Special Report

Department of Public Safety and Correctional Services

Monitoring of Contractor Performance for the Assessment of Liquidated Damages Under the Inmate Medical Healthcare Service Contract

September 2017

OFFICE OF LEGISLATIVE AUDITS
DEPARTMENT OF LEGISLATIVE SERVICES
MARYLAND GENERAL ASSEMBLY

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September 12, 2017

Senator Craig J. Zucker, Co-Chair, Joint Audit Committee
Delegate C. William Frick, Co-Chair, Joint Audit Committee
Members of Joint Audit Committee
Annapolis, Maryland

Ladies and Gentlemen:

We conducted a special review of the Department of Public Safety and Correctional Services' (DPSCS) monitoring of contractor performance for the purpose of assessing liquidated damages under certain provisions of its inmate medical healthcare service contract. Services under this contract began in fiscal year 2013 and during fiscal year 2016, contract payments totaled approximately $100 million. The review was conducted under the authority of the State Government Article, Section 2-1221 of the Annotated Code of Maryland and was based on a legislative request.

DPSCS had established a process to pursue liquidated damages when required statewide medical staffing levels were not met and had properly assessed liquidated damages totaling $2.8 million during fiscal year 2016 for contractor staffing shortfalls. However, processes were not in place during that year for assessing damages for two other contract requirements we specifically targeted for review because they were also deemed by DPSCS to be vital for the quality of inmate healthcare. These requirements relate to the initial reception/intake examinations (RIE) and the administration of medication.

Our inquiries also disclosed that, in addition to these two requirements, DPSCS had not established a process to review or prioritize for review contractor performance for the 38 other contract requirements with liquidated damages provisions. The results of clinical audits to assess quality of care, which had identified performance deficiencies, were not considered by the unit responsible for monitoring contractor performance to target its efforts for the purpose of assessing damages.

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DPSCS did not verify that the contractor conducted complete RIEs for at least 98 percent of inmates within seven days of intake on a statewide basis, which is the standard under which liquidated damages ($50 per occurrence) may be assessed. We noted that contractor's reports containing the dates RIEs were conducted did not necessarily mean all required exam procedures had been completed at those dates, thus affecting reliability. Even when the contractor reported untimely or incomplete RIEs that were below the 98 percent threshold, DPSCS did not assess liquidated damages.

DPSCS had no procedure to verify that the contractor complied with the requirement to provide an individual medication dose to each inmate (generally within two hours of receipt from the pharmacy contractor) or that each individual medication was documented in the medication administration records. Liquidated damages may be assessed at $200 per occurrence below a 95 percent threshold. According to DPSCS, about 104,000 medication orders are administered statewide each month, including 25,000 orders individually administered to inmates by nursing staff.

The lack of automated reports was an impediment to effectively determining the full extent of contractor noncompliance for the purposes of assessing liquidated damages for RIEs and medication administration. For example, contractor reports for RIEs did not contain the necessary data to determine the full extent of untimely RIEs that may have occurred because the reports did not list each required attribute (for example, a specific medical test) and when it was conducted. Furthermore, due to limited reporting capabilities, this information was not readily available from DPSCS' electronic patient health records.

In the absence of automated reports, DPSCS could have used sampling techniques, which would provide a reliable basis for determining the magnitude of any existing problems, gauging overall contractor performance, and assessing liquidated damages. However, for several reasons, DPSCS has chosen not to use sampling techniques even though it was allowed under the contract.

DPSCS' response to this review is included as an appendix to this report. We wish to acknowledge the cooperation extended to us during the course of this review by DPSCS.

Respectfully submitted,

Thomas J. Barnickel III, CPA
Legislative Auditor

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Background Information

Inmate Healthcare Service Contract

In fiscal year 2012, the Department of Public Safety and Correctional Services (DPSCS) entered into a five-year inmate medical healthcare service contract, to provide inmate medical services within DPSCS detention and correctional facilities. As of November 2016, there were 27 detention and correctional facilities covered by the contract and according to DPSCS records, the average daily population was 22,132 inmates.

The contractor is the primary provider of somatic (physical) medical services to inmates using various categories of medical professionals. The contract also has a utilization management component whereby the contractor acts a gatekeeper by referring inmates to other community healthcare providers when certain specialized medical services (such as dental care, mental health counseling, and specialty care) are required, but cannot be obtained on-site. The scope of services to be provided under the contract includes but is not limited to

- an immediate intake screening of inmates upon arrival at a DPSCS facility to determine whether hospitalization or infirmary care is necessary;
- performing a more detailed medical exam of each inmate within seven days of arrival at a DPSCS facility to determine whether each inmate requires routine follow-up care, specialty care, or no additional treatment; and
- prescribing and administering medications to inmates.[1]

Under the original terms, the contract was to terminate on June 30, 2017; however, the Board of Public Works on May 24, 2017 approved a six-month extension through December 31, 2017 while a new contract procurement is being finalized.[2] The original contract was an annual fixed price contract billed semi-monthly with a not to exceed amount of $598 million. On April 17, 2013, a $2.3 million contract modification was approved to obtain enhanced telemedicine services, increasing the five-year total contract value to $600.3 million. After the third year of the contract, the contract amounts were subject to annual evaluation and adjustment based on the consumer price index, but this did not affect the total

[1] The medical healthcare services contractor is responsible for prescribing and administering medication to inmates, but the drugs themselves are obtained from a vendor under a separate DPSCS contract.

[2] A request for proposal for the next contract was solicited on December 29, 2016 with proposals due by May 10, 2017. The review and evaluation of this procurement was not included in the scope of this review.

contract value. The contract was also subject to an adjustment for variations in the inmate average daily population for the month. According to DPSCS records, payments to the contractor over the four-year period ended June 30, 2016 were reduced by approximately $20 million due to lower average daily populations and $8 million for liquidated damages.

According to DPSCS records, total payments for this contract during fiscal year 2016 were approximately $100 million. According to the related contract solicitation documents it was anticipated that labor costs would constitute 95 percent of the total contract value. The contract with the medical service contractor contains staffing requirements expressed as full time equivalent (FTE) positions for each position (for example, physician and registered nurse). For fiscal year 2016, the number of contractor positions budgeted for the medical services contract was approximately 748 FTEs. The contract also allows the contractor to receive reimbursement for allowable and approved expenditures, such as for the purchase of equipment. The contractor is paid a fixed amount each month and submits a monthly staffing report for each facility and service delivery area (SDA).

Liquidated Damages Provisions Within the Contract

Section three of the related request for proposal (RFP), which was incorporated by reference into the inmate healthcare service contract, listed the scope of work to be provided under the contract. The scope included numerous specific contract requirements in approximately 130 pages, including those related to contractor staffing, reporting, the performance of inmate reception/intake, annual, and periodic physical examinations, sick call, medication administration, chronic care clinics, and certain specialty care.

Forty-one of the requirements included in the contract had provisions for liquidated damages when the contractor's performance did not meet certain goals or benchmarks. These liquidated damages provisions are shown in Exhibit 1. Since it is impractical or extremely difficult to correlate an actual dollar amount of damage for the failure to perform up to a specific requirement, the RFP sets forth the actual dollar value of the liquidated damages for each of the aforementioned 41 requirements. The contract documents stated that such amounts were to be considered liquidated damages and not penalties, and permitted DPSCS to deduct any liquidated damages assessed from amounts due to the contractor or bill them as a separate item.

Examples of critical requirements with liquidated damages significantly influencing the level of care an inmate receives include contractor staffing levels, reception/intake examination (RIE), and medication administration.

Staffing Levels

The contract required the contractor to maintain certain monthly clinical staffing levels. The clinical staffing positions consist of medical directors, physicians, physician assistants (or certified registered nurse practitioners), registered nurses, licensed practical nurses, and phlebotomists. In accordance with the contractually required staffing plan approved by DPSCS, the contractor was to provide a certain level of FTE positions for each staffing position in each of the four geographic SDAs established by the contract (Eastern, Western, Jessup, and Baltimore).[3] Although there was a unique staffing plan for each facility in an SDA, DPSCS was only entitled to recover a portion of the contractor's monthly fee by assessing liquidated damages to the extent staffing levels were not met at a statewide level. Specifically, the contract allowed the State to assess damages at the contractor's hourly billable rate for any clinical position that does not meet the 96 percent minimum fill rate per position, in aggregate, at the statewide level.

In accordance with the contract, the contractor was required to use a biometric time and attendance system. Contractor staff use a biometric fingerprint swipe to clock-in and clock-out on days worked. The software contains data analysis capabilities and note taking capabilities, including recording any changes made to staff schedules or any changes made to employee's time and attendance records to determine abnormal staffing behavior. DPSCS had read-only access to this time and attendance system. This system data is the basis for contractually required clinical staffing reports submitted to DPSCS monthly by the contractor; DPSCS reviews these reports, which serve as the basis for assessing liquidated damages.

Reception/Intake Examination

The contractor is required to provide an initial reception/intake health and physical exam (RIE), which functions as a preliminary medical health screening, within seven-days of an inmate's entrance to a DPSCS facility. The RIE is to include a hearing and vision test, oral screening and initial dental examination, relevant diagnostic testing, and an assessment for any necessary follow-up requirements, such as a referral to DPSCS' dental contractor or a chronic care consultation.

DPSCS' Offender Case Management System (OCMS) is a server-based system, which contains data on, and is used to manage and monitor, arrestees housed by

[3] For service delivery purposes, the contract assigns each DPSCS facility into one of four service delivery areas based on their geographic location.

the Division of Pretrial and Detention Services and inmates incarcerated by the Division of Correction. Upon intake of an arrestee at a facility, the contractor performs a preliminary medical health screening using the Intake Medical/Mental Health Screening (IMMS) form that identifies and addresses any urgent medical, mental, or dental needs. Subsequently, the contractor has seven days to complete an RIE, which is a comprehensive medical evaluation that is documented in the Electronic Patient Health Record (EPHR). The IMMS form, and the information it contains, is to be documented within the OCMS and then electronically transferred to the EPHR, which is established following the inmate's commitment. The findings of the RIE and any follow-up needed are required to be documented immediately in the EPHR. The contractor provides a report documenting the seven day RIEs that it performed each month to DPSCS.

The contractual RIE requirement reads, "Conduct a complete medical health examination on all inmates, including parole violators and escapees within 7-days of reception. Provide medical intake evaluations every day." The defined performance standard from a liquidated damages perspective is any occurrence of a failure to perform the above and the amount that may be assessed for damages is $50 for each occurrence of an RIE not completed below a 98 percent threshold.

Administration of Medication

The medical contractor is responsible for administering prescribed medications to the inmate population. A paper monthly medication administration record is maintained by the contractor for each inmate who is prescribed medications, to document the dates and times the medications were administered by clinical staff, and to document the reason for any missed medications. The contractor is required to properly document medical administration records in accordance with DPSCS' policy.

Although the medication prescribed to inmates is recorded in the EPHR, as previously noted, the actual delivery or administration of the medication to the inmate is not. Specifically, DPSCS' pharmacy contractor downloads a text file of prescribed medications from the EPHR and delivers the required medication to the medical contractor at the various facilities at least daily. Medications are to be administered in accordance with written orders and consistent with DPSCS policy, and recorded manually on paper records by the contractor's clinical staff. According to DPSCS records, during March 2017, there were approximately 104,000 medication orders filled across all DPSCS facilities. Due to the nature of the medication, approximately 79,000 of these orders were for medication that was distributed to inmates, who kept a supply of the medication on their person. The remaining 25,000 orders were for medications the contractor directly administered by nursing staff to the inmates.

The liquidated damages provision of the contract for the administration of medication differs from how the administration of medication is actually documented. The contractor is required to maintain an electronic medication administration record (e-MAR) when implemented. Specifically, liquidated damages may be assessed at $200 for each e-MAR that is not completed below a 95 percent threshold, where the measured event is an individual who does not receive medication within 2 hours of receipt of the medication from the pharmacy contractor; or an individual e-MAR not documented (that is, the delivery of the medication is not documented). Since there is no e-MAR either within or outside of the EPHR, DPSCS relies on the paper record to gauge contractor performance.

Contract Monitoring Responsibilities

The responsibility for monitoring the delivery of all inmate health services and overseeing the related contractor's performance for the separate medical, mental health, dental, and pharmacy services contracts rests with DPSCS' Office of Inmate Health Clinical Services (OICS), under the Director of Clinical Services. There are five units within OICS, Contract Administration, Nursing, Substance Abuse, Mental Health, and Social Work, with the Contract Administration Unit (CAU) responsible for monitoring compliance with the health services contract's financial terms and conditions. As of May 2016, CAU had seven employees, all of whom had an accounting/auditing background. CAU's responsibilities with regard to the inmate healthcare service contract include reviewing inmate medical service invoices for agreement with contract terms and billing rates, verifying the mathematical accuracy of the invoice prior to payment by the DPSCS Office of the Secretary, reviewing medical services contract staffing levels, and assessing liquidated damages, as deemed appropriate for the aforementioned 41 contract requirements that have liquidated damages provisions. CAU is also responsible for monitoring several other contracts and performing various procurement and accounting functions.

OICS is generally responsible for monitoring the inmate medical contractor's required quality improvement program. Other responsibilities of OICS include determining whether the contractor adhered to contract requirements to provide sufficient qualified staffing and timely medical healthcare treatment services (such as healthcare for inmates with infectious diseases or chronic health conditions). OICS employees participate in investigations of inmate health-care related complaints received from inmates, DPSCS corrections personnel, and contractor employees. OICS also attends monthly contractor quality improvement meetings held in each of the four SDAs in the State, as well as quarterly statewide meetings at OICS headquarters in Baltimore. Finally, OICS' Nursing Unit routinely meets with the medical services contractor management and on-site personnel, and conducts audits (hereinafter referred to as clinical

audits) to verify compliance with the medical contract's quality of care requirements, in addition to various other duties. The Nursing Unit had 15 positions as of May 2016, 6 of which were vacant.

Scope, Objectives, and Methodology

Scope

We conducted a special review of the Department of Public Safety and Correctional Services' (DPSCS) monitoring of contractor performance for the purpose of assessing liquidated damages related to certain inmate healthcare contract deliverables. We conducted this review under the authority of the State Government Article, Section 2-1221 of the Annotated Code of Maryland based on a legislative request. The scope of our review was less than that of an audit conducted in accordance with generally accepted government auditing standards.

Objectives and Methodology

Our objective was to review DPSCS' procedures for monitoring the inmate healthcare contractor's performance under three key contract requirements and the assessment of allowable liquidated damages. The three key requirements we reviewed were maintaining required staffing levels, conducting timely reception/intake exams, and administering medication timely within DPSCS' 27 detention and correctional facilities.

To accomplish our objective, we obtained and reviewed relevant current medical inmate healthcare services contract documents. We also conducted interviews of the contractor's staff and employees of certain DPSCS facilities and the DPSCS Office of Inmate Health Clinical Services (OICS), which is responsible for monitoring the contract and overseeing the delivery of medical services to inmates. We obtained an understanding of the contract and a general knowledge of each of the 41 contract requirements that had a specific liquidated damages provision. To focus our review, after consultation with OICS staff, we then identified three of the contract requirements deemed vital to the quality of inmate medical care: maintenance of required contractor staffing levels, conducting timely reception/intake medical exams, and the administration of medication to inmates. Our review focused on fiscal year 2016 activity.

Staffing Levels

We reviewed the OICS Contract Administration Unit's (CAU) monitoring procedures to ensure that the minimum clinical staffing levels were being provided and liquidated damages were assessed when levels were below the minimum standard. We reviewed CAU's process to verify contractor reported staffing data accumulated and reported from the biometric timekeeping system. We compared the actual level of staffing provided, as reported by the contractor, against the contractor's staffing plan that had been previously approved by OICS.

For three months during fiscal year 2016, we tested CAU's calculation for liquidated damages when staffing levels at the statewide level were not met and determined whether CAU had properly reduced the invoice payments. We also analyzed staffing levels at each service delivery area (SDA) to determine if it would be appropriate to have a liquidated damages provision at that staffing level.

Reception/Intake Examination

We reviewed OICS' monitoring process over the contractor's completion of timely reception/intake exams, including the contractor's monthly reports of this activity. These intake exams, referred to as RIEs, consist of a number of individual examination procedures and are required to be completed within seven days of admission to a DPSCS facility. For the purposes of our review, we focused our analysis of OICS' RIE monitoring of pre-trial facilities within the Baltimore SDA, which represented 7,964 admissions or 51 percent of the annual admissions during fiscal year 2016. This was done since these RIEs would be conducted for individuals taken directly off the streets for their initial detainment, as opposed to transfers of inmates between DPSCS facilities, and there is a higher health risk concern with these detainees.

For the RIE requirement, we performed several tests. Specifically, we performed a test of RIE timeliness by selecting 20 inmates from a DPSCS report of individuals entering the Baltimore SDA's pre-trial facilities in June 2016. For these individuals we determined whether (1) they were included on the contractor's monthly report; (2) the contractor's reported RIE dates agreed with the electronic patient health records; (3) liquidated damages were assessed for those deemed untimely by the contractor; and (4) the medical tests performed during the RIE were documented in the patient records.

In addition, the Nursing Unit performs clinical audits to determine if various medical tests and exams during the RIE were completed and documented by the contractor in the patient records for quality of care purposes. We reviewed the results of two clinical audits performed during September 2015 and July 2016 to determine what impact they could potentially have for assessing liquidated damages. From those audits, we performed additional testing to determine whether the reported results agreed with the available documentation.

Administration of Medication

For the administration of medication requirement, the Nursing Unit conducts audits of patient records to determine if inmates were receiving the prescribed medications timely and any missed medications were properly documented in the inmate's paper record of medications administered (referred to as medication administration records or MAR).

We reviewed and summarized the results of the Unit's seven MAR audits conducted during fiscal year 2016 to assess the potential impact for assessing liquidated damages. To assess their accuracy, we compared the audit results for 10 individuals under two of these audits with the related inmate paper records of administered medications. Further, we summarized contractor-calculated MAR compliance rates based on 18 self-assessments performed for the period from November 2015 to June 2016. Finally, to determine whether the paper records of administered medications contained all medications to be administered, we selected 20 inmates from the pharmacy contractor's records of medications issued for the month of June 2016 and traced one medication for each inmate to the paper records.

Conclusions

Although the Department of Public Safety and Correctional Services (DPSCS) had established a process to pursue liquidated damages when required contractor medical staffing levels were not met, a process was not in place during fiscal year 2016 for assessing damages for initial reception/intake examination (RIE) and the administration of medication requirements. Except for staffing levels, we found that DPSCS did not have a process to review or prioritize for review the 40 other contract requirements with liquidated damages provisions for contractor non-performance. The results of clinical audits to assess quality of care, which had identified performance deficiencies, were not considered by the unit responsible for monitoring contractor performance to target its efforts for the purpose of assessing damages.

We found that DPSCS was properly calculating and assessing liquidated damages ($2.8 million during fiscal year 2016) when the contractor failed to maintain statewide medical staffing levels for seven types of positions (for example, physician and registered nurse) in accordance with the staffing plans. Nevertheless, certain procedures should be implemented to ensure the reliability of contractor-supplied attendance data, which is used in the calculations.

The approach established under the current contract to assess liquidated damages for staffing shortages, which provides for the aggregation of staffing levels of each position for the four separate service delivery areas (SDA) within the State, does not consider the potential impact on the quality of care at individual SDAs. That is, SDAs with full staffing would offset vacancies at other SDAs, which reduces the overall liquidated damages assessment. SDAs with full staffing do not help ensure the quality of care at SDAs with high vacancy rates. We found that all SDAs had staffing problems, one SDA consistently failed to meet established staffing levels. According to DPSCS, the next contract will provide for assessing liquidated damages at the individual facility level.

DPSCS did not verify that the contractor conducted complete RIEs for at least 98 percent of inmates within seven days of intake on a statewide basis, which is the standard under which liquidated damages ($50 per occurrence below the 98 percent threshold) may be assessed. The timely completion of RIEs as reported by the contractor was not verified to either DPSCS admission records or the electronic patient health records. We found that the contractor's reports containing the dates RIEs were conducted did not necessarily mean all required exam procedures had been completed at that time, thus affecting reliability. Based on the work performed by DPSCS' clinical staff, it is likely that many more untimely RIEs would be subject to liquidated damage assessments if the

completion of all exam procedures was considered. Even when the contractor reported untimely or incomplete RIEs, DPSCS did not assess liquidated damages, which would have totaled $16,250 during fiscal year 2016.

DPSCS had no procedure to verify that the contractor provided an individual medication dose to an inmate timely (based on a standard defined in the contract) or that an individual medication was documented in the medication administration records. According to the contract, a $200 liquidated damage could be assessed for each occurrence of an untimely drug administration or lack of documentation regarding the administration in the records below a 95 percent threshold. According to DPSCS, about 25,000 individual medication orders are administered directly to inmates statewide each month. Based on the results of DPSCS' clinical staff reviews and the contractor's self-assessments of medication administration, it is likely liquidated damages could have been assessed.

The lack of automated reports was an impediment to effectively determining the full extent of contractor noncompliance for purposes of assessing liquidated damages for RIE and medication administration. Regarding RIE, the contractor's reports did not contain necessary data to determine the full extent of untimely RIEs that may have occurred. That is, the contractor reports did not list each required attribute (for example, a specific medical test) and when it was conducted. Furthermore, due to limited reporting capabilities, this information was not readily available from DPSCS' electronic patient health records. Similarly, automated records of medication administered daily to each inmate also would be needed. Currently, only manual records are maintained for each inmate on which the contractor employee records medication given to each inmate when it is administered.

DPSCS did not use audit sampling techniques to assess the contractor's compliance with various contract requirements as permitted under the contract. In the absence of automated summary reports, selecting a random sample of RIEs and instances of medication administration would provide a reliable basis for determining the magnitude of any existing problems, gauging overall contractor performance, and assessing liquidated damages.

Findings

Finding 1
During fiscal year 2016, the Office of Inmate Health Clinical Services (OICS) had not established processes to pursue liquidated damages for contractor noncompliance regarding the timeliness of an inmates' initial reception/intake examination (RIE) and the administration of medications.

Analysis
With the exception of contractor medical staffing levels, for which $2.8 million in liquidated damages were properly assessed during fiscal year 2016, OICS had not established processes to pursue liquidated damages for contractor noncompliance with the other two contract provisions we tested. Specifically, OICS' Contract Administration Unit (CAU), which is responsible for auditing contract payments and identifying when contractor performance warranted the assessment of permissible liquidated damages, did not have an applicable process in place for the initial reception/intake examination (RIE) and the administration of medication requirements.

Our inquiries with CAU personnel disclosed that, except for staffing levels, no substantive efforts were made to pursue liquidated damages as allowed for 40 other contract requirements, including the aforementioned 2 requirements. CAU did not have a process to review or prioritize for review the various contract requirements with liquidated damages provisions for contractor non-performance. In this regard, CAU did not consider the results of clinical audits to identify problems with contractor performance that may warrant further review.

OICS management advised us that a decision was made by the previous CAU contract monitor to discontinue assessing damages on all other contract requirements except for staffing levels. We were further advised that although at one time CAU conducted audits of contractor performance for other requirements (in addition to staffing levels); these were stopped by the previous contract monitor. Apparently, in order to more efficiently audit, the requirements were to be prioritized and audited in that order, however this process was never completed. OICS management was unaware the audits had stopped until a new contract monitor was assigned in June 2016, when, according to OICS management the audits resumed. However, the exact timing of the decision to stop auditing could not be determined by OICS management.

In addition, OICS' Nursing Unit conducted clinical audits of certain medical requirements to assess quality of care; however, these audit results were not used to identify potential areas needing more targeted expanded reviews by CAU for

purposes of assessing liquidated damages, even when these audits indicated problems with contractor performance. OICS management advised us that the Nursing Unit's clinical audits were intended only to improve the quality of care and were not designed to be used for pursuing liquidated damages. Specifically, the purpose of the clinical audits is to determine the causes for noncompliance and methods to improve deficient processes to ensure inmates receive the proper quality of care.

OICS management advised the 41 different liquidated damages contained in the contract, with the exception of the staffing damages, provide a means to encourage performance improvement and are generally used in the event of a serious incident of gross contractor misconduct.

Finding 2
High staffing vacancy rates in some service delivery areas (SDA) during fiscal year 2016 suggest that liquidated damages should be assessed at that level rather than on a statewide level to ensure quality of care is not compromised.

Analysis
Although we determined that liquidated damages were properly calculated and assessed when required staffing levels were not met at the statewide level (see Table 1 for a breakdown of the fiscal year 2016 liquidated damages by medical staff position), we found that many times, high medical staff vacancy rates (where actual position staffing was below that number in the DPSCS approved staffing plan) existed within the four individual SDAs for certain positions. The concept of assessing liquidated damages at the SDA level was included in the original request for proposal (RFP) but subsequently amended to a statewide approach.

The use of a statewide approach, to the exclusion of a liquidated damage provision that also considers vacancies by position in each SDA, means that SDAs with full staffing would offset vacancies at other SDAs, which reduces the overall liquidated damage assessment. But such statewide aggregation does not consider the potential impact on quality of care at individual SDAs. SDAs with full staffing do not help ensure the quality of care at SDAs with high vacancy rates.

We analyzed staffing levels by SDA, see Tables 2 and 3, and found numerous instances when various medical positions within an SDA were less than 96

percent staffed.[4] We noted for example, that in the Baltimore SDA, the physician and physician assistant positions were less than 96 percent staffed during every month of fiscal year 2016 with a staffing percentage ranging from 70 percent to 84 percent and from 53 percent to 69 percent, respectively. In Table 3, we also quantified the number of months, by SDA, during fiscal year 2016 when 96 percent staffing was not achieved for each of the 7 medical contractor positions in each SDA, to demonstrate the prevalence of low staffing levels within certain SDAs. Finally, we quantified the total number of times (months) during the year when each medical position was staffed below the 96 percent requirement.

To accomplish this, we determined the total number of months during the year the contractor was accountable for staffing each medical position at each SDA based on the approved staffing plan. For example in the Baltimore SDA, each of the 7 medical positions was required to be staffed for 12 months during fiscal year 2016 (that is, 7 positions times 12 months equals 84 accountable months for the Baltimore SDA). This calculation was performed for each of the SDAs, which resulted in a combined total of 312 months to be staffed.

As noted in Table 3, we found that the total number of months when a medical position was staffed below the 96 percent requirement to be 199, or stated another way, for 63.8 percent of the accountable months, SDA staffing levels were below the threshold for assessing liquidated damages. While all SDAs had staffing problems during the year, for one SDA, staffing levels were below the requirement for 84.5 percent of the combined months for all medical positions.

Table 1
Fiscal Year 2016 Liquidated Damages by Medical Staff Position

Medical Staff Position	Annual Liquidated Damages	Percentage of Overall Annual Damages
Medical Director/Physician	$570,437	20%
Physician Assistant	$1,356,399	49%
Registered Nurse/Charge Registered Nurse	$655,591	23%
Licensed Practical Nurse	$192,212	7%
Phlebotomist	$30,236	1%
Total	**$2,804,874**	**100%**

Source: Contractor Monthly Staffing Level Report

[4] Table 2 represents full staffing of the DPSCS approved annual staffing plan. The contractor's failure to maintain statewide staffing levels of at least 96 percent of the approved staffing plan can result in the assessment of liquidated damages.

Table 2
Number of Contractor Medical Staff Positions Required Per DPSCS Approved Staffing Plan for Fiscal Year 2016

	Number of Required Positions by SDA			
	Baltimore	**Jessup**	**Eastern**	**Western**
Medical Director	2	3	1	2
Physician	19.4	7.225	1.6	7
Physician Assistant	32.1	11.8	4.8	9.4
Registered Nurse	86.4	46.6	19.4	40
Charge-Registered Nurse	14	11.4	2	3
Licensed Practical Nurse	82.1	59.6	20.3	57
Phlebotomist	6	0	1	0
Total	**242.0**	**139.625**	**50.1**	**118.4**

Source: Contractor Staffing Plan

Table 3
Number of Months During Fiscal Year 2016 When Staffing Levels Were Below the 96 Percent Requirement (by SDA and Position)

	Baltimore		Jessup		Eastern		Western		Total
	Number of Months <96% Staffing	**Staffing Level Range**	**Number of Months <96% Staffing**	**Staffing Level Range**	**Number of Months <96% Staffing**	**Staffing Level Range**	**Number of Months <96% Staffing**	**Staffing Level Range**	**Number of Months <96% Staffing**
Medical Director	3	75%-90%	12	60%-91%	12	60%-93%	6	41%-68%	33
Physician	12	70%-84%	0	All >96%	7	37%-93%	2	91%-94%	21
Physician Assistant	12	53%-69%	12	67%-91%	5	82%-94%	12	56%-95%	41
Registered Nurse	11	83%-94%	5	84%-95%	2	91%-92%	1	91%	19
Charge-Registered Nurse	12	71%-79%	6	87%-95%	12	18%-90%	12	3%-72%	42
Licensed Practical Nurse	9	84%-93%	0	All >96%	3	91%-94%	12	80%-92%	24
Phlebotomist	12	63%-94%	N/A	N/A	7	74%-93%	N/A	N/A	19
Total Understaffed Months	**71**		**35**		**48**		**45**		**199**
Total Accountable Months	**84**		**72**		**84**		**72**		**312**
Percentage of Months Understaffed	**84.5%**		**48.6%**		**57.1%**		**62.5%**		**63.8%**

Source: Contractor Monthly Staffing Level Report

We noted that the solicitation for the new contract being procured by DPSCS includes a provision for the assessment of liquidated damages by staffing levels at each of the 27 facilities. It appears that this new methodology could result in higher liquidated damages assessments as it removes the statewide aggregation methodology.

Finding 3
DPSCS, based on contractor-supplied data, routinely assessed liquidated damages for the contractor's failure to meet required staffing levels, but improvements are necessary to ensure the reliability of that data.

Analysis
During fiscal year 2016, DPSCS assessed the contractor liquidated damages totaling approximately $2.8 million for the failure to maintain certain statewide staffing levels, but that assessment was based on contractor-supplied data that was not verified for reliability. Liquidated damages were assessed because the contractor reported to CAU that it failed to maintain 96 percent of the planned staffing statewide during every month of that fiscal year.

Since CAU did not validate the reliability of contractor-reported staffing data and merely relied on the contractor's own biometric timekeeping system to report contractor staffing at DPSCS facilities, assurance was lacking that all actual vacancies were reported, which could affect the accuracy of the liquidated damages assessments. We noted the following procedures were not performed to help assess data reliability.

- The CAU did not independently verify contractor employee hours during fiscal year 2016. We identified an available report from the contractor's biometric timekeeping system that in real-time shows every contractor employee currently logged into the timekeeping system at a facility, which could be used by CAU with the assistance of DPSCS monitors located at the facilities, to perform periodic spot checks at work locations to verify employee attendance and work time.

- CAU did not use available time reports, which could be generated from the contractor's biometric timekeeping system to determine the extent of and frequency of manual time entries recorded by the contractor for employees who did not swipe-in biometrically. In addition, CAU did not obtain or review forms that were required to be filled out by contractor employees documenting the reason for the manual time entry (in lieu of the biometric entry system).

We reviewed a report of manual entries for May 2016, and noted 262 clinical contractor employees with at least one occurrence of a manual entry. According to the DPSCS approved staffing plan for fiscal year 2016, there were approximately 550 clinical employees. This report could be used by CAU to identify any potential patterns of employees who are not biometrically signing in or out, follow up to ensure the employees did work the reported hours, or target certain employees for future physical sightings at their scheduled work location.

Finding 4
Contractor reports were not verified nor used to assess liquidated damages for RIEs identified as untimely, and those reports did not contain data to determine the full extent of untimely RIEs that may have occurred.

Analysis
The CAU did not verify that the medical contractor conducted complete RIEs for at least 98 percent of inmates within seven days of intake on a statewide basis, which is the standard under which liquidated damages may be assessed. Specifically, the timely completion of an RIE as reported by the contractor was not verified to either DPSCS records or the RIE results in the inmate's Electronic Patient Health Record (EPHR). Further, when untimely or incomplete RIEs below the 98 percent threshold were identified by the contractor's own reporting, CAU did not assess liquidated damages.

The contractor self-reports the completion of RIEs and includes the dates of critical events, which are the individual's intake into a DPSCS facility and the completion of medical procedures that collectively make up an RIE. However, those dates are not verified by CAU against DPSCS records that independently record the same activity, such as facility admission records in the Offender Case Management System and medical notes recorded on the inmate's EPHR. Our tests of 20 inmates entering the Baltimore SDA's pre-trial facilities in June 2016 confirmed that these inmates were included on the contractor's monthly report and the related RIE completion dates reported by the contractor agreed with the EPHR dates. However, it appears that the recorded RIE completion dates do not necessarily mean all required medical procedures were performed at those times. Based on the results of the Nursing Unit's clinical audits and contractor self-assessments of RIE, it is likely that many more untimely RIEs would be subject to liquidated damages assessments if the completion of all exam procedures established in the contract and by DPSCS policies was considered.

Based on the contractor's self-reported fiscal year 2016 RIE results, which showed 325 RIEs (below the 98 percent requirement) had not been completed timely, liquidated damages totaling at least $16,250 could have been assessed for late exams ($50 for each exam below the 98 percent requirement). However, results from limited work conducted by the Nursing Unit indicate that the potential problem of untimely and/or improperly completed RIEs could be much worse.

The Nursing Unit conducted two clinical audits in September 2015 and July 2016 of pretrial facilities with each audit reviewing the associated records for 15 and 30 inmates, respectively. During those clinical audits, the Unit was to review 17 RIE attributes for each inmate record, although not every attribute (for example, a pregnancy test) was applicable for each inmate. After excluding the attributes deemed not applicable, 528 total attributes were subject to review for the two audits combined. The review would rely on the documentation of the performance of each exam attribute in the patient's EPHR.

The Unit found that the overall compliance rate was 60 percent for both audits (with individual audit results of 48 and 68 percent). However, our review of the Nursing Unit's audit work disclosed that at least one exam attribute for each of the 45 inmates tested had not been performed, even though the attribute was applicable. If the failure to perform every attribute means an RIE is incomplete, then all of the 45 tested could have been subject to liquidated damages. Although we did not validate the Nursing Units results, our test of the RIEs performed for 20 inmates also found that certain medical tests required as part of the RIE were not documented in the patient records for 7 inmates.

Consequently, it does not appear that the RIE information self-reported monthly by the contractor for this standard provided assurance that all exam attributes were completed. Specifically, although the contractor data showed the date between intake and when the exam was performed, those reports did not identify all required initial exam procedures (such as medical tests) and when they were performed. Consequently, all contract attributes for RIEs may not have been completed in that timeframe even though the reports may suggest otherwise.

Given the results of the two fiscal year 2016 clinical audits, we inquired with OICS management whether the failure to perform all RIE procedures included in the Nursing Unit's audits would mean an RIE was not complete. They were non-committal since a specific definition of what constitutes a complete RIE exam apparently has not been previously considered for purposes of liquidated damages assessment.

Finally, our review of this situation identified one further issue. The importance of the Nursing Unit's clinical audits in determining and ensuring the quality of care is of paramount importance, but the assessment of liquidated damages plays a role as well. However, the lack of reliable automated reports of RIE results and the seemingly inconsequential individual damage provision ($50 for each exam below the 98 percent requirement), may mitigate the usefulness of assessing liquidated damages. Specifically, if all the initial exams for the approximately 15,000 intakes during FY 2016 had been performed untimely, the maximum liquidated damages assessment would have been approximately $750,000 (based on $50 per occurrence), which could be deemed a relatively insignificant amount compared to the total annual contract payments (in excess of $100 million).

We were advised by OICS management the amount of damages per untimely exam used to be higher under older contracts but a number of years ago they were advised by DPSCS procurement officials that this was too punitive and it was lowered in later contracts, with the lower amount retained in the new RFP. OICS could not explain the basis for the damage amount.

Finding 5
A process had not been established to assess liquidated damages when medication was not administered timely or the administration was not documented in the medical records, even though there were indications of some problems with contractor performance.

Analysis
The CAU had no procedure to verify that the contractor provided an individual medication dose to an inmate timely (based on a standard defined in the contract) or that an individual medication was documented in the medication administration records for purposes of assessing liquidated damages, even though there were indications of some problems with contractor performance. According to the contract, a $200 liquidated damage could be assessed for each occurrence of an untimely drug administration or lack of documentation regarding the administration in the records below a 95 percent threshold. Based on information provided to us by the Nursing Unit, about 25,000 individual medication orders are administered directly to inmates by nursing staff each month.

Based on similar results from both the Nursing Unit's clinical audits and the contractor's self-assessments of medication administration, it is likely liquidated damages could have been assessed. For example, the Nursing Unit conducted seven clinical audits in fiscal year 2016 that indicated the contractor's overall performance was below contract requirements. The purpose of these audits was

to determine if the administration of the medication was properly documented in the paper medical record from a quality of care perspective. Some of the attributes audited included the recordation of the date and type of medication administered, missed medications with reasons, medication start and stop dates, and keep-on person medication (medicine to be retained by the inmate for self-administration).

Medication records were reviewed for 86 inmates during these 7 audits (each at a different facility), with 15 attributes to be reviewed for each inmate record, although not every attribute was applicable for each inmate reviewed. Ultimately, the Nursing Unit tested 1,047 individual attributes for compliance, and concluded that the combined compliance rate was 91 percent (which equates to a 9 percent error rate). Two of those seven audits had compliance rates below 90 percent (at 84 and 67 percent). Of the 15 attributes tested from the audit with 67 percent overall compliance, which was conducted for one facility, one attribute (legibility of nurses' signatures) had 0 percent compliance and 5 attributes (for example, name and dose of medication administered) had compliance rates between 50 and 67 percent. Our tests of 10 individuals from two of the audits disclosed that the results generally agreed with the paper records of medications administered, but a few errors were noted. For these seven audits, DPSCS could have assessed liquidated damages of at least $6,000 after considering adjustments for the errors noted during our review.

Our summary of the results for 18 contractor self-assessments performed from November 2015 to June 2016 for various facilities showed a similar overall compliance rate of 89 percent for the 6 medication administration attributes it tested. Furthermore, our test work disclosed similar problems with the contractor's performance. Specifically, our test of the paper records of medications administered for 20 inmates in June 2016 disclosed that for 10 of the inmates, medications provided by the pharmacy contractor were not always documented on the paper record as being provided to the inmate nor was there an explanation as to why the inmate did not receive the medication on a given day. For these 10 inmates, the number of days with no indication of the medication being provided ranged from 1 to 5 days.

Finding 6
The lack of automated reports was an impediment to effectively determining the full extent of contractor noncompliance for purposes of assessing liquidated damages for RIE and medication administration.

Analysis
The lack of automated reports was an impediment to effectively determining the full extent of contractor noncompliance for purposes of assessing liquidated damages for RIE and medication administration. Our review of three liquidated damages provisions disclosed that, for two of these, automated reports that would enable CAU to identify all occurrences of noncompliance with key contract requirements were not available either from the contractor (finding 4) or DPSCS' records. This condition is in contrast to the medical staffing requirement, where CAU receives monthly reports of staffing levels from the contractor that enable it to identify statewide staffing levels and any related shortages that may trigger liquidated damages.

The lack of automated DPSCS records appears to be a direct result of a past failure to fully implement a comprehensive Electronic Patient Health Record (EPHR) system. For example, in June 2005, DPSCS contracted for the development and implementation of the EPHR system, but the resultant system did not achieve the functionality intended. The system was to record each inmate's comprehensive health history while in DPSCS custody and was to be used to analyze the adequacy of the delivery of inmate health care services. However, we were advised by DPSCS staff that limited reporting capabilities have limited its usefulness. For example, a system module that would have allowed for implementation of an electronic medication administration record was never developed. Since the EPHR does not have the ability to track the administration of medication, a paper record is maintained.

In our opinion, to assess contractor RIE performance effectively for all inmate intakes would require automated summary reports of relevant information from the contractor and from DPSCS' patient health records, such as each medical procedure performed during the RIE and the date and time. This information is not available from the contractor nor does the reporting capability currently exist within DPSCS systems.

Similarly, automated records of medication administered daily to each inmate also would be needed. Currently, only manual records are maintained for each inmate on which the contractor employee records medication given to each inmate when it is administered. Due to the large volume of activity and decentralized nature of the services provided under this contract, automated records are critical to

effective oversight of this contract. If DPSCS systems are not capable of tracking the information needed to monitor key contract requirements, this raises a question as to whether the contractor should be required to provide this information.

Finding 7
DPSCS did not make use of a sampling methodology, as permitted by the contract, for purposes of determining compliance with contract provisions and assessing liquidated damages.

Analysis
The CAU did not use audit sampling techniques to assess the contractor's compliance with various contract requirements. The contract permitted DPSCS to apply a statistically derived compliance rate over activities during a related timeframe at a specific facility, from where the sample was drawn, for purposes of assessing liquidated damages. For example, selecting a random sample of RIEs and instances of medication administration would provide a reliable basis for determining the magnitude of any existing problems and for gauging overall contractor performance, in the absence of automated summary reports. DPSCS could then extrapolate those results to the respective population subject to sampling to assess liquidated damages.

Sampling could be especially efficient for evaluating medication administration, given the number of daily dosages prescribed statewide. For example, DPSCS records indicate that typically 25,000 medication orders are administered monthly directly to inmates. While we cannot assume that the 9 percent error rate noted by the Nursing Unit's clinical audits in Finding 5 are representative of the entire statewide population, if a similar error rate was actually found to exist throughout the entire population based on a sampling methodology which would allow for extrapolating the results, the potential liquidated damages could be significant. For example, those error rates occurring within the aforementioned 25,000 monthly medication orders, at $200 an occurrence, would suggest potential liquidated damages of about $200,000 for the month.

CAU advised that although this sampling provision was allowable under the contract, it had not been used because of likely challenges to the results by the contractor and varying operational conditions at each facility. Therefore, the provision to allow for sampling for extrapolating results and assessing liquidated damages was removed by DPSCS from the upcoming contract. While we recognize that a valid methodology would need to be developed, the lack of automated records as noted in Finding 5 makes statistical sampling the only viable

approach to gauging the full extent of the problem and establishing damages representing the impact on the inmate population.

Recommendations

We recommend that DPSCS:

1. **Establish a process to assess liquidated damages for vital quality of care contract provisions, especially RIE and medication administration. In this regard, a definition of what constitutes a complete RIE should be established. OICS should compile the Nursing Unit's clinical audit results (using the correct definition of the services to be provided) and the contractor self-assessment results to help target CAU's efforts for the purpose of assessing liquidated damages.**

2. **Enhance the reliability of contractor-reported staffing levels based on the contractor's automated timekeeping data. Specifically, OICS should**
    a. **perform spot checks of contractual employees (sight employees at their workstations) using real-time attendance reports available from the timekeeping system, and**
    b. **review reports of manual time entries in the timekeeping system and obtain supporting documentation for the entries.**

3. **Ensure that, in accordance with the provisions under the next contract, staffing levels at each facility are monitored and liquidated damages are assessed as allowed.**

4. **Re-evaluate the suitability of the current liquidated damages provision for RIE to address contractor non-performance and the related potential impact on the quality of inmate health care.**

5. **Investigate approaches for obtaining relevant automated data reports to facilitate the monitoring of contractor performance and the assessment of liquidated damages for key contract requirements, including requiring the contractor to provide such reports as part of the contract provisions.**

6. **Consider whether the next contract should be amended to include a provision allowing DPSCS to use a random sampling audit protocol to assess contractor performance and assess liquidated damages.**

Exhibit 1
DPSCS Inmate Medical Health Care and Utilization Services
Liquidated Damages

Source: Inmate Medical Health Care and Utilization Services Request for Proposal for original contract period 7/1/12 to 6/30/17

(edited for presentation purposes)

	Liquidated Damages Description	Minimum Threshold Percent (if applicable)	Liquidated Damages Amount	Performance Standard
1	Provides clinical staffing (Physician, PA, CRNP, RN, LPN and Phlebotomist) in accordance with its current DPSCS approved staffing plan.	96%	Rate calculated on hourly rate per clinical positions.	An occurrence is total number of hours for each position that does not meet the 96% minimum fill rate per position Statewide.
2	Contractor maintains Credential Files.	99%	$100 for each missing credentialing information item required for each employee past or present below minimum threshold.	An occurrence is each missing credentialing information item required for each employee past or present not submitted to the agency.
3	Contractor shall develop and maintain a comprehensive competency based orientation program for new staff.		$250 for each employee that has not completed a documented orientation.	An occurrence represents any staff that does not receive a pre-service orientation. The orientation shall include a review of the Policies and Procedures manual of the Agency, the Policies and Procedures manual of the Provider, how to access those manuals, electronic health record training basics of working in a prison setting and a review of the limits of the scope of responsibility based on competency.
4	Contractor provides Emergency Care.		$500 per incident that emergency care is not adequately provided.	An occurrence is each individual 911 event that does not follow the first aid and emergency procedures related to emergency triage to a community based hospital or infirmary.
5	Contractor provides On-call Physician List.		$100 per month that on call list is not updated or posted as required.	An occurrence is each time an on call list is not updated or posted as required in the infirmary, dispensary and sick call areas.
6	Contractor provides Equipment Inventory Reporting as required.		$100 per day annual inventory report is greater than 15 days past due date and $25 for each equipment item not affixed with State tag number.	An occurrence is each day past the Annual Inventory Report due date and each equipment item without a State tag number. Liquidated damages will NOT be assessed against the Contractor for a missing piece of equipment that is the responsibility of one of the Other Healthcare Contractors. Liquidated damages will be assessed each day greater than 15 days past the due date.

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Liquidated Damages

	Liquidated Damages Description	Minimum Threshold Percent (if applicable)	Liquidated Damages Amount	Performance Standard
7	Provide Equipment Maintenance Database and Report.	98%	$25 for any element missing below 98% in the database and report.	An occurrence is any element missing in the database and report.
8	Each inmate admitted to the infirmary, shall only be admitted upon physician order which may be performed telephonically.	100%	$100 for each admission without a documented order.	An occurrence is when any inmate assessment is not performed, thus no documentation in electronic health record (EHR).
9	Each Inmate in the infirmary shall receive an Assessment within 24 hours of Admission, which shall include a History, physical, and Treatment Plan documented in the EHR.		$100 for each history and physical on admission not documented in EHR.	An occurrence is any admission history and physical not documented in EHR within 24 hours.
10	Infirmary and isolation unit rounds shall be made daily (1x/day) by the Clinician and documented in the EHR. Nursing rounds shall be performed per shift (3x/day) and evidence of such shall be documented in the EHR.		$50 for each round not made daily by Clinician and documented and $50 for Nursing round not made per shift and documented.	An occurrence is any time daily rounds are not conducted and documented and Nursing rounds not conducted per shift and documented.
11	An intake screening, to include a hearing test, of any newly admitted Inmate to any DPSCS institution conducted utilizing the Intake Medical/Mental Health Screening (IMMS) form within two hours of entry into a facility.	within 10 minutes of 2-hour timeframe (i.e. 2 hours and 10 minutes)	$50 for each occurrence beyond 2-hour 10-minute timeframe.	An occurrence represents any timeframe beyond the 2-hour and 10 minute allowance.
12	An intake screening, to include a hearing test, of any newly admitted Inmate to any DPSCS institution conducted utilizing the IMMS form and the completion of all form questions within two hours of entry into a facility.		$50 per question for each question missed in IMMS.	A question represents any question with a missing component of the receiving process missed in IMMS.
13	Conduct a complete medical health examination on all inmates, including parole violators and escapees within 7-days of reception. Provide medical intake evaluations every day.	98%	$50 for each occurrence of a medical health exam not completed below 98% threshold.	Any occurrence represents any failure to perform.

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14	Offer either blood or oral testing (with blood confirmation) and provide counseling and education.	98%	$50 per occurrence below 98% threshold.	An occurrence is any detainee/inmate that does not have documentation of HIV testing being offered and counseling being completed within the required timeframe.
15	Each inmate with sufficient period of incarceration shall receive physical re-evaluations during his or her period of incarceration.	95%	$50 for each occurrence exam not completed within 10 days of schedule requirements below 95% threshold.	An occurrence is any physical re-exams not completed on inmates once every 4 years (under 50); or if over 50 years of age once per year. Liquidated damages will be assessed again each month that the requirement is not performed, provided the Department has notified the Contractor of the omission or lack of performance.
16	An inmate shall be tested (screened) for tuberculosis annually whether or not scheduled for physical re-examination.	100%	$100 per annual tuberculosis test not provided to patient as required.	Annual tuberculosis tests must be completed on all inmates and detainees as required. Liquidated damages will be assessed again each month that the requirement is not performed, provided the Department has notified the Contractor of the omission or lack of performance.
17	Inmates shall be re-informed of his or her opportunity for HIV testing at every physical re-examination.	95%	$50 for each occurrence re- education not completed within 10 days of schedule requirements below 95% threshold.	An occurrence is any re-educations not completed on inmates at every physical re-examination. Liquidated damages will be assessed again each month that the requirement is not performed, provided the Department has notified the Contractor of the omission or lack of performance.
18	Each sick call clinic shall continue operation on that day until it is completed; i.e. no “backlogs”.	95%	$25 per patient scheduled but not seen in daily sick call below 95% threshold.	An occurrence is when an inmate scheduled for a clinic session is not seen.
19	Each sick call clinic shall continue operation on that day until it is completed; i.e. no “backlogs”. Same day referrals from triage (emergent complaints) shall be seen during a clinic session on the same day that the Inmate appears for services.	100%	$50 per triage patient not seen in daily sick call.	An occurrence is when same day referrals from triage (emergent complaints) not seen during a clinic session on the same day that the inmate appears for services.
20	Contractor maintains Medication Security.	100% (narcotic) 95% (other than narcotic)	$100 for each occurrence of medication not secured appropriately.	An occurrence is any incidence of medication not secured appropriately.

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21	Perform scanning of all medications ordered and shipped.	100%	$100 for each order and shipment not scanned.	An occurrence is each medical medication order (including STAT orders) and shipment not scanned.
22	Contractor maintains electronic Medication Administration Record (e-MAR).	95%	$200 for each e-MAR that is not completed below 95% threshold.	An occurrence is an individual dose not received within 2 hours after receipt; or an individual e-MAR not documented.
23	Shall follow national guidelines for disease/condition specific organizations in the development of treatment programs.	95%	$250 for each deviation from established treatment programs below 95% threshold.	An occurrence is a deviation from established treatment programs.
24	Perform monthly chart review by a RN or Clinician for chronic care patients.	95%	$100 for each occurrence per audited patient record that was not provided in accordance with the OIHS Clinical Care Manuals below 95% threshold.	An occurrence is when a chronic care patient does not receive a chart review by a RN or Clinician every month.
25	Chronic care patients shall be seen by a Clinician every ninety days at a minimum.	95%	$250 for each occurrence per audited patient record that was not provided in accordance with the Office of Inmate Health Clinical Services Clinical Care Manuals below 95% threshold.	An occurrence is where a chronic care patients are not seen by a Clinician every 90 days.
26	Make available appropriate prenatal care, specialized obstetrical services twice weekly and postpartum care for pregnant inmates.	100%	$250 per element not performed as required in the Office of Inmate Health Clinical Services Pregnancy Management Manual.	An element is non-performance as required in the Office of Inmate Health Clinical Services Pregnancy Management Manual.
27	The transfer form designated by the Agency and contained within the EMR, shall be completed by the Clinician within twelve hours of having been notified of transfer or release.	90%	$50 for each medical transfer assessment form not submitted below 90% threshold.	An occurrence represents an incomplete or absent transfer assessment form in EHR.

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Liquidated Damages

	Liquidated Damages Description	Minimum Threshold Percent (if applicable)	Liquidated Damages Amount	Performance Standard
28	Utilize a Continuity of Care Form (hardcopy) consistent with Department Policy and Procedure in conjunction with Inmate release.	95%	$250 for each occurrence a Continuity of Care Form is not complete in the discharge planning process below 95% threshold.	An occurrence represents a Continuity of Care Form not being complete in the discharge planning process
29	Operate a comprehensive infection control program that ensures that communicable diseases are appropriately diagnosed, treated, and controlled to prevent and minimize infectious disease outbreaks.	100%	$150 for each occurrence of failure to document diagnosis/treatment of an infectious disease.	An occurrence represents any failure to document the diagnosis of an Infectious Disease as well as providing the necessary treatment.
30	Contractor addresses Administrative Remedy Procedures (ARP) & ARP Appeals timely and completely.	99%	$50 for each ARP that is not completed by due date below 99% threshold and $25 per day each ARP is past the due date below 99% threshold.	An occurrence is each ARP not submitted by the due date.
31	Implement the continuous quality improvement (CQI) program.	100%	$100 per occurrence	An occurrence represents a failure to conduct required CQI meetings.
32	Performs Safety and Sanitation inspections.	100%	$1,000 per each inspection not performed and $100 per each report not submitted within 30 days as required.	An occurrence is any inspection not performed and any report not submitted within 30 days as required.
33	Performs Morbidity and Mortality (M&M) reviews of adverse patient outcomes.	100%	$125 for each M&M review not performed and $125 per each report not submitted.	An occurrence when the M&M review is not completed within the 72 hours timeframe and the M&M report of Multi-disciplinary input is not submitted within 10 business days.
34	Provide Methadone maintenance according to Federal and State mandates.	100%	$1000 per incident that required Methadone licensure is not in place.	An occurrence is any incident whereby License is not maintained as current and available for inspection.

Exhibit 1

DPSCS Inmate Medical Health Care and Utilization Services

Liquidated Damages

	Liquidated Damages Description	Minimum Threshold Percent (if applicable)	Liquidated Damages Amount	Performance Standard
35	Maintain the methadone program currently in place at any approved DPSCS facility for: (1) Utilization in the detoxification / withdrawal of any Inmate experiencing withdrawal from opiates when prescribed by a physician; or (2) Maintenance on methadone of Inmates arrested at a time where the Inmate is enrolled and participating in a bona fide methadone program in the community.	100%	$250 for each occurrence of non-compliance with Methadone program.	An occurrence is any incident of non-compliance with Methadone program
36	Maintain a complete electronic health record (EHR).	95%	$50 per occurrence of non-completion of patient record in EHR below 95% threshold.	An occurrence is every instance of failure to document patient records properly in EHR.
37	Provides complete utilization management report.	98%	$25 per each missing element below 98% threshold.	An element represents any item described in specific sections of the request for proposal.
38	Submission of all reports.	99%	$25 for each day beyond the due date for each report below 99% threshold.	An occurrence represents any report not submitted as required.
39	Contractor Participation in Meetings as assigned.	99%	$50 per meeting that required representation is not present below 99% threshold.	An occurrence is any instance where the required attendance of a contractor does not report as required.
40	Submit State Stats Reports.	100%	$100 each day past due date.	An occurrence is each day past the due date.

Exhibit 1

DPSCS Inmate Medical Health Care and Utilization Services

Liquidated Damages

	Liquidated Damages Description	Minimum Threshold Percent (if applicable)	Liquidated Damages Amount	Performance Standard
41	Contractor shall not prevent any of its staff below the Statewide management level from working for a successor invoking a non-compete clause.	100%	The equivalent of three month's salary for each State position that is offered employment by a successor contractor but that declines such employment because a non-compete provision it has signed with the Contractor is being invoked by the Contractor. The means to calculate the amount of damages for each position so affected is to take the hourly rate for that position as contained in the Contractor's Attachment R contained in its final technical proposal times 540 hours. (180 hours to obtain a monthly damages amount, times 3 months = 540 hours)	An occurrence is any time current Staff of the Contractor below the statewide management level declines an offer of employment because a non-compete clause it signed with the Contractor is being invoked and it is verified to the satisfaction of the DPSCS Contract Manager that this rationale is accurate.

APPENDIX

Department of Public Safety and Correctional Services

Office of the Secretary

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September 8, 2017

Mr. Thomas J. Barnickel III, CPA
Department of Legislative Services
Office of Legislative Audits
301 West Preston Street, Room 1202
Baltimore, Maryland 21201

Dear Mr. Barnickel:

The Department of Public Safety and Correctional Services has reviewed the Draft Audit Report dated August 2017 for the DPSCS Inmate Medical Healthcare Service Contract. The Department appreciates the constructive findings and recommendations that were made as the result of this audit.

Please find attached the Department's itemized responses to the Draft Audit Report as submitted by Dr. Sharon Baucom, Director of Inmate Health and Clinical Services. Dr. Baucom and her management team have begun, and will continue to implement the necessary corrective action to address the audit findings and recommendations, and will closely monitor their status in order to prevent any repeat audit findings in the next audit.

The Office of the Inspector General will also conduct periodic follow up reviews to monitor the status of compliance.

If you have any questions regarding the Department's response, please contact me.

Sincerely,

William G. Stewart, D.S.A., for Secretary Moyer

Stephen T. Moyer
Secretary

Cc: Sean Powell
Deputy Chief of Staff

Department of Public Safety and Correctional Services

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September 8, 2017

The Honorable Stephen T. Moyer, Secretary
Department of Public Safety and Correctional Services
300 East Joppa Road, Suite 1000
Towson, Maryland 21286-3020

Dear Secretary Moyer:

Included are the itemized responses to the Office of Legislative Audit's Draft Legislative Audit Report dated August 2017. This audit examined the monitoring of contractor performance for the assessment of liquidated damages under the Department's Inmate Medical Healthcare Service Contract.

Recommendation #1:
Establish a process to assess liquidated damages for vital quality of care contract provisions, especially RIE and medication administration. In this regard, a definition of what constitutes a complete RIE should be established. OICS should compile the Nursing Unit's clinical audit results (using the correct definition of the services to be provided) and the contractor self-assessment results to help target CAU's efforts for the purpose of assessing liquidated damages.

We agree.
Although the Office maintains that the process of continuous quality improvement (CQI) should be separated from the liquidated damages process, we do agree that there are circumstances under which liquidated damages should be assessed for failure to provide care that results in adverse outcomes, and we have been able to demonstrate assessment for liquidated damages under those circumstances. We also agree that when the vendor has failed to demonstrate substantial compliance after a corrective action plan has been implemented following the CQI process that the Office will take steps necessary to assess liquidated damages for failure to perform, barring contributory factors beyond the vendor's control.
The Office will take the following steps:

1. We will work with the Human Resources Services Division to fill the vacant nursing staff positions by January 31, 2018.
2. We will re-define a complete RIE for the purpose of assessing liquidated damages by January 31, 2018.
3. The criteria for the assessment of liquidated damages for the medication administration have already been re-defined in the new FY18 RFP.
4. By January 31, 2018, the Nursing Unit will establish a process to collaborate with the CAU for assessment of liquidated damages for contract compliance deficiencies noted during CQI audits for which the vendor fails to implement corrective actions, especially regarding RIE and medication administration.

Recommendation #2:
Enhance the reliability of contractor-reported staffing levels based on the contractor's automated timekeeping data. Specifically, OICS should:

a. **Perform spot checks of contractual employees (sight employees at their workstations) using real-time attendance reports available from the timekeeping system, and**
b. **Review reports of manual time entries in the timekeeping system and obtain supporting documentation for the entries.**

We agree.
A. Effective April 30, 2018, designated OIHS staff shall conduct sight spot checks of contractor employees, one shift per month, in selected facilities using real-time KRONOS generated reports from the SDA.
B. CAU shall obtain the monthly ACOM's employee sight audit report at the end of each month and trace employees worked hours through the contractor's monthly staffing billing audits for the purposes of assessing liquidated damages when warranted. This audit process shall start from the billing period following the end of the new contract transition period (anticipated to be April 30, 2018). In addition, CAU shall verify selected samples of manual time entries monthly. This new audit process shall start from the service month following the end of the new contract transition period (anticipated to be April 30, 2018). Liquidated damages will be assessed for each entry not verified.

Recommendation #3:
Ensure that, in accordance with the provisions under the next contract, staffing levels at each facility are monitored and liquidated damages are assessed as allowed.

We agree.
CAU shall audit each contract position as assigned to each shift, in each facility, at each SDA to ensure that contractor employees provide the required full-time

equivalent work hours. Consistent with the new contract, liquidated damages will be assessed for each position where the required employee work hours were not met each month, in each facility, at each SDA. This new audit process shall start from the service month following the end of the new contract transition period (anticipated to be April 30, 2018).

Recommendation #4:
Re-evaluate the suitability of the current liquidated damages provision for RIE to address contractor non-performance and the related potential impact on the quality of inmate health care.

We Agree.
The Office will re-define a complete RIE for the purpose of assessing liquidated damages by January 31, 2018. In addition, by the end of the new contract transition period (anticipated to be April 30, 2018), the Office will re-evaluate the suitability of the current liquidated damages provision for RIE to address contractor non-performance and the related potential impact on the quality of inmate health care. Finally, the Office will continue to assess liquidated damages for those cases where there is demonstrated quality of care issues leading to preventable ER visits, hospitalization or harm to the inmate.

Recommendation #5:
Investigate approaches for obtaining relevant automated data reports to facilitate the monitoring of contractor performance and the assessment of liquidated damages for key contract requirements, including requiring the contractor to provide such reports as part of the contract provisions.

We Agree.
The Office recognizes that our current electronic record is not capable of generating all the reports necessary for the monitoring of this contract and we are working on an RFP for a new electronic medical record system, which ideally will facilitate the monitoring of the contractor performance and the assessment of liquidated damages for key contract requirements. The RFP is anticipated to be issued by January 31, 2018.

Recommendation #6:
Consider whether the next contract should be amended to include a provision allowing DPSCS to use a random sampling audit protocol to assess contractor performance and assess liquidated damages.

We Agree.
The Office will continue to utilize random sampling to demonstrate contractor compliance, and random sampling is already in use in certain audits to assess overall performance. In the past, the Office has found that extrapolation based on random sampling is difficult to defend when challenged, and is likely to result in futile contract claims where the Department ends up paying interest to contractors on those liquidated damages assessed. However, the Office will consider using a random sampling audit protocol to assess contractor performance and liquidated damages. Specifically, by the end of the new contract transition period (anticipated to be April 30, 2018), the Office will research best practices in other states regarding this protocol.

Sincerely,

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