DEPARTMENT OF JUSTICE | OFFICE OF THE INSPECTOR GENERAL

MANAGEMENT ADVISORY MEMORANDUM

22-113

SEPTEMBER 2022

Notification of Concerns Resulting from Multiple Office of the Inspector General Reviews Related to the Federal Bureau of Prisons Strategy for its Medical Services Contracts

AUDIT DIVISION

September 26, 2022

Management Advisory Memorandum

To: Colette S. Peters
Director
Federal Bureau of Prisons

From: Michael E. Horowitz
Inspector General

Subject: Notification of Concerns Resulting from Multiple Office of the Inspector General Reviews Related to the Federal Bureau of Prisons Strategy for its Medical Services Contracts

The purpose of this memorandum is to advise you of longstanding issues that the Office of the Inspector General (OIG) continues to identify in our work related to the Federal Bureau of Prisons' (BOP) contracts supporting its mission-critical medical functions that allow it to fulfill its obligation to inmates of providing services consistent with accepted corrections community standards.

In fiscal year 2021, the BOP spent over $700 million on medical contracts to address the needs of over 150,000 inmates. OIG audits, reviews, and investigative activities have repeatedly observed the following deficiencies in the BOP's planning, administering, and monitoring of medical contracts: (1) not establishing a framework for performance monitoring, including methods for appraising the quality of the services received; (2) weaknesses in acquisition planning related to inadequate communication and collaboration between the BOP's acquisition office and its institutions, including the acquisition office not leveraging healthcare utilization and pricing data; and (3) weaknesses in contract administration related to Contracting Officer's Representative (COR) delegation, as well as review and approval of medical payments. These deficiencies have led to inefficient management, suboptimal contractor performance, and ultimately, a waste of taxpayer dollars.

This memorandum is based on the work of 11 audits and reviews that the OIG has performed since 2016. Those reviews resulted in 52 recommendations for BOP action. The BOP has made progress towards improving its controls over the specific contracts involved in these reviews and subsequently closed 29 recommendations, leaving 23 remaining open. However, we continue to find similar issues in subsequent reviews involving other contracts, demonstrating that BOP needs a strategic approach to address these recurring deficiencies system-wide. This memorandum is intended to highlight those trending areas within BOP contract management in which we continue to identify deficiencies that need remedial efforts to be instituted for ongoing and future contracts.

We are providing this memorandum to highlight our concerns that we believe require the BOP's concerted attention and recommend that the BOP develop and execute a medical services procurement and oversight strategy that addresses the factors discussed in this memorandum.

Background

The BOP relies on service contracts to provide medical care for inmates that the BOP staff cannot provide. The BOP awards medical services contracts that are intended to provide inmates necessary professional and facility services for both inpatient and outpatient care. The contracting officials at the BOP's Field Acquisition Office (FAO) in Grand Prairie, Texas are responsible for awarding large-scale medical services contracts that exceed the Simplified Acquisition Threshold for inmates housed in BOP institutions.[1] While officials at the FAO initially awarded the BOP's procurement for medical services provided to inmates housed in residential reentry centers (RRC) and home confinement, the BOP's Central Office acquisition staff is currently responsible for awarding medical services contracts for those inmates. The Health Services staff, with the FAO staff's assistance, is responsible for conducting acquisition planning based on the needs and requirements of their respective institutions, while the Reentry Services Division (RSD) is responsible for acquisition planning for the RRCs and home confinement.

As we have also noted in our reports and management advisory memoranda, contributing to the BOP's challenge in controlling its medical costs is the fact that the BOP is the only federal agency providing healthcare services that does not have legal authority to set its reimbursement rate, which other agencies generally set as the Medicare rate.[i] In addition, as we have also reported on, BOP does not have access to pharmaceutical drugs at the discounted rates that are available to four other federal agencies: (1) the U.S. Department of Defense; (2) the U.S. Department of Veterans Affairs; (3) the Indian Health Service; and (4) the U.S. Coast Guard.[ii] Given these costs and environment, the BOP needs to establish a robust and comprehensive strategy to adequately plan, administer, and monitor its medical services contracts. However, since 2016, the OIG has found several instances of the BOP paying excessive costs for healthcare of unknown quality due to its inadequate performance monitoring and contract administration.

[1] As of February 2020, the Simplified Acquisition Threshold is $250,000. Additionally, while the majority of the BOP's medical services contracts are institution-based, the BOP also contracts with vendors for medical services provided to inmates located in residential reentry centers and home confinement.

Performance Monitoring

Elements of Proper Contractor Surveillance and Quality Assurance
Shared Quality Assurance responsibility between the BOP and each contractor
BOP ensures services meet contractual quality and performance requirements
BOP prepares quality assurance plans in conjunction with contract SOW
BOP completes reports in CPARS for awards exceeding the Simplified Acquisition Threshold

Source: FAR and BOP policy

Quality assurance is an essential contract oversight activity and is the responsibility of both the contractor and the BOP. More specifically, the contractor is responsible for providing quality services timely to meet the BOP's needs, while the BOP is responsible for ensuring that the services and products received meet the contractual quality and performance requirements. To ensure that the government and contractor meet these obligations, the Federal Acquisition Regulation (FAR) Subpart 46.4, Government Contract Quality Assurance, requires the development of a quality assurance surveillance plan (QASP) that specifies the work requiring surveillance and the method of surveillance. The FAR also instructs that the QASP be prepared in conjunction with the statement of work (SOW).

However, we found in multiple audits that the BOP did not properly monitor and assess the services received to fulfill medical services contracts. Specifically, we found several instances where the BOP did not establish performance metrics and performance monitoring processes that identified all work requiring surveillance and the method of surveillance, which could have been accomplished using a QASP or QASP equivalent. Without incorporating these well-established monitoring tenets, the BOP could not ensure it received quality services timely that met all contract requirements. For example, in our September 2019 audit of a comprehensive medical services (CMS) contract awarded to Correct Care Solutions, LLC (CCS) for the Federal Correctional Complex in Coleman, Florida (FCC Coleman), we found that the BOP did not establish a QASP to monitor contractually required services and thus could not ensure the services provided met contract requirements.[iii] Additionally, in our March 2022 audit of CMS contracts awarded to the University of Massachusetts Medical School (UMass) for three BOP institutions, we found that the BOP did not have a reliable, consistent process to evaluate the timeliness of inmate healthcare or the quality of the care inmates received.[iv] Finally, in our September 2022 audit of medical services procurements awarded to NaphCare, Inc. (NaphCare), we found that the BOP did not properly monitor and assess the services received under the awards we reviewed, and found that the BOP did not ensure it received quality, timely services that met all award requirements.[v]

In response to an August 2022 draft of this memorandum, the BOP responded that it has mechanisms in place to track certain dates and assess timelines of care. Further, in its most recent response for the open recommendations in the UMass audit, the BOP represented to us that it used these mechanisms to monitor healthcare and provided us reports generated from its electronic medical records system both at the institution level and the regional level to support its monitoring. However, we reviewed this documentation and, as relayed to BOP in our July 2022 response for the UMass audit, the reports do not include information on established milestone dates, actual completion date of each milestone, or associated causes of delays and steps taken to address them. Additionally, no documentation was provided to ensure the milestones were monitored. As a result, we could not conclude that the BOP has a consistent, reliable process in place documenting this monitoring.

In fulfilling their contract monitoring role, BOP staff must also enter performance information into the Contract Performance Assessment Reporting System (CPARS), which is critical to ensuring that the federal government only does business with companies that provide quality products and services. The FAR and BOP policy require that the BOP collect and submit contractor performance information for contracts that exceed the Simplified Acquisition Threshold into CPARS at least annually.[2] In both the CCS and NaphCare audits discussed previously, we found that the BOP did not always enter timely and accurate contractor performance information into CPARS. Not entering information into CPARS, combined with the fact that each institution separately manages its own contracts for medical services, creates a significant risk that the BOP may enter into contracts with poor performing medical service providers.

In July 2020, the OIG issued a Management Advisory Memorandum to Department leadership on systemic issues related to the DOJ's contract management, which applied to all DOJ components.[vi] One of the areas of concern related to insufficient quality assurance practices. The OIG recommended that the Department develop policy or implement procedures to ensure that contractor performance evaluations are completed, accurate, and entered into CPARS in a timely manner. The risks of insufficient quality assurance practices are particularly weighty in the context of medical contracts, given that the BOP depends on these contracts to provide essential medical care to inmates.

Given the risks we have found, the BOP should develop performance metrics, such as those that would have been included in a QASP, for medical service contracts to guide contracting officials in establishing performance-based monitoring activities to evaluate contractor performance and report on such performance in CPARS. Therefore, we recommend that the BOP's medical services contract strategy standardize performance monitoring by establishing guidance for a uniform or universal QASP or QASP equivalent to use as the basis to monitor performance under medical services contracts that contains: (1) measurable performance standards to ensure desirable contract requirement outcomes including those related to quality and timeliness of care; and (2) standards for maintaining documentation related to the ratings in the QASP.

[2] FAR Subpart 42.15, Contractor Performance Information.

Acquisition Planning

Communication and Collaboration

Although FAR Subpart 7.102 requires agencies to use a multi-faceted acquisition planning team comprised of all personnel responsible for significant aspects of the acquisition, the OIG continues to find a lack of direct communication and coordination between the BOP's key internal stakeholders – namely the acquisition offices and its various program and contracting offices. This has resulted in the BOP awarding medical and healthcare-related contracts and agreements that do not reflect an informed assessment of the BOP's overall needs because it did not sufficiently incorporate the program offices' requirements. In practice, the BOP's various institutions' Health Services Division staff have assumed primary responsibility for the acquisition planning process, which we have seen in our reviews being characterized by: (1) prolonged use of simplified acquisition procedures or noncompetitive acquisition methods, such as monthly purchase orders and sole-source awards, thereby stymying opportunities for potentially more advantageous and less costly procurements; (2) staff preparing contract documents outside their area of expertise; and (3) poorly defined procurement award requirements.

For example, in a February 2022 MAM issued to the BOP, the OIG identified inadequate acquisition planning and minimal coordination between key BOP divisions for medical services provided to inmates in residential reentry centers and home confinement.[vii] BOP officials within the Reentry Services Division's Residential Reentry Management Branch (RRMB), which is primarily responsible for overseeing the BOP's agreements with residential reentry centers to house BOP residents, were designated as the CORs for these awards, despite officials in the RRMB having limited expertise in medical services and medical billing. RRMB officials told the OIG that they believed the FAO and the Health Services Division were more qualified in the procurement and management of medical services contracts, yet they experienced difficulties getting RRMB, Health Services Division, and FAO staff together to discuss the proper procurement approach and ultimately used improper procurement methods as a result. As previously stated, Central Office acquisition staff are now responsible for the procurement of medical services for inmates in RRCs and home confinement.

In our March 2022 audit of UMass, the OIG reported that the BOP did not always complete its acquisition planning and awarding of follow-on medical services contracts in a timely manner due to: (1) poor collaboration and communication between the institutions and the FAO, (2) inefficient processes involving the preparation and approval of the Request for Contract Action, (3) technical evaluations of proposals from prospective vendors that were frequently postponed due to a lack of guidance and policies, and (4) lack of written acquisition plans and established milestones. As a result of these deficiencies, the BOP stymied full and open competition, and did not ensure that prices paid for services were fair and reasonable.

To address these risks and prevent future deficiencies, the BOP's medical services contract strategy needs to promote early and sustained collaboration between the BOP program offices, contracting offices, and the acquisition offices to ensure that: (1) the program offices' requirements are accurately reflected in the award SOWs; and (2) staff understand who is responsible for each part of the planning and when tasks should be completed.

Healthcare Utilization and Pricing Data

We have found that the BOP is unable to consider centralizing its acquisition of outside medical services for institutions, and instead must rely on individual institutions to manage medical services contracts because it lacks data that would allow it to consider alternative contract management strategies. Since 2012, the Department has recognized that this institution-based contracting model offers the BOP no competitive advantage or vendors no economies of scale incentives to offer discounts to the BOP during the contract solicitation process and encouraged the BOP to consider awarding medical services contracts on a regional basis.[3] In our 2016 review of BOP's reimbursement rates for outside medical care, we found that the BOP was unable to fully consider the Department's recommendation because the BOP cannot leverage inmate healthcare utilization data that would enable industry to price regional medical services contracts that could offer the BOP discounts relative to the prices it pays through institution-based medical services contracts.[i]

As a result, in our 2016 report we recommended that BOP improve the collection and analysis of inmate healthcare utilization data. However, as of the date of this memorandum, this recommendation remains open because the BOP is still in the preliminary stages of developing a data analytics solution for healthcare utilization data. Given the nearly 6 years that have passed since we made this recommendation and the limited progress the BOP has been able to make in addressing it, we take the opportunity in this memorandum to reemphasize the importance of the original 2016 recommendation. We further note, that until the BOP makes greater progress in addressing this recommendation, it will remain unable to leverage the data necessary to enable industry to price regional medical services contracts, which would in turn enable the BOP to determine the cost effectiveness of alternative medical services contract structures.

We have also found BOP staff lacked data to determine the reasonableness of prices for outside medical services when those services are not included in institution medical services contracts. As a result, we observed that different BOP institutions reimburse outside medical service providers at vastly different rates for similar medical services. For example, in our 2021 memorandum to BOP regarding BOP's procurement of air ambulance services, we found that while medical services contracts list a broad range of outside medical services that will be available at a pre-negotiated rate (usually the Medicare rate plus a premium), the contracts did not specifically reference air ambulance services.[viii] Further, BOP had not implemented any uniform guidance for the reimbursement of air ambulance services.

Absent a baseline against which to reprice air ambulance claims, individual institutions and medical services contractors were responsible for negotiating the reimbursement rate. However, we found that in most cases no such negotiation was taking place and BOP institutions were reimbursing air ambulance claims at significantly varying rates. Indeed, we found that most institutions were simply paying the contractors the amounts they billed for air ambulance services without any adjustments and without regard for whether the rates billed were reasonable. USP Terre Haute for example paid on average more than $40,000 each for three air ambulance claims; we determined it could have saved more than $110,000 on those claims had it used the pricing methodology it had negotiated for other medical services billed through its CMS contract. Conversely, using CMS pricing methodology to determine how much the BOP would have saved if it repriced its air ambulance claims, we determined that the BOP would have paid a little over $5,000 for a similar claim. To

[3] DOJ Justice Management Division (JMD), *Managing Medical Costs in the Bureau of Prisons: Feasibility of Applying the Medicare Rate,* Issue Paper (July 2012).

address this issue, we recommended that the BOP establish a procurement plan for air ambulance services that includes procedures for processing claims with air ambulance providers for current and future medical services contracts, and also communicate that plan to relevant personnel. In May 2021, the BOP reported that it had done so, and we closed these recommendations.

Similarly, we found in our September 2022 audit of NaphCare that the BOP did not properly evaluate the reasonableness of prices offered by NaphCare during its acquisition planning. Specifically, in each NaphCare procurement we reviewed, we found that the BOP did not demonstrate that premiums added to the Medicare rates were cost-effective for the government. Further, we found that approximately $19 million, or 24 percent, of costs incurred by the BOP under these procurements were for out-of-network medical claims. For these costs, NaphCare is paid a 5 percent markup on the amount billed by the provider, which does not provide sufficient incentive to reduce medical costs or negotiate out-of-network costs as low as possible. As it relates to pharmaceutical expenses, the awards state that pharmaceutical costs are to be reimbursed by the BOP at the average wholesale price. We found that the average wholesale price is not a government-related figure, does not include buyer volume discounts or rebates often involved with prescription medication sales, and is subject to manipulation by manufacturers and wholesalers. We believe further data related to pharmaceutical prices during acquisition planning could increase the BOP's negotiating power and potentially realize significant cost savings for the BOP over time. Overall, to avoid similar issues in other contracts, the BOP's strategy for healthcare contracts should leverage its healthcare utilization data to negotiate appropriate rates within its contracts to control healthcare costs. We recommend that the BOP identify strategies to leverage inmate healthcare utilization data that the OIG recommended to collect in 2016, which would enable the BOP to determine the cost effectiveness of alternative medical services contract structures.

Contract Administration

Inadequate COR Delegations

According to FAR Subpart 1.602-2, contracting officers are responsible for ensuring all necessary actions for effective contracting are completed, as well as ensuring compliance with the terms and conditions of the contract. However, Contracting Officers have the authority to designate a COR in writing, to assist in overseeing the contract. Since all BOP contract actions over the simplified acquisition threshold are awarded by Contracting Officers in the FAO, it is necessary to designate a COR at the individual institutions. A COR is required to maintain the Federal Acquisition Certification for CORs (FAC-COR) and must be trained and experienced on the responsibilities delegated. Overall, we found that untrained and inexperienced BOP staff were performing significant contracting tasks that should have been completed by the Contracting Officer or designated COR.

COR Requirements Identified by the FAR

- Must have written delegation of duties letter from contracting officer
- Must maintain Federal Acquisition Certification
- Must have training commensurate of duties delegated by contracting officer
- Cannot obligate or increase contract funding
- Cannot delegate duties to other contracting staff

In our March 2022 audit of UMass, we identified instances where the COR delegation letters were not always up to date or had expired, as well as staff negotiating pricing not covered by the contract

without the proper authority. Additionally, in our September 2019 audit of CCS, we found that the COR approved pricing agreements under the contract, but lacked the authority to do so as stated in the FAR. BOP contracting officials stated that they were not aware of the FAR requirements that state that only the Contracting Officer, not the COR, can approve pricing agreements.[4] Finally, in our September 2022 audit of NaphCare, we found that the BOP did not have a designated COR for the full award period, and also found instances where officials not designated as the COR conducted key contracting duties.

These systemic risks are representative of limited BOP knowledge and training on COR requirements resulting in FAR noncompliance. They put the BOP at risk of paying for goods and services that are not authorized; overpaying for medical services; and being subjected to disputes and claims. As a result, we recommend that the BOP disseminate and reinforce the Department-wide training requirement that all CORs have the appropriate level of FAC-COR certification prior to being designated COR responsibilities. In addition, the BOP should ensure that: (1) staff that are delegated COR responsibilities have the proper experience and knowledge of the services they are overseeing and (2) staff understand who is responsible for performing the delegated contract administration tasks.

Inadequate Review and Approval of Medical Services Billing

As a result of several OIG reviews, we determined that the BOP conducted inadequate review and approval of medical services billing, resulting in improper payments and delayed processing of medical invoices, which led to the BOP paying penalty interest.

In December 2017, the OIG issued a Procedural Reform Recommendation which found that the BOP had incomplete and inadequate healthcare claims data in electronic format and that the BOP's claim adjudication vendor was not providing all required services, including fraud monitoring.[ix] Specifically, the OIG found that most of BOP's healthcare claims were processed primarily through manual methods. In addition, we found that incomplete claims data and ineffective analysis of that data significantly increases the BOP's fraud risks and diminishes both the BOP's and the OIG's ability to detect past and present fraud schemes. In fiscal year 2009, the BOP began utilizing a medical claims adjudication services contract through which BOP sought to ensure compliance with the applicable negotiated fee schedule for medical services. The OIG recommended that the BOP immediately require all medical services contractors to submit electronic claims and that such claims be properly analyzed and maintained by the adjudication vendor. Over 4 years later, the BOP is still completing the necessary tasks to close these recommendations.

The OIG continues to find issues with the review of BOP's healthcare claims and found that some claims are not being reviewed, neither manually nor by the adjudication vendor. For example, in our March 2022 audit of UMass, we found that the BOP did not have a consistent process to review billings for off-site services to ensure they were billed at Medicare rates and since August 2019 the billings with Medicare healthcare claims were not verified at 2 of the 3 BOP institutions we audited.

[4] FAR Subpart 1.602-2(d)(5), Contracting Officers-Responsibilities.

Significant BOP Payments Found in OIG Reviews

$694,593 settlement by BOP contractor to resolve False Claims Act allegations

$318,442 in interest payments made to DOJ medical services contractors

$145,052 in inappropriate payments made to DOJ medical services contractors

Similarly, in our September 2022 audit of NaphCare, we found that BOP officials did not appropriately or timely review claims submitted for reimbursement by NaphCare, resulting in $45,569 in questioned costs, as well as interest payments made to NaphCare totaling $51,539 due to the BOP not timely paying its invoices. This is in addition to a June 2021 OIG investigation that resulted in NaphCare agreeing to pay $694,593 to resolve allegations that NaphCare violated the False Claims Act by knowingly submitting false claims to the BOP in connection with health care services provided to BOP inmates.[x]

In February 2022, the OIG issued a Management Advisory Memorandum to the BOP regarding the potential overpayment by the BOP for inmate health care services.[xi] Through data analytics and OIG investigative activity, we found that at least one medical services contractor sometimes selected and submitted to the BOP Current Procedural Terminology (CPT)/Healthcare Common Procedure Coding System (HCPCS) codes on behalf of its subcontracted medical services providers, instead of having the providers select such codes themselves.[5] We found that this practice was contrary to the approach typically used in traditional medical practices. In addition, we found that when the medical services contractor, rather than the provider, selected the code, in almost every instance the contractor selected the code that represented the highest level, or costliest, in the applicable series. The OIG believes that this scenario could reoccur with other medical services contractors.

In our September 2019 audit of contracts awarded to CCS, we found that the COR inadvertently approved prices billed for out-of-network services not covered by Medicare pricing, and cancellation fees without proper authority. Consequently, the BOP paid CCS $822,888 for services that were non-compliant with the contract terms. That review also found that CCS did not always submit properly priced invoices for onsite services as required by the contract and did not consistently submit timely and accurate invoices for offsite service claims. As a result, the BOP made improper payments to CCS totaling $99,483. Additionally, in our March 2022 audit of contracts awarded to UMass, we found that the BOP did not always rely on adequate supporting documentation when reviewing billings and that invoices were approved for payment by staff who were not the COR.

Furthermore, in our audits of CCS and UMass we found that the BOP did not return improper invoices within 7 days of receipt and a BOP institution paid invoices 30 days after receipt, respectively. These issues resulted in missed deadlines under the Prompt Payment Act and triggered penalty interest of $266,903 on untimely payments that could have been avoided with a more efficient billing process.

Overall, we determined that the BOP would benefit from increased oversight of its medical services billing. In our judgment, the systemic findings described above demonstrate that the BOP is overpaying for medical services and increases the risk that contractors misuse award funds. As a result, we recommend that the BOP establish a uniform or universal billing review and approval

[5] CPT and HCPCS codes are five-digit numeric codes published by the American Medical Association that correspond to a variety of medical procedures and services under public and private health insurance programs. The most commonly used CPT/HCPCS codes for services provided to inmates were for evaluation and management services, such as physician office visits and hospital care visits.

process to: (1) ensure medical claims are properly supported and (2) improve timeliness of processing medical invoices. Furthermore, we recommend that the BOP establish a timeline for utilizing the medical claims adjudication vendor contract awarded in December 2019 to process and ensure healthcare claims are accurate and complete.

Conclusion

The OIG's audits, reviews, and investigations have identified concerns regarding the BOP's ability to effectively manage its responsibility to provide healthcare services to its inmates. The BOP has represented to us that it does not maintain a formalized BOP-wide comprehensive healthcare strategy for the procurement of medical services contracts. Instead, the BOP relies on the autonomy of individual institutions to develop strategies containing varying degrees of comprehensiveness.

The BOP has taken corrective actions to address recommendations in the OIG's individual products at the institution-level and, in April 2021, created the Medical Expenditures Advisory Group to comprehensively evaluate all costs associated with medical service delivery including medical service contracts. However, we believe that the issues and concerns previously highlighted require a more comprehensive healthcare strategy with an enterprise-wide focus on ensuring effective quality of care and efficient use of taxpayer dollars. The establishment of a coordinated, comprehensive, enterprise-wide BOP strategy for the procurement of medical services contracts would provide all BOP institutions with consistent and effective direction, clarify responsibilities, reduce redundancies, and address systemic weaknesses outlined in this memorandum. Thus, ensuring the quality of inmate care at BOP institutions and community clinics, holding contractors who do not deliver quality and timely care accountable, and ensuring taxpayer value. The OIG is concerned that, 6 years after issuing a report that first identified issues relating to BOP medical services contracting, the OIG continues to identify similar issues due to inadequate planning, monitoring, and execution.

Recommendation

The OIG recommends that the BOP take the following action to address the concerns identified in this Management Advisory Memorandum:

1. Create and implement a written nationwide strategy for the procurement and oversight of all medical service contracts. The strategy should address wide-ranging solutions to previously identified deficiencies, to include:

    A. Guidance for a QASP or QASP equivalent to use as the basis to monitor performance under medical services contracts that contains: (1) measurable performance standards to ensure desirable contract requirement outcomes including those related to quality and timeliness of care; and (2) standards for maintaining documentation related to the ratings in the QASP.

    B. Early and sustained collaboration between the BOP program offices, contracting offices, and the acquisition offices to ensure that: (1) the program offices' requirements are accurately reflected in the award SOWs; and (2) staff understand who is responsible for each part of the planning and when tasks should be completed.

C. Strategies to leverage inmate healthcare utilization data that the OIG recommended to collect in 2016, which would enable the BOP to determine the cost effectiveness of alternative medical services contract structures.

D. Dissemination and reinforcement of the Department-wide training requirement that all CORs have the appropriate level of FAC-COR certification prior to being designated COR responsibilities.

E. Guidance to ensure that: (1) staff that are delegated COR responsibilities have the proper experience and knowledge of the services they are overseeing and (2) staff understand who is responsible for performing the delegated contract administration tasks.

F. A uniform or universal billing review and approval process to: (1) ensure medical claims are properly supported and (2) improve timeliness of processing medical invoices.

G. A timeline for utilizing the medical claims adjudication vendor contract awarded in December 2019 to process and ensure healthcare claims are accurate and complete.

The OIG provided a draft of this memorandum to the BOP, and the BOP's response is incorporated as Appendix 2. Appendix 3 provides the OIG's analysis of the BOP's response and a summary of the action necessary to close the recommendation in this memorandum. The OIG requests that the BOP provide an update on the status of its response to the recommendation within 90 days of the issuance of this memorandum. If you have any questions or would like to discuss the information in this memorandum, please contact me at (202) 514-3435 or Jason R. Malmstrom, Assistant Inspector General for Audit, at (202) 616-4633.

cc: William Lothrop
Acting Deputy Director
Federal Bureau of Prisons

Sonya Thompson
Acting Chief of Staff
Federal Bureau of Prisons

Louis Milusnic
Assistant Director
Program Review Division
Federal Bureau of Prisons

Angela Owens
Senior Deputy Assistant Director
Program Review Division
Federal Bureau of Prisons

Oleta Vassilopoulos
Administrator
External Auditing Branch
Program Review Division
Federal Bureau of Prisons

Richard Perkins
Acting Chief
External Auditing Branch
Federal Bureau of Prisons

Louise Duhamel
Assistant Director
Audit Liaison Group
Internal Review and Evaluation Office
Justice Management Division

Bradley Weinsheimer
Associate Deputy Attorney General

David Newman
Associate Deputy Attorney General

APPENDIX 1: PRIOR OIG WORK

Since 2016, the OIG has issued 11 reports and reviews that are relevant for the BOP's strategy for monitoring medical services costs and ensuring acceptable quality of care. A list of the OIG reports and reviews referenced in this memorandum are listed below.

[i] U.S. Department of Justice (DOJ) Office of the Inspector General (OIG), *The Federal Bureau of Prisons' Reimbursement Rates for Outside Medical Care*, Evaluation and Inspections Report 16-04 (June 2016), www.oig.justice.gov/reports/federal-bureau-prisons-reimbursement-rates-outside-medical-care

[ii] U.S. Department of Justice (DOJ) Office of the Inspector General (OIG), *Review of the Federal Bureau of Prisons' Pharmaceutical Drug Costs and Procurement*, Evaluation and Inspections Report 20-027 (February 2020), www.oig.justice.gov/reports/review-federal-bureau-prisons-pharmaceutical-drug-costs-and-procurement

[iii] U.S. Department of Justice (DOJ) Office of the Inspector General (OIG), *Audit of the Federal Bureau of Prisons' Contract Awarded to Correct Care Solutions, LLC for the Federal Correctional Complex in Coleman, Florida*, Audit Report 19-37 (September 2019), www.oig.justice.gov/reports/audit-federal-bureau-prisons-contract-awarded-correct-care-solutions-llc-federal

[iv] U.S. Department of Justice (DOJ) Office of the Inspector General (OIG), *Audit of the Federal Bureau of Prisons Comprehensive Medical Services Contracts Awarded to the University of Massachusetts Medical School*, Audit Report 22-052 (March 2022), www.oig.justice.gov/reports/audit-federal-bureau-prisons-comprehensive-medical-services-contracts-awarded-university

[v] U.S. Department of Justice (DOJ) Office of the Inspector General (OIG), *Audit of the Bureau of Prisons' Procurements Awarded to NaphCare, Inc. for Medical Services Provided to Residential Reentry Management Branch Inmates*, Audit Report 22-111 (September 2022), www.oig.justice.gov/reports/audit-federal-bureau-prisons-procurements-awarded-naphcare-inc-medical-services-provided

[vi] U.S. Department of Justice (DOJ) Office of the Inspector General (OIG), *Management Advisory Memorandum Concerning the Department of Justice's Administration and Oversight of Contracts*, Audit Report 20-082 (July 2020), www.oig.justice.gov/reports/management-advisory-memorandum-concerning-department-justices-administration-and-oversight

[vii] U.S. Department of Justice (DOJ) Office of the Inspector General (OIG), *Notification of Concerns Identified in the Federal Bureau of Prisons' Acquisition and Administration of Procurements Awarded to NaphCare, Inc. for Medical Services Provided to Community Corrections Management Inmates*, Audit Report 22-040 (February 2022), www.oig.justice.gov/reports/notification-concerns-identified-federal-bureau-prisons-acquisition-and-administration

[viii] U.S. Department of Justice (DOJ) Office of the Inspector General (OIG), *Notification of Concerns Identified in Connection with the Federal Bureau of Prisons' Procurement of Air Ambulance Services*, Investigations Division Report 20-059 (April 2021), www.oig.justice.gov/reports/management-advisory-memorandum-notification-concerns-identified-connection-federal-bureau

[ix] U.S. Department of Justice (DOJ) Office of the Inspector General (OIG), *Procedural Reform Recommendation for the Federal Bureau of Prisons*, Investigations Division Report 2016-008873 (December 2017), www.oversight.gov/report/doj/procedural-reform-recommendation-federal-bureau-prisons

[x] U.S. Department of Justice (DOJ) Office of the Inspector General (OIG), Press Release, "Prison Health Care Provider NaphCare Agrees to Settle False Claims Act Allegations," June 25, 2021, www.oig.justice.gov/news/press-release/prison-health-care-provider-naphcare-agrees-settle-false-claims-act-allegations

[xi] U.S. Department of Justice (DOJ) Office of the Inspector General (OIG), *Notification of Concerns Regarding Potential Overpayment by the Federal Bureau of Prisons for Inmate Health Care Services*, Investigations Division Report 22-035 (February 2022), www.oig.justice.gov/reports/management-advisory-memorandum-notification-concerns-regarding-potential-overpayment

APPENDIX 2: FEDERAL BUREAU OF PRISIONS' RESPONSE TO THE DRAFT MANAGEMENT ADVISORY MEMORANDUM

U.S. Department of Justice

Federal Bureau of Prisons

Office of the Director *Washington, DC 20534*

September 13, 2022

MEMORANDUM FOR JASON R. MALMSTROM
ASSISTANT INSPECTOR GENERAL FOR AUDITS

FROM: Colette S. Peters, Director

SUBJECT: Response to the Office of Inspector General's (OIG) Draft Management Advisory Memorandum (MAM): Notification of Concerns Resulting from Multiple Office of the Inspector General Reviews Related to the Federal Bureau of Prisons Strategy for its Medical Services Contract.

The Bureau of Prisons (BOP) appreciates the opportunity to respond to the open recommendation from the draft MAM entitled Notification of Concerns Resulting from Multiple Office of the Inspector General Reviews Related to the Federal Bureau of Prisons Strategy for its Medical Services Contract. Additionally, the BOP appreciates the open dialogue and forthright communications regarding the development of this MAM. In the opening paragraphs of this capstone report, OIG indicates it has already conducted 10 separate audits and reviews of BOP's medical services contracts and issued more than 50 recommendations. Notwithstanding complications resulting from the overlapping scope of these reports and their recommendations, BOP has diligently worked to respond. OIG confirms the majority are now closed as implemented. Regarding BOP's response to the recommendation from this new report, please see as follows:

Recommendation: Create and implement a written nationwide strategy for the procurement and oversight of all medical service contracts. The strategy should address wide-ranging solutions to previously identified deficiencies, to include:

A. Guidance for a QASP or QASP equivalent to use as the basis to monitor performance under medical services contracts that contains: (1) measurable performance standards to ensure desirable contract requirement outcomes including those related to quality and timeliness of care; and (2) standards for maintaining documentation related to the ratings in the QASP.

B. Early and sustained collaboration between the BOP program offices, contracting offices, and the acquisition offices to ensure that: (1) the program offices' requirements are accurately reflected in the award SOWs; and (2) staff understand who is responsible for each part of the planning and when tasks should be completed.

C. Strategies to leverage inmate healthcare utilization data that the OIG recommended to collect in 2016, which would enable the BOP to determine the cost effectiveness of alternative medical services contract structures.

D. Dissemination and reinforcement of the Department-wide training requirement that all CORs have the appropriate level of FAC-COR certification prior to being designated COR responsibilities.

E. Guidance to ensure that: (1) staff that are delegated COR responsibilities have the proper experience and knowledge of the services they are overseeing and (2) staff understand who is responsible for performing the delegated contract administration tasks.

F. A uniform or universal billing review and approval process to: (1) ensure medical claims are properly supported and (2) improve timeliness of processing medical invoices.

G. A timeline for utilizing the medical claims adjudication vendor contract awarded in December 2019 to process and ensure healthcare claims are accurate and complete.

BOP's Response: The BOP agrees with this recommendation.

If you have any questions regarding this response, please contact Louis Milusnic, Assistant Director, Program Review Division, at (202) 307-1076.

APPENDIX 3: OFFICE OF THE INSPECTOR GENERAL ANALYSIS AND SUMMARY OF ACTIONS NECESSARY TO CLOSE THE RECOMMENDATION

The OIG provided a draft of this advisory memorandum to the BOP. The BOP's response is incorporated in Appendix 2 of this final memorandum. The BOP agreed with our recommendation. As a result, the recommendation is resolved. The following discussion provides the OIG analysis of the response and summary of actions necessary to close the recommendation.

Recommendation for the BOP:

1. **Create and implement a written nationwide strategy for the procurement and oversight of all medical service contracts. The strategy should address wide-ranging solutions to previously identified deficiencies, to include:**

   A. **Guidance for a QASP or QASP equivalent to use as the basis to monitor performance under medical services contracts that contains: (1) measurable performance standards to ensure desirable contract requirement outcomes including those related to quality and timeliness of care; and (2) standards for maintaining documentation related to the ratings in the QASP.**

      Resolved. This recommendation subpart can be closed when we receive evidence that the BOP has created and implemented guidance for a QASP or QASP equivalent to use as the basis to monitor performance under medical services contracts that contains: (1) measurable performance standards to ensure desirable contract requirement outcomes including those related to quality and timeliness of care; and (2) standards for maintaining documentation related to the ratings in the QASP.

   B. **Early and sustained collaboration between the BOP program offices, contracting offices, and the acquisition offices to ensure that: (1) the program offices' requirements are accurately reflected in the award SOWs; and (2) staff understand who is responsible for each part of the planning and when tasks should be completed.**

      Resolved. This recommendation subpart can be closed when we receive evidence that the BOP has created and implemented early and sustained collaboration between the BOP program offices, contracting offices, and the acquisition offices to ensure that: (1) the program offices' requirements are accurately reflected in the award SOWs; and (2) staff understand who is responsible for each part of the planning and when tasks should be completed.

   C. **Strategies to leverage inmate healthcare utilization data that the OIG recommended to collect in 2016, which would enable the BOP to determine the cost effectiveness of alternative medical services contract structures.**

      Resolved. This recommendation subpart can be closed when we receive evidence that the BOP has created and implemented strategies to leverage inmate healthcare utilization data that the OIG recommended to collect in 2016, which would enable the

BOP to determine the cost effectiveness of alternative medical services contract structures.

D. **Dissemination and reinforcement of the Department-wide training requirement that all CORs have the appropriate level of FAC-COR certification prior to being designated COR responsibilities.**

   Resolved. This recommendation subpart can be closed when we receive evidence that the BOP has disseminated and reinforced the Department-wide training requirement that all CORs have the appropriate level of FAC-COR certification prior to being designated COR responsibilities.

E. **Guidance to ensure that: (1) staff that are delegated COR responsibilities have the proper experience and knowledge of the services they are overseeing and (2) staff understand who is responsible for performing the delegated contract administration tasks.**

   Resolved. This recommendation subpart can be closed when we receive evidence that the BOP has created and implemented guidance to ensure that: (1) staff that are delegated COR responsibilities have the proper experience and knowledge of the services they are overseeing and (2) staff understand who is responsible for performing the delegated contract administration tasks.

F. **A uniform or universal billing review and approval process to: (1) ensure medical claims are properly supported and (2) improve timeliness of processing medical invoices.**

   Resolved. This recommendation subpart can be closed when we receive evidence that the BOP has created and implemented a uniform or universal billing review and approval process to: (1) ensure medical claims are properly supported and (2) improve timeliness of processing medical invoices.

G. **A timeline for utilizing the medical claims adjudication vendor contract awarded in December 2019 to process and ensure healthcare claims are accurate and complete.**

   Resolved. This recommendation subpart can be closed when we receive evidence that the BOP has created and implemented a timeline for utilizing the medical claims adjudication vendor contract awarded in December 2019 to process and ensure healthcare claims are accurate and complete.