



# **UNITED STATES MARSHALS SERVICE'S PRISONER MEDICAL CARE**

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# **UNITED STATES MARSHALS SERVICE'S PRISONER MEDICAL CARE**

## **EXECUTIVE SUMMARY**

The United States Marshals Service (USMS) is responsible for providing medical care to the roughly 40,000 prisoners it has in its custody at any given time. Federal prisoners in USMS custody are housed in local jails, contract facilities, and the Federal Bureau of Prisons (BOP) facilities throughout the country while awaiting trial in federal courts. These prisoners remain in USMS custody throughout the trial process, which may run anywhere from several days to several years.

Medical care provided to USMS prisoners falls under one of two categories: 1) in-house medical care, or 2) outside medical care. In-house medical care encompasses health care provided at local jail clinics, and in some instances emergency care provided in USMS cellblock operations. Outside medical care comes into play when a prisoner in USMS custody requires advanced or specialized medical care and must be sent to an outside health care facility. In fiscal year (FY) 2002, the USMS spent approximately \$43 million on outside medical services for its prisoners, which included \$36 million for medical services and \$7 million in related guard costs. In addition to the costs of providing outside medical care, there are associated risks, which include the possibility of: 1) escape; 2) death or injury to an innocent bystander, law enforcement official, or the prisoner; and 3) exposure of the general public to possibly infectious diseases.

The objectives of this audit were to determine whether: 1) the USMS is providing prisoners necessary health care; 2) the USMS is screening and treating prisoners for communicable diseases; 3) prisoner medical costs are necessary and reasonable; and 4) the USMS is providing prisoners secure transport to off-site facilities to receive medical treatment.

The audit's scope encompassed the USMS's management of prisoner medical care during period FY 2000 through FY 2003. Our primary focus was on management of prisoner medical care activities by USMS district offices. In conducting the audit we: 1) researched and reviewed applicable laws, policies, regulations, manuals, and memoranda; 2) interviewed USMS

officials at district offices and USMS headquarters; and 3) tested internal controls over prisoner medical care at 14 USMS district offices.<sup>1</sup>

To assess USMS efforts at controlling the spread of tuberculosis (TB) among inmates, we interviewed USMS employees manning the cellblock areas to determine whether they were familiar with the symptoms of TB. We also reviewed files of prisoners in USMS custody during our site visits and determined whether TB skin tests were timely completed and documented. In addition, we reviewed USMS efforts to address the control of HIV/AIDS and hepatitis.

In order to determine whether USMS medical procedures were necessary, accurately recorded, and supported by documentation, we tested a statistical sample of outside medical transactions reported in FY 2002 (See Appendix XI). We also interviewed district officials and reviewed randomly selected medical bills to establish if outside medical services were being procured in accordance with federal acquisition regulations.

We judgmentally selected and reviewed the personnel files for contract hospital guards to determine whether the hospital guards utilized by the USMS met the qualification standards for job experience, background, physical fitness, and training. Guards that do not meet these requirements may not perform their job properly and could endanger the lives of the prisoner, themselves, and the general public.

In addition, we interviewed the Contracting Officer's Technical Representative (COTR) for each district's hospital guard contract to determine whether the COTRs were qualified for their position and to determine if they were effectively monitoring the contractor's performance.

Finally, we reviewed USMS jail inspection reports and interviewed jail inspectors to evaluate USMS efforts to ensure that federal prisoners receive adequate health care at the hundreds of detention facilities contracted by the USMS to house federal prisoners awaiting trial.

## **I. Summary of Audit Findings**

The USMS is not properly managing its prisoner medical care. Our audit determined that USMS district offices often ignore essential internal

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<sup>1</sup> The 14 USMS districts were: District of Arizona, Central District of California, Southern District of California, District of Columbia District Court, Middle District of Florida, Northern District of Illinois, District of Kansas, District of New Mexico, Eastern District of New York, Western District of New York, Eastern District of Pennsylvania, District of South Carolina, Western District of Texas, and Southern District of Texas.

controls and procedures designed to ensure that basic and emergency health care is properly administered and necessary outside medical care is efficiently and safely provided. We also found that by failing to fully comply with statutory cost saving measures, the USMS is paying out millions more than necessary for prisoner medical care on an annual basis. Specifically, the audit determined that:

- USMS districts are not adequately tracking and monitoring communicable diseases, such as TB, hepatitis, and HIV/AIDS.
- The USMS is not obtaining the lowest medical rates allowed by federal legislation, and as a result is paying out an estimated \$7 million annually in excess fees for outside medical care.
- USMS districts are not maintaining personnel documentation or providing training needed to ensure that contract hospital guards are fully qualified to perform their duties.
- USMS districts are not properly reviewing the performance and billings of hospital guard contractors.
- USMS districts are not providing adequate emergency response to prisoners housed in their cellblocks. Uncertainty exists at the district level as to what the current policies are governing health and emergency care in cellblocks.
- USMS districts are not taking the necessary actions needed to ensure that federal prisoners housed in local detention facilities are receiving standard basic health care.<sup>2</sup>
- USMS districts are not following financial control procedures established to ensure that outside medical payments are: 1) valid and legitimate, 2) necessary according to USMS guidelines, 3) accurate and at the lowest cost, and 4) not duplicated.
- USMS districts are obtaining outside medical services in violation of Federal Acquisition Regulations.

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<sup>2</sup> American Correctional Association (ACA) has established criteria defining standard basic prisoner health care.

## II. Background

Initial medical screening of a federal prisoner occurs at the booking of the individual at a USMS district office, which is often located in the local federal courthouse. At booking, USMS deputies observe the arrestee and fill out a booking sheet documenting the arrestee's responses to a few basic medical questions. While awaiting either a court appearance or transport to a federal Bureau of Prisons (BOP) or local jail facility where medical screening will take place, the arrestees are kept in the cellblock. The term "cellblock" refers to a secure area in the USMS office intended to temporarily house prisoners awaiting court proceedings or transport.

Given the short span of time that prisoners usually spend in the cellblock area, medical care is normally not required. In some cases, however, prisoners awaiting trial may have chronic medical conditions, such as asthma or heart disease that may require medical attention. Emergency medical situations can also occur during a prisoner's cellblock stay.

For basic medical screening and routine medical services for federal prisoners, the USMS relies largely on local jails, contract jails, and BOP facilities, most of which are equipped with in-house medical clinics within their facilities. The costs of such in-house medical services are usually covered in the per diem rates charged to the USMS under the terms of an Intergovernmental Service Agreement (IGA),<sup>3</sup> in the case of a local jail, or the contracted jail day rate, in the case of a private contract facility. Medical services provided to USMS prisoners in BOP facilities are provided at no cost to the USMS.

In-house medical services provided by the jails housing federal prisoners can vary substantially. Some local jails may have on-site medical professionals and sophisticated medical facilities, equipped with X-ray and dialysis machines, TB isolation cells, and dental services. Some facilities may even be able to accommodate minor surgical procedures. At the other end of the spectrum are facilities with very limited health care services where a local deputy or administrative official may ask general medical questions to complete paperwork necessary to process the individual. Prisoners at these facilities must often be transported outside the facility for procedures that are routinely performed at jails with more comprehensive medical services.

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<sup>3</sup> The Intergovernmental Agreement states that a negotiated daily rate per prisoner will be paid by the USMS to the jail.

### III. Management of Outside Medical Care

The USMS is incurring millions of dollars in unnecessary costs for outside medical care because it is not re-pricing medical billings at the lowest rate afforded by federal legislation. The USMS currently has a contract with Healthnet, Inc., to re-price all outside medical billings at the Medicare rate. The re-pricing of medical bills from the vendor's full price at the Medicare rate saved the agency approximately \$20.2 million in its first full year of implementation. However, effective November 29, 1999, Public Law 106-113, which amended Title 18 USC Section 4006, requires the USMS to pay prisoner medical claims at the Medicare or Medicaid rates, whichever is less. Based on a recent study that showed that Medicaid rates averaged 81 percent of Medicare rates, we estimated that the USMS spent about \$7 million more on outside medical services in FY 2002 than necessary. The USMS is currently negotiating for a national health care contract that, if fully implemented, will incorporate Medicaid rates into the re-pricing process.

Internal controls over outside medical care at the USMS district offices reviewed were inconsistent and in some cases non-existent. We noted weaknesses in the internal control structure throughout the process, from procurement through payment. Districts were not reconciling invoices with pre-authorizations, in some cases because there were no pre-authorizations with which to reconcile. In tests of procedures, at least 3 percent of medical procedures were determined to be unnecessary. In most instances the unnecessary procedures resulted because districts were not proactively involved in the pre-authorization process, allowing the BOP or local detention facility to dictate whether outside medical treatment was required without notifying the USMS.<sup>4</sup> Often the district office was unaware of the medical treatment or hospitalization until a bill was received.

USMS prisoner case files were not complete with regard to required medical documentation, and in some districts were non-existent. Medical procedures were not consistently entered into the Prisoner Tracking System (PTS). Financial transactions were not classified consistently in the Financial Management System (FMS). Violations of the Federal Acquisition Regulations were commonplace. Based on our audit testing we determined that 84 of the 164 payment transactions that exceeded \$2,500 were not in full compliance with federal procurement regulations because the medical service providers did not have binding written agreements with the USMS.

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<sup>4</sup> District officials stated that the BOP often does not request or seek authorization from the USMS when obtaining outside medical treatment for federal prisoners in USMS custody.

#### **IV. In-House Medical Care**

We found that USMS districts were not adequately monitoring local detention facilities to determine whether federal prisoners were receiving proper health care. In addition, USMS districts were not effectively initiating health care improvements at local jails that provided substandard health care. USMS inspections were cursory and often were not forwarded to headquarters, as required. The inspection reports annually submitted to district officials did not provide enough detailed information, such as observations, interviews, documents reviewed, to support general findings that the health care provided by the jail met the required standards. Further, in three of the districts reviewed, deputy marshals who had not received any training in jail inspections were performing the inspections. In addition, jail inspector duty for deputy marshals is collateral to their normal law enforcement responsibilities. The auditors noted that deputies assigned to perform jail inspections were not specifically rated on their performance evaluations for the quality or timeliness of their jail inspection work.

Our audit questioned not only the quality of the USMS jail inspections but also their timeliness, as many reports were not being submitted annually as required by USMS policy and procedures. In FY 2002, 8 of the 14 districts reviewed did not complete annual evaluations of the prisoner medical care provided by all their major use detention facilities.

Further, inspections by the USMS conflicted with reviews conducted by other groups. In one instance, we noted that USMS district officials had performed an inspection and issued a clean report on a contract facility at the same time that the Department's Civil Division was issuing its own report detailing numerous constitutional rights violations, many related to medical care.

#### **V. Communicable Diseases**

USMS tracking and monitoring of communicable diseases, such as TB, hepatitis, and HIV/AIDS, was not consistent from district to district, and in some districts was not done at all. Current USMS policy concerning communicable diseases addresses TB only. However, we found little evidence that districts were acting in accordance with that policy. Many districts were not performing initial intake screening of prisoners for TB, and many did not maintain information on prisoners' TB status. In general, USMS districts rely on local jails to test and monitor TB status. This is problematic because local jails do not always test for TB and are not always timely when they do test.

We found documentation on prisoners' TB status almost non-existent. The USM Form-553, used to document TB clearance, was either entirely missing from case files, if there were case files, or the form did not contain TB results. Documentation in the PTS was also sparse to non-existent. Only 2 of the 14 districts reviewed were utilizing the PTS, and these districts were doing so only partially. One of those districts had entered only 9 of the 25 inmates selected into the PTS, and the other had entered only one prisoner out of the 25 selected.

We asked each of the districts reviewed to provide us a list of prisoners currently in USMS custody who had been diagnosed with active TB. Of the 14 districts, 6 districts could not provide a list of prisoners with active TB, 3 districts were able to provide a list, and 5 of the districts stated that they had not processed any prisoners with active TB during the review period. However, we later determined that one of the districts claiming not to have processed any prisoners with active TB had paid for treatment of active TB for a USMS prisoner in FY 2002. This lack of awareness was not totally unexpected, given the scarcity of TB-related information in the prisoner files and the PTS. It is, nevertheless, a cause for concern given that prisoners who are suspected of or have been diagnosed with active TB are not to be produced for court or transported (other than to an appropriate local medical facility) by USMS personnel until the prisoner has received the appropriate medical care and is medically cleared by a health professional.

In one incident, a prisoner was released on bond prior to his TB test results being received. Subsequent receipt of the prisoner's chest x-ray results confirmed that he had active TB. In another incident, a deputy marshal was unknowingly exposed to TB when he had escorted a prisoner that, unbeknownst to him, had been diagnosed with active TB. According to the deputy, he was not advised of the prisoner's condition until after he had transported the prisoner. The deputy later tested positive for TB and had to be treated.

No formal USMS policies currently exist at the national level for tracking and monitoring cases of hepatitis and HIV/AIDS. We found that district offices, for the most part, had not taken any steps to fill the policy vacuum at the national level regarding hepatitis and HIV/AIDS. When asked, district officials stated that there were no local policies or that they were not aware of them if there were. Not surprisingly, there was little consistency from district to district in the handling of hepatitis and HIV/AIDS cases. Seven of the districts were documenting the health status for HIV/AIDS and hepatitis for prisoners on USMS forms, six of which entered information into the PTS.



## **VI. Prisoners are Transported and Guarded by Contract Personnel**

A critical factor in providing outside medical treatment to federal prisoners is the secure transport to and from health care facilities and guarding of prisoners during the period of treatment. Contract guards were used in 12 of the 14 districts we reviewed.

Management of contract guard operations relative to prisoner medical care was characterized by inadequate training, breaches in policy, and lapses in internal controls. The problems occurred in nearly all areas of contract guard activity, ranging from lack of documentation to overpayments. More importantly, the ill-managed contract guard operations have created an environment in which the USMS cannot effectively control the risks inherent in transporting federal prisoners to and from off-site health care facilities.

We found that districts were not keeping complete personnel files documenting the guards' experience and other qualifications. Furthermore, several districts reviewed by the audit team did not require that these individuals complete any of the USMS's required training courses.

The USMS is not placing a high priority on monitoring and evaluating the performance of their hospital guard contracts. The U.S. Marshal usually assigns deputies collateral duty as COTR. The COTR is the on-site contract administrator and is responsible for monitoring the contract to ensure that contract performance requirements are being met. We interviewed COTRs to evaluate their knowledge of contractor performance and found that many COTRs lacked a proper knowledge of the hospital guard contract they were managing. We further ascertained that most COTRs had not submitted formal evaluations of the contract to district management.

We noted at least one instance where a guard's failure to follow standard procedure allowed a prisoner to escape from his hospital room. The prisoner, who was hospitalized for treatment of active TB, was placed in a non-secured section of the hospital because the secured wing was full. The unsecured hospital room had no observation port in the door and had windows to the outside that could be opened. Further, because the prisoner had active TB, the contract guard did not stay in the room with the patient. Consequently, the contract guard failed to maintain regular visual contact, in violation of USMS procedures.

As a result, the prisoner was out of the guard's sight for a long enough period to put on his street clothes (which he should not have had), tie several bed sheets together, open the hospital room window and lower

himself to the ground to make his escape. Following his escape, the prisoner hijacked a woman driving her car. He was subsequently apprehended and later died in custody from advanced TB.

## **VII. Office of Program Review**

The internal review function within the USMS falls under the jurisdiction of the Management and Budget Division, specifically the Office of Program Review. On April 19, 2000, the USMS Deputy Director issued a memorandum directing the Program Review Office to suspend its reviews of USMS district operations. Historically, this had been Program Review's primary area of responsibility, with staff completing about 30 reviews annually. The reviews are comprehensive in scope and cover nearly all aspects of district operations, including activities related to prisoner medical care, such as: 1) prisoner transport, 2) contract and IGA billings, and 3) judicial security. The inspection reports, signed by the USMS Director, contain findings and recommendations, and require a formal resolution process, documenting that necessary corrective actions were taken. The district reviews were initially suspended as a short-term measure to deal with staffing shortages in the field, which required that Program Review staff be detailed to district offices in need of administrative support. However, as of the last day of our fieldwork on October 28, 2003, district review activity remained on hold. According to USMS officials, the reason for the continued suspension is that the USMS plans to reorganize its internal review function will remain on hold pending completion of the reorganization.

In the three years since the suspension of these district reviews, the Office has existed in a state of limbo. The staff is now restricted to performing property management reviews, and does so only on a special request basis. Staffing levels at the Eastern office have been reduced from six to two analysts. The staff assigned to the Western office in Denver, Colorado has been reduced from six analysts to four, the remainder of which has been detailed to the Witness Security Program. The Central office in Houston, Texas has been closed.

## VIII. OIG Recommendations

Our report contains 12 recommendations to help improve USMS efforts to manage prisoner medical care. These include recommending that the USMS:

- Require that prisoners' TB test dates and results be entered into the PTS and documented in the prisoners' case files, and ensure that USMS deputy marshals perform initial TB screening of the USMS prisoners that are housed in USMS district holding cells.
- Effectively track and monitor USMS prisoners diagnosed with active TB.
- Implement a policy for tracking and monitoring of HIV/AIDS and hepatitis cases.
- Strengthen the jail inspection program.
- Ensure that deputy marshals are in compliance with cellblock health care policy and that they receive annual Cardio Pulmonary Resuscitation (CPR) and Automated Electronic Defibrillator (AED) training in order to maintain certification.
- Complete on-going effort to negotiate a national managed health care contract for prisoner medical services that remedy non-compliance with Title 18 USC and will effectively streamline the process.
- Enforce current USMS policy regarding the use of prisoners' private insurance, where practicable, to cover the costs of outside medical care.
- Ensure that guard contracts are effectively monitored.
- Ensure that districts adhere to established procedures for authorizing, recording and tracking outside medical procedures.
- Re-institute internal operational reviews of USMS district offices.

**UNITED STATES MARSHALS SERVICE  
PRISONER MEDICAL CARE**

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# UNITED STATES MARSHALS SERVICE PRISONER MEDICAL CARE

## INTRODUCTION

The primary mission of the United States Marshals Service (USMS) is to protect the federal courts and ensure the effective operation of the judicial system. Integral to that mission is the transporting, housing, and guarding of federal prisoners during the trial process. The USMS is responsible for housing and maintaining an average daily population of about 40,000 federal prisoners awaiting trial in federal courts.

Federal prisoners in USMS custody are housed in local jails, contract facilities, and federal Bureau of Prisons (BOP) facilities throughout the country. Depending upon the length of a prisoner's court trial, time spent in USMS custody may run from several days to several years, during which time the USMS is responsible for the well-being of that individual, including providing for adequate medical care.

### **In-House Medical Care**

For basic medical screening and routine medical services for federal prisoners, the USMS relies largely on local and contract jails, as well as the BOP, most of which are equipped with in-house medical clinics within their facilities. The costs of such in-house medical services are usually covered in the per diem rates charged to the USMS under the terms of an Intergovernmental Service Agreement (IGA),<sup>5</sup> in the case of a local jail, or the contracted jail day rate, in the case of a private contract facility. Services provided in BOP facilities are done so at no cost to the USMS.

In-house medical services provided by the jails housing federal prisoners can vary substantially. Some local jails may have sophisticated medical facilities, replete with X-ray and dialysis machines, Tuberculosis (TB) isolation cells, and dental services. Some facilities may even be able to accommodate minor surgical procedures. At the other end of the spectrum are facilities with very limited health care services. Prisoners at these facilities must often be transported outside for procedures that are routinely performed at jails with more comprehensive medical services.

To assess the quality of care provided federal prisoners at local jails, the USMS has a jail inspection program. Current USMS jail inspection

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<sup>5</sup> The Intergovernmental Agreement states that a negotiated daily rate per prisoner will be paid by the USMS to the jail.

guidelines include standards established by the American Correctional Association (ACA).<sup>6</sup> USMS deputy marshals, as a collateral duty, conduct these jail inspections and submit the reports to their district office. The reports rate the jails compliance with ACA standards and list any medical care deficiencies noted at the jail.

USMS officials stated that only a small percentage of local jail facilities met the standards required of the ACA for accreditation. Indeed, some facilities have been subject to prisoner or third-party litigation because of substandard conditions of confinement. Because of the limited number of ACA-accredited jails available to house federal prisoners, USMS district officials are not precluded from using non-accredited jails when warranted by the need for bed space, as long as 24-hour access to emergency medical services is be available.

### **Outside Medical Care**

When a prisoner in USMS custody requires advanced or specialized medical care, the prisoner is usually sent out to a local health care facility. In contrast to in-house medical care, USMS district offices are directly involved in the process of acquiring outside medical care. USMS district offices have the discretion, upon recommendation of a competent medical authority, to acquire and provide reasonable and necessary outside medical services for federal prisoners. Discretion comes into play in situations involving non-emergency procedures. Given that most prisoners are in USMS custody for relatively short time periods, certain non-emergency procedures, while medically appropriate, may be delayed provided there are no health risks to the prisoner. In fiscal year (FY) 2002, the USMS spent approximately \$43 million on outside medical services for its prisoners, which included \$36 million for medical services and \$7 million in related guard costs.

Depending on the nature of the illness or injury, the services provided may involve hospital stays of hours, days, weeks, and in some cases even months. The risks inherent in providing of outside medical care to prisoners are myriad and include the possibility of: 1) escape; 2) death or injury to an innocent bystander, law enforcement official, or the prisoner during an escape attempt; and 3) exposure of the general public to possibly contagious diseases.

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<sup>6</sup> The ACA is a professional membership organization dedicated to the improvement of corrections and the development and training of correctional professionals. The ACA's membership consists of individuals and organizations involved in all facets of corrections, including adult institutions and jails, community corrections, juvenile justice, institutions of higher learning, and probation and parole.



## Management of Prisoner Medical Care

The USMS Office of Interagency Medical Services (OIMS), a branch of the Prisoner Services Division, is responsible for providing overall policy direction and assistance to the field in all matters concerning prisoner medical services. Established in 1994, the OIMS has several functions, including: 1) case management for the districts;<sup>7</sup> 2) establishing policies and procedures; 3) cost management efforts, such as the BOP/USMS medical consolidation program;<sup>8</sup> and 4) TB management.

Management of the day-to-day operations rests with the district offices. Specifically, USMS district office personnel must: 1) approve the medical treatment (sometimes in consultation with OIMS); 2) provide for transportation and guard services for the prisoner; 3) document the procedure(s) and cost; 4) enter medical billings into the Financial Management System (FMS); and 5) ensure that transactions are properly recorded and payments to medical providers are timely paid.

### Prior Reports

The Department of Justice (DOJ) Justice Management Division previously reviewed USMS medical services in its *1998 Detention and Incarceration Study*, as well as in its *Review of the USMS Prisoner Medical Services* issued December 1994. The review and subsequent study highlighted areas of concern and opportunities for improvement including:

- Personnel involved in transporting and guarding prisoners in buses, vans, and Justice Prisoner Alien Transportation System (JPATS) flights may be at risk of exposure to TB and other infectious diseases.
- The BOP and the USMS need to coordinate agreements with hospitals and other health care providers to achieve the best possible rates and reduce duplication. The BOP has since made all its national hospital contracts inclusive of all federal prisoners, thus allowing the USMS to piggyback on these contracts, but the USMS does not always use these contracts.

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<sup>7</sup> The OIMS, in cooperation with the Public Health Service, provides advice to the district offices when a prisoner requires extensive medical treatment, or the district office is unsure of whether specific services are allowable under USMS policy.

<sup>8</sup> In 1993, the USMS and BOP signed a Memorandum of Understanding citing the need for the two agencies to work together to contain health care costs. Toward that end the agencies have developed pilot projects at select institutions that house USMS prisoners. The pilot projects have focused on reducing health care costs through sharing arrangements, joint contracts, and other methods designed to contain medical costs.

- The USMS should incorporate medical care and related services into its IGAs and contracts. Further, the USMS should renegotiate IGAs that are incurring high costs for outside medical services.
- USMS districts should utilize to the fullest extent possible local jails with the broadest range of in-house medical capabilities in order to reduce the need for costly outside referrals.
- The USMS should utilize hospitals with locked wards to reduce guard costs associated with outside care.
- The USMS through its Cooperative Agreement and Excess Property Programs should assist local jails in developing and expanding in-house medical capabilities to reduce the need for outside medical care for federal prisoners.
- The USMS should work with the Immigration and Naturalization Service (INS) (since transferred to the Department of Homeland Security) and BOP to determine the feasibility of negotiating single contracts for medical and guard services to meet the needs of all three agencies.
- The USMS should examine the feasibility and requirements of contracting out prisoner medical care.
- USMS districts should be alerted about what signs and symptoms to look for and precautions to take relative to potential contagious diseases.
- The USMS should make every effort to provide at least 48 hours notice of planned moves and to obtain medical records and medications prior to transporting a sick prisoner.
- The USMS should reexamine its booking forms and procedures to ensure that they adequately cover prisoner health status.

In addition, Booz-Allen & Hamilton, Inc., in a *Streamlining Review* issued July 2002, recommended that the USMS contract for a managed care health system to streamline prisoner medical care.<sup>9</sup> The report stated that the USMS managed care system should provide for the following:

- Negotiated contracts with medical facilities and providers, claims processing and payment, utilization review and quality management that

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<sup>9</sup> The USMS has been pursuing this initiative.

enables USMS districts to arrange for appropriate prisoner health care at substantial savings to the taxpayer.

- A managed care network with community physicians, hospitals, ancillary service support systems, and other ancillary services to support each site where USMS prisoners require outside medical care and are housed in a major-use detention facility.
- An automated centralized medical claims system to process and re-price valid claims for medical care and supporting medical services provided to USMS prisoners.
- Development of a preferred provider network, administration, referral management, denial of care, claims processing and payment management. The contract should also include a utilization and quality management program, referral management and discharge planning.

## **FINDINGS AND RECOMMENDATIONS**

### **1. INTERNAL CONTROLS OVER OUTSIDE MEDICAL CARE COORDINATED BY DISTRICTS WERE INCONSISTENT AND IN SOME CASES NEARLY NON-EXISTENT**

Internal controls over outside medical care at the district offices we reviewed are inconsistent and in some cases almost non-existent. We noted weaknesses in the internal control structure throughout the process, from procurement through payment. Districts are not reconciling invoices with pre-authorizations, in some cases because there are no pre-authorizations with which to reconcile. Prisoner files are often incomplete, sometimes non-existent, and medical procedures are not consistently entered into the Prisoner Tracking System (PTS). Financial transactions are not classified consistently in the Financial Management System (FMS). Violations of the Federal Acquisition Regulations are commonplace. Of significant concern is the fact that while the district operations appear to be awash in internal control problems, the USMS's Program Review Office, previously tasked with reviewing district operations, has been all but dismantled, leaving district offices little in the way of oversight, guidance, and feedback.

#### **Background**

USMS district officials have the authority (upon recommendation of a competent medical authority or physician) to acquire and pay for reasonable and medically necessary care, both emergency and non-emergency, to ensure the well-being of all USMS prisoners. However, it is not the policy of the USMS to provide either elective or, with some exceptions, preventive medical care.

USMS policy requires that a set of procedures be followed to provide reasonable assurance that medical and guard payment transactions are properly authorized, accurately recorded, and fully supported (See Appendix VII).

In our review of the USMS districts' management of outside medical care, we noted internal control weaknesses throughout the aforementioned process. A discussion of the specific areas of concern follows.

## **Pre-Authorization of Medical Procedures**

Districts were not consistently reconciling invoices from health care providers to pre-authorizing documents such as a requisition or medical log.<sup>10</sup> In many cases, this was because there was no authorizing document with which to reconcile. The pre-authorization process is required to ensure that only necessary and reasonable medical procedures are performed on prisoners in USMS custody.

As shown in the following table, our review revealed that, more often than not, districts did not document the authorization process. In 8 of the 14 districts we examined, invoices were not being reconciled to pre-authorizing documents. In six of those districts, there were no pre-authorizing documents to reconcile to. In those cases, the first written documentation pertaining to a particular medical procedure was the invoice received from the health care provider. Absent a reliable audit trail, district personnel could not readily determine whether such an invoice was a valid billing, a duplicate billing, or a fraudulent claim. In fact, when asked how they detected duplicate payments, personnel in two districts stated that they relied on the re-pricing contractor to detect the double billings.

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<sup>10</sup> Authorizing document can be a purchase order, requisition, or a notation in the prisoner's medical log. The information must be enough to indicate that the procedure was approved by the district office and can be reconciled with the medical invoice. This information would normally include: 1) health problem and procedure; 2) prisoner name and number; 3) dollar amount obligated; 4) name of medical provider.

<b>PRE-AUTHORIZATION OF OUTSIDE MEDICAL PROCEDURES</b>			
<b>District Office</b>	<b>Authorizing Documents</b>	<b>Bills Reconciled to Authorization</b>	<b>Duplicate Claims<sup>11</sup></b>
Arizona	Yes	No	\$ 847
Central California	No	No	15,494
DC District Court	Yes	Yes	0
Middle Florida	Yes	Yes	750
Northern Illinois	No	No	800
Kansas	Yes	Yes	6,867
New Mexico	Yes	Yes	42
Eastern New York	No	No	32,596
Western New York	No	No	10,853
Eastern Pennsylvania	No	No	146
South Carolina	Yes	Yes	536
Southern Texas	Yes	No	7,923
Western Texas	Yes	Yes	22,511
Southern California	No	No	\$ 157,914

Source: District records and Contractor records.

### **Recording of Financial Transactions in the Financial Management System (FMS)**

Districts were not obligating funds in the FMS upon procurement of medical services. The districts were not entering an estimated obligated amount prior to or immediately after the medical services has been performed. This stemmed from the fact that procedures were often not pre-authorized, and as such did not enter the financial system until an invoice was received. Thus, the process approaches a cash basis of accounting wherein expenses are recorded when they are paid rather than when they are incurred, as is required under the accrual basis of accounting. The problem was exacerbated by the fact that invoices are often batched, with

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<sup>11</sup> Duplicate claims detected by the re-pricing contractor during FY 2002.

batch sizes ranging from several invoices to several hundred. Batching of invoices is a valid method of processing financial transactions, and in some instances it is impractical to do otherwise. But in the absence of other documentation, batching makes it difficult to track costs related to individual prisoners.

Additionally, we noted some inconsistency in how transactions were classified once they were obligated. In the case of medical procedures, the districts used two sub-object codes to track expenditures for outside medical care, as follows:

- Sub-Object code 1154 - Fees for medical examinations by private physicians except those in contemplation of testimony in court by the examining physician. Includes physical examinations of: 1) injured persons, where trial may result; 2) defendants in criminal cases who allege illness to delay trial; and 3) witnesses who allege illness for failure to respond to subpoena.
- Sub-Object code 2515 - Medical hospital services charges by institutions, including hospitals and clinics, but not private physicians, for: 1) medical and dental care of prisoners, including charges for prescribed medicines, prosthetic devices, and other treatment and devices, e.g., glasses, hearing aids, braces, necessary for the health and well being of prisoners; 2) physical examination of employees; and 3) expenses of health units.

The information accumulated by the above-mentioned cost codes is used by the USMS to determine how funds have been expended for tracking and planning purposes. However, our audit testing determined that some districts used only sub-object code 2515 and did not use sub-object code 1154 in any of its transactions, and some that used it only sporadically.

Similarly, there were inconsistencies in the obligation of charges for hospital guard services. About half of the districts were obligating hospital guard expenses to sub-object code 1150 (Payment of compensation to temporary guards), while the other half were obligating guard expenses to sub-object code 2555 (Charges for guard services provided under contract agreement). Inconsistencies aside, the current code structure does not differentiate between hospital related guard services and other guard services, which makes it difficult for management to track guard service costs related to outside medical services provided to USMS prisoners.

Both the delays in obligating and the inconsistencies in classifying outside medical costs pose a problem for USMS management, which requires

accurate and timely financial data in order to accurately evaluate program performance and effectively plan for future resource needs.

## **Prisoner Tracking System**

The Prisoner Tracking System<sup>12</sup> (PTS) is a distributed database system, operating as a separate database in each of the 94 federal judicial districts that provides case management support for individual prisoners, including the tracking and monitoring of medical care. USMS districts are required to use the PTS for tracking prisoners' medical information. Specifically, districts are required to document in the PTS whenever a prisoner receives outside medical treatment. The data fields include: 1) medical service date, 2) prisoner name and number, 3) dollar amount obligated, 4) name of medical provider, and 5) health problem and procedure.

Despite this requirement, our audit testing revealed that 1 of the 14 districts did not record any of the required information into the PTS. Another district entered only partial information. Further, our review of the entire PTS database revealed that several districts outside of the selected 14 districts were not entering data into the PTS. As will be discussed later, many of the districts were not entering prisoners' TB test results into the PTS, as required by USMS policy. Without complete and consistent medical data the USMS cannot readily determine what medical procedures have been performed on any given prisoner, and cannot make informed decisions regarding the welfare of the prisoner or other parties involved.

## **Prisoner Case Files**

In the absence of a fully implemented PTS, district offices must rely on hardcopy prisoner case files. In addition to photographs and fingerprints, the prisoner case files contain vital medical information such as: 1) a record of all medical care afforded the USMS prisoner, including medications or medical equipment required while in transport; 2) whether the prisoner has been cleared for TB; 3) a record of outside medical billings; and 4) whether the prisoner has private insurance. The documents are an essential control in facilitating effective and secure prisoner transport. In addition, the records are useful to district accounting personnel in verifying medical bills.

However, here too we found that the district offices were less than diligent in tracking prisoner medical care. In 8 of the 14 district offices

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<sup>12</sup> Currently, the OIG is conducting an application controls review of the PTS to assess the effectiveness of application controls and to perform data integrity testing. The forthcoming report will provide a comprehensive analysis of the PTS application.



reviewed, we found that prisoner case files were incomplete. Two districts, the Central District of California and the Southern District of California, did not maintain case files at all. While most of the districts were able to provide a printout of medical expenditures, we were unable to locate medical release forms or TB clearances in most cases.

We reviewed a statistical sample of outside medical transactions using the USMS criteria for reasonable and necessary procedures and determined that in 26 percent of the sample medical procedures reviewed, the auditors could not determine whether the procedure met the USMS criteria, in part because of the lack of reliable documentation available at the district offices.

The lack of documentation at the district offices has both cost and public safety implications. The USMS cannot effectively manage costs if it is not aware of where those costs are being incurred. For example, several district offices had prisoners with high risk, high-cost medical problems, such as a terminal illness. In such instances, the USMS can request that prisoners be transferred from unsecured non-federal medical institutions to secured BOP medical facilities, or in some cases suggest to the court or the U.S. Attorney that the prisoner be released or placed on bond. This can reduce medical care and security costs, as well as reduce the risk exposure involved in transport to and from outside medical facilities. However, without an effective system for tracking these costs, USMS personnel cannot make timely or informed decisions in these matters.

### **Federal Acquisition Regulations**

We found that USMS district offices are not fully complying with the Federal Acquisition Regulation (FAR) by employing simplified acquisition procedures when procuring prisoner health care services that exceed the \$2,500 threshold for micro purchases.

A memorandum dated December 3, 1999, from the USMS General Counsel to the USMS Director stated that prisoner medical services were being procured in violation of the FAR at many USMS district offices. The General Counsel citing 31 U.S.C. §1501, stated that prisoner medical services were being entered into by individuals without contracting authority or by contracting officers in excess of the limits of their delegated authority.

The General Counsel further stated that the USMS's failure to enter into binding agreements for medical services violated the provisions of 31 U.S.C. §1501 because agency expenditures for services must be supported by documentary evidence of a binding agreement between the agency and

the service provider before the expense can be properly recorded as a valid obligation of the United States.

According to the USMS General Counsel's memorandum, if prisoner medical services are procured in the absence of a binding agreement, expenditures associated with the procurement cannot be recorded as valid obligations of the USMS. If these expenditures are not properly recorded and accounted for, the USMS may violate the Anti-Deficiency Act (ADA) by obligating funds in excess of available appropriations.<sup>13</sup>

The General Counsel warned that in order to prevent violations of the FAR, 31 U.S.C. §1501, and the ADA, prisoner medical services acquired on behalf of the USMS must be procured pursuant to orders issued by contracting officers with appropriate levels of delegated authority to bind the government. However, despite these warnings, we determined that some districts continue to procure medical services in violation of federal regulations.

For the 14 sites audited we selected a random sample of 900 voucher payments from a universe of 6,525 payment transactions for review. Based on our audit testing we determined that 83 of the 164 payment transactions that exceeded \$2,500 were not in full compliance with federal procurement regulations because the medical service providers did not have binding written agreements with the USMS.

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<sup>13</sup> According to the ADA, an officer of the U.S. Government may not authorize an expenditure or obligation exceeding an amount available in funds appropriated.

<b>Prisoner Outside Medical Treatment Procured in Violation of the FAR</b>				
<b>Districts</b>	<b>Dollar amount reviewed</b>	<b>Dollar amount in violation of the FAR</b>	<b>Number of outside medical transactions reviewed exceeding \$2,500</b>	<b>Number of transactions exceeding \$2,500 without a binding agreement</b>
Arizona	\$ 39,741	\$ 20,032	3	3
Central California	361,328	0	34	0
DC District Court	103,047	96,080	8	8
Eastern Pennsylvania	63,979	Unknown	5	Unknown
Kansas	156,938	93,604	14	7
Middle Florida	65,916	55,066	8	8
Northern Illinois	329,881	53,488	11	2
New Mexico	38,465	23,327	3	3
Eastern New York	69,384	0	5	0
Southern Texas	111,928	10,638	2	2
Southern California	665,956	431,499	31	31
South Carolina	173,188	0	20	0
Western Texas	762,552	193,150	14	14
Western New York	55,820	50,448	6	6

Source: District records

We tested transactions exceeding the \$2,500 simplified acquisition procedure threshold to determine compliance with the FAR.<sup>14</sup> We determined that the USMS was in compliance with the FAR if the medical provider had a: 1) contract with the USMS, 2) contract with another federal agency,<sup>15</sup> or 3) contract with the local detention facility and the local detention facility was being reimbursed by the USMS.

<sup>14</sup> Purchases equal to or under \$2,500 may be made without securing competitive quotations if the price is considered fair and reasonable by the contracting officer.

<sup>15</sup> The Federal Detention Center in Philadelphia, Pennsylvania has a medical services contract with Medical Development International. This contract provides comprehensive medical services to both BOP and USMS prisoners.

In many cases single invoices were below the \$2,500 limit. However, districts often consolidate multiple prisoner treatments when paying for outside medical costs. Districts will often batch a large number of small payments (less than \$500) owed to a single hospital, clinic or doctor into one large payment. These consolidated payments normally range between \$1,000 and \$100,000. By definition these payments, in aggregate, exceeded the \$2,500 micro-purchase threshold.

Aside from complying with the FAR, by not negotiating contracts, USMS districts could miss the opportunity to negotiate rates below Medicare. We found that districts with negotiated contracts were able to obtain pharmacy discounts and specific medical procedures below Medicare rates, as was the case in the District of South Carolina, which had a contract with a private vendor. The contract statement of work provides that the USMS receives a discount of not less than 37 percent on the list price of drugs. The audit team determined that if the District of Middle Florida had a similar contract, it would have saved \$10,251 on just the four payments that the audit team reviewed.

Conversely, procuring medical services without a contract, other than a micro-purchase,<sup>16</sup> enables a supplier to obtain government business without competition. Not establishing a network of contracted health care providers increases the opportunities for fraud, waste, and abuse by allowing district officials to select medical providers directly, rather than through a competitive process.

## **Office of Program Review**

The internal review function within the USMS falls under the jurisdiction of the Management and Budget Division, specifically the Office of Program Review. Organizationally, the Program Review Office consists of an eastern office, located at USMS Headquarters, a central office, located in Houston, Texas, and a western office, located in Denver, Colorado. Historically, Program Review's primary area of responsibility has been the performance of detailed reviews of district operations. The reviews are comprehensive in scope and cover nearly all aspects of district activity, including: 1) prisoner transport, 2) asset forfeiture, 3) contract and IGA billings, 4) judicial security, and 5) general management and administration. The inspection reports, signed by the USMS Director, contain findings and recommendations, and require a formal resolution process, documenting that necessary corrective actions have been taken.

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<sup>16</sup> Purchases that in the aggregate are equal to or less than \$2,500.

On April 19, 2000 the USMS Deputy Director issued a memorandum directing the Program Review Office to suspend its reviews of USMS district operations. Prior to the suspension of district reviews, Program Review staff conducted about 30 district reviews annually, allowing for reviews of each of the 94 districts every 3 years. The action was defined as a short-term solution to critical staffing shortages in the field, which required that Program Review staff be detailed to district offices in need of administrative support. However, as of the last day of our fieldwork on October 28, 2003, the district review function remained on hold. According to USMS officials, the reason for the continued suspension is that the USMS plans to reorganize its internal review function, and that district review activities will remain on hold pending completion of the reorganization.

In the three years since the initial suspension of these district reviews, the Program Review Office has existed in a state of limbo. The staff is now restricted to performing property management reviews, and does so only on a special request basis. Staffing levels at the eastern office have dropped from six to two analysts. The staff assigned to the western office in Denver, Colorado, has been reduced from six to four analysts, with staff detailed to the Witness Security Program. The central office in Houston, Texas, has been closed.

Given the pervasiveness of the internal control weaknesses at the district level that we encountered throughout this audit, it is difficult to justify the effective dismantling of the agency's internal review function. We believe that USMS management needs to reconsider its decision to suspend detailed district reviews.

## **Recommendations**

We recommend the USMS:

1. Ensure that districts adhere to established procedures for authorizing, recording and tracking outside medical procedures.
2. Re-initiate operational reviews of USMS district office.

## **2. THE USMS IS INCURRING MILLIONS IN UNNECESSARY COSTS FOR OUTSIDE MEDICAL CARE**

While the USMS has achieved significant cost savings in recent years through its re-pricing efforts, it still incurs millions annually in unnecessary costs related to outside medical care. The largest portion of those costs were attributed to the re-pricing of medical billings at the Medicare rate, rather than the lesser of the Medicare or Medicaid rate, as required by 18 U.S.C., §4006. As a result, we estimate that the USMS spent about \$7 million more on outside medical services in FY 2002 than it had to based on recent studies that show that nationwide Medicaid rates average about 81 percent of Medicare rates. Further, the USMS incurred over \$100,000 in outside medical costs that should have been paid by the prisoners' private insurance. Finally, the current structure of USMS outside medical care suffers from an underutilization of private sector resources. The current contract relieves district offices of none of the administrative burden of program, and if anything adds a layer of bureaucracy. The USMS expends roughly \$1 million in administrative costs performing activities that could be better and more efficiently handled through outsourcing to a private health care provider. The USMS has developed but has yet to implement plans for a national health care contract that would more effectively streamline prisoner medical services and would remedy the Medicare versus Medicaid issue.

### **Medicare Versus Medicaid**

Title 18 U.S.C. §4006, as amended by Public Law 106-113, enacted in November 1999 states: "Payment for costs incurred for the provision of health care items and services for individuals in the custody of the United States Marshal Service shall not exceed *the lesser of* the amount that would be paid for the provision of similar health care items and services under: 1) the Medicare program under Title XVIII of the Social Security Act; 2) or the Medicaid program under Title XIX of such Act of the State in which the services were provided."

In January 2001, the USMS implemented a contract with private health care contractor HealthNet, Inc., to process medical billings for USMS prisoners receiving outside medical services. Under the contract, district offices forward all prisoner medical billings to the contractor for re-pricing at the Medicare rate. The re-priced bills are then sent back to the district for payment to the medical provider. In FY 2002, the first full year following

implementation, the USMS reported savings of \$20.2 million in prisoner medical costs.

While the costs savings achieved were significant, they are less than what the USMS could have achieved had it paid for outside medical care at the lesser of Medicare or Medicaid. Rates for Medicaid can vary significantly from state to state, but with few exceptions they are lower than their related Medicare rate, sometimes markedly so. Medicaid rates for physician fees in California, for instance, averaged about 65 percent of Medicare charges, based on a recent study conducted by the Lewin Group, prepared for the Medical Policy Institute, and issued in June 2001. Medicaid fees in New York averaged only 36 percent of commensurate Medicare fees, and New Jersey averaged about 41 percent. Nationwide, Medicaid fees averaged about 81 percent of Medicare fees, according to the study.

Based on that percentage, we estimated that the USMS could achieve additional annual cost savings of roughly \$7 million by paying the lesser Medicaid fees where appropriate. USMS officials we spoke with were aware of this problem and stated that the congressional amendment was unanticipated and they were negotiating for the current re-pricing contract. They said that the additional requirement of paying the lesser of Medicaid or Medicare could not be accomplished by the agency without additional program funding, as it would have required the development of a database that could access Medicaid rates from the 50 states, as well as the national Medicare rate system.

USMS officials at the exit conference stated that hospitals are not compelled to accept Medicaid rates in payment for medical care under §4006, and as a result, annual cost savings may be less than estimated. Nevertheless, the USMS is currently negotiating for a national health care contract, as will be discussed later in this section, that will, among other things, address the shortcomings of the current contract with regard to re-pricing at the lowest rate authorized.

### **Approval of Non-Emergency Outside Medical Care**

In August 1999, the USMS distributed USMS Publication No. 100 "Prisoner Health Care Standards" to the districts. The purpose of the publication was to define "reasonable and medically necessary care" for prisoners in custody of the USMS, and to enumerate the specific elective or preventive medical interventions and procedures that are not authorized for payment by the USMS, absent a court order.

The publication refers to health care services and products that are to be charged to the USMS or that require prisoners in USMS custody to make visits anywhere outside of the facility to which they are confined. Services and products provided to USMS prisoners within correctional facilities at no cost to the USMS are not prohibited.

As previously stated, not all USMS districts reviewed were pre-authorizing prisoner medical procedures and were not consistently consulting with the Office of Interagency Medical Services (OIMS) and its staff of medically trained professionals concerning non-emergency medical care. Only 8 of the 14 districts reviewed reported utilizing the professional resources available at the OIMS for advice on whether or not to approve outside medical procedures. Consequently, medical procedures were approved that should have been denied as unnecessary.

From the universe of 6,525 vouchers for outside medical billings, we selected a random sample of 900 vouchers. In tests of procedures, at least 3.1 percent of medical procedures, totaling \$18,079, were determined to be unnecessary. For the most part, these were elective or preventive procedures not normally authorized for payment by the USMS. Procedures included mammograms, an MRI for lower back pain, an x-ray for carpal tunnel syndrome, and treatment for high cholesterol. In most instances the unnecessary procedures resulted because districts were not proactively involved in the pre-authorization process, allowing the BOP<sup>17</sup> or local detention facility to dictate whether outside medical treatment was required without notifying the USMS. Often the district office was unaware of the medical treatment or hospitalization until a bill was received.

## **Prisoner Insurance**

USMS policy states that districts should request that prisoners covered by their own health insurance use that insurance while in USMS custody. At initial intake, the prisoner is asked to complete a USM Form 552 and disclose medical insurance coverage information. If the prisoner has health insurance and is willing to complete the necessary paperwork to process the claim, the health care provider would submit all medical bills directly to the prisoner's insurance provider. If the prisoner has insurance but is unwilling to assign benefits to the prisoner's insurance provider, and significant medical costs are involved, at its discretion, the USMS may request that the

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<sup>17</sup> District officials stated that the BOP often does not request or seek authorization from the USMS when obtaining outside medical treatment for federal prisoners in USMS custody.



local U.S. Attorney obtain a federal court order to compel use of the prisoner's health insurance. In addition, the USMS is not precluded from assuming the payment of a prisoner's health care premiums if the prisoner is not able to do so.

We found the issue of prisoner insurance to be largely academic because most of the districts did not follow the policy. In 7 of the 14 districts, Form 552 was not completed. In two districts the forms were not consistently completed. The remaining five districts had completed and retained the forms in compliance with USMS policy.

We noted at least one instance in which substantial medical costs were incurred for a prisoner who, according to his case file, had private insurance. The case involved a prisoner who had attempted to hang himself but survived in a brain-damaged state and was confined to a mental ward. The USMS incurred \$112,944 in medical costs despite the fact the prisoner's file indicated that he had coverage with Blue Cross/Blue Shield. We found no evidence indicating that the USMS district office had pursued the private insurance.

District officials explained that use of a prisoner's private insurance is problematic because insurance carriers require patients to use specific doctors or medical facilities in order to qualify for reimbursement. This creates security concerns because prisoners would know in advance what provider they are going to see, and thus could coordinate escape attempts with outside accomplices. In addition, local jails may refuse to make special trips to transport USMS prisoners to providers specified by insurance companies.

The aforementioned security concerns notwithstanding, it would appear that in cases such as the one cited above, the use of a prisoner's existing insurance would be an effective means of defraying the cost of outside medical care.

### **National Health Care Contract**

The current structure of the USMS's outside medical services program suffers from an underutilization of private sector resources. The current re-pricing contract with HealthNet, Inc., is a half-measure that not only fails to take full advantage of congressional mandates authorizing the use of Medicaid rates, but also leaves much of the administrative requirements for outside medical care in the hands of district officials, rather than streamlining the process.

At present the USMS is still heavily involved in the administration of the program at the district level. Our survey of districts (see table below) indicated program administration might require from 2 to 8 staff members, and up to 220 work hours weekly. Service-wide we estimate total salaries and expenses devoted to performing duties associated with providing prisoner outside medical treatment at roughly \$1.8 million annually.

<b>ADMINISTRATIVE COSTS ASSOCIATED WITH MANAGEMENT OF OUTSIDE MEDICAL CARE</b>			
<b>District</b>	<b>Weekly Hours</b>	<b>Weekly Costs<sup>18</sup></b>	<b>Annual Costs</b>
Arizona	141	\$ 2400	\$ 124,800
Middle Florida	40	681	35,402
Northern Illinois	11	187	9,735
Kansas	57	970	50,447
New Mexico	162	2757	143,376
Eastern New York	9	153	7,965
Western New York	12	204	10,620
Eastern Pennsylvania	20	340	17,701
Southern Carolina	35	596	30,976
Southern Texas	155	2638	137,181
Western Texas	220	3744	194,709
Southern California	80	1362	70,803
<b>Total</b>	<b>942</b>	<b>\$ 16,032</b>	<b>\$833,715<sup>19</sup></b>

Source: Survey of District Administrative Officers.

The USMS had developed plans in FY 2002 to negotiate a national health care contract to administer its prisoner outside medical program, but was unable to implement those plans due a reprogramming of designated

<sup>18</sup> Based on hourly wage for GS-9, Step 1 of \$17.02.

<sup>19</sup> Based on workload estimates obtained from USMS field personnel, we determined that the district offices reviewed incurred approximately \$833,715 annually in administrative costs related to outside medical services. The districts represented approximately 46 percent of service-outside prisoner medical care, and from that we extrapolated total administrative costs service of approximately \$1.8 million.

funds in conjunction with the creation of the Department of Homeland Security (See Appendix X). Under the proposed contract, the health care delivery system would be comprised of a national network of community physicians, hospitals, and other ancillary services. Services provided to USMS prisoners would include dialysis, pharmacy discounts, optometry, ambulance, dental, skilled nursing facilities, and outpatient rehabilitation.

While implementation of the proposed national health care contract would not relieve the USMS of all administrative duties related to outside medical care, it would reduce those duties markedly. For example, the contract proposal would require the contractor to establish a nationwide integrated health care delivery system, which would negate the need for individual districts to negotiate separate health care contracts with local hospitals. In addition, the contractor would be responsible for internal controls such as: 1) assigning internal control tracking numbers for each claim, 2) matching pre-authorizations against claims prior to payment, 3) identifying, tracking and blocking duplicate or invalid claims, 4) full accounts payable accounting and financial management reporting. Based on our analysis of the current and proposed contracts, we estimate that the proposed contract would reduce administrative workload by about 60 percent or \$1 million. This represents funds that could be put to better use if the USMS implemented the national health care contract.

## **Recommendations**

We recommend the USMS:

3. Complete the on-going effort to negotiate a national managed health care contract for prisoner medical services that will remedy non-compliance with Title 18 USC and will effectively streamline the process.
4. Enforce current USMS policy regarding the use of prisoners' private insurance to cover the costs of outside medical care.

### **3. INTERNAL CONTROLS OVER IN-HOUSE MEDICAL CARE AT JAILS AND EMERGENCY CARE PROCEDURES IN USMS CELLBLOCKS NEED STRENGTHENING**

USMS districts are not adequately monitoring local detention facilities to determine whether federal prisoners are receiving proper health care; and are not effectively initiating health care improvements at local jails providing substandard health care. USMS inspections are cursory, and more in-depth reviews conducted by external groups are not followed up on. Further, we could not determine whether the USMS was in full compliance with USMS policies and procedures governing emergency health care procedures in its own cellblock operations because there was some uncertainty as to what the current policies and procedures were. The overall lack of monitoring and follow-up creates an environment where misjudgments can occur, with health consequences to both the federal prisoner population and USMS personnel.

#### **Background**

In-house medical care encompasses health care provided at local jail clinics, as well as limited emergency care provided in USMS cellblock operations. While the USMS has direct control over its own cellblock operations, the USMS must monitor in-house care provided by local jails through its jail inspections program, as well as through external review groups.

Initial medical screening of a federal prisoner occurs at the booking of the individual at a USMS district office, which is often located in the local federal courthouse. At booking, USMS deputies observe the arrestee and fill out a booking sheet documenting the arrestee's responses to a few basic medical questions. The arrestees are kept in the cellblock, while awaiting either a court appearance or transport to a BOP or local jail facility, where medical screening will take place.

Given the short span of time that prisoners usually spend in the cellblock area, medical care is normally not required there. In some cases, however, prisoners awaiting trial may have chronic medical conditions, such as asthma or heart disease that may require medical attention. Emergency medical situations can also occur during a prisoner's cellblock stay.

For basic medical screening and routine medical services for federal prisoners, the USMS relies largely on local and contract jails, as well as the

BOP, most of which are equipped with in-house medical clinics within their facilities. The costs of such in-house medical services are usually covered in the per diem rates<sup>20</sup> charged to the USMS under the terms of an Intergovernmental Agreement (IGA) in the case of a local jail, or the contracted jail day rate in the case of a private contract facility. Services provided in BOP facilities are done so at no cost to the USMS.

In-house medical services provided by the jails housing federal prisoners can vary substantially. Some local jails may have on-site medical professionals and sophisticated medical facilities, including x-ray and dialysis machines, TB isolation cells, and dental services. Some facilities may even be able to accommodate minor surgical procedures. At the other end of the spectrum are facilities with very limited health care services, where a local deputy or administrative official may ask general medical questions to complete paperwork necessary to process the individual. Prisoners at these facilities must often be transported outside for procedures that are routinely performed at jails with more comprehensive medical services.

### **Cellblock Medical Care And Emergency Procedures**

We toured the cellblocks in the 14 districts we reviewed and interviewed USMS and contract personnel staffing the cellblock operations to determine whether the districts were in compliance with USMS cellblock medical requirements. We had difficulty determining compliance, however, because there was some uncertainty as to what the current policies and procedures were.

In September 2002, the USMS Prisoner Services Division issued, in draft, a policy directive titled, "Prisoner Health and Emergency Care, Minimum Health Standards for Prisoners." The draft was issued in response to a memorandum from the Inspector General to the Director of the USMS, dated May 6, 2002, that detailed the results of an OIG investigation of an alleged denial of treatment to a federal prisoner held in USMS custody.

According to the OIG memorandum, on February 2, 2001, the prisoner in question had sustained multiple facial fractures from an assault by another prisoner while housed at the Maryland Correctional Adjustment Center. The prisoner received only minimal first aid at the facility. Three days after the incident, the prisoner was transported to the USMS office in Baltimore, Maryland, where arrangements were made for transportation to another contract facility in Orange, Virginia. While in USMS custody, the

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<sup>20</sup> The Intergovernmental Agreement states that a negotiated daily rate per prisoner will be paid by the USMS to the jail.

report cited the prisoner's "repeated requests" to USMS personnel for medical treatment. It was not until February 12, 2001, a week and a half later, that the prisoner's injuries were treated.

While USMS employee personnel generally thought that the contract facility bore primary responsibility for rendering medical treatment, USMS personnel conceded that existing USMS regulations were unclear on handling requests for medical treatment. To address this weakness, the Inspector General recommended that the USMS establish clear guidance for USMS personnel on handling prisoners' requests for medical treatment. The USMS responded by issuing the aforementioned September 2002 draft policy on emergency healthcare procedures in the cellblocks.

While much of what the draft policy addressed was already contained in USMS Policy 99-47 on cellblock operations, there were several important changes in guidance provided to cellblock personnel. Under the current policy, for instance, all medication held by prisoners except nitroglycerin for heart patients must be taken away and secured when entering the cellblock. The draft policy would allow inhalers for asthma patients, as well as nitroglycerin for heart patients into the cellblock. In addition, all emergency care incidents must be documented on a Form USM-210 Field Report under the draft policy, whereas no requirement exists under the current policy.

As of the last day of fieldwork on October 28, 2003, the September 2002 draft policy remained in draft, awaiting the USMS general counsel's approval. However, we noted during the survey phase of our audit in a site visit to the Eastern District of California that the draft policy had been disseminated and implemented. In contrast, several of the 14 districts reviewed during the verification phase of our audit were not aware of the draft policy's existence. An administrative officer in one district said that she had no record of the policy, and that it was her understanding that the policy was still a "work in progress." Contrary to what we found in the Eastern District of California, a chief deputy in another district explained that a draft policy would never be sent to the field for dissemination.

USMS officials at our exit conference explained the policy was still in draft, awaiting the USMS general counsel's approval, which begs the question as to why a policy still in draft had been implemented in at least one district. These inconsistencies notwithstanding, the delays in implementation of the draft policy raises a concern given that the policy in question was created in response to perceived failures on part of USMS management to establish clear guidance for the appropriate action to prevent serious injury or death to prisoners in custody.

Serious injury or deaths in cellblock, while rare, do occur. For example, in February 1999, a federal prisoner died while being transported from the cellblock at the federal courthouse in Tucson, Arizona. The autopsy indicated that the prisoner had acute appendicitis. The prisoner and several of his inmates had notified the cellblock officers that the prisoner was ill and was requesting treatment. The prisoner complained of chills, stomach pain, and the inability to urinate. Rather than being given immediate medical treatment, the prisoner was told he would have to wait until he could receive treatment at the local contract facility.

By the time the van arrived, the prisoner had lapsed into unconsciousness. Despite his condition, he was loaded, unconscious, into the van. En route to the detention center the prisoner stopped breathing and was at that point taken to a local hospital, where he died. The family of the prisoner was paid \$150,000 by the U.S. government in a court settlement arising from the incident.

Subsequent to this event, the USMS issued Policy 99-47 Cellblock Operations, which addressed, among other things, emergency medical care procedures. However, even if the policy had been in place before the appendicitis incident, we are not confident that it would have made a difference because there was no specific guidance given or training provided to assist USMS personnel in determining when a condition requires hospitalization.

The American Correctional Association (ACA) standards address emergency care response in jails and detention facilities.<sup>21</sup> The ACA standards require a four-minute response time for prisoner medical emergencies. Further, the standards require jail personnel to be trained to recognize signs and symptoms of conditions requiring emergency medical care, and the methods of obtaining medical assistance.

### **Cellblock Equipment**

In addition to testing compliance with the primary policies and procedures, we tested for compliance with peripheral policies regarding cellblock equipment. The results were as follows:

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<sup>21</sup> The ACA is a professional membership organization dedicated to the improvement of corrections and the development and training of correctional professionals. The ACA's membership consists of individuals and organizations involved in all facets of corrections, including adult institutions and jails, community corrections, juvenile justice, institutions of higher learning, and probation and parole.

- **Automated External Defibrillator**

The USMS's Automated External Defibrillators<sup>22</sup> (AED) First Responder Policy Directive requires that deputy marshals working in district offices be certified in both Cardio Pulmonary Resuscitation (CPR) and AED procedures.<sup>23</sup> The AED program is administered by the USMS but serves the federal court system by protecting court personnel, civilians, and prisoners alike. The USMS policy specifies that two operational employees at each district be trained as AED instructors. The instructors are in turn responsible for training additional staff. Also, the staff is required to be certified in CPR before receiving AED training.<sup>24</sup>

Our review determined that only six of the districts reviewed had provided the required AED annual training and certification to their deputies during 2002. Five of the districts that had not provided training stated that they had plans to begin training in the near future. However, delays in training and certifying district personnel in these life-saving skills could lead to the improper use of the AED and to possible tragic consequences for a heart attack victim.

- **Medical Assistance Signage**

USMS policy requires that at least one sign be posted in each cellblock advising prisoners how to request emergency medical assistance. We found that 3 of 14 districts did not have signs posted. Without these signs, prisoners may not know that medical assistance is available, and as a result may not notify cellblock personnel as soon as symptoms appear.

- **Prisoner Refusal of Medical Care**

USMS policy states: "If a prisoner refuses transportation and/or medical assistance after complaining of illness or injury, the prisoner

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<sup>22</sup> Defibrillators are devices that deliver an electric shock to a person experiencing a cardiac arrest. The defibrillator sends an electric message by means of a shock to the heart to resume contracting. Studies indicate that with each minute that passes without any intervention, the chances for recovery are diminished by 10 percent for the person experiencing cardiac arrest.

<sup>23</sup> CPR and AED certification must be renewed annually.

<sup>24</sup> CPR must be administered at the same time electric shocks are being given so that the victim is oxygenated.



will be required to sign a USM-210 acknowledging a desire not to receive medical assistance.”

Our review determined that many USMS employees manning the district cellblocks were unaware of USMS prisoner medical procedures that require prisoners who refuse medical treatment to sign a written waiver.

### **Local Jailhouse Medical Care**

To assess the quality of care provided to federal prisoners at local jails, the USMS has a jail inspection program. Current USMS jail inspection guidelines include standards established by the ACA. USMS deputy marshals, as a collateral duty, conduct these jail inspections and submit the reports to the district office. The reports rate the jails compliance with ACA standards and list any medical care deficiencies noted at the jail, with comments on plans or actions to be initiated or undertaken by the district to correct substandard conditions.<sup>25</sup>

However, we noted that the inspection reports annually submitted to district officials are cursory and did not provide enough detailed information (such as observations, interviews, and documents reviewed) to support general findings that the health care provided by the jail meets the required standards. Further, in three of the districts reviewed, deputy marshals who had not received any training in jail inspections were performing the inspections. Finally, jail inspector duty for deputy marshals is collateral to their normal law enforcement responsibilities. Deputies assigned to perform jail inspections were not specifically rated on their performance evaluations for the quality or timeliness of their jail inspection work.

Our audit questioned not only the quality of the USMS jail inspections, but also their timeliness, as many reports were not being submitted annually as required by USMS policy and procedures. In FY 2002, 8 of the 14 districts reviewed did not complete annual evaluations of the prisoner medical care provided by all their major use detention facilities. The following table lists the results of our jail inspection audit testing by district office.

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<sup>25</sup> In addition, a pilot program initiated in 1994 enabled USMS districts to utilize State inspection reports in lieu of reports prepared by the districts. As with the USMS inspection report, deficiencies noted in the state report are to be discussed with facility administrators to correct the condition.

<b>SUMMARY OF USMS DISTRICT JAIL INSPECTIONS</b>			
<b>Districts</b>	<b>Jail Inspections Required in FY 2002</b>	<b>Jail Inspections Submitted in FY 2002</b>	<b>Findings</b>
Arizona	9	6	Yes
Central California	2	1	No
DC District Court	8	0	N/A
Middle Florida	12	3	No
Northern Illinois	6	6	No
Kansas	9	9	No
New Mexico	6	5	Yes
Eastern New York	2	1	Yes
Western New York	7	7	No
Eastern Pennsylvania	1	0 <sup>26</sup>	No
South Carolina	11	11	Yes
Southern Texas	21	15	Yes
Western Texas	24	24	No
Southern California	2	1	No

Source: District records

There also appeared to be little evidence of any follow-up on the inspection reports. The lack of follow-up included external inspections, as illustrated in the discussion below concerning the Department of Justice (DOJ) Civil Rights Division's review of the Nassau County Correction Center (NCCC) in New York

### **Nassau County Correction Center**

On April 19, 1999, the DOJ notified Nassau County of its intent to investigate the NCCC to determine whether its conditions violated inmates' constitutional rights. The DOJ conducted the investigation pursuant to the Civil Rights of Institutionalized Persons Act 42, U.S.C.A. 1997. On September 11, 2000, the DOJ issued its letter of findings containing evidence that the NCCC had, through deliberate indifference to inmates'

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<sup>26</sup> Inspection report was submitted without the health care section completed.

serious medical needs, subjected its inmates to conditions that violated their constitutional rights and caused them grievous harm.

The parties subsequently entered into a settlement agreement to litigation. The following is a partial list of some of the actions that the NCCC was required to take to improve prisoner health care:

- Security personnel trained in first response to medical emergency situations.
- Medical director must be a qualified and licensed physician.
- 24-hour on-site full-time physician.
- The medical contractor must provide and maintain monthly reports of medical staff positions and vacancies.
- Intake screening to be performed on the prisoner's day of arrival.
- Blood tests for syphilis.
- Pneumococcal and influenza vaccinations provided.
- Hepatitis C treated in accordance with CDC guidelines.
- Full health assessment within (7) days of arrival if history and visual indicate good health.
- Sick call five days a week.
- Establish sick call policies.
- No inmate shall be disciplined for accessing health care.
- Chronic disease registry (list of prisoners with chronic diseases).
- Written chronic disease treatment guidelines.
- Only trained and qualified medical staff shall administer medications.
- Drug profile system – listing adverse reactions.
- Seven day supply of medications for released prisoners.

- Policies and procedures for maintaining health records.
- NCCC shall develop and implement written guidelines for female medical care including routine screening for pregnancy, sexually transmitted disease, HIV counseling, and routine gynecological and obstetric care.

USMS policy requires that a written report must be prepared by the district office and submitted to the Prisoner Services Division following the issuance of any court order related to the conditions of confinement at a detention facility used by the district. However, a report on the NCCC court settlement was not submitted to the PSD.

Further, the USMS entered into an IGA with the NCCC in May 2000, shortly after the DOJ investigation had begun, and completed its own inspection in September 2000 at the same time the DOJ was releasing its list of findings. The USMS inspection listed no deficiencies.

The most recent USMS jail inspection of the NCCC was completed on January 22, 2003. That inspection report listed the jail as partially compliant in medical, dental, and mental health appraisals. The inspector's only comments in the January 2003 report were: 1) the facility performs a full medical and mental health screening upon arrival; 2) dental inspections were performed within 14 days of arrival, but only to look for any major dental problems; and 3) full dental inspections were not completed within the first 14 days.

We interviewed district personnel supervising prisoner operations and found that while they were aware of the NCCC litigation, including the settlement agreement, they were largely indifferent towards the issues brought up by it. Our review determined that the inspector did not properly address the DOJ investigative findings or settlement agreement requirements in either the September 2000 or January 2003 inspection reports.

### **Conditions of Confinement Reviews**

In FY 2000, the DOJ initiated a program to assess the conditions of confinement at 40 of the largest non-federal institutions housing federal prisoners. The review process is referred to as the Conditions of Confinement Reviews (CCR) Program. The purpose of the program is to ensure that non-federal facilities housing federal detainees: 1) are safe, 2) are humane, 3) protect detainee statutory rights, and 4) protect detainees' constitutional rights. The impetus for the program arose from the

DOJ's Strategic Goals, one being to protect American society by providing for the safe, secure and humane confinement of persons in federal custody.

Toward that end, in June 2000 the DOJ contracted with PriceWaterhouseCoopers, LLP (PwC) to implement a program to review the conditions of confinement for federal prisoners and detainees in non-federal jails and prisons. The criteria for the assessments were comprised of 59 core standards developed by the DOJ to determine whether detention facilities are safe, humane, and protect individual rights.

As was the case with the DOJ's review of the NCCC, we noted that the USMS had not taken steps to ensure that local jails initiated corrective actions on medical deficiencies reported in the CCRs of federal prisoners detained at local detention facilities.

The following table lists the CCRs completed on detention facilities utilized by the USMS districts reviewed in this audit. The table also shows the health care related findings at each facility and whether the district took sufficient action with these facilities to improve the stated conditions.

<b>CONDITIONS OF CONFINEMENT REVIEWS</b>				
<b>Districts</b>	<b>Detention Facility</b>	<b>Significant Health Care Findings</b>	<b>Districts Verified That Jails Took Corrective Action</b>	<b>Date of CCR</b>
Arizona	CADC	7	No	NOV 2000
Central California	San Bernardino	3	No (District not aware of report)	DEC 2000
Middle Florida	Hillsborough County jail	3	No	SEP 2001
Kansas	CCA	0	N/A	SEP 2001
New Mexico	Dona Ana	12	Yes	JAN 2001
Western Texas	El Paso	8	No	JAN 2001
Southern California	San Diego Correctional Center	7	No	JAN 2002

Source: District records and interviews with district officials

Seven districts had contracts or IGAs with detention centers that had received CCRs. As indicated in the above table, six of the detention centers had significant health care issues.

The USMS PSD or contracting division requested a response and corrective action plan for each CCR finding from the detention center. We observed that in one case, the findings were responded to only in an advisory capacity. The detention administrator stated in his reply that he totally disagreed with some findings and other findings could only be corrected if the USMS increased its per diem rate.

Although we did observe that some detention centers submitted corrective action plans, we saw no evidence that the affected district took any action to ensure the plan was fully implemented. District officials told us that they either did not know a CCR had been performed or were unaware that the detention center had submitted a corrective action plan. One official stated that the district would not get involved unless directed by USMS Headquarters.

## **Conclusion**

USMS internal controls over monitoring of in-house medical care at jail facilities need strengthening and revision to ensure that adequate health care is provided to federal prisoners in USMS custody. In the case of local jails, a lack of proper and thorough jail monitoring and adequate follow-up by the districts does not provide assurance that USMS prisoners are receiving proper and adequate health care services. Similarly, lack of compliance with established cellblock policies and procedures substantially increases the possibility of prisoner injury or death, and leaves the government open to successful litigation.

## Recommendations

We recommend the USMS:

5. Require that a management plan be created that ensures that deputy marshals are in compliance with cellblock health care policy and that they receive annual CPR and AED training in order to maintain certification.
6. Strengthen the jail inspection program by:
  - a. Ensuring that districts comply with USMS policy requiring an annual jail inspection. The PSD should maintain an IGA database which includes the date of the latest inspection.
  - b. Ensuring that district employees assigned as jail inspectors attend inspection training, including refresher courses, that contains a module on prisoner medical care. Employees conducting jail inspections should receive performance evaluations that include jail inspections as a rating element.
  - c. Requiring U.S. Marshals to review and improve their current jail inspection requirements. The reports for prisoner medical services should be more detailed and include supporting documents. The assessment tools provided in the CCRs should serve as a guide in improving the reports.
  - d. Requiring districts to follow up on all CCR findings at least three years after the review has been completed. USMS inspection reports conducted on jail facilities that have submitted corrective action plans should include certification by the jail inspector that the jail is in compliance with the plan.

#### 4. TRACKING AND MONITORING OF COMMUNICABLE DISEASES

USMS tracking and monitoring of communicable diseases, such as TB, hepatitis, and HIV/AIDS, is not consistent from district to district, and in some districts is not done at all. Current USMS policy concerning communicable diseases addresses TB only. However, we found little evidence that districts were acting in accordance with that policy. Many districts are not performing initial intake screening of prisoners for TB, and many do not maintain information on prisoners' TB status. In general, USMS districts rely on local jails to test and monitor TB status. This is problematic because local jails do not always test for TB, and are not always timely when they do test. Formal policies concerning management of hepatitis and HIV/AIDS do not exist at the national level or local level. Failure to effectively track and monitor communicable diseases places at risk all parties involved in the judicial process.

Communicable diseases are more prevalent among prisoner populations than the general public. This is particularly true of TB,<sup>27</sup> where, according to the World Health Organization, prisoner populations are among the groups most at risk because their overall health status tends to be poor, and because they live in a densely populated environment conducive to the spread of airborne diseases, such as TB. According to the National Commission on Correctional Health Care (NCCCHC) report to Congress, dated May 2002, there were an estimated 1,400 cases of active TB in the U.S. prisoner population during 1997, with the infection rate in jails (versus prisons) being about 17 times that of the general U.S. population. In addition, an estimated 566,000 inmates with latent TB infection were released in 1996, the overwhelming majority from jails.<sup>28</sup>

Rates of infection for both hepatitis C and HIV/AIDS, for which there are no known cures, were similarly skewed. The most recent data available

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<sup>27</sup> The bacteria called *Mycobacterium tuberculosis* cause the disease of tuberculosis (TB). TB bacteria usually attack the lungs, grow, and can spread through the blood to the kidney, spine and brain. Active TB is an airborne contagious disease. It is transmitted from a person that has active TB of the lungs or throat via coughs or sneezes. Anyone nearby may contract the infection when they breathe in these bacteria.

<sup>28</sup> Latent TB infection in contrast to active TB is not contagious. However, individuals with latent TB infection could develop active TB, especially if they have compromised immune systems. Like active TB infection, which can be cured through medical treatment, latent TB can also be treated so that individuals never develop the disease.



indicated prisoner infection rates of 18.6 percent for hepatitis C were over 9 times that of the U.S. population. Prisoner infection rates of .5 percent for AIDS were more than 5 times the prevalence in the U.S. population. The rates for HIV infection were about the same as AIDS in jail populations at four to six times the prevalence, and slightly more in prison populations at eight to ten times the prevalence in the U.S. population.

In 1998, the USMS implemented its policy on the control of TB in the prisoner population. The purpose of the policy is to ensure that USMS prisoners who have active TB are identified as soon as possible and isolated from other prisoners, deputies, and other staff to prevent the spread of the disease. The policy outlines procedures for identifying and isolating prison detainees who have active TB disease, to prevent the disease from spreading to fellow prisoners, law enforcement officials, or others at risk of exposure.

TB is the only infectious disease addressed by USMS policy. However, this is not to say that the USMS does not concern itself with other infectious diseases. On April 16, 2003, for instance, the USMS issued an advisory notice with guidance on Severe Acute Respiratory Syndrome (SARS) to all of the USMS districts. Further, the USMS provides guidance to staff on reducing the risk of exposure to blood borne diseases, such as hepatitis C and HIV/AIDS. However, with regard to tracking and monitoring, TB remains the only communicable disease specifically addressed in written USMS policy.

### **Initial Screening for TB**

USMS policy requires that prisoners be visually screened for symptoms of TB when taken into custody by the USMS. The policy further states that if a prisoner is suspected of having or has been diagnosed with TB, the district should immediately report the case to the OIMS, which monitors each case of active TB and works with the districts and courts to safeguard prisoner and public health during any prisoner transfers.

We determined that although some districts perform an initial cursory screening of prisoners for TB, there was no supporting evidence to indicate that any of the districts were actually conducting initial TB screenings. In fact, district officials at four of the districts reviewed stated that they did not screen for TB, but instead relied on the local detention facility for initial screening. Another five stated that they do some form of initial intake screening for TB, but nothing was done to document this on district intake forms.

Furthermore, we determined that at least four of the districts reviewed failed to notify the OIMS of prisoners that had been diagnosed with TB. As a central contact point the OIMS plays an important role monitoring TB and the potential for an epidemic among the federal prison population. To do so, however, the OIMS must be properly notified of active TB cases.

## **Documenting TB Results**

USMS policy and procedures require that TB test results be documented in the PTS and on the USM Form 553.<sup>29</sup> Once completed, copies of the Form 553 are provided to: 1) the district office, 2) JPATS, 3) the local jail, and 4) the OIMS. Standard use of this form ensures that TB clearances are verifiable and also reduces the potential for duplicate testing of USMS prisoners. The form must be signed and dated by a health care professional.

To determine whether USMS personnel adequately screened prisoners for communicable diseases, such as TB, hepatitis, and HIV/AIDS, we interviewed officials at USMS PSD, the OIMS, select USMS districts, and local jails. In each of the districts reviewed, we selected 25 inmates listed as currently in USMS custody in order to determine whether TB testing procedures were in compliance with USMS policy. We examined USMS district prisoner files for evidence of documentation of TB screening, testing and status. We also reviewed printouts from the PTS for information on TB test date and results, and current or past TB diagnosis and treatment.

We found documentation on prisoners' TB status almost non-existent. The USM Form 553, used to document TB clearance, was either entirely missing from case files, if there were case files, or the form did not contain TB results and thus was incomplete. In the D.C. District Court, for example, the auditors could not locate the Form USM 553 in the prisoner files. District officials stated that the district office did not retain a copy in the prisoner files. We then requested that the local jail fax the original Form 553 to the district office, which they did. Upon reviewing the documents, however, we noted that all of the forms were signed on the same day that they were faxed, which suggests that the forms were not accurate.

Documentation of TB results in the PTS was also sparse to non-existent. Only two of the districts reviewed were utilizing the PTS, and they were doing so only partially. One of those districts had entered only 9 of the

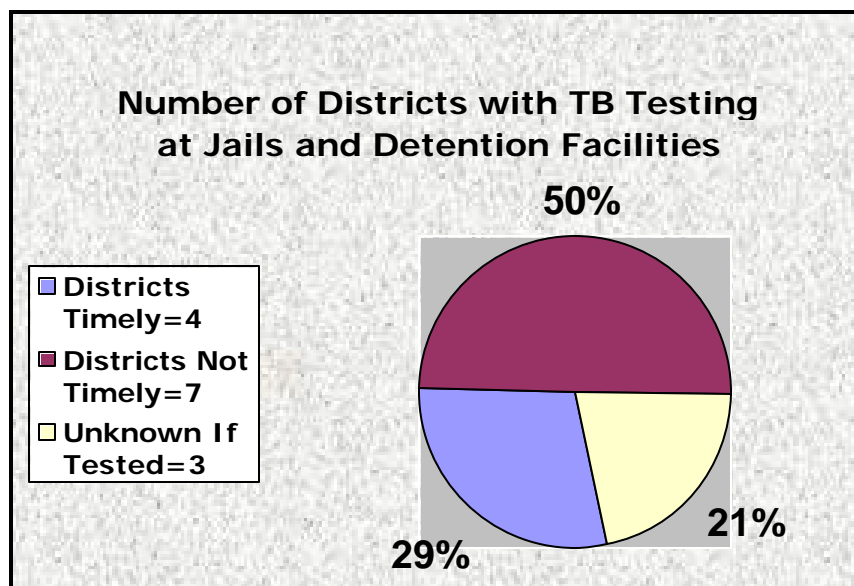
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<sup>29</sup> The USM Form 553 contains an original and three copies and lists the following information: 1) TB Clearance (Yes/No), 2) PPD Completion date 3) Results of PPD, 4) Health Authority Clearance (Yes/No), Signature of Official and date signed.

25 inmates selected, and the other had entered only one prisoner out of the 25 selected.

### Timeliness of TB Testing

USMS TB policy requires that prisoners be tested as soon as possible after intake at the local jail or detention facility, unless there is medical documentation stating that the prisoner has already been tested and cleared for TB.<sup>30</sup> Our audit testing determined that prisoners were not timely tested for TB -- within the 14-day standard established by the ACA -- in 50 percent of the districts reviewed. Depending on the district, prisoners remained untested an average of three to seven weeks after initial incarceration.



Source: Prisoner records

Untimely testing increases the risk of exposing other prisoners, USMS employees, and other parties involved in the judicial process to TB. In addition, delays in TB testing may impede the judicial process because prisoners cannot be transported without a TB clearance.

### Tracking Active TB Cases

We asked each of the districts reviewed to provide us a list of prisoners currently in USMS custody who had been diagnosed with active TB.

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<sup>30</sup> ACA standards recommend prisoner health appraisals, to include testing for TB, within the first 14 days of incarceration.

Of the 14 districts, 6 districts could not provide a list of prisoners with active TB, 3 districts were able to provide a list, and 5 of the districts stated that they had not processed any prisoners with active TB during the review period. However, we later determined that one of the districts claiming not to have processed any prisoners with active TB had paid for treatment of active TB for a USMS prisoner in FY 2002. This lack of awareness was not totally unexpected, given the scarcity of TB-related information in the prisoner files and the PTS. It is, nevertheless, a cause for concern given that prisoners who are suspected of or have been diagnosed with active TB are not to be produced for court or transported (other than to an appropriate local medical facility) by USMS personnel until the prisoner has received the appropriate medical care and is medically cleared by a health professional.

Districts often rely on the local jails or detention facilities to test detainees for TB and keep track of those with active TB. The problem with such reliance is that not all local jails test their prisoners for TB. In 1998 the OIMS conducted a survey of TB testing in jails housing USMS prisoners. At the time about 60 percent of USMS prisoners were housed in local jails under IGAs between the USMS and local jails. The survey revealed that only 74 percent of the local jails tested federal prisoners for TB, most upon intake. Of the remainder, 17 percent did not test for TB, and 9 percent deemed TB testing as optional, provided upon request by the prisoner.

It is the USMS, not local jail facilities, that is responsible for monitoring the health status of federal prisoners. Failure to track active TB cases could endanger the courts, law enforcement officials and the public. In the Western District of Texas, for example, a prisoner was released on bond prior to his TB test results being received. Subsequent receipt of the prisoner's chest x-ray results confirmed that he had active TB. In another incident a deputy marshal was unknowingly exposed to TB when he escorted a prisoner that, unbeknownst to him, had been diagnosed with active TB. According to the deputy, he was not advised of the prisoner's condition until after he had transported the prisoner. The deputy later tested positive for TB and had to be treated.

## **Hepatitis and HIV/AIDS**

Currently the USMS has no formal policies similar to that of its TB policy concerning the tracking and monitoring of HIV/AIDS and hepatitis. This was a cause for concern with regard to HIV/AIDS in particular because its management is inseparable from that of other communicable diseases, such as TB, given the increased opportunity for infection among prisoners with compromised immune systems.

While no formal USMS policies currently exist at the national level we performed audit steps to determine to what extent district offices were tracking and monitoring cases of hepatitis and HIV/AIDS on their own. We found that little was being done at district offices to fill the policy vacuum at the national level regarding hepatitis and HIV/AIDS. When asked, district officials stated that there were no local policies or that they were not aware of them if there were. While some steps were being taken, there was little consistency from district to district in the handling of hepatitis and HIV/AIDS cases.

With regard to screening for HIV/AIDS and hepatitis we noted the following:

- District offices do not monitor the screening of USMS prisoners by jails for HIV/AIDS and hepatitis.
- Four districts stated that they rely on prisoners to volunteer their HIV status.
- One district stated that it screened new arrests but it did not monitor screening by the jails.
- One district visually screens if the prisoner was ill or stated so.
- One district stated it transfers prisoners who are HIV positive to a CCA or BOP facility if the time in USMS custody is expected to be lengthy.
- Six districts documented HIV/AIDS status on USMS forms and annotated the forms with terms such as "transport with caution," "body fluid watch," and "universal health precaution." Four districts entered the infected prisoners' health status into the PTS.

With regard to treatment provided at local jails we noted the following:

- Four of the districts stated that they were reviewing and authorizing requests for treatment of or medications for HIV/AIDS and hepatitis by jails. One of them also discussed contacting the OIMS for assistance, and one mentioned that USMS headquarters is contacted for approval. Another said it relies completely on the jails.
- Four districts stated that they were not aware of current or past diagnosis and treatment of USMS prisoners for HIV/AIDS and hepatitis provided by jails.

- Seven districts were documenting the health status for HIV/AIDS and hepatitis for prisoners on USMS forms, six of which entered information into the PTS.

USMS officials at our exit conference explained that tracking and monitoring of HIV/AIDS was problematic due to privacy issues, which would preclude tracking and monitoring. However, we found evidence of current mandatory HIV testing at both the state and federal level. According to the Bureau of Justice Statistics (BJS) Bulletin, *HIV in Prisons, 2000* (October 2002), the BOP tests all federal inmates at the time of release. Further, the BOP tests a random sample of inmates for HIV in alternate years. The BJS Bulletin also listed 19 state prison jurisdictions, including Colorado, Michigan and New Hampshire that test all incoming inmates for HIV.

## **Conclusion**

The USMS needs to take a more active role in monitoring and tracking TB and other infectious diseases, such as HIV/AIDS and hepatitis. Too often the USMS districts place undue reliance on local jails to provide them information on federal prisoners in USMS custody. Failure to effectively track and monitor these communicable diseases endangers not only the health of those involved in the judicial process, but that of the general public as well.

## **Recommendations**

We recommend the USMS:

7. Ensure that USMS deputy marshals perform initial TB screening of the USMS prisoners that are housed in USMS district holding cells.
8. Ensure that all cases of active TB are reported directly to the OIMS.
9. Require that prisoners' TB test dates and results be documented on the Form USM 553 Medical Summary of Federal Prisoner/Alien In Transit and entered into the PTS, in accordance with USMS TB policy. Copies of the USM 553, either paper or electronic, should be maintained at the district offices.
10. Develop and implement a system to track and monitor active TB cases.
11. Develop and implement a policy for tracking and monitoring of HIV/AIDS and hepatitis cases.

## **5. SECURE TRANSPORT OF FEDERAL PRISONERS TO AND FROM HEALTH CARE FACILITIES JEOPARDIZED BY ILL-MANAGED CONTRACT GUARD OPERATIONS**

Management of contract guard operations relative to prisoner medical care was characterized by inadequate training, breaches in policy, and lapses in internal controls. We noted problems in nearly all areas of contract guard activity, ranging from lack of documentation to overpayments. More importantly, the ill-managed contract guard operations have created an environment in which the USMS cannot effectively control the risks inherent to transporting federal prisoners to and from off-site health care facilities.

A critical factor in providing outside medical treatment to federal prisoners is the secure transport to and from health care facilities and guarding of prisoners during the period of treatment. Typically, the USMS does not utilize deputy marshals for such activity, but instead employs contract guards.<sup>31</sup> Of the \$43 million in prisoner medical care expenditures in FY 2002, \$7.4 million or 17 percent went to providing security for prisoners receiving outside medical care. Security in this case refers to the hiring of contract guards for the transportation and guarding of prisoners requiring external medical treatment. Contract guards for hospital transport were used in 12 of the 14 districts we reviewed.

There are inherent risks associated with the transportation and guarding of federal prisoners while in public, the most serious of which is death or injury to an innocent bystander. The most effective way to minimize those risks is to eliminate or reduce the need for outside medical services. In New York, for example, the USMS has benefited from an interagency agreement with Veterans Administration (VA) hospitals in Manhattan and Brooklyn in which VA doctors make site visits to BOP facilities, thus reducing the need for outside medical services. Such arrangements notwithstanding, the need for outside medical care exists, and to address the associated risks the USMS has established policies and procedures related to contract guards that govern: 1) the transporting of

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<sup>31</sup> The USMS procures contract guards through one of two means: 1) contract guard companies, or 2) personal service contracts. In contrast to formal guard company contracts, which involve competitive bidding and generally run for five years, personal service contracts, as the name denotes, are contracts with individuals and bear more of a resemblance to a temporary worker than a contract employee. For the most part, these involve off-duty or former law enforcement officers whose duties include guarding prisoners in USMS holding cells and transporting prisoners in need of medical treatment to and from hospital facilities.

prisoners, 2) personnel qualifications, 3) work experience, 4) training, and 5) fitness for duty. For these specific policies and procedures, see Appendix V.

Although contractors provide the hospital guards, the district is responsible for: 1) determining the placement of prisoners under the supervision of contracted guards, 2) determining the number of contracted guards required for a detail, 3) ensuring that the qualification of the contracted guards meet established standards, and that 4) ensuring that contracted guards are properly trained to properly perform their assigned duties and responsibilities.

Our review of USMS district compliance with the established controls indicated that many districts were not in compliance with USMS policies and procedures regarding prisoner transportation and hospital guard duty. Often the district offices were not certain if company contract guards met USMS standards. Some district offices did not retain documentation to verify whether contract guards met all of the qualifications and training requirements stated in the USMS policy and procedures manual.

In some instances, the lack of documentation was due to deficiencies in the contracts themselves. We noted that some contracting documents did not contain a clause requiring the contractor to provide the district office with documentation that all USMS requirements are met, and in some instances the contract did not state that personnel qualifications had to be met at all. A discussion of specific areas with regard to both personal service contracts and guard company contracts follows.

## **Contract Personnel Records**

### Personal Service Contracts

USMS policies and procedures require that district offices obtain the following background information for individuals employed to work as hospital guards: 1) valid driver's license, 2) background check, 3) fingerprints, and 4) firearms qualification.

USMS policy requires that these documents be maintained on file to ensure that hospital guards: 1) safely perform their duties, 2) have no criminal background, and 3) can legally transport prisoners. However, our review of personal service contract files revealed that USMS district offices are not properly maintaining personnel information, as illustrated in the table below:



<b>DOCUMENTATION OF PERSONAL CONTRACT GUARD QUALIFICATIONS IN DISTRICT FILES</b>				
<b>District</b>	<b>Firearms Qualified</b>	<b>Background Check</b>	<b>Driver's License</b>	<b>Fingerprints</b>
Arizona	None	None	60%	None
DC District Court	None	100%	20%	None
Kansas	100%	100%	100%	100%
Eastern New York	None	None	20%	None
Western New York	100%	N/A	100%	100%
South Carolina	40%	10%	10%	None
Southern Texas	100%	None	100%	None
Western Texas	100%	None	80%	None

Source: District contract personnel records

Officials at the Eastern District of New York acknowledged that their personal contract guard files were incomplete, and that they were in the process of improving their personnel records. Officials from the Southern and Western Districts of Texas and the District of Arizona all stated that it was their understanding that personnel information was not required for sworn officers and that the guards' primary law enforcement employer had the information on file.

USMS policy does allow for a firearms qualification exemption if the contract guard is a sworn law enforcement officer. However, we found that some guards were retired officers and that many of the guards who were sworn officers had not submitted a USM Form 234 (affidavit of affirmation), as required under USMS policy.<sup>32</sup>

### Guard Company Contracts

As with personal service contracts, the USMS requires that contract guards hired through guard company contracts meet the minimum standards related to experience, fitness, weapons qualifications, physical fitness, criminal background, and training. Of the seven districts reviewed

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<sup>32</sup> USMS policy states that active sworn law enforcement officers are exempt from USMS firearms qualifications if they certify in the affirmation of work qualifications for contract guards that they are currently qualified and authorized to carry their duty firearm. In addition, they must have been qualified by their agency within the past 12 months and must re-qualify at least annually thereafter.

that utilized company hospital guards, our review of personnel files revealed that:

- Contract guard personnel files at three of the districts did not contain fingerprints.
- Contract guard personnel records at two of the districts did not contain information related to the guards' previous experience or qualifications.
- Two districts did not have personnel records on any of the individuals performing hospital guard duties.
- One district was obtaining guard services without a contract.

The USMS requires that the districts document the qualifications and background of all individuals contracted to guard and transport federal prisoners. These controls have been established to ensure that guard personnel are capable of properly performing their duties.

By not complying with these policies the districts increase the risk of hiring an individual who lacks the proper qualifications and experience or has a criminal background, which in turn increases the risk that incidents resulting in injury or death may occur.

## **Training**

USMS policy requires that personal service guards receive specific training within 30 days of providing service in addition to annual refresher training thereafter. The policy permits that past or current agency training may be used in lieu of USMS training but must be annotated on the Affirmation of Qualifications statement in the guard's contract file.<sup>33</sup>

Contract hospital guards are required to: 1) view a video on TB, 2) become familiar with USMS policies and procedures, 3) know how to apply and remove restraints and conduct searches, 4) review and agree to comply with the USMS use of force policy and must certify to their knowledge of the policy, and 5) review USMS Policy Directive 99-18(1) regarding professional standards of conduct and certify to their knowledge of the policy.

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<sup>33</sup> Signed document listing the guard's qualifications including experience, training, background and fitness for duty.

We reviewed the training provided to contract hospital guards at 12 of 14 the district offices.<sup>34</sup> We noted that 8 of the 12 districts using contract guards kept no records on hospital guard training. The following table summarizes the results of our review.

<b>CONTRACT GUARD TRAINING</b>		
<b>District</b>	<b>Company Contract Guards</b>	<b>Personal Contract Guards</b>
	<b>Training</b>	<b>Training</b>
Arizona	None <sup>35</sup>	None
Central California	Yes <sup>36</sup>	N/A <sup>37</sup>
DC District Court	N/A	None
Northern Illinois	None	N/A
Kansas	N/A	None
Eastern New York	N/A	None
Western New York	N/A	Yes
Eastern Pennsylvania	None	N/A
South Carolina	None	None
Southern Texas	N/A	Partial <sup>38</sup>
Western Texas	N/A	None
Southern California	Yes	N/A

Source: District contract personnel records

The District of South Carolina was somewhat unusual in that guard personnel files contained letters signed by the U.S. Marshal stating that the

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<sup>34</sup> Two districts did not utilize contract guards (personal or company).

<sup>35</sup> "None" indicates the auditors found no documentation in the files related to guard training.

<sup>36</sup> "Yes" indicates that the district had documentation indicating that the guards had received the required training.

<sup>37</sup> "N/A" indicates the district did not use that type of contract guard.

<sup>38</sup> "Partial" indicates the district had some documentation indicating guard training but the files were incomplete.

hospital contract guards had met USMS experience qualifications and did not require additional training. Based on our review and interviews with district officials, we concluded that despite USMS policy requiring training for hospital guards, the U.S. Marshal made a decision to not provide training for their personal contract guards. We also concluded that this decision was based on the Marshal's determination that if a personal contract guard had met the experience requirements, then the USMS training requirements were not applicable. While this may have been done in good faith and based on confidence in the contract personnel, a decision to circumvent internal controls increases the risk that an incident will occur that may jeopardize public safety.

### Prisoner Escape

We encountered such an incident in our review of the district office in Southern California when a prisoner with active TB managed to escape from his hospital room. The prisoner, who was hospitalized for treatment of active TB, was placed in a non-secured section of the hospital because the secured wing was full. The unsecured hospital room had no observation port in the door and had windows to the outside that could be opened. Further, because the prisoner had active TB, the contract guard did not stay in the room with the patient. Consequently, the contract guard failed to maintain regular visual contact, in violation of USMS procedures. In this instance, the prisoner was out of the guard's sight for a long enough period to put on his street clothes (which he should not have had), tie several bed sheets, open the window and lower himself to the ground to make his escape. Following his escape, the prisoner hijacked a woman driving her car. He was eventually apprehended and later died in custody from advanced TB.

The woman filed a lawsuit against the hospital and the USMS and the USMS was found not to be liable. While the incident ended without serious physical injury to the innocent bystander, the escape of a violent felon with a highly contagious disease into the community could have had far more serious consequences.

### Alleged Prisoner Abuse

In another incident, this one in the Northern District of Illinois, a prisoner undergoing dialysis treatment alleged that two contract guards engaged in misconduct, stating that while in a hospital bed watching TV he was beaten by a guard for changing the channel. According to the prisoner, the guard warned him "not to change the TV channel or he would kick his ass." The prisoner stated that he hit the nurses call button, and when she arrived the guard told the nurse that the prisoner had been acting up.

On a separate occasion, the prisoner complained about another contract guard handcuffing him in a manner that was very painful because he was undergoing dialysis. He stated that while the jail guards had handcuffed him in a manner that was not painful, the contract hospital guards handcuffed him in a manner to induce severe pain. He added that when he refused to be handcuffed in such a manner the contract guard made disparaging remarks about the prisoner's mother.

District officials stated that they contacted the contractor and asked that they suspend the two accused guards until an investigation could be completed. Further information obtained by the audit team indicated that the accused guards were suspended temporarily, but there was no evidence that the USMS followed through with an investigation into the prisoner's complaint.

### **Contract Monitoring**

At the heart of the aforementioned problems is the issue of contract monitoring. In most cases, the responsibility for monitoring contract performance rests with the Contracting Officer's Technical Representative (COTR).<sup>39</sup> An active and well-trained COTR is central to the effective management of any contract operation.

USMS policy requires that district office employees meet specific requirements to qualify as a COTR.<sup>40</sup> We interviewed the COTR at each of the six districts with guard company contracts to evaluate their knowledge of contractor performance requirements, such as guard training and guard qualifications. We also asked to review annual written evaluations of the contractors' performance to determine if the evaluations were comprehensive and submitted timely.

We determined that most of the COTRs lacked a proper knowledge of the hospital experience, billing procedures and rates, problems and complaints, and, in general, the guard contract they were managing. We

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<sup>39</sup> Contracting officers may appoint individuals selected by the district office to act as authorized representatives in the monitoring and administration of a contract. Such officials are designated in the contract as the COTR.

<sup>40</sup> COTRs must attend and successfully complete a 16-hour basic COTR course and obtain a minimum of 3 hours training specifically in procurement ethics. Once the COTR signs a certification for procurement officials required by the Procurement Integrity Act, the contracting officer designates in writing that the COTR can act as an authorized representative to monitor contract performance and deliveries in accordance with the contract requirements and certify satisfactory delivery of supplies or services before contractor invoices are paid.

further determined that most COTRs had not submitted formal evaluations of the contract to district management.

While most of the COTRs had received the required training, only one of those we interviewed indicated active involvement in monitoring of the contract. This was not a wholly unexpected outcome, as the COTR function in the USMS is a collateral duty, often performed by deputy marshals with a full workload and little background experience in contracts.

An example of the limited oversight provided at the district level was seen in the Northern District of Illinois, which had been utilizing the Magic Security, Inc., over a four-year period to both transfer and guard federal prisoners receiving outside medical treatment.

Our review of the district office determined the following regarding the contractor:

- We determined that the district had made overpayments in excess of \$211,411 over a two-year period on the guard company contract. We reviewed several invoices from FY 2002 and determined that the rates listed on the invoice were consistently above the negotiated rate on the most current contract.<sup>41</sup>

In addition, we detected several contractor errors in the summary total of billing sheets listing the number of guard hours and transports provided. We noted that the district office did review the billings as evidenced by numerous corrections. However, based on the large number of undetected errors we determined that the district office was not adequately reviewing the invoices and billing sheets.

- The guard company had used their own vehicles to transport federal prisoners to medical appointments. Our audit indicated that the district had not inspected the vehicles to ensure that they met USMS security specifications.
- The district did not retain documentation demonstrating that the contract guard personnel met USMS standards.
- Contract personnel were not provided the training required by USMS policies.

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<sup>41</sup> When we informed the USMS of the overpayments, district officials stated that because the USMS had other contracts with Magic Security there would be a financial audit of all their contracts.

- The contractor was in Chapter 11 bankruptcy at the time of our review, but had not notified the district office of its financial condition.
- USMS guard identification badges were not being returned to the USMS after contractor employees separated from the contractor.
- The district did not perform periodic formal written evaluations of the guard contractor. Contractor officials stated that they have never been reviewed by the USMS.

## **Conclusion**

Overall, contract guard management at the district offices was characterized by a lack of documentation and verification stemming from an absence of strong oversight on the part of the district COTRs. District offices were not verifying whether guard companies were providing hospital guards that met USMS personnel requirements. These lapses in oversight increase the risk of hiring unqualified or incompetent guards, which could ultimately result in incidents of escape and injury or death to an innocent bystander, law enforcement official, or the prisoner.

## **Recommendation**

We recommend the USMS:

12. Ensure that guard contracts are effectively monitored by:
  - a. requiring that the COTR submit comprehensive guard contractor evaluations every six months. These evaluations should be thorough and should require documentation that supports the determinations and findings of the COTR.
  - b. requiring that the COTR submit to the contracting officer, along with the contractor evaluation, a list of the district's active contract guards. This list should include identifying information, prior experience, and training.
  - c. requiring that COTR evaluation elements be included in the personnel ratings of USMS employees assigned as COTRs.

## AUDIT OBJECTIVES, SCOPE, AND METHODOLOGY

### Audit Objectives

The objectives of the audit were to determine whether management controls established by the USMS will reasonably assure that: 1) prisoners are provided necessary health care, 2) prisoners are screened for communicable diseases, 3) costs are necessary and reasonable, and 4) prisoners are provided secure transport to off-site facilities to receive medical treatment.

### Scope and Methodology

The scope of the audit encompassed USMS management of prisoner medical care from FY 2000 through FY 2003 and was conducted in accordance with generally accepted government auditing standards. Our primary focus was on management activities at the district office. We conducted fieldwork at 16 USMS district offices and performed statistical sampling of internal controls over prisoner medical care at 14 of those district offices.

To complete the audit, we: 1) researched and reviewed applicable laws, policies, regulations, manuals, and memoranda; 2) interviewed officials at the USMS and BOP; 3) conducted fieldwork at 16 district offices located in Los Angeles, CA; San Diego, CA; San Francisco, CA; Sacramento CA; Philadelphia, PA; Brooklyn, NY; Buffalo, NY; Tampa, FL; Topeka, KS; Phoenix, AZ; Albuquerque, NM; Chicago, IL; Washington, DC; Columbia, SC; Houston, TX; and San Antonio, TX, as well as USMS Headquarters in Washington, DC; 4) selected and reviewed a statistical sample of 900 vouchers from a universe of 6,525 obtained from the USMS FMS system. In conducting our audit, we relied on computer-processed data. We tested the accuracy of the data by tracing it to original source documents.

For objective 1, we interviewed USMS officials, reviewed USMS policy and procedures, prisoner files, and documents related to: 1) prisoner deaths, 2) litigation resulting from prisoner medical issues, 3) evaluations and audits of health care services provided by contract jail facilities, and 4) internal controls associated with the USMS cellblock health screening.

For objective 2, we obtained and reviewed USMS policies and procedures related to internal controls established to mitigate the risk of spreading such infectious diseases as TB, HIV/AIDS and hepatitis.



We interviewed a judgmental sample of deputy marshals to determine if they understood the outward signs of TB and knew what action to take if they encountered a prisoner displaying symptoms of the disease.

In addition, we reviewed records of prisoners in USMS custody from October 1, 2001, through September 30, 2002, who were diagnosed with active TB. We determined if the case was reported to the Office of Interagency Medical Services (OIMS). We verified if the prisoner was immediately taken to a medical facility for treatment and remained in a medical facility until the diagnosis was confirmed and treatment completed.

To determine whether USMS personnel adequately screened prisoners for communicable diseases, such as TB, hepatitis, and HIV/AIDS, we interviewed officials at USMS Prisoner Services Division (PSD), the OIMS, select USMS districts, and local jails. We also examined USMS district prisoner files for evidence of documentation of TB screening, testing and status. We reviewed printouts from the Prisoner Tracking System (PTS) for information on TB test date and results, and current or past TB diagnosis and treatment. Further, we analyzed BOP and jail communiqués regarding medical clearance of prisoners.

For objective 3, we selected a statistical sample of outside medical payment transactions for review from FY 2002 vouchers listed on the USMS's Financial Management System to determine whether: 1) the prisoner was eligible for treatment, 2) the procedure was properly authorized, 3) the medical procedure was necessary, and 4) the payment was accurately recorded and supported by documentation.

We interviewed district officials in order to assess the internal controls that have been established to mitigate the risk of fraud, or the excessive cost resulting from: 1) treatment of ineligible prisoners, 2) unnecessary medical treatment, 3) duplicate or over-priced medical bills, 4) payment of costs covered by the prisoner's private medical insurance, and 5) procurement of non-generic drugs.

We interviewed district officials and reviewed randomly selected medical bills to establish if outside medical services were being procured in accordance with federal regulations.

To complete objective 4, we randomly selected hospital guard payment transactions for review from FY 2002 vouchers listed on the USMS's Financial Management System and determined if the payments were properly authorized, accurate, and fully supported by documentation.

We judgmentally selected and reviewed the personnel files for contract hospital guards. By reviewing these files we found if the hospital guards utilized by the USMS met the qualification standards for job experience, background, physical fitness, and training.

We interviewed the COTR of the district's hospital guard contract in order to determine if the COTR was qualified for their position and to determine if they were fully performing the COTR duties.

**SCHEDULE OF DOLLAR-RELATED FINDINGS**

<b>FUNDS TO BETTER USE:</b>	<b>AMOUNT</b>	<b>PAGE</b>
Administrative Costs of Outside Medical Services at District Offices	\$ 1,000,000	21
<b>TOTAL FUNDS TO BETTER USE</b>	<b>\$ 1,000,000</b>	

**QUESTIONED COSTS:**

Medicare Versus Medicaid Payments	\$ 7,000,000	17
Overpayments on Guard Contract	\$ 211,411	48
<b>TOTAL QUESTIONED COSTS</b>	<b>\$7,211,411</b>	

**FUNDS TO BETTER USE** are defined as future funds that could be used more efficiently if management took actions to implement and complete audit recommendations.

**QUESTIONED COSTS** are expenditures that do not comply with legal, regulatory, or contractual requirements, or are not supported by adequate documentation at the time of the audit, or are unnecessary or unreasonable. Questioned costs may be remedied by offset, waiver, recovery of funds, or the provision of supporting documentation.

**GLOSSARY OF TERMS AND ACRONYMS**

- Administrative Officer (AO): Civilian employee usually tasked with obligating medical expenses.
- Automated External Defibrillator (AED): A fail-safe machine that can deliver a life-saving electric shock to a victim experiencing a cardiac arrest, dramatically improving his or her chance of survival.
- Batched transactions: Many USMS district offices combine several medical bills into one payment transaction.
- Cellblock: A secure area in the U.S. Marshals Service Office intended to house prisoners waiting for their court proceedings.
- Common Procedural Terminology (CPT) code
- Company Hospital Guards: Guards employed by a company that has contracted with the USMS.
- Contracting Officer's Technical Representative (COTR): A person designated by a Contracting Officer to assist with seeing that a contractor's total performance is in accordance with the requirements of the contract and to protect the best interests of the Government. The individual who is responsible for the technical evaluation of a contractor's performance.
- Deputy U.S. Marshal: Includes all operational employees assigned to either the 0082 or 1811 job series.
- Diagnostic Related Group (DRG)
- Elective Care: Medical care that is not medically necessary to preserve the life or health of the prisoner.
- Emergency Care: Medical care immediately necessary to preserve the life, health, limb, sight or hearing of the prisoner.
- Financial Management System (FMS): USMS's automated financial accounting system.

- Generic Medications: Prescription medications, the names of which are not protected by a trademark, but which are of the identical chemical structure to medication, which is protected by a trademark. Such medication is generally much less expensive than brand-name medication.
- Centers for Medicare and Medicaid Services (CMS)
- Individual Hospital Guards: Guards hired on individual contracts to the USMS and are not staffed to a Security or Company guard service.
- Infectious Disease Screening: Medical care to identify infectious diseases such as tuberculosis, HIV, hepatitis, etc., Such care is considered medically necessary to protect the health and well being of prisoners, USMS staff, correctional staff, and the public.
- Inside Care: Basic medical care routinely provided inside the confines of the jail or institution, e.g., intake screening, infectious disease control measures, sick call. The level of services included will vary among institutions, depending upon the institutions' capabilities.
- Intergovernmental Agreement (IGA): An IGA is a formal written agreement between the USMS and a local or state government for the housing, care and safekeeping of Federal prisoners
- Jail Inspector: A U.S. Marshals Deputy or staff who performs an inspection of local jails. These jails house USMS prisoners for the district under an IGA.
- Medically Appropriate Care: Medical care that is necessary to preserve the life or health of the prisoner.
- Micro purchase: Acquisition of goods or services when less than \$2,500.
- Modification: Change to an IGA or contract usually related to per diem rates.
- Obligation: A monetary liability of the Government.
- Office of Interagency Medical Services (OIMS): Established in 1994, the OIMS's functions include: 1) Medical case management for the districts; 2) Oversight the U.S. Public Health Service program at USMS, 3) Medical standards and policy, 4) Medical cost containment, 5) BOP/USMS Medical consolidation program, and 6) TB Management.

- Outside Medical Care: Medical care provided to a prisoner outside the confines of the jail or institution.
- NCIC/NLETS: National Crime Information Center/National Law Enforcement Telecommunication System (Automated background checks).
- Piggybacking: One government agency, e.g., USMS, obtains services from a vendor that has a contract with another federal agency, e.g., Bureau of Prisons.
- Pre-authorization: Authorization for the provision of a particular medical treatment or service obtained before providing the treatment or service. For the USMS, preauthorization applies to USMS prisoner medical care provided outside the jail or institution and for which the USMS is financially responsible.
- Prisoner file: The primary district file containing all pertinent prisoner information. At many district offices portions of this file are in an electronic format.
- Prisoner Services Division (PSD): The overall responsibility for all prisoner services is the USMS Prisoner Services Division (PSD). The PSD oversees all local jail inspections and these inspections require a review of prisoner medical care. The Office of Interagency Medical Services (OIMS) is under the PSD.
- Prisoner Tracking System (PTS): Automated data system developed to support the tracking and handling of prisoners in district offices and sub-offices.
- Remanded to USMS custody: Court places a prisoner in custody of the USMS to await trial.
- Re-pricing: Medical invoices, after being reviewed, are sent by the district office to a contractor who modifies the billing amount in accordance with established Medicare rates.
- Statement of Work (SOW): The portion of a government contract which describes in precise terms the work (tasks, materials, and services) to be provided by the contractor.
- Secure wing: Hospital wing with security features, e.g., barred windows.

- Tuberculosis (TB): TB is an infection caused by exposure to the tubercle bacillus organisms. TB infection can progress to disease. TB infection (latent) and TB disease (active) make up the two dimensions of TB.

**STATEMENT ON COMPLIANCE WITH LAWS AND REGULATIONS**

As required by the standards, we tested selected transactions and records to obtain reasonable assurance about the USMS's compliance with laws and regulations that, if not complied with, we believe could have a material effect on operations. Compliance with laws and regulations applicable to prisoner medical care is the responsibility of USMS management.

An audit includes examining, on a test basis, evidence about laws and regulation. The specific requirements for which we conducted tests are contained in the Unites States Code, Title 18, §4013, §4006, and Public Law 106-113.

We found that the USMS was not in full compliance with Section 4006, as amended by Public Law 106-113, which authorizes the USMS to pay for health care provided to federal prisoners at the lesser of the Medicare or Medicaid rates for said health care services (See Finding 3).

Except for the abovementioned issue and other issues discussed in the Finding and Recommendations sections of this report, nothing came to our attention that causes us to believe that USMS management was not in compliance with the sections of the United States Code cited above.



**USMS POLICIES AND PROCEDURES  
FOR TRANSPORTING FEDERAL PRISONERS**

- Prisoners will be fully restrained when transported by the USMS. Full restraints consist of handcuffs, waist chains, and leg irons.
- Visual contact with prisoners must be continually maintained
- If a rest stop is necessary, police facilities should be used when possible. Rest areas along the highways should be avoided. Facilities are to be selected at random after departing thoroughfares.
- Handcuff and leg iron keys will not be carried on the same key ring as vehicle ignition keys or other general use keys.
- While in transit, prisoners will not be permitted to: (a) select places routes of travel, rest stops, or influence in any other manner the travel itinerary; (b) possess or expend any funds, consume tobacco products, or place telephone calls; (c) converse with anyone except other prisoners and custodial personnel; or (d) possess or consume medication, except that prescribed by a physician or as indicated by the custodial facility. If medication must be taken, a deputy<sup>42</sup> will maintain custody and dispense the medication as needed. If administered by hypodermic syringe, a deputy will maintain custody of the syringe and issue it as needed. The prisoner will inject the medication, or it will be administered by medical personnel.
- Districts will establish procedures addressing contingencies for the following situations that may occur during transportation, including an action plan for each route routinely taken by the district.
  - (a) Prisoner illness or injury
  - (b) Disruptive prisoner
  - (c) Vehicle accident or breakdown
  - (d) Prisoner escape or attempted escape
  - (e) Alternative routes to every facility
- Deputies shall not engage in any unauthorized activities or unscheduled stops while transporting prisoners. However, if there is a risk of death or bodily injury to a prisoner, USMS personnel or a citizen, deputies may

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<sup>42</sup> The policy is directed at deputy marshals and contracted hospital guards.

stop or alter routes to render assistance in emergency situations. District management will be notified immediately for guidance or assistance. Under no circumstances will a prisoner or prisoners be left out of visual contact of the transporting deputies.

- Prisoner escapes/attempted escapes will be reported immediately to district management and USMS Communications Center. The Communications Center will notify the Investigative Services Division and Prisoner Services Division duty officers.
- If a prisoner is injured or becomes sick following an arrest, the prisoner will be transported to a medical facility or examined by a medical professional prior to processing. The following security, control, and transportation procedures will apply:
  1. Prisoners will be searched. Control over the prisoner will be maintained at all times. The prisoner will be restrained unless there are compelling medical reasons.
  2. If emergency medical technicians (local public safety EMT/EMS) respond to the scene, the deputies may request that the EMT/EMS transport the prisoner to an appropriate medical facility, if necessary. At least one deputy will remain with the prisoner during transportation by ambulance. A second deputy will follow the ambulance and be part of the security team while the prisoner is being treated. If an ambulance is not required, deputies will transport the prisoner to and from a medical facility, if necessary, and remain with the prisoner during treatment.

#### Medical appointments

The time and place of medical appointments should not be known to the prisoner. The minimum staffing required for medical appointments is one-on-one plus one. The detention facility staff or a hospital guard service may move a prisoner to the hospital when emergency medical conditions exist or for routine outpatient care. The district will be notified when a move has been made by the detention facility or guard service. Removal for routine medical care may not be initiated without prior approval of the district management. Visual contact with prisoners will be maintained at all times.

### High-threat or high profile moves

Districts will establish a procedure for planning and conducting high-threat prisoner movements within the district. Any movement or treatment that could be construed as "special" should be documented to have a record of activity. The documentation and procedure shall include, but not be limited to, dates and times, chain-of-command, routes to be taken, resources to be used, alternative plans/routes, and the reasons for special measures.

### Incident reports

Significant incidents pertaining to a prisoner in the custody of the USMS will be immediately reported to the district management. This would include: escape, escape attempts, the use of force against prisoners, vehicle accidents, hijacking or attempted hijacking of any vehicle used for prisoner movement, and threats and actual attacks upon prisoners or escorting personnel by external sources.

**USMS CONTRACT GUARD POLICY**

The contract guard is providing services as an independent contractor, and no master/servant, employer/employee, or agency relationship is created by the contract, individuals engaged as contract guards are not entitled to pension benefits, health insurance benefits, or other federal employee benefits or services.

**Scope of duties**

- Guarding and transporting federal prisoners to and from medical appointments
- A USM-7, Bi-weekly Time Report is to be used to record all personal service guard hours.
- Contract guards cannot be scheduled for more than 16 USMS duty hours per day.
- Overtime compensation will be paid after 40 hours have been worked per workweek.

**Personnel requirement and work experience**

All applicants must fulfill the following requirements:

- a. Be a United States citizen,
- b. Be at least 21 years of age,
- c. Speak, read and write the English language,
- d. Possess a valid driver's license,
- e. Demonstrate a proficiency in firearms that meets USMS standards if the assignment requires the use of an armed contract guard,
- f. Be physically able to perform the full range of contract guard duties as described in the Statement of Work (SOW) without limitation.

- g. Have no medical problems, e.g., amputations, deformities, disabilities, etc., that would restrict strenuous exertion or prevent satisfactory performance,
- h. Have no history of medical problems, e.g., high blood pressure, heart or respiratory disease, etc., that would restrict strenuous exertion; and
- i. Have no other health-related problems such as alcohol dependency, controlled substance abuse, illegal drug use, mental illness, or psychological disorders.

Categories are used to separate contract guard applicants into groups for the purpose of contracting procedures and processing. These categories do not represent any hierarchy of qualifications.

Category 1: Actively employed sworn state or local enforcement officers.

Category 2: Reserve sworn state or local law enforcement officers with a minimum of 1-year full-time law enforcement employment/experience.

Category 3: Former/retired sworn federal, state, or local law enforcement officers with a minimum of 1-year full-time law enforcement experience who are separated no longer than 5 years from law enforcement employment.

Category 4: Former/retired military police with full-time experience in the performance of guard duties over prisoners on a regular basis who are separated no longer than 5 years from law enforcement.

Category 5: Private security/correctional officers. Employment as a private security guard does not qualify applicants unless they have at least 3 years of full-time guard duties supervising prisoners on a regular basis. Applicants must also have received an accredited law enforcement course of training. Academic or technical training may not be substituted for experience.

## **Training**

- The districts and JPATS are responsible for ensuring that the contract guard receives the following training, if applicable, within 30 days of

providing service. All the following training is required. However, past or current agency training may be used in lieu of USMS training.

- View the video entitled Invisible Enemies: Blood borne/Airborne Pathogens.
- Review and become familiar with USMS policies and procedures regarding cellblock operations. JPATS operations, in-district prisoner movement, and the Prisoner Tracking System.
- Receive training from district or JPATS personnel on the proper application and removal of all USMS restraints. Contract guards must demonstrate their proficiency to the satisfaction of USMS district and JPATS management.
- Receive training from district or JPATS personnel on the proper procedures and policies for conducting all USMS searches of a person, vehicle and other articles. Contract guards must demonstrate proficiency to the satisfaction USMS district and JPATS management.
- Contract guards must receive, review, and agree to comply with the current USMS use of force policy, and must certify to their knowledge of the policy

### **Firearms qualification:**

Categories 1 and 2 contract guards are exempt from USMS firearms qualifications if they certify in the Affirmation of Work Qualifications for contract guards that they are currently qualified and authorized to carry their duty firearm. Otherwise, the USMS is required to qualify Categories 1 and 2 contract guards in accordance with USMS firearms policy.

Categories 1 and 2 contract guards must have been qualified by their agency within the past 12 months and must re-qualify at least annually, thereafter. Otherwise, the USMS is required to qualify the contract guards in accordance with USMS firearms policy.

Categories 3, 4, and 5 contract guards are required to qualify in accordance with USMS firearms policy.

**USMS POLICIES AND PROCEDURES  
FOR OUTSIDE MEDICAL SERVICES**

1. District office is notified by the jail of need for outside medical care, at which point they determine whether they will authorize the treatment. If necessary, the district office should consult with the OIMS in making that determination.
2. District office prepares an authorization document and assigns a voucher number. The use of the USM-157 (requisition of goods and services) is not required for credit card buys or payments. However, in lieu of the USM-157 district offices are required to use some type of obligation form, i.e., Pre-Approval Form or Prisoner Medical Attention Notice, and maintain a written log or (PTS) computer file of all medical services. The log should contain a record of the log number, name, prisoner number, medical provider, date of service, services rendered, estimated cost, actual cost.
3. The prisoner is transported to the outside medical provider.
4. The outside medical provider, if possible, notifies the district office of what procedures will be performed and the estimated cost.
5. Upon determining the estimated cost of the medical care the district office must enter the obligated amount to the correct object code 1020 and sub-object code (2515 – hospital or 1154 - physician) for the assigned voucher number into the FMS.
6. District office receives and reviews the provider's medical invoice and billing statement, then verifies that the prisoner was in USMS custody during the service period.
7. District office forwards the invoice and billing statement to the contractor for re-pricing.
8. The contractor reviews, re-prices and processes the medical claim. If all documents are complete, the contractor attaches a re-pricing document listing the amount to be paid by the district to the invoice and billing sheet. These documents are returned to the district office for further processing and filing.

9. The district office pays the medical provider the amount listed on the re-pricing document (Treasury check or credit card).
10. The district office enters the re-priced expense in the FMS and adjusts the obligated amount.



## APPENDIX VIII

### USMS POLICIES AND PROCEDURES FOR CELLBLOCK OPERATIONS

The USMS has policies and procedures that cover medical situations encountered in the cellblock. These policies require that:

- If a prisoner in the cellblock needs emergency medical assistance, the local medical emergency service (EMS) will be immediately contacted. Each deputy will ensure that any prisoner with a medical emergency will be provided immediate medical assistance. Any prisoner who exhibits signs of illness or injury will be offered medical treatment.
- At least one sign will be posted in each cellblock advising prisoners how to request emergency medical assistance. The signs will be written in English and any other language prevalent in the geographic area. The signs should be posted in an area that the prisoners occupy.
- If a prisoner refuses transportation and/or medical assistance after complaining of illness or injury, the prisoner will be required to sign a USM-210 acknowledging a desire not to receive medical assistance.
- Deputy marshals will not diagnose ailments. However, the supervisory deputy marshal (SDUSM) will be informed when a deputy suspects a prisoner is exhibiting symptoms of TB.
- A first aid kit will be available in each cellblock and replenished as necessary. The SDUSM will inspect the first aid kit weekly to ensure it is adequately supplied and note the inspection in the cellblock activity log.
- Prescribed medications, except for nitroglycerin, found in the possession of a prisoner will be taken away while the prisoner is in the cellblock. If a medical professional confirms the prisoner requires medication while being housed at the cellblock, the prescribed medication will be issued by and taken in the presence of a deputy. Any remaining medication will be returned to the detention facility where the prisoner is housed in accordance with the facility's policy and procedure. Over-the-counter medications will not be provided to prisoners while housed in the cellblock.

**RE-PRICING CONTRACT WITH HEALTHNET, INC.**

The re-pricing contract establishes a centralized system to re-price medical claims incurred by the U.S. Marshals Service. The contractor re-prices all USMS medical claims according to Medicare rates and its preferred pricing schedules to determine the lowest cost to the USMS.

Effective November 29, 1999, the agency was granted legislative authority (PL 106-113, amended Title 18 U.S.C. §4006), to authorize the USMS to pay prisoner medical claims not to exceed the lesser of the Medicare or Medicaid rate.

Contractor Services

The contractor receives medical claims from the district offices and reviews them to determine if they are valid. Invalid claims are those claims that are: incomplete, duplicates, improperly submitted, illegible, or missing mandatory information.

The contractor then correctly re-prices all valid medical claims. These claims are re-priced in accordance with the Medicare Correct Coding and Payment Initiative Rules and Procedures (Public Law 101-239). The contractor provides and operates an automated processing system for re-pricing claims submitted by USMS district offices. The contractor also determines if their preferred pricing rates should be applied to generate additional savings for the USMS.

All processed claims are then returned to the sending district along with an explanation of benefits (EOB) for each claim and a district batch summary sheet. The districts then pay the medical care provider the re-priced amount. The contractor will also maintain automated records in a database to track savings and related USMS medical program data. The contractor also provides the districts and the OIMS with various reports in manual and electronic format in accordance with the contract.

If a sending district later finds that a processed claim should not be paid then it must also inform the OIMS and the contractor in writing of such changes so that the USMS claims database is accurate with regard to savings achieved.

## Contractor Reports

The contractor generates and sends a monthly transaction report to each district that lists all claims received and processed for that district.

### **Re-pricing Contractor Automated Reports**

The contractor shall furnish the USMS with required statistical information and reports. Each report will display the report period, the fiscal year, and be broken out by district on a separate sheet, and with a national summary page. Standard reports to be provided to the USMS include:

- (1) District batch summary report – Report shall display the district batch number, district name and number, date received, the prisoner's names, claim number, provider, and date of service. Valid and invalid (both incomplete and duplicate) claims shall be listed in separate sections of the report so that the sending district can follow up promptly on incomplete claims for resubmission.
- (2) Explanation of benefits for each claim.
- (3) Monthly prisoner transaction report (sorted and displayed by prisoner)  
Report will display the prisoner's names sorted first in alphabetical order and then sorted alphabetically by medical care provider, report columns will show prisoner name, prisoner number, provider, claim number, district batch number, date received to district, amount billed, Medicare amount, USMS allowed amount, amount saved, and percentage saved. Sub-totals of activity by prisoner and for each district will be displayed as well as a national summary sheet provided. This report will include only valid claims processed for the month.
- (4) Report will display the provider's names sorted.
- (5) Monthly report of invalid claims will contain two sections (one of incomplete claims and the second of duplicate claims submitted. Section 1 (incomplete claims) will display prisoner name and number, provider, claim number assigned, amount billed, description of missing information, date of service, date received by contractor and the district transmittal sheet number. Section 2 (duplicate claims submitted) shall be sorted first by district and then alphabetically by prisoner name. Report columns will display the prisoner name, prisoner number, original claim number, each of the dates a duplicate was received by contractor, date returned to district, provider, date of service and amount billed, the district transaction batch number.

- (6) Monthly hospitalization report (sorted and displayed first by the hospital and then by the prisoner), hospital, prisoner, total number of hospital days, DRG, amount billed, USMS allowed amount, amount saved, percentage saved. The reports will be broken out by district with a summary sheet with national totals.
- (7) Year to date reports.
- (8) Special reports.
- (9) Monthly invoice – Each month the contractor shall generate a master invoice for the OIMS broken out by district to reflect the number of patients, valid claims processed, invalid claims handled, amount billed, amount allowed, amount saved, and percentage saved.

The contractor shall also send a copy of the monthly transaction report, which reflects district activity for the month to each district. The monthly transaction report shall contain a certification block to be signed and dated by the district. The OIMS will require that each district promptly return a certified copy of the monthly transaction report summary to support payment to the contractor each month.

All inpatient hospital claims are independently priced and verified by the contractor at the correct DRG by using the Centers for Medicare and Medicaid Service's (CMS) approved pricing program to calculate the Medicare allowable cost. The contractor also applies any new Medicare pricing initiatives as soon as CMS mandates their implementation.

Once the proper DRG has been ascertained, the contractor uses a CMS approved Prospective Payment System to calculate 100 percent of the Medicare allowable cost.

The contractor shall review and date/time stamp all district batches of medical claims/transmittal sheets. The contractor shall review the batches to identify valid and invalid claims and enter all claims received and also have an automated mechanism in place to track and report on any duplicates received from the districts.

Valid claims are those submitted on a district transmittal sheet, on the proper CMS form, and contain at a minimum all the required information. It is the responsibility of the sending district to verify USMS prisoner custody and to ensure that all claims submitted for processing are complete and are not duplicates.

The contractor shall process and send back to the district for payment, all valid claims within five calendar days of receipt. An explanation of benefits (EOB) shall be completed for each valid claim processed.

Invalid claims are claims not submitted on the proper form or missing information considered mandatory. Duplicate claims will also be considered invalid. Information on invalid claims shall be reported back to the sending district in the district batch summary. All duplicate claims shall be stamped "duplicate" and returned to the district of origin with the district batch in which it was received.

## PROPOSED NATIONAL MANAGED CARE CONTRACT

The purpose of the proposed contract is to: 1) establish a nationwide integrated health care delivery system, including Preferred Provider Networks (PPN);<sup>43</sup> and, 2) process and pay medical claims consistent with the Medicare and/or Medicaid payment standards required by 18 U.S.C. §4006 as amended. A managed health care system would include negotiated contracts with medical facilities and providers, claims processing and payment, utilization review and quality management.

### Managed Care Network

The contractor would be required to establish a managed care network with community physicians, hospitals, and other ancillary services. These services provided to USMS prisoners would include dialysis, pharmacy discounts, optometry, ambulance, dental, skilled nursing facilities, and outpatient rehabilitation.

Also the contract would ensure that emergency services are available within each network site 24 hours a day, 7 days a week. Those services would be available at the hospitals or emergency care facilities that support the USMS's major use detention facilities.<sup>44</sup>

The contractor would be required to incorporate USMS Prisoner Health Care Standards, USMS administrative procedures, financial terms and rates, hospital affiliations, and USMS security requirements into all PPN provider agreements.

In some cases the PPN provider may choose to refuse to accept the provisions of Public Law 106-113 (Medicare or Medicaid). If the contractor determines that the particular provider specialty is essential the contractor should be required to have the provider agree to accepting rates approved by the USMS.

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<sup>43</sup> Hospitals, clinics and doctors who have agreements with the nationwide health care delivery contractor to service USMS prisoners.

<sup>44</sup> Major use facilities require an average in-mate population of four or more prisoners in the custody of a USMS district office.

A national health care contract will also enable the USMS to obtain preferred pricing<sup>45</sup> which will result in additional savings over and above the USMS allowed amount (Medicare or Medicaid).

Once the USMS allowed amount has been determined for each claim, the contractor will then review each claim to identify any additional savings that could be generated through preferred pricing. For example, a medical procedure is billed at \$10,000, but the Medicare rate for this claim is \$8,500. However, due to preferred pricing, the contractor is able to reduce the amount to be paid by the USMS to \$5,000.

In that case, the preferred pricing amount (\$5,000), not the billed amount or the Medicare rate, is determined to be the lesser amount and the revised USMS allowed amount. In the instance cited savings for the USMS above the Medicare amount would be \$2,500, less a percentage paid to the contractor for the cost savings provided.

The OIMS believes that the national health care contract would reduce USMS prisoner medical expenses by obtaining preferred pricing rates below Medicare or Medicaid, pharmacy discounts and other reduced rates.

### **Centralized Medical Claims**

The contractor would be required to establish an automated centralized medical claims system to process and re-price valid claims for medical care and supporting medical services provided to USMS prisoners in accordance with USMS allowed amounts.

The following is a listing of tasks and responsibilities that should be shared by the contractor, district office and the Office of Interagency Medical Services (OIMS) required to authorize, pay and manage prisoner outside medical claims.

- Prior authorization involves the assessment of appropriateness of a proposed service. The basic elements of prior authorization include: eligibility verification, benefit interpretation, and medical necessity review for both inpatient and outpatient services.
- The contractor shall provide toll-free phone support during regularly scheduled USMS working days to provide a means for districts and

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<sup>45</sup> Preferred pricing is a contract rate agreed by the preferred provider to be charged to patients covered by the USMS health care contractor.

detention facilities to request and receive authorization for medical treatment for USMS prisoners.

- The contractor would review for authorization all medical care with providers within their managed care networks and non-network providers with the exception of emergency services, inpatient stays and operative procedures, which will be reviewed by OIMS.
- The district will be required to verify that the prisoner was in USMS custody during the period of medical service. In addition, the district office should also be responsible for forwarding medical referral to the appropriate decision making entity (OIMS/Contractor).
- The contractor will identify and track medical claims that are disallowed according to the USMS prisoner health care standards and inform the OIMS, the district, and the provider.
- The contractor will receive, control and distribute claims and automatically assign an internal control tracking number for each claim.
- The contractor will match pre-authorization with the associated medical claim prior to payment, identifying, tracking and blocking duplicate, and invalid claims from being processed and tracking potential cases of fraud and abuse. The contractor will also track the allowed amount for medical services, e.g., type and number of claims re-priced at Medicare, Medicaid, local contract rates or Preferred Provider Network rates.
- Contractor provides accounts payable and financial management reporting.
- Contractor will track and report all cost savings generated by re-pricing and PPN discounts.
- Contractor will provide program reports, special or routine, i.e., cost or disease trends, jail, provider, and individual patient reports. The reports will be requested either nationally, by USMS district, or as specified by OIMS.

### **Utilization Review Program**

The Utilization Review (UR) program is designed to foster access to appropriate, quality and cost effective care for USMS prisoners. The review involves the assessment, evaluation, planning and implementation of health care services. The UR program provides a formal process that promotes



objective, systematic monitoring and evaluation of appropriate resources throughout the continuum of care.

Concurrent review is an assessment of on-going medical services to determine continued medical necessity and appropriateness of care. Case management is a process for the management of chronic medical/behavioral health conditions that includes unexpected catastrophic occurrences, as well as proactive management of anticipated medical management situations. Discharge planning is the coordination of a patient's continued care needs when discharged from the inpatient setting.

The OIMS is responsible for examining the utilization of inpatient services to assess medical necessity and appropriateness. As part of the concurrent review function, the OIMS should monitor and track the length of stay for all inpatient admissions. The contractor's database and website would provide direct automated support to OIMS to enable them to carry out this function.

**STATISTICAL SAMPLING MODEL**

The statistical sampling universe for our model was defined as vouchers submitted during FY 2002 for United States Marshal Service (USMS) prisoner medical services from 14 of the 94 USMS districts. The 14 districts selected accounted for 91.3 percent of the total dollar value of vouchers submitted. Our sample test results were projected only to the prisoner medical service activities in the 14 districts tested.

We used a random sampling method with stratified design to provide effective coverage of the units and to obtain precise estimates of the characteristics tested. Each unit was tested for multiple characteristics as discrete variables involving nominal measures. Statistical analysis was conducted on the test results of four variables. An explanation of the audit test results and relevance of the tests to the audit's objectives is provided in the body of the audit report. We present 95 percent confidence limits on the expected value of the proportions by using the formulae given at the end of this appendix.

From the universe of 6,525 vouchers, we selected as first stage sample units a random sample of 900 vouchers (an average of 64 vouchers per district). The random sample of 900 vouchers out of 6,525 provided a sampling fraction of 13.8 percent. From each of the randomly selected vouchers a random sample of up to 10 transactions (second stage sampling units) was tested. The sample test results were projected to the universe of transactions at the 14 USMS districts.

The table below provides the test results and projections for the random variables tested. Following the table are the mathematical model notations, and formulae used to compute the estimates of expected values and variances.

## Test Results Projections for the Random Variables Tested

Question (Variable Tested)	Answer (Results of Test)	Rate of Occurrence (%)	Projection at 95 Percent Lower Confidence Limit* (%)
1. Was the prisoner in USMS custody during the treatment?	Yes	94.5	
	No	0.2	0.19
	Unk	5.3	5.2
2. Was the transaction accurately recorded?	Yes	51.9	
	No	1.0	0.99
	Unk	47.1	47.0
3. Was the transaction fully supported?	Yes	67.8	
	No	27.3	26.9
	Unk	4.9	4.5
4. Were the procedures necessary?	Yes	69.7	
	No	3.3	3.1
	Unk	27.0	26.4

\*This is the most conservative projection at the 95 percent confidence level. In other words, the projected percentage is *at least* the percentage of occurrence present in the corresponding universe.

## Mathematical Model Notations and Formulae used to compute the Estimates of Expected Values and Variances

The mathematical model notations, and formulae used to compute the estimates of expected values, and the variances are as follows.

$H$  The number of strata

$N_h$  The number of units in the stratum  $h$ , where  $N = \sum_h N_h$

$n_h$  The number of units sampled from the stratum  $h$

$y_{hijk}$  Variable  $k$  corresponding to  $j^{\text{th}}$  selected item within the  $i^{\text{th}}$  sampled item from the  $h^{\text{th}}$  stratum

$$y_{hijkl} = \begin{cases} 1 & \text{If the randomly selected 2nd stage unit } j \text{ has value of} \\ & \text{the type } l \text{ for the random variable } k \\ 0 & \text{Otherwise} \end{cases}$$

$$\sum_l y_{hijkl} = 1 \quad \forall \quad h, i, j, k$$

$$y_{hikl} = \sum_{j=1}^{n_{hi}} y_{hijkl}$$

$p_{hikl}$  Sample proportion of hits of  $l^{\text{th}}$  type of the  $k^{\text{th}}$  variable in the  $i^{\text{th}}$  sampled item in  $h^{\text{th}}$  stratum

$$\hat{p}_{hikl} = \hat{y}_{hikl} = \frac{\sum_{j=1}^{n_{hi}} y_{hijkl}}{n_{hi}}, \quad \hat{p}_{hkl} = \frac{\sum_i p_{hikl} n_{hi}}{\sum_i n_{hi}}, \quad \text{and} \quad \hat{p}_{kl} = \sum_h \frac{N_h}{N} \hat{p}_{hkl}$$

To compute the variance of the estimate  $\hat{p}_{kl}$  the formulae used are as follows.

$$V(\hat{p}_{kl}) = \frac{1}{N^2} \sum_h N_h (N_h - n_h) \frac{s_L^2}{n_h}$$

Where  $s_L^2$  is the variance of lower level terms.

The 95 percent lower confidence limits on the estimate is given by

$$\hat{p}_{kl} \pm 2 * \sqrt{V(\hat{p}_{kl})}$$

26 JAN 2004



U.S. Department of Justice

United States Marshals Service

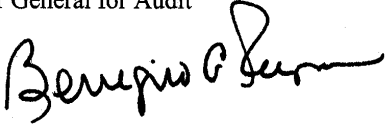
Office of the Director

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Washington, DC 20530-1000

January 16, 2004

MEMORANDUM TO: Guy K. Zimmerman  
Assistant Inspector General for Audit

FROM: Benigno G. Reyna   
Director

SUBJECT: Draft Audit Report - The United States Marshals Service's  
Prisoner Medical Care Program

The United States Marshals Service (USMS) appreciates the opportunity to review the Office of the Inspector General's draft audit report of the USMS Prisoner Medical Care Program. The USMS welcomes such external reviews as it gives the agency the opportunity to better assess the effectiveness of its programs and to improve them where appropriate.

Attached is our response to the audit with a discussion of each recommendation. Thank you for the opportunity to respond to this audit report.

Attachment

cc: Gary E. Mead  
Assistant Director  
Business Services Division

Broadine M. Brown  
Assistant Director  
Management and Budget Division

Sylvester E. Jones  
Assistant Director  
Judicial Security Division

Patricia Hanson  
Procurement Office  
Business Services Division

Charles Coburn  
Office of General Counsel

Isabel Howell  
Audit Liaison  
Management and Budget Division

Robert A. Whiteley  
Office of Finance  
Management and Budget Division

**USMS REVIEW OF OIG DRAFT RECOMMENDATIONS**  
**PRISONER MEDICAL CARE**

**I. USMS PROGRAM OVERVIEW**

It is important that the background against which this program functions and the numerous factors which influence its effectiveness also be stated for the record. Every day, the 94 United States Marshals Service (USMS) district offices face an enormous level of workload and unlike other law enforcement agencies, field managers must respond effectively and promptly to a number of entities (i.e., federal judiciary, U.S. Attorneys, defense counsels, members of Congress, state and local governments, Bureau of Prisons (BOP), Department of Homeland Security, as well as prisoners and their relatives).

The USMS shares the Office of Inspector General's (OIG) concern for adequate prisoner security but increases in workload make this problematic. During FY 2003, the USMS received 154,400 individuals into custody, produced 587,700 for court, and transported an additional 411,800 by air and ground transportation modes. In coordination with the Office of the Federal Detention Trustee (OFDT), the agency is responsible for managing an annual detention budget of more than \$800 million. Each year new federal law enforcement initiatives are funded that generate an ever increasing workload for the agency, however, only a small percentage of the new positions included in the President's budget for the USMS have been funded by the Congress.

During the past 5 years, the USMS average daily prisoner population grew by 53 percent (an increase of 15,300 new prisoners). Finding adequate detention space for such a large number of prisoners is a major challenge. Logistically, the district offices must locate detention bed space close enough to the 300 federal court cities to support the judicial process. Faced with such massive prisoner population increases, field staff have had to become increasingly dependent on guards to perform vital local transport functions.

The USMS also faces a national detention space crisis as it tries to find adequate bed space. There are only 3,618 jails in the United States. Currently, 63 percent of USMS prisoners are housed in state and local facilities. It is compelling to note that only 2.8 percent of these facilities are certified by the American Correctional Association and 12.5 percent are certified by the National Commission on Correctional Health Care (NCCHC). The districts' ability to track prisoner medical status is extremely limited as levels of medical care provided are determined by the attending physician of the jail. District staffs have no medical expertise. This situation is exacerbated by the lack of a centralized national prisoner database.

In spite of these program constraints, the USMS has done an outstanding job of developing and implementing an effective Prisoner Medical Program during the past 9 years. Not only has the agency developed and implemented extensive prisoner health care policies and procedures, it has managed to reduce prisoner medical costs by \$103,126,945 (see attached). Such significant savings have been generated by the establishment of a national prisoner medical claims processing system and the agency's success in obtaining passage of legislation for Medicare rates (Public Law 106-113) in November 1999. A major program success was achieved in 1999 when the USMS and Westchester County, New York, received the Department of Justice (DOJ), JustWorks Award for outstanding performance in developing a managed care network in the New York City area. This program success was made possible by taking an innovative interagency approach and obtaining vital technical support from the Department of Veterans Affairs (VA).

Throughout this process, the district offices have been directly involved in program development and steadfast in their support to implement procedural changes. While the USMS was able to partially implement the Medicare portion of this law through the use of a VA contractor, full compliance with this law is not possible until funding for a national managed care contract is provided. The USMS national managed care contract will also resolve a number of the OIG findings in this report.

It should be noted that the congressional conference language for the USMS, FY 04 appropriation, if enacted, will require the USMS to eliminate 85 administrative positions. This may adversely impact our ability to address the recommendations made in this audit report.

## **II. USMS COMMENTS ON OIG RECOMMENDATIONS**

### **1. Ensure that districts adhere to established procedures for authorizing, recording, and tracking outside medical procedures.**

**(a) Pre-Authorizations of Medical Procedures** - The USMS will instruct district staff to improve their communications with jail medical staff on outside medical care referrals. It is the position of the agency that the successful implementation of a national managed care contract will resolve this problem. Under the terms of the scope of work of this contract, all outside medical care will be preauthorized by the USMS contractor in coordination with the district offices and the Office of Interagency Medical Services (OIMS), Prisoner Services Division (PSD). The contract also requires creation of an interactive web site where districts will be required to concur, from a security aspect, on all preauthorized medical trips.

**(b) Recording of Financial Transactions in the Financial Management System (FMS)** - To the extent that this recommendation addresses the need for a consistent methodology for identifying, authorizing, recording and reporting medical expenses, the USMS concurs with



the recommendation. The Office of Finance, Management and Budget Division, will work with the district offices and OIMS to improve both the policies and procedures for recording and tracking these expenses.

To the extent that the recommendation refers to the different sub-object codes (SOC) used by district offices for recording guard costs associated with prisoner medical expenses, the USMS does not concur. The difference between SOC 1150 and SOC 2555 is based upon the nature of the procurement. SOC 1150 is a personal service contract between the USMS and the guard performing the service. As such, this person is considered an employee of the USMS for income tax purposes and is reported under object class 1100 for external reporting to the Office of Management and Budget. Guards paid under 2555 are contract guards working for a vendor who has a contract with the USMS to provide such guard services. Payments to these vendors are properly recorded under object class 2500. The nature of the underlying contractual relationship will dictate which sub-object class is charged.

(c) **Prisoner Tracking System (PTS)** - The USMS will instruct district staff to ensure that all required PTS entries are accomplished.

(d) **Prisoner Case Files** - The USMS will instruct district staff that prisoner case files (manual or paperless) must be properly maintained. In particular, the field will be reminded that completed copies of Forms USM 552 (Prisoner Medical Records Release Form) and USM 553 (Medical Summary of Federal Prisoner/Alien in Transit) must be maintained for each prisoner.

(e) **Federal Acquisition Regulations (FAR)** - As already presented to the OIG Audit Team, the USMS will be able to efficiently resolve field FAR compliance issues with the award and implementation of a national managed care contract. It should also be noted that prior to the Office of General Counsel's (OGC) issuance of the December 3, 1999, memorandum on District FAR noncompliance issues, PSD had already worked with the Procurement Office to establish on December 1, 1998, a special Administrative Officers' Advisory Group for the Procurement of Health Care Services. This group created a viable medical credit card program effective January 18, 2001, which greatly enhanced field FAR compliance with medical service acquisitions. This group also strongly recommended that a national managed care contract be established to resolve the remaining medical procurement issues.

**Estimated Date for Completion of Actions** - It is estimated that guidance for the field on audit compliance for items 1a-1d will be accomplished by February 27, 2004. Item 1e (FAR Compliance) will be subject to USMS receipt of the necessary resources to support this major initiative.

**2. Re-initiate operational reviews of USMS district offices.**

The USMS concurs with the OIG recommendation to re-initiate operational reviews of USMS district offices. The USMS is currently reviewing the position and staffing levels required to establish an Office of Inspections that would include an expansion of the responsibilities of the current Program Review Office. The proposal currently under consideration would include an increased emphasis on the operational aspects of the work performed in the districts and the Office of Inspections would be under the management of a GS-1811 Criminal Investigator.

**Estimated Date for Completion of Action** - The USMS will keep the OIG advised of its progress in re-initiating these reviews.

**3. Complete the on-going effort to negotiate a national managed health care contract for prisoner medical services that will remedy non-compliance with Title 18 U.S.C. 4006 and will effectively streamline the process.**

The USMS fully anticipates awarding a national managed health care contract this fiscal year. Over the past few years, the agency did take steps in order to improve performance on the procurement of health care for prisoners until the national health care contract could be established. The USMS has implemented both a medical services credit card program and a national medical claims program. Both have afforded the agency to go from zero compliance to partial compliance on procurement regulations until the national managed health care contract is fully implemented this year.

On January 21, 2003, the Department of Health and Human Services' PCS issued a Request for Proposals (RFP) for the national managed health care contract. The Technical Evaluation Board (TEB) has begun meeting and soon will be entering the final stages of its evaluation process. If funding from this year's Federal Prisoner Detention Account is approved by the Office of the Federal Detention Trustee (OFDT) for this project, then an award can be made and national implementation will begin in late spring.

The USMS would like it noted that the original legislation proposed in September 1998 by the USMS, and formally supported by Justice Management Division, DOJ, did **not** have a provision that medical payments "shall not exceed the lesser of the amount under the....Medicare....Medicaid program." Unfortunately, the legislative proposal was changed unexpectedly during the legislation process without input of the potential ramifications that such a change would have on the program office or the agency's resources needed to meet the new legislation.

The agency would also be concerned that the demand for only Medicaid rates may significantly result in the loss of a substantial number of medical care providers and a potential decline in the quality of medical care provided to prisoners. Physicians may refuse to treat USMS prisoners at Medicaid rates. In particular, medical specialists tend not to accept Medicaid rates for their specialized treatment.. If this occurs, most speciality medical care would then have to be obtained by visits to the Emergency Rooms which presents a significant security concern. In fact, the USMS is so concerned about the adverse impact of the current legislation that on December 20, 2002 it submitted a formal legislative proposal to DOJ to modify this law and delete the Medicaid requirement. It is the agency's belief that it would be more appropriate to utilize private industry with a performance based procurement (as the USMS national managed care contract is currently structured) to obtain rates below the Medicare pricing structure.

The USMS is concerned with the accuracy of the audit report's claim that the agency expended \$7 million more in medical funds than necessary. As confirmed in the exit interview, the amount was estimated using price averaging rather than a formal analysis of individual medical claims data.

**Estimated Date for Completion of Action** - Completion of this action will be subject to USMS receipt of the necessary resources to support this major initiative.

**4. Enforce current USMS policy regarding the use of prisoners' private insurance to cover the costs of outside medical care.**

The USMS will instruct district staff to ensure that the Form USM 552 (Prisoner Medical Records Release Form) is to be completed for all new prisoners at intake, a copy placed in the prisoner case file, and information on medical insurance is entered into PTS. It should be noted that in November 2001, OIMS conducted an informal survey of twelve districts (which represented approximately 42 percent of all USMS prisoners in custody) to determine the number of prisoners who might have medical insurance. The survey revealed that less than one percent (approximately 300 individuals of a population of 36,000 nationwide) might have such coverage. Even so, the position of the USMS is that any prisoner with medical insurance should be required to utilize that coverage as the financial benefits can be significant.

In an on-going high profile case in the Central District of California, OIMS and the district worked hard to enforce utilization of the prisoner's medical insurance to avert payment of approximately \$1.2 million in medical care costs for the USMS. This is an excellent example of the benefits and mutual support of OIMS working closely with the field offices on medical case management.

**Estimated Date for Completion of Action** - It is estimated that guidance for the field on audit compliance will be accomplished by February 27, 2004.

**5. Require that a management plan be created that ensures that deputy marshals are in compliance with cellblock health care policy and that they receive annual CPR and AED training in order to maintain certification.**

(a) **Prisoner Healthcare Policy Compliance** - The USMS will require that district management conduct a formal review of all USMS prisoner health care policy with the appropriate district staff and provide to headquarters written certification of full compliance with cellblock policy and procedures.

**Estimated Date for Completion of Action** - It is estimated that guidance for the field on audit compliance will be accomplished by February 27, 2004, and district certification of policy compliance completed by April 30, 2004.

(b) **CPR and AED Training** - The Judicial Security Division (JSD) will issue additional guidance to the field with regard to USMS policy on CPR and AED training.

**Estimated Date for Completion of Action** - It is estimated that a reminder for the field from JSD on USMS CPR and AED training requirements will be issued by February 27, 2004.

**6. Strengthen the jail inspection program by:**

(a) **Ensuring the districts comply with USMS policy requiring an annual jail inspection. The PSD should maintain an IGA database which includes the date of the last inspection.**

PSD has a database that records the current and future dates of all the jail inspections throughout the USMS. Currently, the USMS is working to update the system so reports can be generated to alert the districts that their jail inspections are due.

**Estimated Date for Completion of Action** - This database upgrade should be operational by the middle of 2004.

(b) **Ensuring that district employees assigned as jail inspectors attend inspection training, including refresher courses, that contains a module on prisoner medical care. Employees conducting jail inspections should receive performance evaluations that include jail inspections as a rating element.**

Jail Inspector training, otherwise known as Conditions of Confinement Training (CCT), has resumed as of June 2003. Two sessions have been conducted and three more are scheduled for 2004. A module on prisoner medical care is already included in the training. Refresher training will begin as soon as PSD is satisfied that all districts have an adequate number of

trained jail inspectors. Then, past jail inspectors will begin to attend the new training. The latter two sessions in 2004, May and August, will begin to include those inspectors who need refresher training.

With regard to changing rating elements for employees who hold the collateral assignment of jail inspector, these personnel are already evaluated on this duty as an element of their overall job performance. It is not necessary to separately evaluate the employee on a collateral duty.

**Estimated Date for Completion of Action** - Jail inspection training for all districts should be completed by the end of FY 2004.

**(c) Requiring U.S. Marshals to review and improve their current jail inspection requirements. The reports for prisoner medical services should be more detailed and include supporting documents. The assessment tools provided in the CCRS should serve as a guide in improving the reports.**

OFDT is currently working with BOP, USMS, and the Bureau of Immigration and Customs Enforcement (BICE) to improve the jail standards as well as the inspection process. PSD sees no need for more detailed medical service reports. Furthermore, the jail inspectors are not medical personnel and have limited medical knowledge. Any serious medical problems identified by district jail inspectors are to be referred to PSD for review.

**Estimated Date for Completion of Action** - Completion of this action will be determined by OFDT's completion of their interagency review of jail standards and the inspection process.

**(d) Requiring districts to follow up on all CCR findings at least three years after the review has been completed. USMS inspection reports conducted on jail facilities that have submitted corrective action plans should include certification by the jail inspector that the jail is in compliance with the plan.**

PSD is currently organizing a working group to review the CCR findings and coordinate action plans with district jail inspectors.

**Estimated Date for Completion of Action** - This project is planned for the summer of 2004.

**7. Ensure that USMS Deputy Marshals perform initial TB screening of the USMS prisoners that are housed in USMS district holding cells.**

The USMS will require that district management conduct a formal review of all USMS prisoner health care policy with particular emphasis on airborne infectious disease control (TB)

with the appropriate district staff and provide USMS Headquarters with written certification of full district compliance with USMS cell block policy and procedures. However, it should be noted that district staff have no medical expertise and rely appropriately on the attending physician at the local detention facility to conduct intake medical screening, record medical histories, and determine appropriate medical care for each prisoner.

USMS cellblock personnel are directed by current USMS policy only to “visually screen for symptoms of TB” and isolate any suspected case of active infectious airborne disease (i.e., TB, SARS, etc.). OIMS has requested that JDIS or an upgraded PTS contain an expanded prisoner medical module that would permit national tracking of compliance and infectious TB cases by OIMS staff. This module would also have a cellblock intake screen which gives the intake cellblock deputy a “checklist” of medical items to review with the prisoner which can be immediately documented in the system. Such an approach is more efficient and effective than paper documentation.

**Estimated Date for Completion of Action** - It is estimated that guidance for the field on audit compliance and district certification of policy compliance will be accomplished by April 30, 2004. Modification of current or planned USMS automated systems will depend upon resource availability.

**8. Ensure that all cases of active TB are reported directly to OIMS.**

The USMS will require that district management conduct a formal review of all USMS prisoner health care policy with particular emphasis on airborne infectious disease control (i.e., TB, SARS, etc.) with the appropriate district staff and provide USMS Headquarters with written certification of full district compliance with TB control policy and procedures.

**Estimated Date for Completion of Action** - It is estimated that guidance for the field on audit compliance and district certification of policy compliance will be accomplished by April 30, 2004.

**9. Require that prisoners' TB test dates and results be documented on the Form USM 553 Medical Summary of Federal Prisoner/Alien in Transit and entered into PTS, in accordance with USMS TB policy. Copies of the USM 553, either paper or electronic, should be maintained at the district offices.**

The USMS will instruct district staff to ensure that prisoner TB test dates and results are documented for each USMS prisoner on a Form USM 553 (Medical Summary of Federal Prisoner/Alien in Transit) by the appropriate local detention facility medical staff and those results are entered into PTS and a completed copy of the form maintained in the prisoner case file.

**Estimated Date for Completion of Action** - It is estimated that guidance for the field on audit compliance will be accomplished by April 30, 2004.

**10. Develop and implement a system to track and monitor active TB cases.**

OIMS has continued to request that funding for an additional US Public Health Service Officer be provided so that an Infectious Disease Control Officer position could be created to track and monitor prisoner airborne infectious disease cases. Without adequate medical staff in OIMS and a national automated prisoner tracking capability, the agency will have to continue to rely on district communications to OIMS by phone and fax.

As stated previously, district staff have no medical expertise and rely on the attending physician of the detention facility to determine the health care needs of prisoners and to communicate those needs (if outside medical care is required) to the U.S. Marshal. Active TB is a reportable disease (under state and federal law) which means that local or state health departments must report all active cases to the Centers for Disease Control (CDC).

The USMS strongly agrees that field staff are responsible for ensuring that access to adequate health care (especially emergency care) is provided to all prisoners in USMS custody. Current USMS prisoner medical policy clearly directs field staff to obtain all emergency medical care immediately by contacting their local "911" service. District staff will also facilitate non-emergency care provided outside of detention facilities if such medical needs are known by the district, in accordance with USMS Prisoner Health Care Standards, and are verified by the attending physician. District staff should immediately confer with district management and OIMS medical staff when they are unsure on how to proceed. OIMS also maintains a United States Public Health Service (USPHS) Medical Duty Officer available 24 hours a day to assist district offices. These policies have been in effect since 1999.

In an effort to work and coordinate with other federal agencies as well as local jails in the D.C. area, USPHS nurses from OIMS participate in monthly meetings of the Washington Metropolitan Council of Government Subcommittee on Correctional Health Care (COG). This Subcommittee ensures informal and face-to-face liaison with regional community and federal detention facility health care managers that house USMS prisoners. The meeting format includes a medical case study presentation and discussion to identify and manage chronic and infectious disease seen in the correctional community, bench marking, communication and implementation of process to improve shared health care issues and concerns. Medical topics that have been discussed include HIV/AIDS, specifically bridging the gap between incarceration and release, Diabetes, Smallpox, Anthrax, SARS, Palliative/End-of-Life Care for pre- and post- release individuals, and newly approved pharmaceutical agents. This valuable forum provides a cross-sectional look into the challenges that are faced in the D.C. area (Virginia, Maryland, and the District of Columbia), keeps the OIMS staff members abreast of emerging health care issues in

the detention community, and allows input and exchange from the USMS perspective on such issues as standards, formularies, transportation, costs and disease management as they relate to correctional health care.

It should also be noted that OIMS already receives approximately 2,000 medical cases for management and assistance from the field each year. As the USMS prisoner population continues to increase, medical case loads will grow dramatically as well as the pressure for receipt of additional OIMS medical resources.

**Estimated Date for Completion of Action** - Completion of this action will be subject to USMS receipt of the necessary resources to support this major initiative as well as completion of needed enhancements to existing USMS automated prisoner systems. The USMS remains firmly committed to ensuring that infectious airborne disease is adequately monitored and potential exposure to employees, other prisoners, and the public is prevented.

**11. Develop and implement a policy for tracking and monitoring of HIV/AIDS and Hepatitis cases.**

The USMS disagrees with this recommendation. The USMS relies on state and local jails, contract jails and BOP facilities to provide medical screening and medically necessary health services to USMS detainees. The USMS is not responsible for determining the medical status of its detainees. This responsibility falls on the attending physician at the facilities that house the detainees. The USMS is responsible for the costs of the medically necessary detainee health care that is ordered by the attending physician.

BOP has advised us that BOP correctional staff are not routinely provided information on the HIV status of inmates in BOP institutions. Such information is maintained in a separate inmate medical database, within the BOP's SENTRY system that is accessible only by BOP medical staff assigned to the BOP institution and BOP headquarters.

The National Commission on Correctional Healthcare (NCCHC) Standards for Health Services in jails recognizes that if a detainee is labeled HIV positive, the detainee may be placed at undue risk for compromised personal safety. The standards provide that, in a detention setting, "it is particularly important that the rules of physician/patient confidentiality regarding HIV test results and diagnoses of AIDS be followed." See 2003 NCCHC Standards, Position Statement on Administrative Management of HIV in Corrections, p.189. Thus, the privacy of this information should be protected where possible.

Consistent with NCCHC standards, USMS detainee HIV and Hepatitis information is disseminated on a "need to know" basis and is not routinely shared with USMS staff. All USMS staff have been formally instructed to use universal precautions, in accordance with CDC guidelines and USMS policy, with regard to the searching, production, and transport of all detainees. In our view, it is inappropriate for USMS law enforcement staff to attempt to



routinely diagnose, track, or document the HIV/Hepatitis status of USMS detainees except as otherwise required on a case-by-case basis.

**Estimated Date for Completion of Action** - No action is required.

12. **Ensure that guard contracts are effectively monitored by:**

**(a) Requiring that the COTR submit comprehensive guard contractor evaluations every six months. These evaluations should be thorough and should require documentation that supports the determinations and findings of the COTR.**

The USMS agrees that agency guard documentation management and training requirements for personal services guards need to be reviewed. As a result, PSD will establish a work group composed of members of field operations, field administration, PSD, and Procurement staff from the Business Services Division (BSD). The mission of this workgroup will be to review current USMS guard policy and procedures and oversee implementation of any modifications deemed necessary. In the interim, the USMS will require that district management conduct a formal review of the following priority program items and certify compliance:

(1) Ensure immediate and full compliance with the financial terms and all other conditions of all formal guard contracts currently in force.

(2) Comply with USMS training requirements for all guards.

**Estimated Date for Completion of Action** - The USMS guard work group should conclude their review and issue recommended corrective actions and policy changes by the end of the third quarter, FY 2004. Implementation will take place as soon as such policy changes have been approved and issued to the field and district management has had adequate time to implement needed changes.

With regard to the more immediate action items (guard contract terms and guard training), the USMS will require that district management conduct a formal review and provide USMS Headquarters with written certification of compliance by April 30, 2004.

**(b) Requiring that the COTR submit to the contracting officer, along with the contractor evaluation, a list of the district's active contract guards. This list should include identifying information, prior experience, and training.**

The USMS will instruct district management that formal evaluations and adequate documentation for formal guard company contracts must be maintained in accordance with current contract terms and conditions. Other OIG recommendations in this area will be considered by the USMS guard work group.

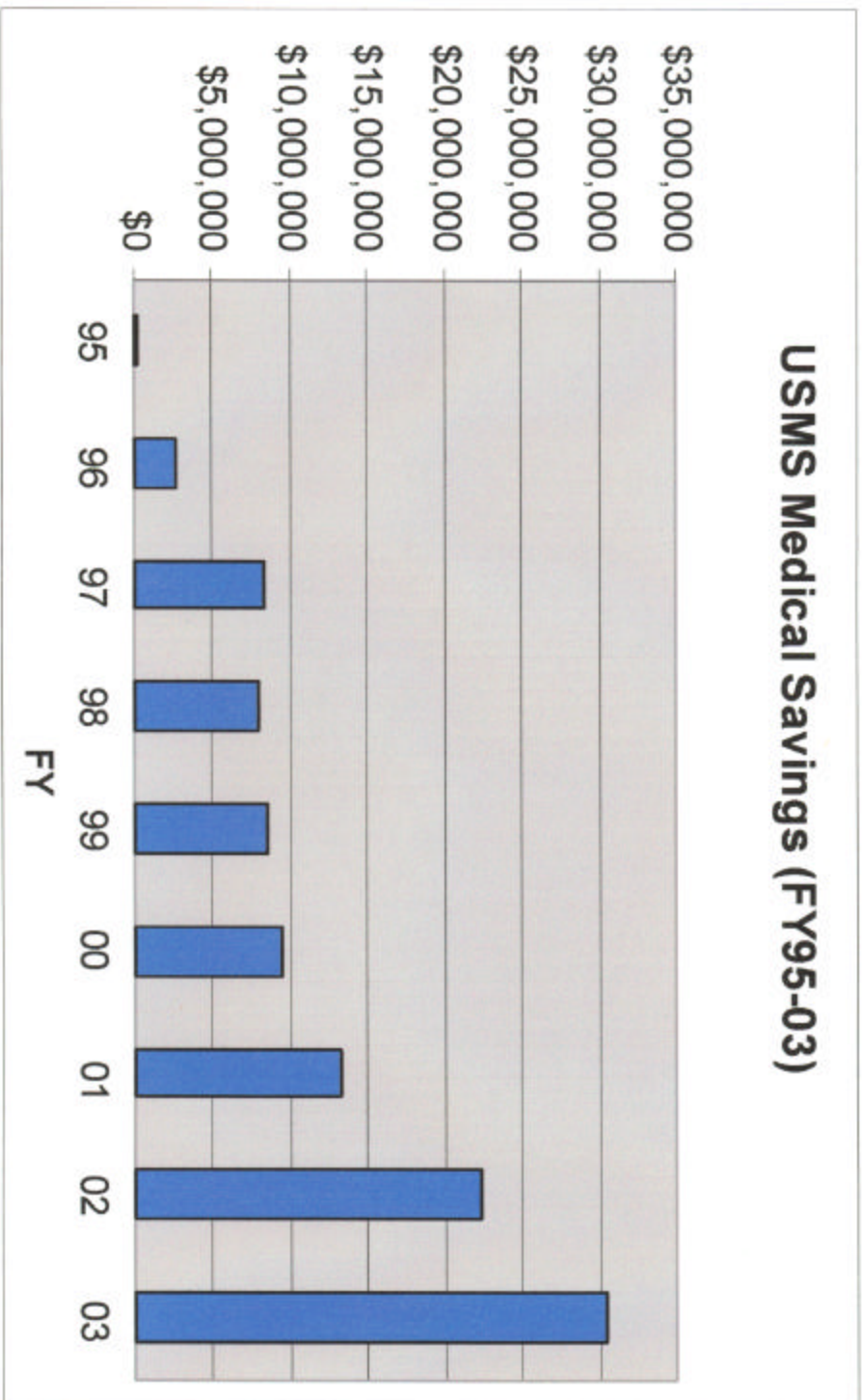
**Estimated Date for Completion of Action** - The USMS will require that district management conduct a review of all formal guard company contracts currently in force and provide written certification of compliance with contract terms and conditions by April 30, 2004.

**(c) Requiring that the COTR evaluations elements be included in the personnel ratings of USMS employees assigned as COTRS.**

All collateral duties are taken in to account when an evaluation is done on an employee.

**Estimated Date for Completion of Action** - No action is required.

### USMS Medical Savings (FY95-03)



Data Source: Health Net Medical Claims Database  
Date: December 30, 2003

SMS PRISONER MEDICAL SAVINGS FY 1995-PRESENT

JIMS MEDICAL SAVINGS GRAND SUMMARY REPORT - Dated November 17, 2003																																				
FY 2003 - October, 2002 through September, 2003																																				
FISCAL YR	ORIGINAL OIMS FIELD SPT	CENTRALIZED HOSPITAL SAVED	FIELD REPORTED SAVINGS	NYC MANAGED CARE NETWORK	HEALTHNET VA MEDICAL CLAIMS NATIONAL SYSTEM	GRAND TOTAL SAVINGS																														
1995	\$185,852	\$0	\$0	\$0	\$0	\$185,852																														
1996	\$1,526,336	\$0	\$0	\$1,193,241	\$0	\$2,719,577																														
1997	\$3,440,541	\$0	\$0	\$4,816,417	\$0	\$8,256,958																														
1998	\$3,378,394	\$0	\$0	\$4,647,919	\$0	\$8,026,313																														
1999	\$2,772,404	\$0	\$0	\$5,656,213	\$0	\$8,428,617																														
2000	\$281,279	\$5,769,583	\$1,706,903	\$1,627,535	\$0	\$9,385,300																														
2001	\$0	\$8,462,031	\$3,322,446	\$0	\$1,463,097	\$13,247,574																														
2002	\$0	\$1,623,786	\$491,659	\$0	\$20,231,900	\$22,347,345																														
2003	\$0	\$0	\$0	\$0	\$30,529,410	\$30,529,410																														
TOTAL	\$11,584,806	\$15,855,400	\$5,521,008	\$17,941,324	\$52,224,407	\$103,126,945																														
<table border="0" style="width:100%"> <tr> <td style="width:33%;"></td> <td style="width:33%; text-align:center">Actual Cost</td> <td style="width:33%;"></td> </tr> <tr> <td></td> <td style="text-align:center">Per Claim**</td> <td style="text-align:center">VISN Fee</td> </tr> <tr> <td></td> <td style="text-align:center">FY 2002</td> <td style="text-align:center">FY 2002</td> </tr> <tr> <td></td> <td style="text-align:center">FY 2003</td> <td style="text-align:center">FY 2003</td> </tr> <tr> <td></td> <td style="text-align:center"># Claims Processed</td> <td style="text-align:center">Armt Paid Healthnet</td> </tr> <tr> <td></td> <td style="text-align:center">30,031</td> <td style="text-align:center">\$676,397</td> </tr> <tr> <td></td> <td style="text-align:center">42,874</td> <td style="text-align:center">\$866,524</td> </tr> <tr> <td></td> <td></td> <td style="text-align:center">\$22.52</td> </tr> <tr> <td></td> <td></td> <td style="text-align:center">\$20.21</td> </tr> </table>											Actual Cost			Per Claim**	VISN Fee		FY 2002	FY 2002		FY 2003	FY 2003		# Claims Processed	Armt Paid Healthnet		30,031	\$676,397		42,874	\$866,524			\$22.52			\$20.21
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		\$20.21																																		

Data Source: Health Net Medical Claims Database

Date: December 30, 2003

12/31/02 BUDGET SUBMISSIONS FOR FY 2000 THROUGH FY 2004

SUBMITTED 1998  
 FY 2000 - BUDGET REQUEST/INITIATIVE (000) USMS DOJ OMB President's Budget

\$75 - District Prisoner Medical Case Management 1 Approved  
 1 USPHS Position  
 \$1.5M - Medical Claims System Approved  
 1 USMS ADP Specialist Position  
 \$340 - National Managed Care Training Approved  
 \$1M - Telemedicine Initiative Approved

1999  
 FY 2001 - BUDGET REQUEST/INITIATIVE (000)

1.5M - National Managed Care Network Management 8 USMS Positions Approved  
 \$340 - National Managed Care District Training Approved  
 \$75 - Prisoner Medical Inpatient Preauthorizations 1 USPHS Position Approved  
 \$1.5M - Medical Claims System 1 USMS ADP Specialist Position Approved

2000  
 FY 2002 - BUDGET REQUEST/INITIATIVE (000)

\$1.5M Develop National Managed Care Network Approved  
 \$485 - Managed Care and District Support 1 USMS Position - Financial Analyst Approved  
 \$1.9M - 9 USMS Positions - Managed Regional Care Coordinators located district offices Not approved

SUBMITTED

2001

FY 2003 - BUDGET REQUEST/INITIATIVE (000)

\$10M - 5-Year National Managed Care

Contract Cost & 6 USMS Positions

\$340 - Medical Case Management Initiative

4 USPHS Positions

\$170 - Infectious Disease Initiatives/Coordination

2 USPHS Positions

\$170 - Quality Assurance for Jail Medical Services

2 USPHS Positions

President's

Budget

\$675,000

\$5.3M Managed

Care Contract

OFDT

\$5.3M Managed

Care Contract

USMS

DOJ

OMB

Not approved

Not approved

Approved

Approved

\$1.3M

Not approved

Not approved

Approved

Not approved

Not approved

Not approved

Not approved

Approved

Not approved

Not approved

Not approved

Not approved

Approved

Not approved

Not approved

Not approved

Not approved

SUBMITTED

2002

FY 2004 - BUDGET REQUEST/INITIATIVE (000)

\$183 - Management of Prisoner Inpatient Care

2 USPHS Positions

\$16 - Quality Assurance for Managed Care Network

2 USPHS Positions\*

\$1.5M - National Prisoner Medical ADP System

\$627 - District Prisoner Medical Support

6 USPHS Regional Positions

Not approved

Not approved

Not approved

Not approved

Not approved

Not approved

Not approved

Not approved

Not approved

Not approved

Not approved

Not approved

Not approved

Not approved

Not approved

Not approved

Not approved

Not approved

Not approved

Not approved

Not approved

Not approved

Not approved

Not approved

Not approved

Not approved

Not approved

Not approved

Not approved

Not approved

-Does not include salary

## APPENDIX XIII

### ANALYSIS AND SUMMARY OF ACTIONS NECESSARY TO CLOSE REPORT

The USMS response to the audit (Appendix XII) describes the actions taken or planned to implement our recommendations. Our analysis of the USMS's response to specific recommendations is provided below. In addition to responding to the recommendations, the USMS made a number of claims in the program overview section of its response to which we first respond.

We recognize the challenges that the USMS faces in confronting the increases in prisoner population and its effect on day-to-day operations. However, these challenges do not absolve the USMS of its responsibilities to provide adequate prisoner medical care, especially with regard to areas concerning public safety. Further, we question the validity of the arguments put forth by the USMS to explain its lack of compliance with federal regulations, as well as its own policies and procedures.

Among the mitigating factors cited, the USMS stated "field staff have had to become increasingly dependent on guards to perform vital local transport functions." We agree the use of guard services for prisoner handling can be problematic if not managed properly, and indeed it was one of the problems cited in our report. But the use of contract guards should not in and of itself have any bearing on whether the USMS meets its commitments with regard to prisoner medical care.

In addition, the USMS stated that district personnel have no medical expertise and that operations suffer from the lack of a centralized national prisoner database. However, we noted that a number of districts we reviewed had deputies on staff who are trained and certified as Emergency Medical Technicians (EMT). Also, while we agree the USMS needs a centralized national prisoner database, the problems we encountered in the tracking and monitoring of TB, for example, would not have been affected by the existence of such a database because the districts were not maintaining the required data either manually or electronically.

The OIG report does not minimize the strides that the USMS has made with regard to cost savings in medical billings resulting from implementation of the claims processing contract with Healthnet and the development of the managed care network in the New York City area in cooperation with the Department of Veterans Affairs. In fact, both of these initiatives are mentioned in our report. However, while the USMS claims success in obtaining passage of Public Law 106-113, it has yet to become compliant

with the legislation regarding the payment of medical services at the lesser of Medicare or Medicaid rates. In addition, while we note the USMS's efforts in developing prisoner health care policies and procedures, their successful implementation has been problematic, as indicated throughout this report. For example, USMS guidance on documenting the incidence of TB in the districts was almost universally disregarded. Further, the USMS had failed to implement its September 2002 draft policy on prisoner health and emergency care in a timely manner. The policy was still in draft at the time this report was issued to the USMS for comment in November 2003.

In summary, the OIG recognizes the need to view program functions within the context of an agency's overall mission. In the case of the USMS, we understand the challenges associated with an increasing workload placed upon their workforce. However, the information provided in the program overview section of the USMS response, while informative, does not mitigate or undermine our findings, nor does it justify delays in the implementation of corrective actions.

#### **Recommendation Number:**

1. **Resolved.** In its response, the USMS stated that it would disseminate guidance to the field by February 27, 2004, regarding the authorization, recording, and tracking of outside medical procedures. The OIG has no problem with the USMS using different sub-object codes for company guards and personal service contract guards, as long as the districts are consistent in their approach. This was not the case in at least three districts, where payments for personal service contract guards were recorded under the sub-object used to track payments for guard company contract guards. We also note that establishment of a national managed care contract should address the administrative problems encountered with regard to pre-authorization and FAR violations. In the interim, however, the USMS needs to address all of the weaknesses identified in this report. In order to close this recommendation, please provide to the OIG copies of all procedural guidance disseminated to the districts in response to this recommendation pertaining to the authorization, recording, and tracking of outside medical procedures by March 12, 2004.
2. **Resolved.** The USMS stated that it would re-initiate operational reviews of USMS district offices and is currently reviewing a proposal to establish an Office of Inspections. It has now been nearly four years since the USMS suspended "periodic" reviews of district operations. The USMS should develop interim action to be taken in the event that its proposed Office of Inspections cannot be established



within a reasonable timeframe. In order to close this recommendation, please provide to the OIG by March 12, 2004, a definitive timeframe for the re-establishment of operational reviews.

3. **Resolved.** In its response, the USMS stated that it anticipates awarding a national managed health care contract in fiscal year 2004. In order to close this recommendation, please notify the OIG upon the successful conclusion of contract negotiations and provide to the OIG a copy of the signed contract. With regard to USMS non-compliance with legislation requiring payment for medical services at the lower of Medicaid or Medicare rates, USMS management disputed the accuracy of the report's "finding" that the agency expended an estimated \$7 million more in medical funds than necessary, and suggested that the estimate is overstated or inflated. To the contrary, we believe that the estimate is conservative based on the fact that the Medicaid rates in the states with the largest share of medical costs were less as a percentage of Medicare rates than the 81 percent overall average used in our analysis. Medicaid rates in California and New York, for example, which accounted for over 30 percent of total outside medical costs, averaged 65 and 78 percent of Medicare rates respectively. In all likelihood, the formal state-by-state analysis alluded to in the USMS's response would have yielded an even greater estimate of potential cost savings. While the OIG understands the concerns voiced by the USMS over enforcement of the current legislation, the USMS should achieve compliance with the law, particularly given the cost savings attainable, or obtain appropriate legislative relief.
  
4. **Resolved.** The USMS stated that it would disseminate guidance to the field by February 27, 2004, regarding the use of prisoners' private insurance to cover the costs of outside medical care. It also stated that only a small number of prisoners have private insurance. Yet, the instances noted in our report and by the USMS in its response indicate that the benefits of enforcing utilization of prisoners' medical insurance outweigh the minimal administrative efforts required. In order to close this recommendation, please provide to the OIG copies of all procedural guidance disseminated to the districts in response to this recommendation by March 12, 2004.

5. **Resolved.** In order to close this recommendation, please provide to the OIG by March 12, 2004, copies of procedural guidance disseminated to the field regarding cellblock health care policy and CPR and AED training.
  
6. **Unresolved.** Part (a) is resolved and can be closed when the USMS notifies the OIG that it has completed its database upgrade. Part (b) is resolved and can be closed when the USMS provides a copy of the training module pertaining to jail inspections and notifies the OIG that jail inspection training for all districts has been completed. In addition, please provide to the OIG a copy of the language in the current performance evaluations addressing deputy marshal performance as jail inspectors. Part (c) is unresolved. As pointed out by the USMS in its overview section, only 2.8 percent of state and local facilities are certified by the American Correctional Association and only 12.5 percent are certified by the National Commission on Correctional Health Care. Statistics such as these illustrate the need for greater scrutiny of jail operations by the USMS. The quality of jail inspections we reviewed varied considerably from district to district, with the majority lacking meaningful detail. However, there are USMS districts that can serve as an example of how to complete well-documented jail inspections, such as Eastern California and the El Centro sub-office. The USMS needs to assess all of its jail inspection reports and require the same thoroughness and attention to detail from all districts that it currently receives from a few districts. In order to resolve part (c) of this recommendation, please provide the OIG by March 12, 2004, with plans to review district jail inspections and provide guidance on the minimum level of testing required to adequately complete a jail inspection. Part (d) is resolved and can be closed when the USMS provides the OIG with the results of the PSD working group. Please provide specific plans of action and timetables by March 12, 2004.
  
7. **Resolved.** The USMS stated that it would disseminate guidance to the field regarding prisoner health care policy and airborne infectious disease control (e.g., TB, SARS), and require district certification of policy compliance by April 30, 2004. While we recognize that district personnel are not medical experts, we note that many individuals are acquiring medical knowledge through AED and CPR training. In addition, a number of the USMS districts we reviewed had deputies on staff trained and certified as Emergency Medical Technicians. Until the USMS implements an automated system capable of national tracking of infectious TB cases, the USMS must use paper or computer-based documentation (spreadsheet or other mechanisms) to document

compliance with visual screening of TB symptoms and isolation of suspected infectious airborne disease cases such as TB and SARS. In order to close this recommendation, please provide to the OIG copies of procedural guidance to the field regarding cellblock policy and procedures, a summary report of written certification of full compliance by districts, and a definitive timeline for modification of USMS automated systems by May 7, 2004.

8. **Resolved.** The USMS stated that it would disseminate guidance to the field on prisoner health care policy and airborne infectious disease control by April 30, 2004. In order to close this recommendation, please provide to the OIG copies of procedural guidance to the field with regard to TB control policy and procedures, and a summary report of written certification of full compliance by districts by May 7, 2004.
9. **Resolved.** The USMS stated that it would instruct district staff concerning documentation of TB test dates and results on Form USM 553, as well as entering the test dates and results into the PTS by April 30, 2004. The USMS must also direct staff to maintain either a completed copy of the form in the prisoner case files or, in the absence of these files (paper or electronic), a scanned copy of the form. In order to close this recommendation, please provide to the OIG copies of all instructions provided to the districts in response to this recommendation concerning the documentation of TB test dates and results by May 7, 2004.
10. **Resolved.** The USMS stated that it would continue to rely on districts to report active TB cases to OIMS by phone and fax until the USMS is able to hire an additional U.S. Public Health Service Officer position as an Infectious Disease Control Officer at the national level. This individual will track and monitor prisoner airborne infectious disease cases. The USMS added that it does not currently have a national automated prisoner database system to track and monitor prisoner airborne infectious disease cases. We note that the USMS's TB policy requires districts to report all cases of active infectious TB to the OIMS. Given the severe health consequences, we believe it would not burden the OIMS to document and compile this information. In order to close this recommendation, please develop a computer-based system, such as a spreadsheet or other mechanism, at the OIMS to monitor and track active TB cases reported by phone, fax, or pager and provide copies to the OIG of plans describing this system by May 7, 2004. In addition, please notify the OIG about the prospects for funding of the Public Health position by the same date.

11. **Unresolved.** The USMS stated it disagrees with this recommendation, citing reliance on detention facilities for medical screening and necessary prisoner medical care from attending physicians as the reason that it should not develop and implement a policy for tracking and monitoring HIV/AIDS and Hepatitis cases. As earlier stated and acknowledged by the USMS in its overview, only a small percentage of the local jails that the USMS claims to place full reliance on for medical screening and medical care are certified by the ACA or the NCCHC. Further, there is some inconsistency in the USMS's position on this issue given that it currently has policies and procedures in place for tracking and monitoring TB, and has thus acknowledged the need to track and monitor the incidence of communicable diseases. The CDC underscores that the issue of HIV, in particular, is not readily separable from that of TB. The CDC further points out that individuals with weakened immune systems typical of HIV infection are more likely to develop active TB. Notably, the Eastern District of California has already incorporated the relationship between HIV/AIDS and TB into its local training curriculum. We believe that the USMS cannot afford to ignore the connection between TB and HIV because the CDC has reported outbreaks of TB in HIV-infected inmates, including one outbreak in South Carolina during 1999-2000 and another in California during 1995-1996. The Joint United Nations Program on HIV/AIDS stated, "Worldwide, TB is the leading cause of death among people infected with HIV." The problem with the USMS relying on local jails to provide medical screening is that according to the NCCHC report to Congress, dated May 2002, no major jail systems have a mandatory testing policy of inmates for HIV.

With regard to the confidentiality issues cited in the USMS response, the Bureau of Justice Statistics (BJS) reported that the BOP tests all inmates for HIV at the time of release. The BOP also tests a random sample of inmates for HIV on alternate years. While the USMS stated that the BOP said that it does not routinely inform its guards about the HIV status of prisoners, we do not believe that the BOP practice is a suitable excuse for not reviewing the health status of USMS prisoners. In addition to testing at the federal level, the BJS Bulletin, HIV in Prisons, 2000, dated October 2002, listed 19 state prison jurisdictions, including Colorado, Michigan, and New Hampshire, that test all incoming inmates. Fifteen state prison jurisdictions also test inmates in high-risk groups. The USMS also raised concerns regarding the issue of confidentiality of HIV status information. However, this is a legal matter decided differently by each state. The issue also is highlighted in the NCCHC Standards for Health Services in Jails: "since the legal status regarding the confidentiality of such information

varies from state to state and from time to time, the facility should keep informed of any changes enacted by legislatures or determined by the courts." In order to resolve this recommendation, please provide to the OIG plans to implement a system for tracking and monitoring HIV/Hepatitis status of USMS prisoners while in the custody of the USMS, similar to that of the current policies and procedures covering management of TB, by May 7, 2004.

12. **Resolved.** Part (a) is resolved and can be closed upon notification that the USMS has implemented corrective actions and policy changes arising from its guard work group. In the interim, please provide the OIG with documentation certifying district compliance with guard contract terms and guard training requirements by May 7, 2004. Part (b) is resolved and can be closed when the USMS provides to the OIG verification that all districts have reviewed all formal guard company contracts and provided written certification of compliance with contract terms and conditions. Please provide the aforementioned by May 7, 2004. Part (c) is resolved. The USMS states that collateral duties are taken into account when an evaluation is done on an employee. In order to close this part of the recommendation, please provide to the OIG by May 7, 2004, the current performance evaluation elements that specifically address COTR performance.