prospectively and to meet this end I am kindly asking that you send the following documents electronically;*
    - *All contracts including all rate and other monetary agreements negotiated and held by CCS on behalf of VTDOC*
    - *All MOU/A meeting the same criteria as in number one*
    - *Other agreements, contracts or documents on monetary value not otherwise included that pertain to the provision of healthcare services to VT inmates or in the operation of the VTDOC/CCS contract"*
13. The ensuing response provided some of the requested contracts which were reviewed resulting in my request for additional information regarding more detailed information on pharmacy costs including additional reports containing re-stocking and dispensing fee information.
14. Based on information obtained in the review of pharmacy costs and quality of data provided a decision was reached to begin the discussion of using another pharmacy provider who offered a different pricing structure.

15. During this same period (email dated 2/1/12) the CM (2) sent an email to the CCS Corporate Accounting Manager relative to an a true up invoice requesting backup and detail as to how a specific credit was calculated.
16. The CCS Corporate Accounting Manager then provided further financial data from FY 2011 which the CM reviewed *information provided in that email substantiated that a Financial Meeting had been held between CCS and DOC April of 2011.
17. 2/23/12 CM(2) sent an updated (2/3/12) Performance Guarantees Report via email to CCS Regional Office Manager noting that she had reviewed the contract and needed to know how to verify and match specific reports to specific sections of the contract and performance guarantees –the list of contract sections was provided. The information was discussed in the financial meeting 2/29/12 and during a follow-up meeting between the CM (2) and the ROM on 3/20/12.
18. The CM(2) and HSD requested a Financial meeting with CCS which was held in VT on 2/29/12- copies of the general ledger were requested for our review and discussion during that meeting- staffing reports were discussed and CCS again stated they were forthcoming.
19. Additional information requested for the 2/29/12 meeting included the composition of costs of 15 separate line items reported for Financials of November and December of 2011.
20. 3/7/12 email from CM to HSD re: continued oversight and approval of CCS capital expenditures as request for purchase of $5,000 stretcher- explored use of VSH stretchers unable to use due to size then performed cost comparison on internet finding similar item at ~30% less cost and no tax to State.
21. 3/12 The CM (2) began to calculate and assess penalties related to the Medical Records audits for entire contract period to date.
22. 3/14/12 HSD review of financials for 12/11 raises questions re: billing of time for coverage of VT positions by Corporate staff that seemed to raise questions regarding transparency these were addressed after review of CCS' Best and Final Offer (BAFO)
23. 3/21/12 – CM(2) follow-up to meeting (3/20) email to CCS Regional Office Manager (ROM) regarding " CCS reports and missing information which she provided in detailed spreadsheet; date set for completion 3/26 provided agreement being reached on their completeness. CM requested reports due from 8/10-3/12 in reverse order. Request made for electronic copy of staffing matrix and repeat request for November December financials.
24. Documentation exists over the next several weeks and months of detailed reviews of financial and operational data and VTDOC insisted on resolutions to problems based on these findings; for example the HSD determined that questionable spending existed in travel expenses and use of employees to pick of medications rather than couriers at certain sites (a contract requirement). Memo dated 3/19/12.
25. HSD and CM(2) review of financial lines related to travel by Regional Office Manager (ROM) resulted in curtailment of what seemed to be excessive out of state travel to CCS headquarters which was being charged to the contract.
26. During this same period of time the Health Services Division was also charged with formulating a plan to explore implementation of the recommendations from the PCG report which could potentially result in a financial savings to the State-this involved multiple meetings and time consuming research.
27. HSD sent memo to ROM 3/27/12 "Cost Containment and Transparency in Spending" for distribution to all staff-memo outlined cost reductions and care improvement in area of pharmacy.
28. Health Services Division determines that problem exists in payment of claims for Feds, ICE and ISC inmates (problem with unpaid bill) leads to request for reconciliation on denied claims. Meeting held with CCA Corporate.
29. April 2012 the CM(2) received a promotion and began to work both the new job and as CM(2)-despite this and slow progress by CCS in completing the reports to our liking they were finished in May and underwent review by Health Services Division and necessary calculations and finalization was made by the CM.
30. 4/4/12 email to ROM from HSD and CM(2) re: agenda for meeting on pharmacy expenses, reduction in agency usage and off-site costs and improved accountability for site expense reporting
31. 4/23/12 HSD, CNO and CM (2) met to discuss and follow up on outstanding reports (8/2010-present). CM(2) developed process to provide summary page for each month and link with dates of request contact and also began work on matrix reconciliation required for staffing reports
32. During the many months during the transition of the CM(2) to her new position and hiring of a new CM(3) the HSD performed a monthly review of all documents sent to her in detail including the financial, operational and QA/QI aspects of the contract. This resulted in a request for additional reports and invoices for validation of costs as needed and regularly for the area of medical supplies, pharmacy, petty cash expenditures by each site, site expense reports. Additional reports developed and requested by the HSD included the following:
    1. CBA Blue to VHAP Reconciliation - Quarterly
    2. Clean Claims Report - Quarterly
    3. Assets by Location - Monthly
    4. General Ledger Detail - Monthly
    5. Reserve Analysis - Quarterly
    6. Medical Dental Supply Invoices - Monthly
    7. Supplies summary (accompanies above document) - Monthly
    8. Offsite adjustment detail - Monthly

33. An additional 7 reports for monitoring contract costs were requested by the Contract Monitor (prior to leaving) and the HSD in the first 6 months of 2012.
34. The HSD and the new CM (3) as of October 2012 requested CCS provide pharmacy reconciliation report.
35. The new CM (3) has requested two additional new reports and developed several others since starting in October 2012.
36. 11/2012 Cost monitoring and validation also occurred through a comparative analysis of CCS' Specialty Pharmacy Costs (HIV, Hepatitis C, Immune modulator Meds) conducted by the QAA at the request of the HSD with those of the supplier of these medications for the State, Briova Pharmacy. The outcome of the comparison revealed that the costs paid under the contract were competitive and there was not much to gain through changing supplier.
37. DOC Health Services currently and throughout the majority of this contract has received and reviewed **543** total reports from CCS the majority on a monthly basis; of these, **81.45** are financial and; **493** are operational reports dealing with every aspect of the contract. **15** new reports were added from January 2012 through December 2012. Reports include credentialing, grievance, monthly statistics, quality assurance and performance improvement, off site health care, chronic disease statistics, demographics, nursing staff meetings, infirmary census and admission data and inmate health education, intake statistics, INCAP statistics, mental health and medical sick call stats, dental stats to name a few.

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REPORT OF THE VERMONT STATE AUDITOR – CORRECTIONAL HEALTH CARE ANNUAL COST OVERRUNS, BUT CONTRACT OVERSIGHT IMPROVED
ATTACHMENT C – *SHORT TERM RECOMMENDATIONS 1*

Management Comments

1. **Evaluate CCS's process for controlling un-used and expired medications and ensure that controls are in place to provide safeguards that medications designate for return to the pharmacy subcontractor are accounted for and returned.**

   CCS Response: CCS has engaged the pharmacy provider for the Department to provide locked containers for the purpose of securing un-used and expired medications and to ensure that controls are in place. Each site will have one such containers onsite within the next two weeks and the containers will be kept in a secured area. The containers are standalone wooden locked cabinets that have a slot in the front for nurses to drop med cards into, which then cannot be retrieved, unless the unit is unlocked by the appropriate personnel. CCS will adopt and enforce the following outlined pharmacy protocol related to returns, discontinued and expired medication collection and controls.

   VERMONT/MAXOR PHARMACY RETURNS PROCEDURE

   A. As Returns, Discontinued, and Expired medications are collected, write them up on the Maxor Correctional Pharmacy Services Record of Release/Receipt of Drugs returns form. The Bar Code Refill Sticker from the prescription label may be used in place of writing the RX#, Drug Name, and Strength. Be sure to write in the quantity of each medication being returned and if it is a full or partial package. Be sure to write in the information requested at the top and bottom of the form. (Alternatively, a list may be created using the Web Pharmacy Application and the barcode scanner)

      (i) Peel the bar code refill label, or handwrite if no refill label left on card, and affix to the Record of Release-Receipt of Drugs form. Write the quantity of drug remaining into the right hand column of the form.
      (ii) Ensure staff processing returns has access to the active Record of Release-Receipt of Drugs form so that additions can be made as needed.

   1. Place all returns, discontinued, and expired medications in the designated locked box labeled pharmacy returns, except Controlled Substance medications.

2. Expired and discontinued Controlled Substance medications will be handled at the site level in accordance with State and Federal regulations. Do not send Controlled Substance medications back to Maxor Correctional Pharmacy Services. The site administrator has information for handling of discontinued and expired Controlled Substance medications.

3. When the locked container is 1/2 full, remove cards and prepare to return to pharmacy in a cardboard box, make copies of all returns forms for your files. The stationary locked box will remain locked at all times except when designated employee is preparing medications for return to pharmacy.

4. Reconcile the Record of Release-Receipt of Drugs form against the returns box contents just prior to sealing the box for shipment. Sign and date the form at the bottom.

5. Make a photocopy to place in the box. Keep a copy for your records. Peel off the bar coded FedEx tracking portion of the shipping label and affix to your copy of the Record. Files must be kept on-site and readily retrievable for at least three (3) years. Check your State regulations for exact length of time.

6. Returns forms must be sent with the returned medications to Maxor Correctional Pharmacy Services to the attention of the Credit Department.

7. Call the Customer Service Department at Maxor Correctional Pharmacy Services and ask for a Fed Ex or UPS call tag for all boxes. They will ask for the number of packages and approximate weight. Inform Customer Service if Refrigerated items are to be returned.

8. Arrange for Return boxes to get to Fed Ex or UPS delivery personnel.

CCS will train its staff on the implementation and execution of the above policy to assure compliance with the same.

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ATTACHMENT D – *SHORT TERM RECOMMENDATIONS 2*

Management Comments

This Policy is in development but minimally until complete the following will occur

1. **Develop a policy that minimizes the cost of bridge medication upon discharge and directs CCS to ensure that this policy is consistently followed at all of the correctional facilities.**

   CCS Response: CCS practice and procedure complies with the following:

   - Nurses have been instructed to have Medication Verification Form filled out in its entirety upon a patient's admission into the facility; this would include date last prescription picked up and how many refills remaining on active script.
   - Nursing will check with patient once discharge date is known as to when follow up appointments are to occur and order only prescribed amount of medication needed till follow up appointment date.
   - If a patient is incarcerated less than 30 days nursing will review medication verification form to see when last prescribed meds were picked up and if no changes in meds, verify with patient that they have these meds at home. If new meds ordered since incarceration they will inquire as to when follow up appointment with provider is scheduled and order limited amount of new med.
   - If a patient has recently received inhaler medications nurses will complete appropriate documentation in ERMA, and have appropriate forms signed by patient and not order new inhalers but give patient his specific inhalers to go home with.

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ATTACHMENT E – *SHORT TERM RECOMMENDATION 3*

Management Comments

1. **Part I: CCS should collect insurance information.**

   CCS Response: CCS does collect insurance information from inmates. The intake process includes CCS staff questioning the inmate whether they have insurance or not, and if so what the insurance is. Should the patient subsequently require healthcare services offsite, CCS's policy is to instruct the provider (local hospital, physician's office, etc.) to bill such insurance as primary. As a general rule of thumb many (although not all) insurance companies do not maintain coverage once an individual is incarcerated, and nearly all insurance companies will deny coverage if an individual requires medical care as a result of criminal conduct – for example if an individual is injured by the police while being arrested. Medicare does not cover incarcerated individuals at all, nor does the Veteran's Administration. Medicaid, as we know, will provide coverage to inmate inpatients in certain circumstances which can and do vary by state.

   Part II billing – Addressed Above

   CCS Response With respect to VTDOC inmate insurance coverage, an ad hoc IT report for the nine months ended September 30, 2013 was run yesterday and is currently being analyzed. The report does show that while many inmates stated they have coverage, the overwhelming majority (approximately 95% +) of responses listed either "Medicaid" or "VHAP". Nearly all the remaining responses were noted as "Blue Cross" or some variant of Blue Cross. The listing is being analyzed and compared to payments made or not made for services during this same time period (which is a manual process), and we will provide the results as soon as they are available. The results are anticipated to available by October 11th.

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The following presents our evaluation of one of the comments made by the Commissioner of the Department of Corrections.

Comment 1.	DOC disagreed with our statement that its cost monitoring had improved since late 2012; asserting that the improvement began in January 2012 and providing a list of activities that it had performed throughout 2012. We reviewed the totality of our evidence related to DOC's cost monitoring in 2012 and considered the list of activities included in DOC's response to the draft report. Based on this review, we believe that our statement accurately reflects the condition of DOC's monitoring of costs during the course of the contract period in the scope of our audit.