State of New Jersey
Office of the Inspector General
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Department of Corrections
Inmate Dental Services Report

October 15, 2007

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I. INTRODUCTION

A. Scope of Investigation

On March 22, 2005, the New Jersey Department of the Treasury (Treasury) awarded a two-year contract to Correctional Medical Services[1] (CMS) to furnish inmate health services, including dental services, to the Department of Corrections (DOC). At its inception the two-year contract was valued at an approximate maximum $168 million (net of inpatient hospital costs), including an approximate maximum $7.5 million for the dental portion. It is one of the largest contracts entered into by the State. Shortly after the April 1, 2005 commencement of the contract, Treasury's Contract Compliance and Administration Unit (CCAU) audited the dental services portion of the contract to determine whether DOC was monitoring CMS's compliance with, and CMS was adhering to, the contract specifications and relevant New Jersey Administrative Code requirements.

[1] Correctional Medical Services ("CMS") is based in St. Louis, MO. Founded in 1979, CMS reports that it now serves over 250,000 inmates at 300 sites in 27 states. CMS is the contracted healthcare provider for 11 statewide correctional health care systems, reportedly more than twice the number of CMS's closest competitor. CMS provides medical, dental, nursing, behavioral health and pharmacy services. CMS is not a publicly-traded company but is indirectly owned by a variety of investment companies; most recently its annual revenue was reported to be $750 million.

CMS reports that it employs or contracts with approximately 900 healthcare professionals and administrative staff in New Jersey. CMS claims that it fills the DOC contracted 533 full time (or their equivalent) medical positions through an active roster of 883 medical personnel.

CCAU found internal control deficiencies in DOC processes and procedures for managing the dental provisions of the inmate health services contract. Essentially, CCAU concluded that DOC did not have an automated information system in place to monitor performance requirements. DOC disagreed with some of the conclusions, and CCAU asked the Office of the Inspector General (OIG) to determine whether CCAU's conclusions are valid. This report is the result of OIG's investigation.

B. Investigative Process

In conducting the investigation, OIG interviewed 24 people, many of them multiple times, including DOC employees, CMS representatives, the president of the former dental services provider, and representatives from Treasury's Division of Purchase & Property. OIG gathered over 12,000 pages of documents that were logged into a database. OIG also performed a site visit at the DOC Central Reception and Assignment Facility, including an observation of the dental intake process.

OIG provided a draft of this report to the Commissioner of the Department of Corrections for review and comment. The Commissioner's comments and the comments of responsible staff have been included in this report as appropriate.

C. Format of Report

This report contains the results of OIG's review of DOC's monitoring of the dental portion of the inmate health services contract as well as findings regarding CMS compliance with timeliness provisions of the contract. It is divided into five sections: Section I is this Introduction; Section II is a summary of OIG's conclusions; Section III contains relevant background information; Section IV contains a detailed analysis of the evidence supporting OIG's conclusions; and Section V contains recommendations for corrective actions. This report also contains appendices.

During the course of OIG's review several observations were made that require further investigation and analysis. OIG is currently reviewing those matters and the results will be reported separately after OIG's continuing review is completed.

Importantly, neither CCAU's audit, the OIG investigation that is the subject of the current report, nor OIG's continuing review addresses the quality of the medical and dental treatments provided by CMS.

II. SUMMARY OF CONCLUSIONS

The health services contract awarded to CMS as of April 1, 2005, required CMS to deliver health treatments and services, including dental treatments and services to approximately 40,000 inmates annually -- approximately 26,000 inmates housed in corrections facilities on a daily basis and an additional 14,000 inmates who are incarcerated for some portion of, and released during, the contract year. To address concerns for improving the provider's performance that developed during the prior contract for health services and as a mechanism to guarantee the provision of services, this contract directed that certain services be provided within specific timeframes with associated "liquidated damages" assessed against the provider for failure to meet some of the timeliness requirements. DOC was responsible for monitoring CMS's compliance with the contract requirements, including the timeliness requirements, and the assessment of liquidated damages.

The evidence gathered during OIG's investigation indicates that at the inception of the contract, DOC's electronic medical record database (EMR) was not structured to readily provide relevant information in a format that would be useful to systematically and accurately monitor CMS's compliance with contract requirements, including the timeliness requirements, in the provision of dental services or to compute any liquidated damages associated with failures to comply with those provisions. Thus, evidence gathered during OIG's investigation indicates that CCAU correctly concluded that at the time of its audit, DOC did not have a reliable automated system to monitor CMS's

compliance with the dental segment requirements of the inmate health services contract. The evidence also supports the validity of CCAU's concerns for the apparent absence of a reliable automated system to assess liquidated damages. OIG investigated whether these deficiencies in DOC's monitoring abilities were corrected after CCAU's audit.

The evidence indicates that at the time the contract was bid, DOC was aware that its electronic monitoring system was not programmed to provide the monitoring services required by the contract; and at least eight months prior to the contract award, DOC's Office of Information Technology had begun designing automated programs to monitor compliance with the health services contract. During the two years of the contract, DOC introduced automated programs intended to use EMR data to systematically monitor CMS's compliance with contract requirements for the provision of services and to determine whether -- and how much -- liquidated damages were applicable:

- Seven months into the contract, DOC implemented automated programs intended to enable DOC to use EMR data to systematically monitor CMS compliance with certain contract requirements (performance indicators) and to calculate associated liquidated damages, including requirements for two services that had both medical and dental components and associated liquidated damages for failures to meet those requirements.
- Fourteen months into the contract, DOC implemented additional automated programs using EMR data to provide reports of CMS's compliance with timeliness requirements for several other dental treatments specified in the

contract as performance indicators but that did not have associated liquidated damages.

However, the system utilized by DOC to monitor CMS's compliance contained known weaknesses that had the potential to significantly affect the validity of the information reported: (1) the data was entirely entered by the vendor (who theoretically had an interest in not reporting missed deadlines triggering liquidated damages) and was essentially unverified by DOC; (2) known errors in the data for timeliness of dental treatments were not corrected in the EMR; and most significant, (3) historical data essential to assessing CMS's compliance with contract requirements -- information about the timeliness, or the lack thereof, of treatments for inmates who were released during the contract period -- was automatically removed from the EMR file shortly after an inmate's release and stored elsewhere in the system.

Despite its obvious relevance to determine CMS's compliance with contract requirements, information about treatments of inmates released during the contract period was therefore not available and not utilized in the program assessing CMS's contract compliance. With the progressive release of approximately 270 inmates a week, accumulating to approximately 14,000 inmates in the first contract year and 14,000 more in the second year of the contract, and the removal of related data about CMS's treatment of those 28,000 inmates from relevant files and consideration, the amount of relevant data not utilized by the program intended to assess CMS's compliance was significant and cumulative over the period of the contract. The negative impact of the removal of data

on the reliability and the accuracy of reports produced to determine CMS's compliance in providing timely services was magnified by the passage of time. Moreover, the reports could only increasingly underestimate CMS's historical failure to comply.

During the period of the contract, DOC produced system reports on a weekly basis and essentially used them as a snapshot of CMS's weekly performance. Recognized errors in the "raw" weekly reports were corrected by DOC employees and CMS representatives and corrections were reflected in reformatted reconciled reports used by DOC employees and CMS representatives at weekly meetings to discuss recent treatments and shortfalls in meeting contract requirements.

Responsible DOC representatives recognized that the automated reports as produced had little value in assessing or auditing CMS's overall compliance during any significant period of the contract and that the automated programs designed to systematically monitor CMS's compliance with contractual timeliness provisions could not be used to produce accurate reports regarding CMS's compliance. The evidence gathered during OIG's investigation indicates that DOC did not otherwise comprehensively and systematically monitor CMS's compliance with contract requirements. There was no reliable evaluation of CMS's compliance with contract requirements for any significant period during the contract year longer than a few weeks. Despite responsible DOC employees' knowledge that CMS had missed contract deadlines for provision of services, DOC did not implement a methodology to audit CMS's compliance or assess liquidated damages against CMS.

OIG was told by the responsible DOC employee that according to the contract, the assessment of liquidated damages against CMS was discretionary. The employee further told OIG that a decision was made that because CMS was performing well overall and improving in performance, the assessment of liquidated damages was not warranted because the action would have been punitive and counter-productive.

The evidence does not support the basis of the decision. Instead, it indicates that any DOC long term assessment of CMS's compliance was and could only be based on impressions and recollections of the DOC employees involved because accurate automated or documented data demonstrating CMS's performance was not available to DOC. Indeed, as demonstrated by OIG's analysis of available data, CMS had consistently failed to comply with some contract requirements. Moreover, the language of the contract does not strongly support an interpretation that the imposition of liquidated damages was discretionary, and the responsible DOC employee had not sought legal advice on the matter from the Attorney General's Office. Finally, even if discretionary, the responsible employee had not documented on a single or regular basis whether liquidated damages were due, the amount, and the basis for not assessing them against CMS.

The evidence indicates that CMS had not complied with certain requirements of the dental portion of the contract, including the requirement to provide treatments and services within specified timeframes, and that DOC had not comprehensively monitored CMS's non-compliance with those requirements. OIG was told that recently, DOC had

undertaken efforts to include information about releasees in the automated system producing weekly reports of CMS's compliance but little progress had been made in the process. Since historical data was not available in the DOC system, OIG attempted to find a reasonable way to determine the extent of non-compliance and the amount of liquidated damages, if any, that could have been assessed against CMS during the contract period.

Because of the removal of data regarding releasees, and thus a constantly changing database, historical "raw" weekly reports could not be reproduced. Even if the weekly reports could be reproduced, after the passage of many months since the start date of the contract, it was unlikely that DOC employees and CMS representatives could agree on errors in them to be corrected. OIG was told that DOC did not maintain electronic or paper copies of the DOC produced "raw" weekly reports of CMS's compliance or of the reformatted and reconciled weekly reports produced by CMS and DOC, and OIG was told of no other DOC programmatic effort useful in the evaluation of CMS's compliance.

OIG's analysis indicates, however, that information in the DOC/CMS reformatted reconciled weekly reports could have been manually compiled by DOC to provide a reasonable evaluation of CMS's compliance with contract requirements, as well as an assessment of any liquidated damages that could have been charged against CMS for lack of compliance. At least some, if not all erroneous data had been corrected in these reports. Moreover, the reports were produced weekly; and the information in them was static: each weekly report would contain some information about the treatment, lack of

treatment, or dental status of an inmate subsequently released. Therefore, they would likely contain more data than the EMR about the timeliness of dental treatments to inmates who were released. OIG was told that DOC did not maintain copies of the reformatted reconciled weekly reports but learned that CMS maintained copies of the reformatted reconciled reports and obtained copies of them from CMS. DOC representatives agreed with OIG's methodology and that the reports provide a basis to evaluate CMS's compliance with contract timeliness requirements, whether liquidated damages are appropriate, and the amount of liquidated damages that could be assessed against CMS.

OIG used the information in the reformatted reconciled weekly reports provided by CMS to assess CMS's compliance with the contract performance indicators for the dental portion of the contract. When analyzed, the data revealed that CMS had in fact consistently failed to comply with certain contract requirements, including one of the indicators with a dental component that had associated liquidated damages and some of the other dental performance indicators that did not have associated liquidated damages provisions. Where the analysis demonstrated a lack of compliance with the timeliness requirements of the dental portion of the contract, OIG further analyzed the evidence to determine the level of noncompliance, including calculating an estimate of liquidated damages when appropriate. The results of OIG's analysis are incorporated into this report.

Summarily, the evidence gathered during OIG's investigation supports the following conclusions:

- At the time of CCAU's audit, DOC did not have a reliable automated reporting system in place to monitor CMS's compliance with requirements of the dental segment of the inmate heath services contract.

- DOC developed a system designed to monitor CMS's compliance with contract requirements for timeliness of dental treatments, but the system was not sufficiently reliable for monitoring CMS's overall contract compliance.

- Although responsible DOC employees were aware of weaknesses in the automated system, as of OIG's investigation, those weaknesses in the system remain.

- DOC has not comprehensively monitored the contractual requirements of the dental segment of CMS's contract to determine whether required treatments were provided and whether treatments were provided within required time frames to assure that DOC was receiving appropriate and timely dental services for the fees paid to CMS.

- Several months after the start date of the contract, DOC's system had been modified to produce reports containing information that could have been used by DOC to compute the extent of any CMS failure to meet contract requirements.

Although DOC was aware that CMS failed to comply with some contract requirements for timeliness of dental treatments throughout the two-year contract period, DOC did not perform an overall analysis for the dental segment of the contract to determine the extent of non-compliance.

- The contract between DOC and CMS calls for the assessment of liquidated damages for CMS's failure to comply with two contractual requirements to provide dental services within specified time frames: intake and transfer screenings. DOC was aware that CMS failed to comply with timeliness requirements for one of these requirements on numerous occasions and as well as occasionally with the other. Nonetheless, DOC did not calculate nor assess liquidated damages against CMS for failure to provide the treatments within the required time frame.

- Using data supplied by CMS, OIG has calculated that CMS could be assessed between $850,000 and $1,000,000 in liquidated damages for 17 months of the two-year contract because of failure to comply with contract timeliness requirements for services that have a dental component: intake and transfer screenings.

- DOC's failure to monitor contractual compliance could have resulted in payments to CMS for services not provided or for services provided but for which CMS was not contractually allowed to separately invoice DOC. For instance,

OIG's review revealed that CMS billed DOC the amount of $132,345 for a service for which CMS was not permitted to separately bill DOC; and DOC has paid CMS the incorrect amount.

- DOC had not adequately monitored CMS's compliance with the staffing requirements of the dental segment of the contract nor taken effective steps to fully correct dental staffing deficiencies.

- DOC has agreed to pay CMS only a pass-through amount for dental staffing, but DOC does little, if anything, to verify the staffing hours and payments invoiced by CMS.

- OIG's limited review of the medical portion of the inmate health services contract indicates that DOC uses the same system with known weaknesses to monitor CMS's compliance with the contract timeliness requirements of the medical portion of the contract; and raises a concern of potential deficiencies in DOC's monitoring of CMS's compliance with the medical portion of the health services contract.

III. BACKGROUND

A. DOC Dental Program Description

DOC operates fourteen correctional institutions (nine for adult males, three for youthful offenders (not juveniles), one for adult females, and a male central reception/intake unit), housing an average daily population[2] of approximately 26,000 inmates. Located within the fourteen facilities are twenty-five separate dental clinics which have thirty-nine dental chairs. (See Appendix A.) Dental services are furnished by dentists and dental assistants.[3]

DOC's Internal Management Procedures include job descriptions and qualifications for dentists and dental assistants. Dentists perform clinical services such as dental assessments, performing and interpreting x-ray studies, providing emergency treatment, restorative dentistry (e.g., fillings, root canals, dentures), periodontal therapies, and certain extractions. Dental assistants assist dentists during examination and treatment of patients, including performing x-ray studies, preparing the operatory (dental suite), mixing and fabricating restorative materials, sterilizing instruments and disinfecting the

[2] Each year, DOC admits approximately 14,400 inmates and releases a similar number, most of them on parole.

[3] Following a pilot program in the second contract year, DOC and CMS have in the third contract year (a one-year extension of the contract) introduced dental hygienists into the inmate dental program. They are projected to provide 100 hours of dental services each week. It is anticipated that the dental hygienists, who will be located at DOC's three intake facilities, will provide dental cleanings to inmates upon their admission. This could significantly change CMS's performance and the amount CMS charges DOC. The third contract year is outside of the scope of OIG's review. OIG has been told that Treasury and DOC are planning to issue an RFP for a new contract to provide inmate medical and dental services.

operatory between patients, scheduling patients, and maintaining dental charts and records (including manual logs and entering treatment data in the EMR).

According to DOC's organizational structure, the provision of inmate health services, including dental services, is in DOC's Division of Operations Health Services Unit (HSU). The Division of Operations is managed by an Assistant Commissioner. The HSU is led by the Assistant Director, Division of Operations, and has a staff of clinical personnel, including a physician, who serves as Statewide Medical Director; and a dentist, who serves as Statewide Dental Director. At the facility level, monitoring and oversight of medical services, including dental services, is the responsibility of the facility's on-site Health Services Manager, who reports to the DOC Director, Continuous Quality Improvement Activities.

OIG was told that during the entire period of the contract under consideration in this report, the HSU was the DOC entity responsible for monitoring CMS's clinical performance at the various DOC facilities, but that the then Commissioner of DOC had directed the then DOC Assistant Commissioner of the Division of Administration[4] to take responsibility for oversight of the business side of the contract and the assurance of the delivery of care under the CMS contract. The DOC Division of Administration was the State "contract manager" for the CMS contract with a staff of three who were responsible for oversight of billing and payment of the vendor's invoices. Since the DOC

[4] The then DOC Assistant Commissioner of Administration has since been promoted to Deputy Commissioner of Administration. However, until September 1, 2007 he was responsible for managing the inmate health services contract.

Office of Information Technology was in the Division of Administration, the then DOC Assistant Commissioner of Administration also had ultimate responsibility for developing the automated programs to be used to oversee the vendor's performance.

B. History of Inmate Health Services Contract

For a number of years DOC, using state employees, operated its own health care delivery system, including the delivery of dental services. On February 1, 1996, DOC contracted with an outside vendor to deliver health care. Two potential vendors submitted bids in response to a Request for Proposals (RFP). CMS was the successful bidder and has had the contract to deliver all health services (mental health services were later carved out) since that time. The original contract was for three years with an option to extend it for another three years. CMS was given three extensions to the 1996 contract, the last of which expired on March 31, 2005.

CMS supplied the dental services using a subcontractor, Correctional Dental Associates (CDA), a New Jersey based professional service corporation headquartered in Trenton. The president and founder of CDA had been employed by DOC for fifteen years prior to privatization, serving as both a senior staff dentist and chief of dental services at New Jersey State Prison. Utilizing the majority of the then-existing DOC dental staff, CDA was formed in July 1995 in anticipation of the privatization of the inmate health services program in 1996. Serving as a subcontractor to CMS, CDA furnished dental services to inmates from 1996 to 2005.

According to the current DOC Commissioner, as a result of continual escalation in cost in excess of the contracted level over an extended period of time and a concomitant deterioration of the State's relationship with CMS, in 2002, DOC attempted to rebid the health services contract. The 2002 RFP permitted vendors to bid on select services (medical and dental, mental health, substance abuse) or all services offered under the contract. CMS, the incumbent contract provider, was the only vendor to bid on all services under the 2002 RFP.[5] DOC determined that CMS's bid was non-responsive, and DOC officials, deciding to explore other options for the delivery of health services, extended the contract with CMS on an emergency basis. Through this process, the overall approach to delivery of services to DOC was revised and bid specifications were subsequently restructured.[6] The determination was made to rebid the medical and dental components together, inclusive of the related pharmaceutical services, with mental health services designated to be delivered separately by the University of Medicine and Dentistry of New Jersey.

In contrast to the 1996 contract, the 2004 RFP included features such as shared risk components, specified staffing and staff compensation parameters, as well as

[5] The current Commissioner of DOC told OIG that the effort failed because the 2002 RFP, approved and published by the Division of Purchase and Property, was unrealistic and overreaching in its requirements and punitive approach to contractor performance.

[6] On November 10, 2003, DOC awarded a contract in the amount of $52,500 to Dr. Ronald Shansky to serve as a consultant to provide advice and guidance in the selection of the outside vendor. Dr. Shansky assisted DOC in the preparation of an RFP. On January 12, 2004, DOC awarded a contract in the amount of $114,477 to the National Commission on Correctional Health Care (NCCHC), a not-for-profit 501(c)(3) established in the early 1980s as an outgrowth of an American Medical Association program to study health conditions in jails. The contract required NCCHC to prepare an analysis of DOC's inmate health care needs; review service delivery alternatives and options (e.g., continue privatization, provide services in-house, outsource operations to UMDNJ, etc.); assess the merits of various options available for the delivery of inmate health services; develop an implementation plan; and draft a new RFP.

measurable performance standards to ensure adequate performance in specified areas of care. The standards include Objective Performance Indicators (OPIs) representing specific requirements of the contract for which liquidated damages would be assessed to the contractor based on the failure to comply with certain threshold performance requirements. OIG was told that the performance indicators were included in the RFP at the insistence of the then Commissioner of DOC because of his intent to have a mechanism to control the vendor's performance. Moreover, DOC documents indicate that during the RFP revision, the then Assistant Director, Division of Operations, who was responsible for the Health Services Unit, supported the necessity for performance indicators and liquidated damages.

The 2004 RFP was advertised on July 16, 2004. On August 3, 2004, bids were submitted by Prison Health Services (PHS) and CMS. The bids were opened on September 3, 2004, and a notice of intent to award the contract to CMS was issued on October 25, 2004.

The specific requirements of CMS's proposal submitted in response to the RFP became a part of the contract awarded by DOC and accepted by CMS. Following an unsuccessful protest by PHS, the contract was awarded to CMS on March 22, 2005, with a commencement date of April 1, 2005.

Pursuant to the contract, CMS was required to furnish the following dental services:[7]

- an intake screening (within 7 days of admission);[8]
- a comprehensive dental examination with x-rays (within 7 days of admission);
- transfer screenings (chart review within 24 hours of transfer);
- restorations (initiated within 30 days of diagnosis);
- extractions (initiated within 30 days of diagnosis);
- specialty dental care, such as oral surgery (initiated within 30 days of referral);
- initial cleaning (within 60 days after the comprehensive dental examination or arrival into a major facility);[9]
- dentures (within 60 or 90 days of impressions, depending on complexity); and
- biennial (or more frequent if clinically indicated) dental cleanings.[10]

As written, contract compliance was highly dependent on providing treatments within specific timeframes. Two of the dental requirements, intake screenings and

[7] Other dental treatment requirements include the performance of daily sick call, (Mon. - Fri.); 24-hour telephone consultation (7 days a week); for each facility, no lapses in on-site coverage for a period greater than 48 hours (Mon. - Fri.); emergency care provided immediately when clinically indicated; urgent care provided within 48 hours of occurrence; and inmate complaints responded to within 7 days of receipt.

[8] With respect to intake screening, there is a discrepancy between requirements of the New Jersey Administrative Code and the contract. The Administrative Code requires that a dental intake screening, including x-rays, be performed within 72 hours of an inmate's admission to a reception unit. N.J.A.C. 10A:16-3.9(a). In contrast, the contract states that a brief screening of significant dental issues is to be completed as part of the initial medical/dental/mental health screening, which is to occur upon admission, but in no case beyond 7 days following admission. RFP § 3.1.7(a) and Appendix 4. DOC's Internal Management Procedures provides that a dental screening (including a panorex or bitewing x-rays) should be accomplished within 7 days at all reception facilities. MED.DEN.002(IV)(C).

[9] The CMS statewide proposal, which forms a part of the contract, provides for an initial cleaning within 60 days of admission or 30 days after a comprehensive dental examination or arrival into a parent institution.

[10] The New Jersey Administrative Code provides that an annual dental cleaning is to be provided to all inmates. N.J.A.C. 10A:16-3.13(a). In contrast, the contract provides for biennial cleanings, unless more frequent cleanings are clinically appropriate. Section 3.1.7(g).

transfer screenings (as well as a number of the medical treatments), were OPIs, having associated liquidated damages for failure to meet time specifications. The other dental requirements with specific timeframes, known as Continuing Quality Indicators (CQIs), did not have associated liquidated damages but were also considered performance indicators.

The contract requires that DOC will monitor inmate health services to assure CMS's compliance. Specifically, the contract provides: "It is the intent of the State of New Jersey to monitor the Contractor's performance in a continuous and ongoing effort to ensure that all requirements are being met in full." On August 4, 2004, anticipating a January 1, 2005 start date of the contract, DOC began developing computer programs to automatically track the OPIs and calculate liquidated damages. However, because of the delay in awarding the contract, the DOC Office of Information Technology had until April 1, 2005 to complete the process.

The RFP provided requirements for statewide minimum staffing levels, but invited respondents to propose alternative minimum staffing levels. CMS proposed an alternative minimum staffing level with higher levels of full time (or their equivalent) dentists and dental assistants than those proposed in the RFP.[11] For both the first and second contract years, CMS agreed to provide the following full-time personnel, or their equivalents: one statewide dental director; at least 14.56 full time dentists; and at least

[11] The CMS proposal provided that CMS would not accept an award of the contract with the level of staffing DOC proposed because CMS was of the opinion that the staffing levels proposed by DOC would be inadequate to provide the services required in the contract.

19.33 full time dental assistants. DOC accepted CMS's alternate staffing proposal for minimum staffing levels, and CMS's alternate proposal became the contract requirement.

The contract requires CMS to comply with the following Administrative Code reporting requirements:[12]

> ● Maintenance of a daily record, describing the activity of the Dental Department on a statistical and narrative basis, compiled by the week, month and year
>
> ● Preparation of monthly and annual reports,[13] submitted to the (1) Assistant Commissioner, Division of Operations; (2) Correctional Facility Administrator; and (3) Director of Dental Services, including:
>
> 1. A narrative summary of the major developments and highlights, including, but not limited to: (i) meetings, conferences, workshops and the like attended by staff; (ii) future plans for services; and (iii) problem areas;
>
> 2. A statistical summary of dental amounts;
>
> 3. A statistical summary of required examinations and specialty care;
>
> 4. A statistical summary of dental prosthetics ordered and dispensed;
>
> 5. A statistical summary of inmate complaints received and resolved; and
>
> 6. Any information required by contract.

The contract provided that the State could, in its sole discretion, reduce the scope of work for any task or subtask called for under the contract. In addition, Treasury's

[12] Pursuant to the contract, in addition to the clinical, reporting and staffing requirements, CMS has administrative requirements including establishing a quality improvement program and a statewide continuous quality improvement committee; procuring and stocking all medical, dental, pharmaceutical and office supplies for the routine and specialty care of inmates; and, preparation of various monthly, quarterly, and annual reports.

[13] The annual report must be submitted by August 31 of each year and will include all periods involved on a fiscal year basis.

Director of the Division of Purchase and Property could terminate the contract: (1) at any time, in whole or in part, upon thirty (30) days written notice for the convenience of the State; (2) upon ten (10) days notice if CMS fails to perform or comply with the contract and/or fails to comply with the complaint procedure in N.J.A.C. 17:12-4.2 et seq.; or (3) upon ten (10) days notice where CMS continues to perform the contract poorly as demonstrated by formal complaints, late delivery, poor performance of service, etc.

According to the 1996 contract, CMS's total compensation for providing medical and dental services was a fixed fee for each inmate -- i.e., a "per capita" rate -- based upon the average monthly inmate population housed within the correctional system.[14] Among the many changes in the 2004 contract was the manner of compensation. CMS was to be paid a smaller per capita amount to cover the cost of pharmaceuticals, inpatient hospitalization, outpatient/ancillary services, fees for oral surgeons, laboratory costs for fabricating and repairing dental prosthesis, and incidentals, such as the cost of amalgam and composite filling materials, and other costs for each inmate housed within the system.[15] No longer included in the per capita payment, however, was the cost of dentists and dental assistants. CMS was to be paid the actual cost of wages and benefits for all individuals providing inmate health services, including all dentists and dental assistants. Going forward, these costs were to be a "pass-through," and CMS was to

[14] The per capita fee was and is a uniform amount for each inmate and does not vary with the amount of utilization of health care services, or an inmate's age, gender, status, or history.

[15] The monthly per capita payment in the first contract year was $150.41; the monthly per capita payment in the second contract year was $158.81.

invoice the actual cost of these service providers to DOC. CMS was also to be paid a fixed percentage of the total contract for overhead[16] and management costs.

With respect to the provision of inmate dental services, in its proposal, CMS presented two options to DOC: CMS would have full responsibility for and directly provide dental services or at an additional cost to DOC of approximately $2.8 million per year, CMS would contract with CDA, the company that had supplied dental services under the prior contract.[17] DOC opted to have CMS provide the services directly.[18]

OIG was told by the then DOC Assistant Commissioner of Administration that as he understood what had occurred in the selection process, those State representatives who were responsible for making the decision simply selected the lower priced option without understanding why one option was priced below the other. He further understood that neither the contract nor CMS's response to the RFP clearly explained why the two services were priced differently. He was unaware of any criticism of CDA's performance under the prior contract. He also said that he was unaware of any due diligence that was

[16] Overhead charged to DOC excluded the cost to CMS for corporate administrative positions.

[17] According to the CDA President, CDA had continued to supply dental services during the three months of the contract dispute and had agreed to work as a subcontractor to either CMS or PHS providing the same services at the same cost to either company. He informed OIG that at the time the new contract commenced, CDA employed 64 correctional professionals, including dentists and dental assistants and that its staff had an average of 10.1 years of experience, a collective total of over 570 years of correctional experience, and an average tenure of six years with CDA (6.5 years for dentists and 5.4 years for dental assistants). CDA is currently the dental services provider to the New Jersey Juvenile Justice Commission.

[18] CMS representatives told OIG that because of requirements in New Jersey regulations regarding ownership of dental service provider companies, CMS was not legally permitted to supply the dental services directly. Consequently, CMS subcontracted to a newly formed company, AllCare Dental Group, to provide the inmate dental services.

done to provide assurance that CMS had the resources and ability to perform the dental services directly.

At its inception, the contract was valued at a not-to-exceed amount of approximately $168 million (net of inpatient hospital costs paid directly by DOC to St. Francis Medical Center) for the two-year term. As billed by CMS, DOC has paid CMS approximately $156 million for the two years. (See Appendix B.) The payroll and benefits for the dental staff (CMS statewide dental director, dentists, and dental assistants) were budgeted at an amount not to exceed approximately $7.5 million for the two years. (See Appendix C.) As billed by CMS, DOC has paid approximately $6 million in pass through compensation for dental services for the first two contract years to cover the cost of salary and benefits for the number of dentists and dental assistants reportedly used by CMS to perform the contract dental services. The remaining costs of providing dental services are incorporated in the per capita payment made to CMS covering both medical and dental services.

Although DOC was invoiced less than the not-to-exceed amount budgeted for dental staffing, it does not necessarily follow that this was the result of DOC's adequate monitoring of CMS's performance or that CMS provided the services economically. The invoiced amount is at least partially lower than the not-to-exceed amount because during the first four months of the contract, CMS did not have a full complement of dental staff and provided only minimal or less than required dental services. Further, although CMS

budgeted for full-time back-up staff, throughout the term of the contract, CMS did not have that staff in place.

It is not possible to assess the exact cost of dental services under the new contract and to compare the costs with the prior contract because neither the new contract, nor CMS invoices to DOC, indicate the portion of the per capita payment CMS attributes to dental services. Moreover, as described below, DOC did not have a system that readily and accurately accounted for the services performed by CMS and how much the State paid for them. The exact amount DOC paid for dental services under the contract is not known by State representatives.

C. CCAU Audit

In July 2005, CCAU undertook an audit intended to determine whether DOC was monitoring CMS's performance of the contract requirements, and whether CMS was adhering to the contract specifications and Administrative Code requirements for:

- Daily dental sick call;
- Oral surgery consults (initiated within 30 days of referral);
- Initial dental exam (within seven days after admission to a reception facility); and
- Prosthetic services (delivery within 60 - 90 days of initial impression, depending on complexity).

In addition to the timeliness of clinical services, CCAU also examined:

- Compliance with required staffing levels; and

● Response to inmate complaints (due within seven days of receipt).

As explained above, pursuant to the contract, CMS is required to document its performance in a monthly report (known as the "monthly indicator report"). At the time of CCAU's audit, the monthly indicator report included the number of various dental treatments provided during the month. (The monthly indicator reports did not report whether the services were furnished within the time requirements of the contract.) In order to test the accuracy of the data provided, CCAU requested a list of inmates who received the treatments reported in the July and November 2005 monthly indicator reports. CMS was unable to produce the names of the inmates treated or provide any other corroborating documents. DOC was also unable to provide CCAU with corroborating documents.

The audit report further explains that CCAU representatives (in conjunction with DOC personnel) made repeated efforts to reconcile the data from the monthly indicator reports with reports generated from DOC's EMR, but that the system was unable to generate reports that directly related to the contract specifications or the reporting requirements under the State Administrative Code.[19] Based on DOC's inability to provide CCAU with auditable automated reports that could be reconciled with substantive patient data, CCAU concluded that DOC was unable to generate useable

[19] Unable to confirm the accuracy of the monthly indicator reports through the use of supporting documents or EMR reports, CCAU developed a protocol to test a sample of July and November 2005 data. CCAU utilized queries of the EMR by dentist which listed his/her activity at each facility for the two months to draw an audit sample to verify compliance with the selected performance criteria. CCAU found: (1) CMS was compliant for July and November 2005 for intake screenings, and (2) CMS was 82.15% compliant for November 2005 for complaints (but that there was no standard or level of performance established within the contract for handling inmate complaints).

management reports from the EMR and did not have management tools in place to monitor and audit performance requirements of the contract.

In part, CCAU's audit reported that as of November 2005, neither DOC nor CMS produced monthly reports that indicate the level of compliance with contract requirements, including detailed reporting by inmate and facility, for daily sick call, oral surgery consults, and prosthetics. Further, CCAU found that DOC was not monitoring the contract to determine if CMS was actually providing the staffing represented on the invoice.

Basically, CCAU found that DOC had implemented a performance-based contract without having an automated reporting system in place to monitor and audit contractual requirements. Specifically, CCAU concluded:

> The EMR is not a data base system set up to generate treatment reports containing timelines that reflect or monitor contract requirements. The RFP requires monitoring of the contract for time lapses for various treatments and associated liquidated damages. CCAU has determined that in order to properly monitor State Contract T-2296, independent logs, spreadsheets or records must be developed that will enable the DOC to track and document treatment for each inmate, by facility, and include dates of the various service intervals.

CCAU also found that DOC was cognizant of its need to monitor and audit contract performance and its failure to do so at the time.

In the absence of automated reporting, CCAU found that no monitoring of contract requirements or auditing of contract performance was occurring, and DOC was

without any reliable statistics to manage the delivery of dental services. While DOC could identify treatments received by individual inmates, DOC could not readily determine whether those inmates were receiving the services within the timeframes specified by the contract or whether all inmates requiring services were receiving them.

DOC responded to the CCAU audit agreeing that automated compliance reports did not exist at the time of the audit, but DOC took issue with CCAU's characterization of the EMR. DOC further responded that DOC personnel were nonetheless monitoring CMS's performance of dental services on a daily basis by reviewing treatment records entered into the EMR by the CMS dental staff. Essentially, DOC claimed that it was monitoring the quality of the dental services and that it was aware of CMS's level of compliance with dental treatment requirements. DOC further stated that it had since developed some, and was in the process of developing other, programs designed to use EMR data to track compliance with contract requirements.[20]

[20] CCAU circulated its draft audit report on February 22, 2006, held an exit conference with CMS representatives on April 7, 2006, and held an exit conference with DOC representatives on May 19, 2006.

IV. OIG INVESTIGATION

OIG was asked by Treasury to evaluate the accuracy of the CCAU conclusions for the first nine months of the contract that were disputed by DOC. In addition to responding to Treasury's request, OIG examined DOC's monitoring of CMS's compliance with contract requirements during the entire initial two-year term of the contract ending on March 31, 2007.

Any evaluation of DOC's oversight of the health services contract must be in context: the service provider is responsible for treatment of approximately 40,000 inmates annually, and therefore DOC's monitoring system must be sufficient to track the various treatments contractually required to be provided to that population. Moreover, as described above, the new contract was different from the old in that it contained several specific and measurable treatment requirements, and DOC's oversight was required to consider those requirements.

DOC's capacity and methodology for monitoring the health services providers evolved over time. OIG learned that as of April 1, 2005, at the start of the new inmate health services contract, DOC was utilizing the same system to track patients' medical and dental treatments that had been in use for several years. DOC documents patient medical and dental encounters in an electronic medical record -- Centricity EMR -- maintained by DOC's Office of Information Technology. Through an interface with DOC's inmate management system, known as "ITAG," a blank medical record is

automatically created for each new inmate. When an inmate transfer is recorded in the ITAG system, the inmate's medical record is updated to reflect the new facility. Individual inmate records are actively maintained by DOC until the individual is no longer in custody. At that point, the patient's record is transferred to a separate stored file that does not interface with the EMR. OIG was told by DOC that the transfer of information about releasees was necessary because the volume of information overburdens the system.

The EMR uses a database to store data (patient contacts, cleanings, extractions, scheduling, etc.). CMS dentists and dental assistants at each facility contemporaneously enter data in the DOC's EMR system as patients receive treatment. A handwritten record of patients seen and procedures performed each day is also maintained at each facility by CMS dental assistants. OIG was told that DOC continues to use this process to maintain inmate health records as of the time of OIG's review.

The DOC Statewide Dental Director reported that at least from the beginning of the current contract until recently, he regularly reviewed every new dental entry into the EMR. His review considered the appropriateness of dental treatments provided rather than the contract requirements to provide treatments within the specified timeframes. To the extent that he observed failures to meet time requirements, his review was not systematic and his observations were not stored in a permanent DOC record. Thus, he was attempting on a case-by-case basis to monitor the quality of dental services but not

whether CMS was in compliance with contract requirements to provide treatments within specified time frames.

A. DOC Monitoring Between April 1, 2005 and October 30, 2005

The contract with CMS called for DOC auditors to conduct an audit as often as quarterly of 5% to 20% of the dental records including records in the EMR of the relevant population at each correctional facility to determine CMS's performance, including compliance with the time requirements of OPIs.[21] If the percentage of substandard audit results at an institution was below the OPI threshold percentage triggering liquidated damages, the percentage determined by the audit was to be applied to the entire relevant population of the institution for the audit period to determine the amount of liquidated damages to be assessed.[22] Thus, if the audit indicated that compliance with the transfer screening process was only 93%, CMS would be assessed $100 per 7% of the total number of inmates who transferred into the facility during the period covered by the audit.[23]

[21] The contract requires that the audits systematically assess CMS's performance by means of "medical records reviews and direct observation of medical records, logs, manuals, critical incident reports, and other appropriate sources."

[22] According to the liquidated damages provision of the RFP, the damages were to be assessed for the entire inmate population. CMS believed that the calculation would result in an unfair assessment and that calculating the amount of liquidated damages on a facility by facility basis would allow CMS to lower the total program costs it charged to DOC.

[23] While not so stated in the contract, OIG was told by DOC employees that they believed that calculating the amount using the percentage of the shortfall from 100% was too harsh and that the calculation should be for only the amount by which CMS missed the threshold for liquidated damages. Based on this example, DOC would assess liquidated damages on only 5% of the relevant inmate population (98% threshold amount - 93% compliance percentage = 5%).

OIG was told by the current DOC Commissioner that the Department determined that its automated systems were capable of reporting on all inmate treatments, and DOC, therefore elected to use the system to monitor all treatments concluding that the process would benefit the State through comprehensive, continual, and statewide monitoring. In August 2004, DOC had begun to develop programs using the EMR to track compliance with medical and dental provisions of the inmate health services contract, particularly contract requirements with associated liquidated damages for failure to comply, i.e., the Objective Performance Indicators (OPIs). However, the then Assistant Commissioner of Administration told OIG that as of the start date of the contract, the programs for monitoring the contract were still under development.

As such, between the April 1, 2005 start date of the contract and October 30, 2005, the EMR was capable of providing limited information regarding CMS's performance. For instance, it could be used by DOC to obtain an inmate's medical records, including dental treatments provided. It could be used to determine patients seen by a particular CMS dentist on a given day at a particular DOC facility, but it required a search of an individual patient's dental record to identify the treatments provided to the patient by the CMS dentist. On a patient-by-patient basis, the EMR could provide information that, when examined in conjunction with contract requirements and a calendar, could be used to determine whether a particular patient's treatment was received within the time parameters required by the contract.

On the other hand, the EMR could not readily provide information regarding the type of dental treatments provided, timeliness of treatments, and number of patients still requiring treatment on a facility-wide or state-wide basis. Since contract compliance required treatments within specified time periods, the EMR programs in place had little, if any, value for monitoring or tracking CMS contract compliance and were not used by DOC for this purpose.

The programs to be used to assess missed benchmarks for purposes of calculating liquidated damages were still in development stages during the first five months of the contract. During that time, DOC's monitoring of CMS's performance relied largely upon a review of manually prepared records and was geared toward quality and clinical issues. OIG was told that each month, at each DOC facility, a CMS dental assistant used the handwritten logs to compile a productivity report describing the number of patients who were scheduled to be seen, who were seen, or who failed to appear for: dental sick calls and initial and annual dental exams; the number of dental prosthesis ordered, received, and pending that month; the number of oral surgery consults referred, approved, and pending for the month; and the number of inmate dental complaints received, answered, and pending for that month at a facility. The CMS dental assistant at each of the fourteen facilities forwarded the productivity reports to CMS headquarters where the data was totaled statewide per type of treatment. This compilation of data was known as the monthly indicator report. CMS provided this information to DOC.

In the early months of the contract, the manually produced indicator reports were used as the basis for discussion of clinical issues at weekly meetings of DOC and CMS personnel. If the discussion required information regarding an individual inmate's treatment or a particular dentist's work, the EMR would be used to produce a report about the inmate or the work of the dentist.

The monthly indicator report was not useful in monitoring CMS's contract compliance since it did not indicate: (1) whether treatments were performed within the contract-required time frames; (2) whether there were missed benchmarks; or (3) whether treatments that should have been provided were not. Moreover, there was no DOC effort to verify the information in the monthly indicator reports prepared by CMS. OIG has been told by DOC that the monthly indicator reports continued to be prepared in this way by CMS throughout the contract period.

B. DOC Monitoring Between October 30, 2005 and June 18, 2006

On October 30, 2005, seven months after the contract start date and fourteen months after DOC had begun to develop programs to track compliance with the health services contract, DOC generated the first OPI reports, and thereafter the reports were automatically generated on a weekly basis. While most of the OPIs in the contract were associated with medical services, as stated above, two were for dental services. According to the then Assistant Commissioner of Administration, even as of October 30, 2005, the reports were not sufficiently reliable for DOC to use them to evaluate CMS's

compliance with contract requirements and to calculate and assess liquidated damages against CMS.

However, from October 30, 2005, the OPI reports were modified to increase their usefulness in monitoring at least CMS's weekly performance. From the outset of their production, OPI reports were reformatted by CMS and reviewed by DOC and CMS health services personnel for errors or anomalies.[24] Any errors were manually corrected in the reformatted reports, and the reformatted reconciled OPI reports, called weekly reports, were used at weekly meetings of DOC and CMS personnel to discuss treatments provided, whether or not CMS had complied with contract requirements (specifically, performance timeframes) within the past week or possibly even the past few weeks, and to develop corrective action plans.

OIG's analysis revealed several reasons why, during the entire two years of the contract, the OPI reports were of limited value in monitoring CMS's compliance with contract requirements for dental services. Initially, between October 30, 2005 and June 18, 2006, only two dental indicators, those with associated liquidated damages (intake screenings and transfer screenings) were tracked in OPI reports. Failures to meet the time requirements for the seven other contractual dental treatment requirements, none of which had associated liquidated damages, were not tracked in OPI reports even though these requirements were important indicators of and formed the bulk of CMS's compliance with contract dental specifications. It is foreseeable that CMS could comply

[24] A lock down in an institution or other circumstances not within the control of CMS might have caused a failure to provide timely treatment. Those failures would not therefore be attributed to CMS.

with time requirements for intake and transfer screenings and miss deadlines for all or many of the other treatment time requirements, and that to a large degree, missed deadlines could go unnoticed and uncorrected. Indeed, OIG's review indicates that CMS consistently missed certain timeliness requirements for CQIs.

Second, the data in the EMR making up the OPI reports was entered entirely by CMS staff as treatment was provided at DOC facilities, and DOC did not verify the accuracy of CMS data. It is foreseeable that CMS staff could have an interest in bolstering their own or CMS's performance statistics. In fact, DOC representatives acknowledged that for some period of time, CMS staff entered data in the EMR about the performance of a treatment creating the appearance that the treatment was performed within the contractual time limits when it may not have been. DOC modified the program, and OIG was told that as of the time of the modification, the correct dates of treatments appear in the OPI reports.

Indeed, the EMR is known to contain errors. During OIG interviews, both CMS and DOC representatives reported that it was generally recognized that there are numerous opportunities for incorrect data to be entered by CMS dentists and dental assistants at the DOC facilities. The CMS Statewide Dental Director told OIG that he believes the information to be only 80% accurate. Even after the OPI report is generated and reconciled (that is, recognizing and correcting errors), the reconciled data is not recorded in the EMR. The DOC Statewide Medical Director told OIG that as an official medical record, data in the EMR cannot be changed, and no other method of accounting

for errors had been developed in the relevant programs. Therefore, corrections are not automatically carried forward into subsequent OPI reports generated for that time period. New reports generated for earlier time periods contain only raw, uncorrected data and are likely to be flawed.

Another reason OPI reports are of limited value in accurately monitoring CMS's compliance with contract requirements and for calculating liquidated damages is that relevant information, medical records for released inmates, is removed from the EMR database and is not included in subsequent OPI reports used to assess CMS's contract compliance. Data regarding inmates released during the contract week but who were not provided the required treatments in a timely fashion while incarcerated would not be reflected in all subsequent OPI reports for the contract period. DOC and CMS representatives acknowledged to OIG that they have been aware that the exclusion of data for released inmates limits the use of the OPI reports to only the current week and that the reports are not useful in monitoring contract compliance over an extended period.

Responsible DOC administrators acknowledged that the OPI reports do not contain information about releasees, but indicated that this was not significant since a very small number of inmates (approximately 270) are released each week. The then Assistant Commissioner of Administration defended the use of weekly reports as an effective method of overseeing the medical and dental treatments of 26,000 inmates who constitute the average inmate population on a daily basis stating that DOC was not

interested in CMS's past compliance during the contract term or assessing liquidated damages but was only interested in CMS's present performance.

Focusing on the number of inmates released weekly and whose data is no longer available for the following weekly meeting minimizes both the significance of the actual amount of data removed from consideration in assessing CMS's contract compliance and the inability of the system to provide an accurate assessment of CMS's compliance. The lack of cumulative historical data in the record has the effect of understating CMS's contract failures in subsequent reports, as well as the amount of liquidated damages CMS could be assessed and reducing the assessment of CMS's compliance to subjective recollections of those involved.

Because an average of 14,400 inmates are released from custody each year, more than 1,200 per month, the understatement could be significant resulting in a more favorable picture of CMS's contractual compliance for a contract period than is actually deserved. In the first month of the contract, the data removed from consideration could include information about approximately 5% of the inmate population served during the nascent contract year (the approximate 1,200 inmates released that month compared to the average 26,000 incarcerated). When, in the seventh month of the contract year, the first automated programs were implemented, the releasees' data removed from consideration would likely include information of about one-third of the population served to that point in the contract year (the approximate 8,400 inmates release during the seven months of the contract year compared to the average 26,000 incarcerated). By the

end of a contract year, the releasees' data removed from consideration would likely include information about approximately one-half of the inmate population served that year. Moreover, since non-compliance with performance indicators is the trigger for liquidated damages, the removal of data from consideration of CMS's contractual compliance could only minimize exposure of CMS's potential non-compliance and hamper DOC's ability to accurately calculate the full extent of liquidated damages.

More importantly, because DOC does not have ready access in the EMR to historical data, DOC cannot be assured that it has an accurate picture of CMS's contract compliance during the contract term. The inadequacy of the system for tracking historical contract compliance for the dental portion of CMS's contract is further exacerbated by DOC's failure to mandate maintenance of the reconciled OPI reports produced by CMS and DOC representatives, and reformatted by CMS for use at the weekly meetings. Each week, volumes of data are prepared, distributed, and reviewed, but there are no policies and procedures regarding the collection and maintenance of the data. OIG learned during interviews that some DOC employees maintained their own electronic or paper copies of the data, but DOC has no official repository for the data and no "official" copy exists. The importance of maintaining the data is critical to monitoring CMS's performance because historical data cannot be readily reproduced by the EMR.

During an interview, the then Assistant Commissioner of Administration acknowledged the amount of data removed from consideration of CMS's past compliance, and stated that DOC's Office of Information Technology was in the process

of implementing programs that include information regarding releasees. Progress has been slow, however, and as of the end of the second contract year, only one of the CQI reports contained the data for released inmates, leaving all of the OPI reports with a dental component and the remaining dental CQI reports deficient.

According to the then Assistant Commissioner of Administration, while the OPI reports were introduced on October 30, 2005, they were not considered reliable until much later; the DOC Statewide Medical Director confirmed that the OPI reports were finally considered reliable by DOC as of July 9, 2006. However, the reports were generated by a system with the described weaknesses, resulting in unreliable reports for measuring CMS's overall compliance with contract requirements.

C. DOC Monitoring After June 18, 2006

On March 1, 2006, DOC held an internal meeting to discuss the draft CCAU audit report. Shortly thereafter, DOC began developing programs to produce compliance reports for four other dental treatments required by the CMS contract to be performed within specific time parameters, but with no associated liquidated damages for failure to perform within those time frames, as well as for two other dental treatments that were not a part of the contract requirements.[25] The first reports for these indicators, called

[25] These reports were for initial cleaning, biennial cleanings, dental prosthesis, and oral surgery.

Continuous Quality Improvement (CQI) reports, were generated by DOC on June 18, 2006.[26]

Although the CQI reports are generated to further monitor CMS's contract compliance, the same limitations on the usefulness of OPI reports described above -- known errors in the data; failure to verify and correct the data; lack of cumulative and historical data; no maintenance of an official historical record; and purging data of released inmates -- are present in the use of CQI reports.

D. Liquidated Damages

1. DOC Failed to Calculate and Assess Liquidated Damages

As stated above, the contract provides for the assessment of liquidated damages if CMS fails to provide treatments -- the OPIs -- within the time parameters specified in the contract; two of those services have a dental element.[27] More particularly, CMS is required to perform a medical and dental screening of each inmate within seven days of admission. When compliance with either component of the intake screening falls below 95% of the relevant population, liquidated damages of $50 per failure are assessed. CMS was also required to review the medical and dental records of each inmate within 24

[26] A fifth report, measuring whether inmates with known history of cardiac problems received prophylactic antibiotics prior to a dental cleaning, was also released at that time; the indicator measured by this report is not required in the contract. In addition, a sixth report, measuring whether inmates without permanent teeth were examined, was released on December 17, 2006; the indicator measured in this report is also not required by the contract.

[27] There are several more medical services with attendant liquidated damages provisions.

hours of transfer. When compliance with either component of the transfer screening falls below 98%, liquidated damages of $100 per failure are assessed. At some point during the contract, DOC extended the time in which the dental transfer screening could be provided without triggering liquidated damages to within 72 hours of transfer.

At the time the contract was entered, DOC did not have the capacity to generate OPI reports. However, as described above, the contract specified a sampling process for calculating liquidated damages that was not dependent upon automated OPI reports.[28] The information supplied to OIG by DOC indicates that during the two years covered by the initial contract (as well as the months during which the contract has been extended), DOC had not audited CMS's compliance with contract dental requirements, calculated liquidated damages, nor assessed liquidated damages against CMS.

The then Assistant Commissioner of Administration explained the decision to withhold the assessment of liquidated damages. He stated that it was his belief that the imposition of liquidated damages was discretionary, although he had not sought a legal interpretation of the contract to support that position. Instead of basing the assessment of liquidated damages on CMS's failures to meet contract requirements, the then Assistant Commissioner of Administration stated that it was DOC's policy that liquidated damages would be triggered in circumstances of "persistent non-improvement." That is, DOC

[28] The contract provides that audits for the first three contract months (April - June, '05) would be informational only and would not result in the assessment of liquidated damages. Liquidated damages would be assessed commencing July 1, 2005. For the month of June, '05, DOC used preliminary OPI reports to calculate liquidated damages; this appears to be the only time that DOC calculated liquidated damages. Although the calculations indicated that liquidated damages should be assessed against CMS, they were not. It was explained to OIG that these preliminary reports were developmental versions of the OPI reports.

would assess liquidated damages only when CMS failed to make progress, or failed to make timely progress, in addressing non-compliance with a contract requirement. He explained that since CMS has been very responsive and collaborative in making changes where the need was identified, which have resulted in improvements to CMS's overall performance, no liquidated damages have been assessed.[29] The then Assistant Commissioner of Administration based his understanding of CMS's overall satisfactory performance on information developed for and obtained at the weekly meetings.

OIG told the then Assistant Commissioner of Administration that OIG's analysis of available information had demonstrated that CMS had not performed satisfactorily on a number of contract requirements. OIG further pointed out that OIG's analysis revealed that DOC had no systematic methodology for evaluating CMS's overall performance. Therefore, any DOC conclusion that CMS was making timely progress in addressing non-compliance with a contract requirement was subjective and in itself not reliable. The then Assistant Commissioner did not dispute OIG's conclusion. He responded that his superiors, including the former Commissioner of DOC, who had insisted that performance indicators be a part of the contract, were aware of his decision not to assess liquidated damages. He said that since DOC concentrates on current performance, weaknesses in the monitoring system and the lack of trending data are unimportant. The then Assistant Commissioner of Administration further told OIG that he kept no records

[29] DOC management also expressed a concern that assessing liquidated damages against the provider could alienate the vendor, could cause the vendor to withdraw from the contract, or could cause the vendor not to bid on future contracts. OIG is not aware of a specific basis for this concern. On the other hand, the evidence gathered during OIG's investigation tends to indicate that CMS fully expected to be assessed liquidated damages for failure to comply with contract requirements: CMS entered the contract with the understanding that liquidated damages could be assessed; CMS contract negotiations included the method for computing liquidated damages to lessen the amounts assessed; and CMS set aside several hundred thousand dollars in reserves specifically to pay liquidated damages.

of the amount of potential liquidated damages that were waived and that he had not documented his authority to waive them or his reasons for waiving them at the time.

The evidence supports the conclusion that DOC based its assessments that CMS's overall performance was improving and its decisions to waive liquidated damages on incomplete and unreliable information. Despite the fact that DOC began preparation of the programs necessary to generate the reports in August 2004, some eight months prior to the start of the contract, the programs were not introduced until October 30, 2005, some fifteen months after development efforts commenced and some seven months after the contract commenced.[30] Even then, the programs were not reliable. DOC did not consider the OPI programs reliable until July 9, 2006, almost two years after development began and some fifteen months into a two-year contract. (The CQI reports were introduced on June 18, 2006.) However, as described in this report, the programs introduced on July 9, 2006 (and currently used) contain weaknesses which result in the generation of unreliable reports. Further, the lack of automated trending data effectively prevents DOC from quantifying the effects of changes implemented by DOC and readily determining whether CMS's overall performance is improving or deteriorating. As such, DOC's own records do not support the decision of the then Assistant Commissioner of Administration, purportedly made with the knowledge and approval of his superiors, to withhold the assessment of liquidated damages based on a claim of improvements to CMS's overall satisfactory performance.

[30] DOC has an Information Technology Office of 70 computer professionals who serve the 10,000 DOC employees and 1,000 CMS medical and dental professionals. DOC management pointed out that since August 2004, the Information Technology Office has made several modifications to the system including, the modifications resulting in the OPI and CQI reports, in what was essentially a short time frame.

2. Calculation of Minimum Liquidated Damages

CMS reported to OIG that through December 31, 2006, CMS amassed a liquidated damages reserve of $673,593. Despite contractual provisions for the assessment of liquidated damages, CMS reserves in anticipation of assessment of liquidated damages, and documented shortfalls in CMS's compliance with contract requirements, DOC has not assessed liquidated damages against CMS for either the dental or medical non-compliant OPIs. While OIG was told that on six occasions DOC implemented the audit process for seven non-automated medical OPIs,[31] OIG's investigation did not uncover evidence that DOC ever followed the audit process described in the contract to determine CMS's compliance and to calculate and assess liquidated damages for shortfalls associated with the two OPIs with dental elements.

The evidence indicates that on October 30, 2005, DOC introduced programs designed to use the EMR to generate weekly OPI reports that would enable the calculation of liquidated damages based on actual incidents of non-compliance rather than a sampling of the facility's population. Because EMR data and the data in the monitoring programs would have been potentially erroneous, significantly underreported, and not reliable, the system could not provide reliable reports of liquidated damages for CMS's failure to meet timeliness requirements. However, at least as of that time, DOC employees and CMS representatives met to review reformatted and reconciled EMR generated reports to discuss particular incidents and areas where CMS had fallen short of

[31] The Director of DOC's Bureau of Auditing reported to OIG that his office had performed six separate audits of seven various medical OPIs that were never automated. OIG was told that none of the audits resulted in the assessment of liquidated damages.

compliance requirements during the period. The evidence indicates that despite the known weaknesses in the OPI reports, DOC could have used the reformatted reconciled reports to calculate estimated liquidated damages for CMS's failure to meet time requirements.[32] Because the reconciled weekly reports are static, and contain information for some released inmates, they are more complete than the OPI reports.[33] During an interview, the former DOC Assistant Commissioner of Administration acknowledged the reasonableness of OIG's methodology. However, DOC had not made use of these reports to determine whether and the amount of liquidated damages that could be assessed against CMS.

OIG attempted to determine whether CMS's non-compliance with time requirements fell below the liquidated damages threshold for the two OPIs with dental components, and if so, to what extent. OIG reviewed the reformatted reconciled reports supplied by CMS for these two OPIs, intake and transfer screenings, and manually computed CMS's compliance with contract timeliness requirements for treatments with

[32] As discussed earlier, DOC representatives explained that the OPI reports from October 30, 2005 through July 9, 2006 were not sufficiently reliable for use to evaluate CMS's compliance with contract requirements and to calculate and assess liquidated damages against CMS. In addition to the deficiencies previously discussed, infra, DOC does not verify that the data reconciling errors in the EMR is accurately transferred by CMS into the reports that are used at the weekly meetings to discuss CMS's weekly compliance. Moreover, even though the process of reconciliation requires documented reasons for changes to the OPI reports, the CMS weekly report is not always completed to reflect the reasons for these changes. Nonetheless, these are records provided and agreed to by CMS and the reformatted reconciled weekly reports rectify many of the weaknesses in the OPI reports. Therefore, it is not unreasonable to use the reformatted reconciled reports to calculate estimated liquidated damages, including liquidated damages for the period of October 30, 2005 through July 9, 2006.

[33] Although data for 270 released inmates is not included in a weekly report, and the results are necessarily understated by that amount, once the weekly report is reformatted and reconciled, it is not thereafter changed and further data is not lost for the week. For example, by using weekly reports, an inmate who is reported as an error in week #1 always remains an error, even if released in week #2. Conversely, that same inmate and the attendant error would not appear in a quarterly report because he would have been released and his data purged by the time the quarterly report was run. As such, the use of weekly reconciled reports will result in a more accurate calculation than the use of quarterly reports.

associated liquidated damages; because of the insufficiencies in the data, the calculation results is an estimated minimum. OIG conducted the same type of review to determine an estimate of CMS's minimum compliance with timeliness requirements for CQIs, performance indicators without associated liquidated damages. As is demonstrated in Appendices D and G to this report, CMS was often not in full compliance with the timeliness requirements of the contract.

OIG calculated estimated minimum liquidated damages for the period beginning October 30, 2005, when the weekly reports began to be prepared, through March 31, 2007.[34] The two OPIs contain both medical and dental elements. It should be noted that DOC did not monitor the medical and dental components of these two OPIs separately and the historical reports did not separate the medical from the dental elements. According to DOC representatives, failure to meet time requirements for either the medical or the dental component of the screenings results in an assessment of liquidated damages. OIG has determined that for the 17 months of the contract years for which CMS supplied reformatted reconciled weekly reports, between $850,000 and $1,000,000 of liquidated damages associated with failures to meet time requirements for either dental or medical intake and transfer screenings have accrued.[35] By far, most of those incidents

[34] The weekly reformatted reconciled reports contained the statewide number of errors and the size of the relevant prison population. A comparison of those numbers results in a performance ratio. If a performance ratio fell below its associated threshold amount, liquidated damages for the week were calculated.

[35] The final number depends upon the point from which shortfalls are calculated: the difference between the shortfall from the threshold amount and the amount of services for which there was compliance (the methodology that DOC employees assert) or the actual shortfall from 100% compliance (the methodology asserted by CCAU representatives).

of non-compliance were associated with failure to meet the time requirements for transfer screening.

OIG did not investigate CMS's compliance with the medical contract liquidated damages provisions. Using similar data prepared by CMS, OIG has determined that for the 17 months of the contract years for which CMS supplied reformatted reconciled weekly reports, the total liquidated damages accrued over the remaining OPIs in the inmate medical services contract without dental elements appears to be between $1,700,000 and $2,500,000.

From review of treatment records and the review of weekly reconciled OPI reports, DOC was aware of CMS's shortfalls -- although not likely the precise amount and perhaps not the magnitude of them. DOC could have done the same manual computation that OIG did to assess lack of compliance with contract requirements and where relevant, to calculate estimated minimum associated liquidated damages. Even in the face of documented significant shortfalls, DOC did not use all of the tools available to ensure that CMS provided the contractually obligated services for which the State was paying.

DOC representatives told OIG that a decision was made not to assess liquidated damages in part because during the period of the contract, CMS was improving in providing services within the required time. A review of OIG's week-by-week calculations, showing a decline in the amount of estimated minimum liquidated damages

that could be assessed, would tend to support the claim that over time, CMS did improve in providing timely inmate transfer screenings -- the screening requirement resulting in the greater number of non-compliances. (See Appendix D.) However, other evidence is relevant to both the justification and the significance of this conclusion.

For instance, during the years of the contract, DOC expanded the time in which CMS was required to provide the transfer screening, thereby lessening the likelihood that CMS would miss the deadline and incur liquidated damages. Further, CMS and DOC representatives told OIG that CMS tended to concentrate its efforts on improving in its delivery of services with which there were associated liquidated damages; and the computation demonstrated that there were continuous shortfalls in CMS's provision of services for which there were contractual time requirements but no associated liquidated damages, the CQIs. Moreover, CMS's shortfalls are likely understated because a substantial amount of potentially negative information was removed from the system. OIG's analysis is for the last ten months of the two year period of the contract (the only months of the two year period of the contract for which data for the CQIs was available). OIG's analysis revealed that CMS consistently and significantly failed to meet the time requirements for some of these indicators even at the end of the contract term. For instance, there were only three months when CMS provided more than 30% of the required initial cleanings within 60 days of admission. CMS also fell far short of compliance with the time requirements for the delivery of dental prostheses. (See Appendix G.)

E. Staffing

DOC did not have adequate programs in place to systematically monitor CMS's compliance with contract requirements for dentist and dental assistant staffing. OIG learned from DOC staff that there were shortfalls in the staffing and hours worked by CMS dentists and dental assistants. Nonetheless, DOC was not able to demonstrate the number of dentists and dental assistants CMS provided and to track the hours worked by them at each facility as required by the contract.

The contract requires CMS staff to use the DOC timekeeping system. The then Assistant Commissioner of Administration told OIG that the electronic time card system that DOC had attempted to install had not worked properly, and at the request of Treasury, DOC had provided the card system provider more time to install a working system and had not sought another time card system. Throughout the term of the contract, and through to the present, DOC has relied on a time card system owned and operated by CMS. DOC pays CMS based on CMS's self-reported hours and attendance. The then Assistant Commissioner of Administration explained to OIG that an audit performed by DOC confirmed that CMS is, in fact, passing-through the compensation paid by DOC to the CMS employees. Despite the availability of manual attendance logs (and some information, albeit of limited usefulness, from the DOC timekeeping system), the then Assistant Commissioner acknowledged that DOC did not confirm the attendance of CMS's dentists at the facilities; he explained that an independent confirmation was unnecessary because CMS's monthly invoices were always within the amount anticipated.

1. Dentists

OIG's analysis of the CMS invoices reflecting billing for dentists' hours revealed that for the first four months of the contract, CMS fell far short of the minimum level of dentist staffing. Thereafter, the hours billed by CMS indicate that CMS was close to meeting, met, or exceeded the minimum staffing level for dentists.

More particularly, during the first year of the contract, CMS was to have furnished a minimum of 14.56 full time dentists (or their equivalent)[36] each week for 40 hours a week.[37] This equates to a minimum requirement of 30,288 dentist hours during the first contract year. The evidence indicates that it was mainly because of CMS's failure to provide anywhere near the minimum dentist staffing level during the first four months of the contract (approximately 16%, 27%, 71% and 82% respectively), that CMS only provided dentist staffing at a rate of 84.7% of the minimum annual requirement; that is, CMS billed for 25,647.5 dentist hours for the first contract year, indicating a shortfall of 4,640.5 hours less than the 30,288 dentist hours required by the contract. (See Appendix E.)

[36] One full time dentist can be made up of multiple dentists whose weekly work hours aggregate to 40.

[37] Although the contract specified staffing on a weekly basis, CMS billed DOC monthly. OIG compared the annual dentists' hours billed by CMS to the annual minimum contract requirement for dentist staffing.

During the second year of the contract, CMS was to have furnished a minimum of 14.96 full time dentists[38] (or their equivalent) each week for 40 hours a week. This equates to a minimum requirement of 31,116 dentist hours during the second contract year. OIG's analysis of CMS's invoices reveals that for ten of the twelve months of the second year, CMS provided more than the minimum number of dentist hours required by the contract. CMS provided dentist staffing at a rate of 110.4% of the minimum required by the contract, providing a total of 34,352.5 hours. Thus, hours worked for the second contract year were 3,236.5 hours over the minimum hours required by the contract.

2. Dental Assistants

CMS invoices billing for dental assistants' time often did not reflect calendar months but were for longer periods of time. For that reason, OIG did not calculate CMS's compliance with contract time requirements for dental assistants on a monthly basis. However, OIG totaled the number of hours for which CMS billed for dental assistants' time during a contract year and compared that number of hours to the annual contractual requirement.

During the first year of the contract, CMS was to have provided a minimum of 19.33 full time dental assistants (or their equivalent) each week for 40 hours a week. This equates to a minimum requirement of 40,208 dental assistant hours during the first

[38] Although the dentist staffing level for the second year was to have been 14.56 full time dentists or their equivalent, CMS and DOC agreed that CMS should increase dentist staffing to 14.96 full time dentists or their equivalent in the second contract year.

contract year. CMS only provided dental assistant staffing at a rate of 77.91% of the minimum required for the year; that is, CMS billed for 31,328 hours, indicating a shortfall of 8,884 hours less than the 40,208 dental assistant hours required by the contract. (See Appendix F.)

During the second year of the contract, CMS was to have furnished a minimum of 19.53 full time dental assistants[39] (or their equivalent) each week for 40 hours a week. This equates to a minimum requirement of 40,728 dental assistant hours during the second contract year. CMS billed for dental assistant staffing at a rate of 98.31% of the minimum required for the year; that is, CMS billed for 40,040.5 hours, indicating a shortfall of 687.5 hours less than the 40,728 dental assistant hours required by the contract.

Although staffing levels were a contract requirement, DOC was not systematically monitoring staffing levels. DOC never developed an automated program to monitor staffing levels, nor did DOC analyze the staffing reported on the CMS invoices. DOC relied on reports generated from the CMS timekeeping system, and DOC did not demonstrate that DOC was verifying the staffing levels CMS reported. Since payment for dental services was supposed to be based on actual compensation paid to dentists and dental assistants rather than a fixed amount as in the prior contract, DOC's

[39] Although the dental assistant staffing level for the second year was to have been 19.33 full time dental assistants or their equivalent, CMS and DOC agreed that CMS should increase dental assistant staffing to 19.53 full time dental assistants or their equivalent in the second contract year.

failure to monitor and verify the staffing levels could have resulted in overpayments by DOC.

Furthermore, the contract required that there must be relief staffing available -- same shift, same day -- in order to maintain the required minimum staffing levels. That is, if a dentist or dental assistant has either a planned or unexpected absence, relief staff was to be available to cover the position so that services are not interrupted.[40] Although CMS indicated in its response to the RFP that it would provide same shift, same day relief staffing and included a relief staffing factor in its budget (which became a part of the contract), the evidence gathered by OIG indicates that CMS did not provide relief staffing for either dentists or dental assistants during the first two years of the contract. OIG did not find evidence indicating that DOC enforced the maintenance of the minimum staffing level by requiring CMS to obtain relief dental staff.

In an interview with OIG, the DOC Statewide Dental Director confirmed that during the first two years of the contract, most dental service provider absences were not covered with same day, same shift relief staff. During OIG's visit to Central Reception and Assignment Facility, OIG learned of a longstanding dentist vacancy at that facility which had not been filled, either through relief staff or replacement.

The level of performance required under the contract is directly related to the level of staffing provided. Because compliance under the contract is based on the timely

[40] In its proposal to CMS, CDA proposed an additional 2 full time dentists (or their equivalents) and 4 full time dental assistants (or their equivalents) to serve as relief staff.

delivery of services, once a deadline has passed, CMS has failed. While it is possible to provide the services after the deadline has passed, this will not correct the contract deficiency, nor will it ameliorate a condition exacerbated by lack of timely treatments. Furthermore, dental treatments required but missed may never have been provided because inmates were released.[41] Thus, while CMS may have occasionally provided additional dentist hours in the second year of the contract, CMS did not thereby relieve the deficiencies in its prior performance.

F. Overpayment for Oral Surgeons

The OIG investigation has uncovered evidence indicating that DOC was improperly charged -- and in fact, has paid CMS double -- for the services of oral surgeons. Under the heading "Responsibility for Cost of Specialty Care," the contract states that CMS "shall pay all costs of such care provided by specialists and other service providers." The DOC Statewide Dental Director has confirmed to OIG that the cost of oral surgeons should be absorbed by CMS as covered by the per capita payment and not billed separately to DOC.

[41] As stated above, the contract allows CMS to invoice DOC for the actual number of hours worked by dentists and dental assistants. However, CMS may actually realize additional profits from the lack of professionals providing treatments to DOC inmates since the per capita payment (based only on the number of inmates and not the number or type of treatments) remains the same regardless of the number of dentists and dental assistants performing treatments. Theoretically, the fewer number of treatment providers, the less use of items covered by the per capita payment (i.e., restorations, prostheses, pharmaceuticals, etc.). The ability for CMS to profit from the failure to provide treatments would be dependent, however, on inmates being released before conditions worsened requiring treatments covered by the per capita payment (restorations, prostheses, oral surgery, etc.).

DOC did not require itemized invoices for dental services. An itemized invoice would have revealed that the services invoiced were oral surgeries and should not have been billed to DOC. OIG's review of CMS invoices indicates charges for dentists who performed oral surgery services were part of a lump sum amount invoiced to DOC for dental hours. OIG was only able to discern these payments after requesting the list of oral surgeons used by CMS in the DOC contract and comparing that list to the list of dentists named (without detail) on invoices.

Despite the obligation of CMS to cover the costs of oral surgeons, a review performed by OIG found that during the two-year contract term, CMS has invoiced DOC -- and DOC has paid CMS -- the amount of $132,345 for oral surgeons' fees.

The then Assistant Commissioner of Administration acknowledged the overpayment found during OIG's investigation and said that DOC would withhold the amount from a future payment. He said that this was an anomaly limited to dental services because in the case of medical services, inmates requiring specialist care are transported off site.

V. RECOMMENDATIONS

As a result of OIG's review, OIG makes the following recommendations:

● DOC should develop an electronic system capable of storing, utilizing and analyzing current and historical data in order to monitor contractual compliance by the medical/dental services provider, including whether dental staffing levels at DOC facilities are in compliance with contract requirements.

● DOC should develop policies and procedures to provide for accurate medical and dental reporting in the areas of data collection, maintenance, retention of medical/dental reports, verification, analysis, and distribution.

● DOC's internal audit group should perform routine systematic audits of the inmate health services program, including whether services required by the contract are delivered and routine staffing levels are met.

● DOC should withhold $132,345 from future payments to CMS to make up for improper charges for oral surgeons.

● DOC should review dental services invoices to determine whether other improper amounts were charged by CMS to DOC.

● Under the direction of the Division of Purchase and Property, DOC should determine the amount of liquidated damages to be assessed against CMS for the entire period of the contract and assess liquidated damages.

● The Division of Purchase and Property should undertake a thorough review to determine whether to terminate the inmate health services contract with CMS for failure to perform or failure to comply with contract requirements.

● DOC should undertake a review of the entire inmate health services contract to assure contract compliance and proper billing.

● DOC should verify that the agreed-upon errors are accurately reflected in OPI/CQI reports.

● DOC should implement a systematic staffing review and verify staffing billed on CMS invoices before authorizing payment.

Appendix A

New Jersey Department of Corrections
List of Facilities and Clinics

	Facility	Details	Size
1	ACWYCF Albert C. Wagner Youth Correctional Facility	(1) Main - 5 days/week	2 chairs
2	ADTC Adult Diagnostic Treatment Center	(1) Main - 5 days/week	1 chair
3	BSP Bayside State Prison	(1) Medium - 5 days/week (2) Farm - 1 or 2 days/week (3) Ancora - 1 day/week	2 chairs 1 chair 1 chair
4	CRAF Central Reception and Assignment Facility	(1) Main - 5 days/week	1 chair
5	EJSP East Jersey State Prison	(1) Main - 5 days/week (2) Ad Seg - 1 or 2 days/week	3 chairs 1 chair
6	EMCFW Edna Mahan Correctional Facility for Women	(1) Main - 5 days/week	3 chairs
7	GSCF Garden State Correctional Facility	(1) Main - 5 days/week	2 chairs
8	MSCF Mid State Correctional Facility	(1) Main - 3 days/week	1 chair
9	MVCF Mountain View Correctional Facility	(1) Main - 5 days/week (2) FMU - 1 or 2 days/week	2 chairs 1 chair
10	NJSP New Jersey State Prison	(1) Main - 5 days/week (2) Ad Seg - 1 day/week	2 chairs 1 chair
11	NSP Northern State Prison	(1) Main - 5 days/week (2) Ad Seg - 5 days/week	2 chairs 1 chair

	Facility	Details	Size
12	RFSP Riverfront State Prison	(1) Main - 5 days/week	2 chairs
13	SSCF Southern State Correctional Facility	(1) Compound A - 5 days/week (2) Compound B - 2 days/week	1 chair 1 chair
14	SWSP South Woods State Prison	(1) Facility 1 (2) Facility 2 (3) Facility 3 (4) ECU (5) V Bldg } Two full time dentists rotate through the clinics	2 chairs 2 chairs 2 chairs 1 chair 1 chair
	14 facilities	25 clinics	39 chairs

Appendix B

Contract Payments - Inmate Health Services (Dental + Medical) (Note #1)

Contract Year	Paid to CMS (net of St. Francis)	Paid to St. Francis Medical Center (for inpatient hospital services)	Total Actual Payments	Total Contract Not-to-Exceed Amount
Year #1 4/1/05-3/31/06	$74,506,838	$10,332,358 (Note #2)	$84,839,196	$92,643,039
Year #2 4/1/06-3/31/07	$81,202,353	$12,689,070	$93,891,423	$97,423,224
Years #1 + #2	$155,709,191		$178,730,619	$190,066,263

Note #1. Does not include mental health spending.

Note #2. Eleven month period ending 3/31/06.

Appendix C

Contract Not-to-Exceed Personnel Costs

	Contract Year #1	Contract Year #2	Contract Years #1 + #2
Dentists (Note #1)	$2,271,889	$2,340,046	
Statewide Director of Dentistry	196,000	201,880	
Dental Assistants (Note #2)	763,865	794,419	
Benefits (Note #3)	450,506	478,006	
Total (Note #4)	$3,682,260	$3,814,351	$7,496,611

Note #1. This is calculated using the not-to-exceed compensation amount allowed under the contract, based on 14.56 full time dentists (or their equivalent) each week for 40 hours a week in Contract Year #1 and 14.96 full time dentists (or their equivalent) each week for 40 hours a week in Contract Year #2.

Note #2. This is calculated using the not-to-exceed compensation amount allowed under the contract, based on 19.33 full time dental assistants (or their equivalent) each week for 40 hours a week in Contract Year #1 and 19.53 full time dental assistants (or their equivalent) each week for forty hours a week in Contract Year #2.

Note #3. Pursuant to the RFP, benefits are based on 14.84% of total compensation in Year #1 and 15.25% in Year #2.

Note #4. This amount represents total personnel costs of providing inmate dental services and does not include incidental costs included in the per capita payments (e.g., oral surgeons, dental lab expenses, equipment and supplies).

Appendix D

Estimated Minimum Liquidated Damages - Initial Health Assessment Not Completed Within Seven Days of Admission (According to All Weekly Reconciled Reports Provided by CMS)

	#1	#2	#3	#4
Report Date	Percentage of Compliance	Number of Incidents of Noncompliance	Liquidated Damages for Incidents of Noncompliance Calculated From Threshold	Liquidated Damages for Incidents of Noncompliance Calculated From 100%
10/30/05	94%	88	$712.50	$4,400
11/10/05	96%	58	0	0
11/14/06	98%	74	0	0
11/27/05	94%	77	$392.50	$3,850
12/4/05	- (Note 1)	-	-	-
12/11/05	95%	71	0	0
1/1/06	97%	53	0	0
1/8/06	98%	33	0	0
1/15/06	97%	47	0	0
1/18/06	97%	16	0	0
1/29/06	-	-	-	-
2/3/06	98%	6	0	0
2/12/06	100%	0	0	0
2/18/06	100%	0	0	0
2/26/06	100%	0	0	0
3/4/06	99%	2	0	0
3/11/06	97%	8	0	0
3/19/06	100%	3	0	0
3/26/06	100%	1	0	0
4/2/06	100%	1	0	0
4/9/06	100%	2	0	0
4/16/06	99%	4	0	0
4/22/06	100%	1	0	0
4/29/06	99%	6	0	0
5/7/06	99%	4	0	0
5/15/06	99.46%	3	0	0
5/22/06	99.4%	3	0	0

Estimated Minimum Liquidated Damages - Initial Health Assessment Not Completed Within Seven Days of Admission (According to All Weekly Reconciled Reports Provided by CMS)

	#1	#2	#3	#4
Report Date	Percentage of Compliance	Number of Incidents of Noncompliance	Liquidated Damages for Incidents of Noncompliance Calculated From Threshold	Liquidated Damages for Incidents of Noncompliance Calculated From 100%
5/29/06	99.3%	3	0	0
6/4/06	98.8%	11	0	0
6/12/06	99.6%	2	0	0
6/18/06	97.9%	11	0	0
6/25/06	97.9%	12	0	0
7/3/06	98.8%	6	0	0
7/10/06	98.6%	7	0	0
7/17/06	96.1%	5	0	0
7/23/06	94.7%	8	$22.50	$400
7/30/06	98.0%	0	0	0
8/6/06	97.5%	4	0	0
8/13/06	96.1%	6	0	0
8/20/06	100%	0	0	0
8/27/06	93.7%	9	$95.00	$450
9/3/06	99.3%	1	0	0
9/10/06	99.1%	1	0	0
9/17/06	97.5%	3	0	0
9/24/06	99.5%	3	0	0
10/1/06	99.3%	4	0	0
10/10/06	99.4%	4	0	0
10/15/16	98.7%	6	0	0
10/22/06	98.6%	7	0	0
10/29/06	97.9%	11	0	0
11/5/06	98.1%	10	0	0
11/12/06	98.7%	7	0	0
11/19/06	96.2%	15	0	0
11/26/06	99.7%	2	0	0
12/3/06	99.3%	2	0	0
12/10/06	99.7%	2	0	0
12/17/06	97.8%	11	0	0
12/24/06	99.6%	2	0	0
12/31/06	98.4%	7	0	0

Estimated Minimum Liquidated Damages - Initial Health Assessment Not Completed Within Seven Days of Admission (According to All Weekly Reconciled Reports Provided by CMS)

	#1	#2	#3	#4
Report Date	Percentage of Compliance	Number of Incidents of Noncompliance	Liquidated Damages for Incidents of Noncompliance Calculated From Threshold	Liquidated Damages for Incidents of Noncompliance Calculated From 100%
1/1/07	98.6%	5	0	0
1/14/07	96.8%	12	0	0
1/21/07	97.4%	6	0	0
1/28/07	99.6%	1	0	0
2/4/07	98.9%	3	0	0
2/11/07	95.5%	11	0	0
2/18/07	95.5%	11	0	0
2/25/07	98.8%	3	0	0
3/4/07	98.5%	113	0	0
3/11/07	100%	0	0	0
3/18/07	98.6%	4	0	0
3/25/07	99.7%	1	0	0
4/1/07	98.9%	3	0	0
Total:			$1,222.50	$9,100

This indicator measures whether the inmate's initial health assessment (which includes both medical and dental components) was completed within seven days of admission.

Column #1, the Percentage of Compliance, is the number of initial health assessments completed within seven days of admission divided by the number of newly admitted inmates for the period (generally one week), expressed as a percentage. This calculation is performed following the expiration of seven days for each date in the period. Liquidated damages are triggered when the Percentage of Compliance falls below 95%.

Column #2, the Number of Incidents of Noncompliance, is the number of initial health assessments not performed within seven days of admission.

Column #3. Once the Percentage of Compliance falls below the threshold of 95%, Liquidated Damages for Incidents of Noncompliance Calculated From Threshold, shows the amount of liquidated damages of $50 each for those Incidents of Noncompliance in excess of threshold amount for the period. For instance, for the report dated 10/30/05, the

Percentage of Compliance was 94% and the Number of Incidents of Noncompliance was 88; based on an inmate population of 1,480 new admissions, the threshold amount is 5% of 1,480 = 74. Liquidated Damages for Incidents of Noncompliance Calculated From Threshold are calculated as 88 - 74 = 14 x $50 = $700. [Slight discrepancies result from rounding.]

Column #4. Once the Percentage of Compliance falls below the threshold of 95%, Liquidated Damages for Incidents of Noncompliance Calculated From 100%, shows the amount of liquidated damages of $50 each for all Incidents of Noncompliance. For instance, for the report dated 10/30/05, the Number of Incidents of Noncompliance was 88 and Liquidated Damages for All Incidents of Noncompliance are calculated as 88 x $50 = $4,400.

Note 1. Missing information indicates that OIG was not provided with the Number of Incidents of Noncompliance for that period.

Estimated Minimum Liquidated Damages - Transfer Screening Not Completed Within 72 Hours of Transfer (According to All Weekly Reconciled Reports Provided by CMS)

	#1	#2	#3	#4
Report Date	Percentage of Compliance	Number of Incidents of Noncompliance	Liquidated Damages for Incidents of Noncompliance Calculated From Threshold	Liquidated Damages For Incidents of Noncompliance Calculated From 100%
10/30/05	- (Note 2)	-	-	-
11/10/05	85%	568	$48,828	$56,800
11/14/06	81%	735	$65,730	$73,500
11/27/05	83%	672	$59,246	$67,200
12/4/05	-	-	-	-
12/11/05	-	-	-	-
1/1/06	88%	446	$36,924	$44,600
1/8/06	91%	334	$25,820	$33,400
1/15/06	99%	0	0	0
1/18/06	-	-	-	-
1/29/06	84%	357	$31,174	$35,700
2/3/06	84%	373	$32,544	$37,300
2/12/06	85%	367	$31,866	$36,700
2/18/06	89%	279	$22,906	$27,900
2/26/06	88%	286	$23,746	$28,600
3/4/06	71%	700	$65,096	$70,000
3/11/06	73%	726	$67,312	$72,600
3/19/06	74%	699	$64,550	$69,900
3/26/06	76%	627	$57,442	$62,700
4/2/06	80%	526	$47,214	$52,600
4/9/06	79%	615	$55,738	$61,500
4/16/06	78%	130	$11,800	$13,000
4/22/06	89%	50	$4,082	$5,000
4/29/06	86%	119	$10,166	$11,900
5/7/06	94%	31	$2,118	$3,100
5/15/06	93.9%	50	$3,884	$5,000
5/22/06	90.4%	53	$4,192	$5,300
5/29/06	82%	83	$7,380	$8,300
6/4/06	88.6%	45	$3,712	$4,500
6/12/06	94.1%	28	$1,852	$2,800

Estimated Minimum Liquidated Damages - Transfer Screening Not Completed Within 72 Hours of Transfer (According to All Weekly Reconciled Reports Provided by CMS)

	#1	#2	#3	#4
Report Date	Percentage of Compliance	Number of Incidents of Noncompliance	Liquidated Damages for Incidents of Noncompliance Calculated From Threshold	Liquidated Damages For Incidents of Noncompliance Calculated From 100%
6/18/06	86.1%	64	$5,476	$6,400
6/25/06	95.2%	22	$1,274	$2,200
7/3/06	54.7%	34	$3,250	$3,400
7/10/06	82.5%	85	$7,528	$8,500
7/17/06	82.6%	57	$5,044	$5,700
7/23/06	98.7%	5	0	0
7/30/06	-	-	-	-
8/6/06	96.8%	12	$210	$1,200
8/13/06	95.6%	23	$1,262	$2,300
8/20/06	90.6%	52	$4,094	$5,200
8/27/06	92.4%	38	$2,802	$3,800
9/3/06	98.7%	31	0	0
9/10/06	94.5%	20	$1,268	$2,000
9/17/06	98.4%	7	0	0
9/24/06	97.2%	14	$416	$1,400
10/1/06	95.2%	28	$1,638	$2,800
10/10/06	90%	43	$3,240	$4,300
10/15/16	95.5%	20	$1,104	$2,000
10/22/06	98.3%	8	0	0
10/29/06	97.3%	13	$336	$1,300
11/5/06	94.1%	29	$1,914	$2,900
11/12/06	98%	8	0	0
11/19/06	96.7%	14	$556	$1,400
11/26/06	96.9%	17	$616	$1,700
12/3/06	98.3%	5	0	0
12/10/06	98.2%	8	0	0
12/17/06	97.2%	11	$304	$1,100
12/24/06	96.3%	16	$746	$1,600
12/31/06	91.5%	26	$1,990	$2,600
1/1/07	96%	12	$606	$1,200
1/14/07	99.8%	1	0	0

Estimated Minimum Liquidated Damages - Transfer Screening Not Completed Within 72 Hours of Transfer (According to All Weekly Reconciled Reports Provided by CMS)

	#1	#2	#3	#4
Report Date	Percentage of Compliance	Number of Incidents of Noncompliance	Liquidated Damages for Incidents of Noncompliance Calculated From Threshold	Liquidated Damages For Incidents of Noncompliance Calculated From 100%
1/21/07	99.1%	12	0	0
1/28/07	97.2%	39	$1,078	$3,900
2/4/07	98.7%	18	0	0
2/11/07	92.6%	30	$2,194	$3,000
2/18/07	93.3%	27	$1,980	$2,700
2/25/07	96.4%	14	$628	$1,400
3/4/07	93.9%	27	$1,820	$2,700
3/11/07	93.7%	31	$2,116	$3,100
3/18/07	94%	40	$2,666	$4,000
3/25/07	97.6%	11	$200	$1,100
4/1/07	95.6%	21	$1,152	$2,100
Total:			$844,830	$978,900

This indicator measures whether the inmate's transfer screening (which includes both medical and dental components) was completed within 72 hours of transfer.

Column #1, the Percentage of Compliance, is the number of transfer screenings completed within 72 hours of transfer divided by the number of inmates transferred during the period (generally one week), expressed as a percentage. This calculation is performed following the expiration of 72 hours for each date in the period. Liquidated damages are triggered when the Percentage of Compliance falls below 98%.

Column #2, the Number of Incidents of Noncompliance, is the number of transfer screenings not performed within 72 hours of admission.

Column #3. Once the Percentage of Compliance falls below the threshold of 98%, Liquidated Damages for Incidents of Noncompliance Calculated From Threshold, shows the amount of liquidated damages of $100 each for those Incidents of Noncompliance in excess of threshold amount for the period. For instance, for the report dated 11/10/05, the Percentage of Compliance was 85% and the Number of Incidents of Noncompliance was

568; based on an inmate population of 3,986 transfers, the threshold amount is 100% - 98% = 2% of 3,986 = 79.72. Liquidated Damages for Incidents of Noncompliance Calculated From Threshold are calculated as 568 - 79.72 = 488.28 x $100 = $48,828. [Slight discrepancies result from rounding.]

Column #4. Once the Percentage of Compliance falls below the threshold of 98%, Liquidated Damages for Incidents of Noncompliance Calculated from 100%, shows the amount of liquidated damages of $100 each for all Incidents of Noncompliance. For instance, for the report dated 11/10/05, the Number of Incidents of Noncompliance was 568 and Liquidated Damages for Incidents of Noncompliance are calculated as 568 x $100 = $56,800.

Note 1. Missing information indicates that OIG was not provided with the Number of Incidents of Noncompliance for that period.

Appendix E

Dentist Staffing Invoiced by CMS - Contract Year #1

Contract Month and Year	Number of Dentists Billed (Note #1)	Hours Billed During Month (Note #2)	Number of Hours Over or (Under) Minimum Requirement of 2,524 Hours (Note #3)	Percentage of Compliance
Apr. '05	6	385.5	(2,138.50)	15.27%
May '05	10	676.50	(1,847.50)	26.80%
Jun. '05	22	1,784.75	(739.25)	70.71%
Jul. '05	24	2,058.75	(465.25)	81.57%
Aug. '05	27	2,527	3.00	100.12%
Sept. '05	28	2,590.25	66.25	102.62%
Oct. '05	26	2,286.25	(237.75)	90.58%
Nov. '05	26	2,458.25	(65.75)	97.40%
Dec. '05	27	2,516.5	(7.50)	99.70%
Jan. '06	28	2,944.75	420.75	116.67%
Feb. '06	27	2,516.25	(7.75)	99.69%
Mar. '06	28	2,902.75	378.75	115.01%
Totals		25,647.5	(4,640.50)	84.68%

Dentist Staffing Invoiced by CMS - Contract Year #2

Contract Month and Year	Number of Dentists Billed (Note #1)	Hours Billed During Month (Note #2)	Number of Hours Over or (Under) Minimum Requirement of 2,593 Hours (Note #3)	Percentage of Compliance
Apr. '06	27	2,574.75	(18.25)	99.30%
May '06	27	2,948.25	355.25	113.70%
Jun. '06	27	3,024.5	431.5	116.64%
Jul. '06	23	2,530.25	(62.75)	97.58%
Aug. '06	24	2,899.5	306.5	111.82%
Sept. '06	24	2,804	211	108.14%
Oct. '06	25	2,727.5	134.5	105.19%

Contract Month and Year	Number of Dentists Billed (Note #1)	Hours Billed During Month (Note #2)	Number of Hours Over or (Under) Minimum Requirement of 2,593 Hours (Note #3)	Percentage of Compliance
Nov. '06	28	2,965.5	372.5	114.37%
Dec. '06	27	2,853.75	260.75	110.06%
Jan. '07	26	3,166.5	523.5	120.19%
Feb. '07	28	2,718.75	125.75	104.85%
Mar. '07	30	3,189.25	596.25	122.99%
Totals		34,352.5	3,236.50	110.40%

Note #1. Individual dentists; not including oral surgeons.

Note #2. Does not include hours for oral surgeons.

Note #3. Although the contract specified hours on a weekly basis, CMS billed DOC on a monthly basis. In order to evaluate compliance on a monthly basis, OIG divided the total minimum required hours for each contract year by 12 months, obtaining an average of 2,524 minimum required hours per month in Year #1 and an average of 2,593 minimum required hours per month in Year #2. Thus, the number of dental staffing hours over or under the minimum contract requirement and the percentage of compliance with the requirements is a near approximation.

Appendix F

Dental Assistant Staffing Invoiced by CMS - Contract Year #1

Invoice Date (Note #1)	Hours Billed
Apr. '05	255
May '05	1,300.75
Jun. '05	1,802.75
Jul. '05	3,976.75
Aug. '05	2,860.25
Sept. '05	2,585.50
Oct. '05	2,682.5
Nov. '05	2,814.5
Dec. '05	3,914.5
Jan. '06	2,930.5
Feb. '06	3,155.25
Mar. '06	3,050
Totals	31,328
Number of Hours (Under) Minimum Requirement of 40,208 Hours	(8,884.00)
Percentage of Compliance	77.91%

Dental Assistant Staffing Invoiced by CMS - Contract Year #2

Invoice Date (Note #1)	Hours Billed
Apr. '06	2,974.5
May '06	3,168.75
Jun. '06	4,302.25
Jul. '06	2,658.5
Aug. '06	2,955.5
Sept. '06	3,025.75
Oct. '06	3,284

Invoice Date (Note #1)	Hours Billed
Nov. '06	3,417.5
Dec. '06	4,513.5
Jan. '07	3,139
Feb. '07	3,207.25
Mar. '07	3,394 (Note #2)
Totals	40,040.5
Number of Hours (Under) Minimum Requirement of 40,728 Hours	(687.5)
Percentage of Compliance	98.31%

Note #1. CMS invoices often did not reflect calendar months but were for longer periods. Therefore, the date of the invoice does not reflect the date of the services provided. For instance, the July '05 invoice is for the period June 19 - July 30, 2005 (42 days). For that reason, OIG could not demonstrate compliance on a monthly basis (as was done for dentists), but only for an entire contract year.

Note #2. Projected amount based on an average of 3,394 minimum contracted hours per month in the second contract year.

Appendix G

Contract Required Continuous Quality Indicators (According to All Weekly Reconciled Reports Provided by CMS) – Note # 1

	#1	#2	#3	#4	#5	#6
Date (Note # 2)	Biennial Dental Summary	Dental Prosthesis Compliance	Oral Surgery Consults Completed Within Thirty Days	Provide Receive Antibiotic Prophylaxis With Known Cardiac History	Initial Cleaning Completed Within Sixty Days of Admission	Dental Edentulous Recall
06/18/06	91.1%	68.5%	91.3%	0.0%	9.0%	-
06/25/06	91.2%	68.3%	-	-	-	-
07/03/06	91.1%	66.7%	91.1%	0.0%	8.3%	-
07/10/06	91.4%	65.4%	90.5%	66.7%	8.3%	-
07/17/06	-	83.7%	94.2%	99.6%	-	-
07/23/06	94.1%	58.8%	91.7%	-	-	-
07/30/06	94.0%	57.1%	91.0%	-	6%	-
08/06/06	93.6%	60.9%	91.3%	-	6.6%	-
08/13/06	93.4%	60.6%	-	50.0%	13.0%	-
08/20/06	93.0%	61.0%	-	50.0%	17.9%	-
08/27/06	94.2%	62.8%	-	-	12.2%	-
09/03/06	94.9%	75.6%	-	0.0%	2.0%	-
09/10/06	94.7%	72.0%	94.3%	-	37.7%	-
09/17/09	95.1%	70.8%	95.0%	100.0%	28.2%	-
09/24/06	95.9%	84.4%	96.3%	100.0%	32.3%	-
10/01/06	95.1%	63.5%	95.3%	66.7%	8.5%	-
10/10/06	95.1%	67.8%	95.6%	-	9.6%	-
10/15/06	95.1%	69.9%	96.1%	-	53.0%	-
10/22/06	95.4%	70.1%	97.1%	0.0%	23.1%	-
10/29/06	-	-	-	-	-	-
11/5/06	96.2%	65.6%	97.4%	0.0%	15.2%	-
11/12/06	96.4%	67.5%	97.9%	50.0%	12.6%	-
11/19/06	96.3%	66.3%	98.2%	60.0%	15.8%	-
11/26/06	96.2%	64.4%	98.5%	0.0%	1.3%	-
12/03/06	96.1%	64.8%	93.6%	0.0%	0.7%	-
12/10/06	96.4%	63.0%	98.6%	40.0%	1.7%	-
12/17/06	96.7%	57.9%	98.8%	25.0%	-	100.0%
12/24/06	97.1%	55.8%	99.1%	-	-	100.0%
12/31/06	97.1%	60.0%	99.0%	25.0%	22.4%	100.0%

	#1	#2	#3	#4	#5	#6
Date (Note # 2)	Biennial Dental Summary	Dental Prosthesis Compliance	Oral Surgery Consults Completed Within Thirty Days	Provide Receive Antibiotic Prophylaxis With Known Cardiac History	Initial Cleaning Completed Within Sixty Days of Admission	Dental Edentulous Recall
01/07/07	97.1%	50.5%	98.9%	0.0%	0.5%	88.9%
01/15/07	-	-	-	-	-	-
01/22/07	97.0%	38.6%	98.9%	-	4.3%	-
01/28/07	97.0%	54.3%	98.8%	50.0%	1.0%	89.5%
02/04/07	97.1%	46.8%	97.0%	33.3%	27.4%	90.7%
02/11/07	98.9%	54.9%	98.8%	14.3%	23.2%	96.0%
02/18/07	97.7%	59.6%	93.7%	20.0%	20.4%	96.6%
02/25/07	97.9%	72.3%	97.6%	-	21.5%	96.5%
03/04/07	97.7%	74.9%	97.6%	0.0%	22.7%	97.1%
03/11/07	97.9%	83.3%	97.7%	66.7%	36.6%	98.8%
03/18/07	97.6%	83.9%	97.6%	71.4%	23.7%	95.4%
03/25/07	97.6%	85.7%	97.7%	50.0%	24.0%	94.9%
04/01/07	97.8%	83.3%	-	100.0%	23.7%	99.2%

Note #1. Although no liquidated damages are associated with Continuous Quality Indicators, the contract requires certain services to be performed within stated timeframes or based on other health-related issues. With respect to columns #1, #2, #3 and #5, the percentages shown reflect levels of performance within the required timeframes. Columns #4 and #6 reflect requirements which must be performed as necessary.

Note # 2. Data was not available for compliance with these indicators for the first fourteen months of the contract