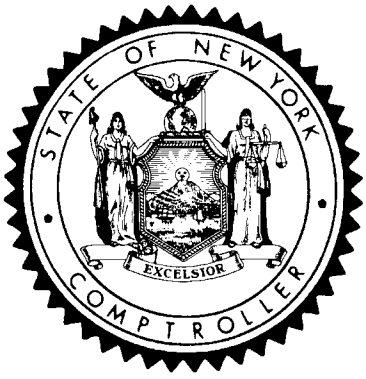
State of New York
Office of the State Comptroller
Division of Management Audit and State Financial Services

DEPARTMENT OF CORRECTIONAL SERVICES

REGIONAL MEDICAL UNITS

REPORT 97-S-40



H. Carl McCall

Comptroller

State of New York
Office of the State Comptroller

Division of Management Audit and State Financial Services

Report 97-S-40

Mr. Glenn S. Goord
Commissioner
Department of Correctional Services
Building #2, State Campus
1220 Washington Avenue
Albany, NY 12226-2050

Dear Mr. Goord:

The following is our report on the Department of Correctional Services, Regional Medical Units.

This audit was performed pursuant to the State Comptroller's authority as set forth in Article V, Section 1 of the State Constitution and Article II, Section 8 of the State Finance Law. We list major contributors to this report in Appendix A.

Office of the State Comptroller
Division of Management Audit
and State Financial Services

February 29, 2000

Executive Summary

Department of Correctional Services Regional Medical Units

Scope of Audit

The Department of Correctional Services (Department) provides for the confinement and rehabilitation of about 70,000 inmates in 70 State correctional facilities. The Department is responsible for providing inmates appropriate and humane medical care efficiently and cost-effectively in a secure environment. The Department's Division of Health Services establishes health services policy, delivers health services and oversees facility medical unit operations. Inmates receive medical care in facility infirmaries, in Regional Medical Units (RMUs) on facility premises or in outside hospitals. RMU inpatient units house inmates who need skilled nursing care, but do not need to be admitted to a hospital, and RMU outpatient units provide specialist services in clinical settings.

The Department currently operates the Walsh, Coxsackie and Wende RMUs, which opened in March 1991, February 1996 and July 1998, respectively. The Walsh and Wende RMUs are operated by State employees, and the RMU at Coxsackie is operated by a private contractor. The Department plans to add two more RMUs to its health care delivery system: one at Bedford Hills in mid-2000 and the other at Fishkill in early 2000.

Our audit addressed the following questions about Department oversight of RMU inpatient units for the period February 1, 1996 through May 31, 1999:

- Has Department management performed adequate analyses to determine the most cost-effective means of delivering RMU inpatient services?

- Does the Department ensure that all its RMU inpatient units provide a consistent and appropriate quality of care?

Audit Observations and Conclusions

We found that Department management has not adequately analyzed the comparative costs of State-operated and contractor-operated RMU inpatient units to make informed decisions about the most cost-effective means of delivering these services at existing and future RMUs. We also found the Department has not established a formal quality assurance program to assess whether all inmates receive consistent and appropriate care.

When the Department proposed using a private vendor to operate the Coxsackie RMU, the Department assured the Office of the State Comptroller (OSC) it would compare the costs of State-run and contractor-run inpatient units, use this information to make cost-effective decisions and report any savings to the State. This information was requested by OSC in August 1996. The Department submitted a cost comparison to OSC in 1997, however, we found that it contained inaccurate data. Since then, the Department has not

done any comparisons of State-operated versus contractor-operated inpatient costs, or reported any information to OSC as it had agreed to do when the contract was approved. (See pp. 5-10)

We found that the Department's initial 1995 cost study, which estimated a net annual savings of $900,000 from using a contractor to operate Coxsackie, and its subsequent analyses of costs at Coxsackie and Walsh (a State-operated unit) overstated savings by nearly 50 percent. Further, subsequent analyses of costs at Coxsackie and Walsh improperly included some costs and excluded others. The expected savings did not materialize; in fact, adjusted 1998-99 cost projections show lower per-patient costs at Walsh (State-operated) than at Coxsackie (private vendor). (See pp. 6-9)

In 1998, the Department decided to operate Wende and Bedford Hills as State-run and contractor-run RMUs, respectively, based on a 1996-97 internal study which compared Coxsackie and Walsh costs. However, we question this study's reliability because of problems we identified in the 1995 cost study. We also question whether this one-year comparison gave reliable enough information on which to base future decisions on how best to operate RMUs, particularly since Coxsackie had been operating for only two months when the 1996-97 study began. Department management recognized this limitation and suggested a follow-up study; it was, however, never done. Thus, the Department made decisions about RMU operations without doing cost studies it acknowledged were needed for decision-making. (See pp. 9-10)

While the Department has acknowledged the importance of quality assurance programs and performance indicators in providing medical services, it has not established a formal quality assurance program applicable to all RMU inpatient units, established quality of care standards or developed performance indicators to measure progress in meeting these standards. (See pp. 13-15)

Response of Department Officials

We provided a draft copy of this report to Department officials for their review and comment. The Department disagreed with some of our conclusions and recommendations. However, overall the Department recognizes the importance of reliable analysis of its RMU operations and the need for assuring quality of care. The response indicates that some improvements in these areas are underway.

Contents

Introduction

Background

The New York State Department of Correctional Services (Department) provides for the confinement and rehabilitation of approximately 70,000 inmates in 70 correctional facilities throughout New York State. The Department is responsible for giving inmates appropriate and humane medical care efficiently and cost-effectively in an environment that is secure for inmates, staff and the general public. The Department's Division of Health Services is charged with establishing policy, overseeing operations of facility medical units and delivering medical services to inmates. Based on inmates' health care needs and bed availability, the Department generally assigns inmates who need medical care to facility infirmaries, Regional Medical Unit (RMU) inpatient units or outpatient clinics, or outside hospitals. RMU inpatient units house inmates who require skilled nursing care. These inmates' health care needs cannot be accommodated in facility infirmaries, but they do not warrant the inmates' admission to, or continued stay in, a hospital. RMU outpatient units provide specialist consultation services in clinical settings.

The Department's objective in building RMUs on the grounds of existing correctional facilities is to provide inmates with high-quality cost-effective medical care. The Department currently operates the Walsh, Coxsackie and Wende RMUs which opened in March 1991, February 1996 and July 1998, respectively. The RMUs at Walsh and Wende are operated by State employees, and the RMU at Coxsackie is operated by Correctional Medical Services, Inc., a private contractor. The Department plans to add two more RMUs to its health care delivery system by February 2000: one is at Bedford Hills women's facility (planned to open in mid 2000), which the Department expects to operate with a private contractor; the other is at Fishkill facility (planned to open in early 2000), whose operator the Department has not yet determined.

The Department reports that the estimated operating costs for the existing RMUs total approximately $39 million for fiscal years 1996-97 through 1998-99. These RMUs provide a total of 237 inpatient care beds: 112 at Walsh, 60 at Coxsackie and 65 at Wende; the Bedford Hills and Fishkill RMUs will add another 90 beds.

Audit Scope, Objectives and Methodology

We audited the Department's direction and oversight of RMU inpatient operations for the period February 1, 1996 though May 31, 1999. Since the RMU at Wende had been open for only six months at the time our field work began, we focused our audit on the RMU inpatient operations at Coxsackie and Walsh. The objectives of our performance audit were to determine whether Department management has performed adequate analyses to determine the most cost-effective means of delivering quality services at its

RMUs, and whether the Department assesses if all of its RMU inpatient units provide a consistent and appropriate quality of care. Our intent in examining RMU inpatient units was not to conclude that one type of operation (i.e., public or private) was superior to the other, but rather to evaluate the decision-making process the Department uses to select its RMU operators. Further, we did not specifically examine RMU outpatient or clinic operations, or the Department's role in overseeing this aspect of RMU services. To accomplish our objectives, we interviewed Department officials, as well as officials from Correctional Medical Services, Inc. and the Department of Health. We also reviewed applicable laws, rules, regulations, policies and procedures; reviewed and analyzed relevant Department and contractor records and reports; assessed data and analyses used to make Department decisions; and observed RMU operations.

We conducted our audit in accordance with generally accepted government auditing standards. Such standards require that we plan and perform our audit to adequately assess those operations which are included in our audit scope. Further, these standards require that we understand the Department's internal control structure and its compliance with those laws, rules and regulations that are relevant to the operations included in our audit scope. An audit includes examining, on a test basis, evidence supporting transactions recorded in the accounting and operating records and applying such other auditing procedures as we consider necessary in the circumstances. An audit also includes assessing the estimates, judgments, and decisions made by management. We believe that our audit provides a reasonable basis for our findings, conclusions and recommendations.

We used a risk-based approach when selecting activities to be audited. This approach focuses our audit efforts on those operations that have been identified through a preliminary survey as having the greatest probability for needing improvement. Consequently, by design, finite audit resources are used to identify where and how improvements can be made. Thus, little audit effort is devoted to reviewing operations that may be relatively efficient or effective. As a result, our audit reports are prepared on an "exception basis." This report, therefore, highlights those areas needing improvement and does not address activities that may be functioning properly.

Response of Department Officials

We provided a draft copy of this report to Department officials for their review and comment. Their comments have been considered in preparing this report and are included in Appendix B. Where appropriate, we have made changes to our report. In addition, the State Comptroller's Notes to the Department's response are included as Appendix C.

Within 90 days after final release of this report, as required by Section 170 of the Executive Law, the Commissioner of the Department of Correctional Services shall report to the Governor, the State Comptroller, and the leaders of the Legislature and fiscal committees, advising what steps were taken to implement the recommendations contained herein, and where recommendations were not implemented, the reasons therefor.

The Decision-Making Process

The Department has operated the Walsh RMU as a State-operated facility since its opening in 1991, but Department managers decided to use a private contractor to run the RMU operation at Coxsackie when it opened in 1996. This decision was based, in part, on a 1995 Department cost study which indicated the Department's use of a private contractor for Coxsackie's inpatient operations would result in a net savings of more than $900,000. Department managers also stated in 1996 that the use of a private contractor at Coxsackie would make it possible to compare the costs of State-run and contractor-run inpatient operations. This information would help them decide the future direction, operationally-speaking, of the Department's existing and planned RMUs. At the time Department managers submitted the proposed Coxsackie contract for approval by the Office of the State Comptroller (OSC), they assured OSC that the State would benefit through such comparisons because they would help the Department make cost-effective decisions for RMU operations. OSC approved the Coxsackie contract, in part, because of this anticipated benefit. As part of the comparison process, OSC required the Department to report, on a periodic basis, the detailed savings that accrued to the State from the private contractor's operation of Coxsackie's inpatient unit.

The Department provided only one report in 1997, however, when we examined the data in the report that supported the Department's decisions about RMU operations, we found the Department had not achieved the expected savings or performed the cost comparisons. We note these issues below and describe them further in this section of our audit report.

- The savings from using a private contractor at Coxsackie did not materialize. The Department's most recent cost projections show lower per-patient costs at Walsh, (State-operated) than at Coxsackie (vendor-operated).

- The Department has not established any reliable means of accumulating cost data or savings detail information. The Department's existing cost information is neither accurate nor updated.

- The Department did not do any meaningful comparisons of State-operated versus contractor-operated inpatient costs, and did not report this information to OSC as it agreed to do when the contract was approved. Department management did not do cost studies it acknowledged were needed for decision-making. Thus, the Department made decisions about RMU operations without appropriate plans or adequate information and may make uninformed

decisions about RMUs upon renewal of vendor-operated RMU contracts.

Estimating Expected Savings

The Department's 1995 cost study compared the costs of operating a 60-bed inpatient unit at Coxsackie with State employees or with contract employees, and found the Department would realize net annual savings of $900,000 ($15,000 per bed, or 22 percent of the fiscal year 1996-97 cost per bed at Coxsackie) by using a private contractor to run the unit. In 1997, the Department completed a review of fiscal year 1996-97 operations of the inpatient units at Coxsackie and Walsh and found that initial cost savings at Coxsackie, as compared to Walsh, were actually greater than expected: over $1.3 million (over $21,000 per bed). However, fiscal year 1998-99 Department projections of these units' comparative operating costs show that Coxsackie's significant cost advantage had disappeared, and that Walsh now had a cost per bed advantage of more than $6,440. We analyzed the Department's cost study, as well as its subsequent review and estimates, to determine whether the methodologies were reliable and the results were accurate. We also wanted to understand why, over a two-year period, there was a dramatic turnaround in the per bed cost advantage between the two units.

We determined that the Department's 1995 projection of $900,000 in savings from using a private contractor at Coxsackie was overstated by nearly $415,000. The Department established these projected savings by comparing the projected annual cost of running Coxsackie's inpatient unit with State employees ($4.7 million) to the cost of a private vendor's bid proposal of $3.8 million. However, we found the Department's $4.7 million cost figure included personal service costs for outpatient and specialty clinical positions which the vendor did not include in his bid.

When we discussed this issue with Department managers in April 1999, they indicated that the particular positions are included in the per diem charged by the contractor who operates the inpatient unit. Therefore, it was appropriate for such charges to have been included in the projection of the unit's State-operated cost. However, we did not find this argument convincing or supportable for the following reason. The contractor who submitted the successful $3.8 million bid for the Coxsackie inpatient unit operated the unit from its opening in February 1996 until April 1998 when a second contractor assumed the contract to perform these services. The Department used the initial contractor's bid to do the 1995 projection, and that bid did not include the $415,000 for clinical positions.

The second contractor, who currently operates the unit, told us he does include the cost of these clinical positions in the inpatient per diem charges, as Department managers stated. However, our analysis of 1998 contract

negotiations showed that per diem charges were raised at that time, in part, to cover the cost of funding additional staff.

By contrast, we found that the Department's 1995 Request for Proposal discussed both outpatient and inpatient program proposals. The outpatient proposal required the vendor to include a budget that "shall cover…outpatient clinical consultation/evaluation/treatment …" costs. The inpatient proposal did not require vendors to include costs for clinical services. Accordingly, the initial contractor submitted a bid that included costs of clinical services in the outpatient proposal, but did not include costs for clinical services in the inpatient proposal. As a result, the initial contractor's bid at $3.8 million to operate the inpatient unit did not include $415,000 for clinical positions which were included in the Department's projection of State-operated cost.

The Department also analyzed the cost of Coxsackie and Walsh inpatient operations for fiscal years 1996-97 through 1998-99. These analyses (*see Table 1*) show dramatic changes in the costs in their comparative operating costs. The 1996-97 analysis showed that Coxsackie's costs per bed were $21,669 less than Walsh's costs; the 1997-98 analysis determined that Coxsackie's costs per bed were only $143 less than Walsh's costs; and the 1998-99 Department data indicated that Walsh's costs per bed were $6,440 less than Coxsackie's costs. Since the Department used the same methodology in all these analyses, we did a detailed review of the Department's analytical procedures, data and documentation for only the 1998-99 analysis. We found problems with the analysis, ranging from understatements and overstatements of costs to reconciliation errors and incomplete information. The following are examples of the problems we found in the Department's 1998-99 analysis. This analysis reported operating costs per bed based on the average number of inmates in RMU inpatient unit beds.

- The operating cost analysis improperly includes personal service costs of clinic personnel.

- The analysis is based, in part, on projected rather than actual numbers.

- Personal service costs for the Walsh inpatient unit are inflated by a total of almost $400,000 because of the inappropriate inclusion of vacant items and a reconciliation error.

- The analysis overstates other-than-personal service (OTPS) costs for the Coxsackie inpatient unit, and understates these costs for the Walsh unit. This over/understatement occurs because OTPS clinic costs are segregated out for Walsh, but are not for Coxsackie.

In addition, costs for purchases are not correctly coded and/or recorded. We reviewed a judgmental sample of approximately 50 purchase orders at the Walsh RMU for fiscal year 1998-99. As the Walsh RMU is on the grounds of the Mohawk Correctional Facility, all medical purchase orders are processed through one business office. A sample was chosen which represented all Walsh RMU "other than personal service" cost centers, as well as two medical "other than personal service" cost centers for the Mohawk Correctional Facility infirmary. We found instances in which incorrect cost centers were applied to purchases. Although these errors caused a relatively small dollar understatement in Walsh purchases, the occurrence of miscoding was over 10 percent. The results of the analysis could, therefore, be misleading if Department managers use it to reach conclusions about the comparative cost-effectiveness of RMU operations.

After correcting the errors we found in the 1998-99 analysis and adjusting costs, we found that the Walsh inpatient unit had indeed become the more cost-effective of the two operations, but by a slightly smaller margin.

TABLE 1

RMU Inpatient Facility	Department Reported 1996-97 Operating Costs Per Bed (Actual)	Department Reported 1997-98 Operating Costs Per Bed * (Projected)	Department Reported 1998-99 Operating Costs Per Bed * (Projected)	1998-99 Costs as Adjusted by OSC
Coxsackie	$68,268	$70,339	$79,212	$74,414
Walsh	$89,937	$70,482	$72,772	$69,143
Difference in Operating Cost	($21,669)	($143)	$6,440	$5,271

* The Department used nine months of actual data and three months of projected data to do this analysis.

Despite the fact that we were given these Department-prepared comparative analyses for the Coxsackie and Walsh units, Department managers questioned the utility of our doing such a comparison. According to these managers, the two inpatient facilities contain different types of operational units and are not suited to a side-by-side comparison. However, Department management informed us on several occasions that both units treat patients with the same medical conditions, and that the numbers of patients with these conditions are generally the same at both units. We also point out that we simply made corrections to the Department's own side-by-side analyses.

Department managers also contend that, since the Walsh unit has grown from a 62-bed unit in 1996 to a 112-bed unit in 1998, it is reasonable to expect that its per-patient costs would be lower than those of the 60-bed unit at Coxsackie

because of economies of scale. We acknowledge that some of Walsh's savings are almost certainly attributable to economies of scale. However, Department managers do not know how much may be due to sharing operating costs among more patients, and how much may be due to other efficiencies, or to better practices. We also suggest that, if the Department believes it can achieve this level of savings from economies of scale, it should consider this as a factor in planning for future inpatient units. (The new units at Bedford Hills and Fishkill are expected to contain 30 and 60 beds, respectively.) In determining capacity needs, the Department should evaluate geographic conditions as well as demand for space. Notwithstanding, over a three-year period, the Department's expected savings at Coxsackie did not materialize, while Walsh's costs have decreased by comparison. Department managers should find out the reasons for these outcomes.

It is essential that Department managers have access to accurate historical cost information to be able to make informed decisions about how best to operate inpatient units in the future. The Department should develop a sound methodology for comparing inpatient unit costs at all RMUs, and establish a reliable system for accumulating accurate data.

The Department should also tighten controls over the recording of purchasing data to increase the accuracy of reported information. For example, we were told that Walsh personnel sometimes understate charges to meet the operating budget of the cost center to which the inpatient costs are charged. In our review, we also found ten purchase orders, or 20 percent of our sample, with purchase requisitions that had incomplete information describing the "area of use" of the purchase which is necessary to identify what cost center to apply to the purchase. This could contribute to the high incidence of miscoding. We also believe there should be regular and better communication between the Department and the inpatient units. In this way, Department analysts could obtain data useful for cost analyses, such as a break out of OTPS costs between an RMU's clinic and inpatient units.

Performing Cost Comparisons

The Department decided to run the RMU unit at Wende, which opened in July 1998, as a State-operated unit, and to run the Bedford Hills RMU, which was scheduled to open in June 1999, as a contractor-operated unit. Managers stated that these decisions were based, in part, on the results of the 1996-97 study of the comparative costs of the Coxsackie and Walsh inpatient units. Of the Department's three comparisons of the Coxsackie and Walsh units, only this study used actual costs and included demographic and clinical factors for patient populations.

A Department official stated in the study that he did not believe a one-year comparison gave reliable enough information on which to confidently base

future decisions on how best to operate RMUs, particularly since Coxsackie had been operating for only two months when the study period began. He also expected cost savings derived from Coxsackie's contractor-operated unit to decrease as contract costs increased to cover higher medication and salary costs. Thus, the Department recommended doing a follow-up study before drawing any conclusions about the relative costs of State-operated versus contractor-operated units. However, this study was never done. Since Coxsackie had been operating for over two full years by the time Wende opened, the Department would have had ample time to do such a follow-up study before deciding on the type of operation Wende should be.

When we asked Department managers about the decisions they made, and how they made them, they indicated they decided to make Wende a State-operated unit because of a "gut feeling" the savings anticipated at Coxsackie were never realized, and a belief they could recruit State employees in the area surrounding Wende. Department managers indicated the Bedford Hills RMU operation would be put out to bid because it would be difficult to recruit State employees for the RMU in that area of the State (Westchester County). Managers said they made the decision for out-sourcing the Bedford Hills RMU using the same process of cost comparison they used in deciding about the Coxsackie RMU. When we asked Department managers how they planned to run the Coxsackie inpatient unit upon the expiration of the current contract in 2000, they told us they will continue with a private contractor because, "if it isn't broken, don't fix it."

When the Department first sought OSC approval for the original contract for Coxsackie's operation, it indicated that using a private contractor to run this inpatient unit would enable the Department to compare the costs of State-operated to contractor-operated units so they could decide the future direction of RMU operations. The Department claimed the State would benefit from such comparisons, since they would result in cost-effective decision-making. The Department performed only one comparison in 1997 which it acknowledged was inadequate for decision-making purposes.

We believe it is essential that the Department perform thorough cost comparisons of State-operated and contractor-operated inpatient units. The Department should determine the costs of these operations, not simply because they agreed to do so, but because good strategic planning and informed decision-making require it.

Recommendations

1. Establish reliable systems for capturing and reporting cost information for RMU inpatient units and do cost analyses using actual cost data.

2. Use cost analysis data, together with any relevant qualitative information, to do comprehensive comparisons of State-run and contractor-run RMU inpatient operations. Based on the results of these comparisons, decide the most cost-effective way to operate RMU inpatient units.

3. Report cost savings results to OSC, as agreed.

Quality of Care

Quality assurance programs are essential to assist healthcare purchasers, regulators, consumers, and providers assess how well all aspects of healthcare delivery systems are managed. Management standards of quality of care are important to assess health care system. A primary goal of most quality assurance programs is to objectively and systematically monitor and evaluate the quality and appropriateness of care and service provided, and to pursue opportunities for improvement.

The importance of quality assurance programs and performance indicators in the health care environment has been recognized by the Department and other governmental organizations for nearly a decade. In 1990, the Department's Division of Health Services (Division) produced a draft Quality Assurance Program which emphasized the necessity of quality assurance programs and continual monitoring to improve health services. The New York State Department of Health highlighted the significance of quality assurance programs in its 1992 assessment of the Walsh RMU. In 1994, the Department again recognized the importance of quality assurance programs and monitoring practices when it hired a consultant to develop health care performance indicators for facility infirmaries. In 1996, the Department confirmed to OSC that it would monitor the effectiveness of the level of care provided at the Coxsackie RMU inpatient unit that is operated by a private contractor.

While the Department has acknowledged the importance of quality assurance programs and performance monitoring, we found that it has not established a formal quality assurance program that pertains to all RMUs, or ensured that RMUs have formal programs in place. The Division has not finalized its 1990 draft Quality Assurance Program; further, it is still developing a formal quality assurance program at the Walsh inpatient unit, which has been operating for eight years.

The American Correctional Association (ACA) accredits and audits the Department's RMU operations. ACA certification standards require RMUs to have ongoing quality assurance programs designed to objectively and systematically monitor and evaluate the quality and appropriateness of inmate health services. In June 1998, the ACA found the Walsh RMU was in compliance with this and 80 other standards during a two-day on-site audit. However, our detailed evaluation of the Walsh unit found that, ACA certification notwithstanding, there was no formal quality assurance program at Walsh at the time of the ACA audit. We found limitations in the two sources of documentation the Division used as evidence that it maintained an ongoing quality assurance program.

- Although Walsh personnel state Quality Management Meetings are held monthly, Division managers could find the minutes of only four meetings held during a 12-month period. Members indicated in the minutes that a quality assurance program could not be effective without the support of upper management. Of the minutes we reviewed, the Deputy Superintendent for Health Care at Walsh and Division managers attended no meetings and the Medical Director attended only two.

- The Division indicated that its Multidisciplinary Inmate-patient Care Conferences for Quality Care were evidence of a quality assurance program. However, the chairperson of the Quality Management Meetings said these conferences are not a part of a quality assurance program.

Walsh managers confirm that they did not begin to develop a formal quality assurance program at Walsh until 1997, and that it was still in the development stage in February 1999. At that time, they stated it was too early to decide what quality measures would be considered. Division managers indicated they were unsure who, within the Division, was responsible for ensuring a quality assurance program existed at Walsh.

The contractor operating Coxsackie's inpatient unit has implemented a quality assurance program as required by the terms of the contract. However, we determined that Division managers do not use the results of the quality assurance program to assess the contractor's management of operations. The contractor is also required to develop an annual health care plan containing measurable objectives for operation of the RMU inpatient unit but has never supplied the Division with such a plan. Division managers stated the contractor is paid to manage the inpatient unit and they do not want to tell the contractor how to run the unit. We believe that oversight at the Division level is essential to help ensure contract compliance.

In 1994, the Department hired a consultant to assess existing quality assurance programs at Department facilities and to implement a broad and dynamic quality management program dedicated to continuous improvement in the overall quality of inmate health care services. This contract extended over three years, and included the development of a system to establish, capture and monitor quality performance indicators. However, the Department did not have the contractor review RMU inpatient operations or develop quality of care standards and related performance indicators for RMU inpatient operations.

Division managers told us they would like to develop performance indicators for quality of care at RMUs and set up systems to measure how inpatient units are doing. However, they believe it is too early in the development of RMUs to set up these systems and perform meaningful comparisons. They also contend they do not have the resources to do these management tasks.

However, Walsh and Coxsackie have been open for eight and three years, respectively. Since the Department is responsible for the operation of all its RMUs, it should also have formal quality of care standards that apply to all RMUs. Allowing for the unique characteristics of specific RMU operations, such a program should set quality of care standards that all units should meet, and establish the means to systematically monitor, evaluate and report on performance as measured against these standards.

Recommendation

4. Set quality of care standards that all RMU inpatient units should meet. Develop performance indicators related to quality of care and evaluate performance indicator data to measure progress in meeting the standards.

Major Contributors to This Report

William Challice
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GLENN S. GOORD
COMMISSIONER

December 14, 1999

Mr. William Challice
Audit Director
Office of the State Comptroller
Division of Management Audit
& State Financial Services
270 Broadway, 19th Floor
New York, New York 10007

Re: Draft Audit 97-S-40
Oversight of Regional Medical Units

Dear Mr. Challice:

In accordance with Section 170 of the Executive Law and in response to your correspondence of November 1, 1999, attached is the Department's reply to the draft audit of Oversight of Regional Medical Units.

We are complying with the provisions of the Budget Policy and Reporting Manual, item B-410 by simultaneously forwarding two copies of this response to the Division of the Budget on December 6, 1999.

Sincerely,

Glenn S. Goord
Commissioner

Attachment

STATE OF NEW YORK

DEPARTMENT OF CORRECTIONAL SERVICES

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GLENN S. GOORD
Commissioner

LESTER N. WRIGHT, M.D. MPH
ASSOCIATE COMMISSIONER/
CHIEF MEDICAL OFFICER

December 2, 1999

William P. Challice
Audit Director
Office of the State Comptroller
Division of Management Audit & State Financial Services
270 Broadway, 19th Floor
New York, NY 10007

Dear Mr. Challice:

Enclosed is our response to your draft report (97-S-40) on the Department of Correctional Services, Oversight of Regional Medical Units.

Please let us know if any additional information is required.

Sincerely,

Lester N. Wright, MD, MPH
Associate Commissioner/Chief Medical Officer

cc: Stephen M. Bernardi, Deputy Commissioner

The Office of State Comptroller addressed the following questions about Department oversight of Regional Medical Unit Inpatients Units for the period February 1, 1996 through May 31,1999:

- Has Department management performed adequate analyses to determine the most cost-effective means of delivering RMU inpatient services?

- Does the Department ensure that all its RMU inpatient units provide a consistent and appropriate quality of care?

Listed below are the Department's responses to specific OSC recommendations on each of these questions. Additionally, we have provided comments in response to some OSC "statements" within the body of their findings.

Question #1 - "The Decision-Making Process."

Recommendation #1:
Establish reliable systems for capturing and reporting cost information for RMU inpatient units and do cost analyses using actual cost data.

Answer:
We have reliable systems in place for capturing and reporting cost information. Is is standard practice to use actual data. However, at the time of OSC inquiry into 1998-99 cost data, actual data were not available as accounts for this fiscal year were still active. This was explained to the auditors on several occasions. A preliminary analysis of actual figures for fiscal year 1998-99 indicates that the operating cost for both the Coxsackie and Walsh Regional Medical Units was lower than anticipated. DOCS will provide OSC with actual data once it is available.

* Note 1

Recommendation #2:
Use cost analysis data, together with any relevant qualitative information, to do comprehensive comparisons of State-run and contractor-run RMU inpatient operations. Based on the results of these comparisons, decide the most cost-effective way to operate RMU inpatient units.
Answer:
The Department's Division of Budget & Finance has done comparisons of State-run and contractor run inpatient operations. A side by side comparison of estimates for FY 98-99 for all four Regional Medical Units (Coxsackie, Walsh, Wende and Bedford Hills) was done and provided to the auditors. (Copy is attached) However, as we pointed out to the auditors, cost should not be the only factor considered. Quality of care and ability to recruit and retain staff must also be considered.

Furthermore, because of the differences in the configuration and geographic location of these units, a more appropriate analysis would be to compare the cost of operating the Coxsackie RMU with contract staff to the cost of running the unit with state run staff, updating the original analysis for negotiated salary increases and other factors. The Department conducted such an analyses in 1998 and determined that contracting saved the taxpayers $608,000. This was also shared with the auditors.

* Note 2

*See State Comptroller's Notes, Appendix C

Additionally, we must have confidence that we have an ability to recruit and fill health services positions within these RMUs. During the beginning of this year, we initiated a bid process for the operation of our 30-bed Regional Medical Unit at Bedford Hills. Subsequently four bids were received and are currently under review. The Bid Review Panel will weigh the cost of state run operation vs. the budget submitted in these proposals as one of their evaluative criteria. As is our normal practice, copies of all proposals as well as evaluation criteria will be made available to the Office of the State Comptroller as part of the contract approval process, if the Department determines it is in the best interests of the State to award a contract.

Recommendation #3:
Report savings results to OSC, as agreed.

Response:
The Department will provide all cost savings analysis to the Office of State Comptroller.

Comments specific to "statement" made within the "Decision Making" Findings:

Statement pg. 5..... We determined that the Department's 1995 projection ....was overstated by nearly $415,000.....However, we found the Department's figures included personal costs for outpatient and specialty clinical positions which the vendor did not include in his bid.....When we discussed this issue with Department managers they indicated that the particular positions were included in the per diem charged by the contractor who operates the unit.....however, we did not find this argument convincing or supportable.....

Response: We fail to understand how the Comptroller's staff can support this conclusion given the documentation provided them by Department as well as vendor staff. During the course of our discussions, auditors acknowledged the existance of our proof but choose to ignore it. Documentation was provided to OSC from the original contractor (United Correctional Managed Care) which clearly and explicitly indicated that the outpatient and specialty clinical positions were included in the Coxsackie RMU Inpatient Table of Organization. Additionally, OSC confirms that the second contractor advised that they (CMS) included the cost of outpatient clinical positons in the inpatient unit costs. Finally, inpatient RMU per diem charges were raised during contract negotiations in part to cover the additional staff associated with increased clinic activity. It is our position that conclusive documentation has been submitted to OSC which supports the inclusion of clinic staff within the inpatient per diem costs.

* Note 3

Statement pg. 7.....we found that the Walsh inpatient unit had indeed become the more cost effective of the two operations but by a slightly smaller margin.
Response: We continue to assert that we expect Walsh costs per bed to be lower due to lower per bed fixed costs and economies of scale resulting from allocation of similar fixed costs to a 112-bed operation compared to a 60-bed operation. This is consistent with the fixed cost analysis provided to the OSC auditors.

* Note 4

*See State Comptroller's Notes, Appendix C

If the Department operated the Coxsackie RMU with state staff instead of by contract, it would still be more expensive per bed to run 60-bed Coxsackie than either 112-bed Walsh or 80-bed Wende. As such, Coxsackie's higher operating cost is not necessarily the result of privatization.

Statement pg. 8.....We also suggest that if the Department believes it can achieve..savings from economies of scale, it should consider building larger-capacity inpatient units....In determining capacity needs, the Department should evaluate geographic conditions as well as demand for space...

Response: We refer OSC auditors to the Health Care Plan of Action (HCPA) (copy provided to them after the opening audit meeting). This comprehensive study had input from several state agencies. It evaluated such factors as geography, access to services, location of prisons, existing physical plants, and development of a statewide space program and regionalization of services. Based on this study, which was adopted at the highest levels of state government, the appropriate size and placement for each of the RMU's was determined and the facilities were constructed accordingly. We disagree with a conclusion that suggests that this effort was not the best way to plan for provision of the Department's future health care needs

* Note 5

As a final comment on decision-making, Mr. Theodore Sacawa, of the Office of the State Comptroller, was recently forwarded a letter by our Deputy Commissioner and Counsel, Anthony J. Annucci, which summarized the status of coordinated specialty care contracts, including the operation of the Coxsackie RMU. We refer you to that letter as an indication as to the alternative approaches being considered by the Agency in the delivery of inmate healthcare.

Question #2 - "Quality of Care"

Recommendation #4
Set quality of care standards that all RMU inpatient units should meet. Develop performance indicators related to quality of care and evaluate performance indicator data to measure progress in meeting the standards.

Response:
The Division's policies and guidelines do provide a system for monitoring care. We recently received approval from the Division of Budget to fill the vacant Supervisor of Utilization and Management Program. Upon appointment to this position, the primary focus of the incumbent will be to assemble the pieces into a " Quality Assurance (QA) Program." DOCS has convened Task Forces including representatives from all RMUs to standardize operating practices and help assure quality of care. Upon completion of a QA manual, we will forward a copy to the Office of State Comptroller.

Comments specific to "statements" made within the "Quality of Care" Findings:

Statement pg. 12.....upper management did not attend QA meeting at Walsh.

Response: We documented the attendance of RMU and Central Office Management at Walsh QA meetings in our May 24, 1999 correspondence to the auditors.

* Note 6

Statement pg. 12....Division managers stated the contractor is paid to manage the inpatient unit and they do not want to tell the contractor how to run the unit.

Response. We emphatically deny that Central Office Division managers made this statement. What Central Office Division managers said was that they do not get involved in the day to day operations since the Deputy Superintendent of Healthcare posted at each RMU is the person responsible for monitoring the day to day activities of their facilities.

* Note 7

LNW/TAW/SJR

*See State Comptroller's Notes, Appendix C

Estimated full year cost of operating Regional Medical Units in Fiscal Year 1998-99

Indices	Coxsackie	Walsh	Wende	Bedford Hills
Personal Service (salaries) *	$97,113	$4,986,802	$3,528,981	$1,715,036
Other Personal Service	$200	$105,200	$76,600	$37,200
Non Personal Service	$99,534	$602,344	$515,966	$192,118
Drugs from Cent. Pharmacy	$0	$562,221	$482,034	$179,483
Payments from Ctl. Accts.	$0	$0	$0	$0
Contract Payments	$4,519,620	$0	$0	$0
Total Direct Cost	$4,716,467	$6,256,567	$4,603,581	$2,123,836
Fringe Benefits @ 32.65%	$31,773	$1,662,539	$1,177,222	$572,105
Indirect cost @ 4.64%	$4,506	$231,388	$163,745	$79,578
Total cost	$4,752,746	$8,150,493	$5,944,548	$2,775,519
Authorized State Staff	2	154	136.5	61.5
Average # of Inmates	60	112	80	30 **
Cost per inmate	$79,212	$72,772	$74,307	$92,517

*Personal service estimates include 3.5% raise in October.

** 30 Bed Mental Health unit at Bedford staffed by OMH.

State Comptroller's Notes

1. During the audit, Department management acknowledged that their 1996-97 cost data was not reliable. Further, the Department never produced actual cost data for the 1997-98 fiscal year. In addition, as stated on pages 6 and 7 of our report, we found control weaknesses in the Department's systems in place for capturing and reporting cost information such as the improper inclusion of some costs and the exclusion of other costs. We hope that these control weaknesses have been addressed and, that upon final evaluation of the fiscal year 1998-99 data, the Department concludes that the data is reliable.

2. Department management that we questioned indicated that they relied on experience and "gut feeling" in making decisions on how to operate RMU inpatient units rather than actual cost data in their decision-making process. We had received and reviewed the fiscal year 1998-99 side by side comparison for Coxsackie and Walsh, and, as indicated on pages 7 and 8 of our report, we found problems with the data. The data for Wende and Bedford Hills was not reviewed as Wende was only operational six months at the time of our audit, and Bedford Hills was not yet operational. As stated in our recommendation, we do recognize that, in addition to cost data, relevant qualitative information should also be considered.

   The 1998 analysis citing the $608,000 savings referred to in the response was developed using the same assumptions as the Department's 1995 cost study. As discussed on page 6 of our report, use of those assumptions resulted in cost savings from using a private contractor to run Coxsackie being overstated by $415,000.

3. The response is inaccurate. We considered all of the documentation submitted by the Department which demonstrated three significant events. First, the facts in question relate to documents provided by the original contractor (United Correctional Managed Care) in 1995; the second contractor (CMS) did not take over the contract until 1998. Second, the documentation which supports the Department's 1995 projection is the original contractor's bid proposal submitted in response to the Department's RFP for clinical and inpatient unit operations at Coxsackie. The bid proposal clearly shows that clinical positions were not included in the contractor's original budget proposal. Further, the Table of Organization cited in the response is in reference to a June 1996 organization of the entire Coxsackie RMU after the withdrawal of the originally planned operator. The only organization chart submitted in support of the $3.8 million budget proposal, which was used in the Department's 1995 projection, was the one included with the original contractor's 1995 bid proposal which did not include clinic staff. Third, as indicated on page 7 of our report, the contracted price of the 60-bed inpatient unit increased in subsequent years of operation, in part, due to per diem charges which were raised partly to cover the cost of funding additional staff in that unit. Documentation submitted by the current vendor clearly shows that the original staffing component at the 60-bed unit did not include clinic staff, but that they were later added.

4. As stated on page 9 of the report, we acknowledge that some of Walsh's savings are almost certainly attributable to economies of scale. While we requested a breakdown of fixed costs at Coxsackie and Walsh for the fiscal years 1996-97 through 1998-99, we received only salary costs of the positions that were used in the Department's 1995 projection (see page 5 of our report). Given the information provided, we conclude that the Department does not know the financial impact that sharing operating costs among more patients will have.

5. We modified the text of the report to clarify out intent on planning for future units. The Health Care Plan of Action is now almost eight years old. At the time it was developed, only one RMU was in operation. We suggest that with eight years of experience behind it, and the availability of actual cost and operating data, the Department should, going forward, evaluate its options. It should be noted that the letter referred to in the response, that was sent to Mr. Sacawa of our Office, generally refers to outpatient/clinic services as opposed to RMU inpatient services.

6. As stated on page 14 of our report, we received only four of a requested twelve meeting minutes. A Department manager stated the four meeting minutes were the only ones produced due to staff shortages.

7. In a meeting on February 10, 1999 with Division and Department management, attended by representatives from Coxsackie and Walsh, as well as three State Comptroller auditors, the statement referred to in the Department's response was made.