



Testimony

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Committee on Government Reform
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DISTRICT OF COLUMBIA RECEIVERSHIP

Selected Issues Related to Medical Services at the D.C. Jail

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District of Columbia Receivership: Selected Issues Related to Medical Services at the D.C. Jail

Mr. Chairman and Members of the Subcommittee:

I am pleased to be here today to discuss selected topics concerning the District of Columbia Medical Receiver's contract for medical and mental health services¹ at the D.C. Jail. As you know, the D.C. Jail's medical care facility was placed under court-ordered receivership in August 1995, after the District was held in contempt for repeatedly failing to implement court orders. These orders emanated from long-standing litigation intended to ensure adequate medical services to jail inmates. The Receivership is scheduled to expire in August 2000. In January 2000, the Receiver awarded a 1-year contract, with 4 option years, to a private, not-for-profit firm to provide medical services to individuals housed at the D.C. Jail. Performance on the contract began in March 2000.

Based on your request, our work has focused on four questions: (1) What are the costs of providing medical services at the D.C. Jail as compared with jurisdictions said to be similar? (2) What would constitute an acceptable level of medical service and staffing at the jail? (3) What effect did the contracting process have on medical service costs? (4) Did the failure of the Receiver's employees to resign from their positions prior to being awarded the contract violate D.C. law or regulations? As you know, we have been conducting our work for only a matter of a few weeks, so we do not have complete answers to all of these questions.

To answer these questions, we analyzed available cost, staffing, and contracting information and conducted interviews with cognizant officials. Specifically, we spoke with officials from the Office of the Receiver for Medical and Mental Health Services, the Office of the Corrections Trustee, the Office of Corporation Counsel, and the Department of Corrections (DOC). We also spoke with the District's Deputy Mayor for Public Safety and Justice. Further, we spoke with counsels for both the Receiver and for the plaintiffs whose suit resulted in the D.C. Jail's being placed in receivership. In addition, we spoke with officials of all three private companies that made offers on the contract. The Special Officer—appointed by the U.S. District Court for the District of Columbia and charged with overseeing the Receiver's activities—cited constraints placed on her by the Code of Judicial Conduct and declined to be interviewed. We performed our review from May 17 to June 27, 2000, in accordance with generally accepted government auditing standards. We did not independently verify the cost and staffing data or the other information we

¹ The term "medical services" will be used in the remainder of the testimony to refer to both medical and mental health services.

obtained, nor did we evaluate the individual proposals submitted in response to the solicitation.

In this statement, I would like to make the following points:

- Our comparison of contract budget data for medical services at the D.C. Jail and two reportedly comparable facilities—in Baltimore and Prince George’s County, Maryland—indicated that the D.C. Jail’s per capita costs were higher. Officials with whom we spoke during our review agreed that the D.C. Jail provided certain medical services—and had staffing levels—usually not provided by other jurisdictions. Accordingly, the cost differences between the D.C. Jail and those in Baltimore and Prince George’s County are likely due, in part, to differences in staffing levels, which in turn are likely due, in part, to the types of medical services provided. For example, the inmate to staff ratio, as reported by the Office of the Corrections Trustee, at the D.C. Jail’s medical facility is 13.4 to 1; compared with 74 to 1 in Baltimore and 48 to 1 in Prince George’s County. The fact that the D.C. Jail provides a fully staffed on-site pharmacy and mental health and dental services, whereas Baltimore and Prince George’s County provide these services differently, offers a context for understanding some of the differences in the inmate to staff ratios. Officials with whom we spoke and documents we reviewed indicated that a court-ordered Remedial Plan is the primary reason why the D.C. Jail provides medical services and has higher staffing levels than other jurisdictions. The Trustee felt, however, that adequate medical services could be provided with fewer staff and at lower cost.
- There is no single specific threshold that determines what an acceptable level of medical service and staffing is at a jail. According to correctional medicine experts, generally, the level of service and staffing is a function of many factors, including the situation and circumstances to be addressed. It is also a function of the specific constraints and demands placed on the service delivery system at a particular location. Standards, such as those developed by the National Commission on Correctional Health Care (NCCHC), define minimum recommended medical service requirements for jails to voluntarily obtain accreditation. For example, the standards include “essential” requirements, such as inmate receiving screening, and “important” requirements, such as pregnancy counseling for female inmates. While the standards recommend at least 1 full-time equivalent (FTE) physician in jails with an average daily population of 500 or greater, they also state that the staffing level at a facility depends on a range of factors, including the type and scope of the medical services being offered.

- The current contract maintains levels of medical service and staffing that were already in place at the D.C. Jail, but possibilities exist to reduce future contract costs. The current contract can be modified at any time. In addition, it can be recompeted at its current or scaled-back levels of service and staffing when its first year ends. The solicitation that resulted in the current contract did not preclude offerors from submitting proposals that would reduce staffing and costs over the existing levels, as long as quality health care services would be provided. The solicitation encouraged offerors to submit such “alternate” proposals for providing quality medical services differently or more economically than they were currently being provided. In addition, the Receiver decided, in consultation with District officials, to require offerors to submit “comparison” proposals that maintained the current levels of service and staffing at the jail. According to officials we spoke with, the District sought to maintain services at their current level in order to ensure that the Receivership is successfully terminated in August 2000 and control of the jail is returned to the District. Each of the three offerors submitted a comparison and an alternate proposal. The evaluation committee rated all of the proposals. The Receiver and the committee determined that none of the alternate proposals provided specific enough information to ensure that the alternative approach would maintain the same level of medical services as did the comparison proposals. Thus, the final recommendation of the committee was to endorse a comparison proposal.
- The Receiver employees that were awarded the contract were not subject to D.C. Personnel Regulations because they were not D.C. employees. According to these personnel regulations, a District employee can make an offer on a contract, but generally cannot be awarded one when still in District employment status. Separately, the D.C. Contract Appeals Board (CAB)—in a May 24, 2000, ruling on the protest of one of the losing offerors—stated that, while there was not proof sufficient to challenge the award, certain actions by the Receiver gave an appearance not conducive to confidence in the fairness of the procurement. CAB nevertheless denied the protest and, in June 2000, denied the protester’s motion to reconsider.

Background

In 1971, pretrial detainees at the D.C. Jail filed suit in U.S. District Court alleging that, in violation of their civil and constitutional rights,² they and others were denied minimally adequate medical care and treatment while in custody. In 1975, a group of post-trial inmates at the jail brought suit on

² See Campbell v. McGruder, C.A. No. 14 62-71 (D.D.C.).

similar grounds, and the cases were eventually consolidated.³ Between 1971 and 1994, the Court entered several remedial orders, including a detailed Initial Remedial Plan submitted to the court in 1994 by the Special Officer. In July 1995, the court determined that DOC was in continued noncompliance with the 1994 Remedial Plan and entered an order to remove control and operation of medical and mental health services at the D.C. Jail from DOC and place them in receivership under the Court's supervision. The Receivership commenced in August 1995 and is set to expire in August 2000 unless the court finds cause to extend the appointment.

The court order appointing the Receiver required that the Receiver establish procedures and systems within DOC to ensure that compliance with court orders would be maintained after the receivership was terminated. In 1998, the Receiver decided to issue a solicitation to acquire the services of a private company in providing ongoing medical services at the D.C. Jail after the Receivership ends.

A five-member committee—consisting of the Court's Special Officer, two DOC representatives, and one representative each for the Corrections Trustee and the plaintiffs' counsel—evaluated the proposals. The committee recommended to the Receiver that one of three firms that had submitted proposals be selected as the awardee. The Receiver independently evaluated all three proposals; concurred with the recommendation of the committee; and, as the contracting officer, made the decision to award the contract to that firm.

D.C. Jail Medical Costs Higher than Other Jurisdictions, But Caution Needed in Interpreting Differences

We compared available reported budget and staffing data for the D.C. Jail with budget and staffing data for the Baltimore City Detention Center (BCDC) and the Prince George's County Correctional Center (PGCCC). According to information provided by the Corrections Trustee, these jurisdictions are said to be comparable to the D.C. Jail. This comparison serves as an illustration only, because, as discussed below, correctional medicine experts—including those retained by the Office of the Corrections Trustee—strongly caution against comparing costs across correctional systems. It is important to note, however, that officials with whom we spoke and documents we reviewed during our review indicated that the D.C. Jail provides certain medical services not usually provided by other jurisdictions.

³ See *Inmates of D.C. Jail v. Jackson*, C.A. No. 75-1668 (D.D.C.).

Our comparison of information provided to us showed that the reported per capita costs at the D.C. Jail—at \$20.56 per day—were higher than at BCDC (\$8.66 per day) and at PGCCC (\$5.48 per day). These cost differences reflected, among other things, differences in staffing levels and in the types of medical services offered by these jurisdictions. Specifically, in terms of staffing, the D.C. Jail contract has 125.2 FTE positions for an average population of 1,650 inmates,⁴ while BCDC's has 44.04 FTE positions for an average population of 3,100 inmates, and PGCCC's has 26.2 FTE positions for an average population of 1,258 inmates. The Trustee reported that these staffing levels result in inmate-to-staff ratios of 13.4 to 1, 74 to 1, and 48 to 1 for the D.C. Jail, BCDC, and PGCCC facilities, respectively. In terms of the reported number of physicians, the D.C. Jail has 10.85 FTE physician positions, while BCDC has 2.3 FTE physician positions, and PGCCC has 1 FTE physician position.

In terms of medical services, we judgmentally identified and compared the broad level of mental health, dental, and pharmaceutical services offered at these jurisdictions. The D.C. Jail offers fully staffed, on-site mental health, dental, and pharmaceutical services. BCDC offers on-site mental health services, emergency dental services, and pharmaceutical services through a regional pharmacy that serves other jurisdictions. PGCCC offers access to mental health services but does not have an on-site facility; it also offers limited on-site dental services and pharmaceutical services through its own pharmacy located in another state.

Several officials we spoke with and documents we reviewed indicated that the D.C. Jail's current budget—and thus its relatively high per capita cost—reflects the level of medical services and staffing required by the 1994 court-ordered Remedial Plan, as amended by annual budgets submitted by the Receiver. The Remedial Plan is a detailed document developed by the Court's Special Officer in consultation with medical experts and the parties to the litigation. The Plan required the defendants to provide a wide range of medical services, such as mental health (including suicide prevention), dental, and pharmaceutical services. The Plan also established the policies, procedures, and staffing structure needed to accomplish its requirements. To provide the medical services, the Plan required an original staffing level of 152.4 FTE positions, including 16.5 FTE physician positions. The privatization contract reduced the number of positions to 125.2 FTEs. The Trustee, however, has

⁴ The number of FTE positions is obtained by dividing the total number of hours worked by 2,080 hours (40 hours per week times 52 weeks per year). The source of the average population of inmates is from an analysis prepared by the Office of the Corrections Trustee.

indicated that the current levels of staffing and costs are above what is required to provide adequate medical services at the D.C. Jail.

Our review of information on correctional costs revealed that comparing cost data across jurisdictions could be highly problematic. Recent publications, including The Corrections Yearbook, published by the not-for-profit Criminal Justice Institute, caution that jail medical cost figures may not be easily comparable across jurisdictions. This is because jurisdictions may include (or exclude) the cost of different types of services in their medical cost figures. For example, some jurisdictions may include costs for mental health services and for inpatient hospitalization, while others may not. Also, they may or may not include items such as employee fringe benefits and renovations of medical services' space. Finally, there may be different ways of tabulating and reporting costs

No Single Threshold Defines Acceptable Levels of Medical Service and Staffing

There is no single factor or specific threshold that delineates the point at which an acceptable level of medical care is achieved in a jail. According to correctional medicine experts—including two consultants retained by the Office of the Corrections Trustee—the acceptable level of service and staffing is a function of many factors, including the medical situation and circumstances to be addressed. It is also, according to the Office of Corrections Trustee, a function of the specific constraints and demands placed on the service delivery system at a particular location.

Regarding “constitutional” standards of medical care, pursuant to the Eighth Amendment, the government has an obligation to provide medical care to prisoners. The U.S. Supreme Court, in Estelle v. Gamble,⁵ concluded that “deliberate indifference to serious medical needs of prisoners constitutes the unnecessary and wanton infliction of pain proscribed by the Eighth Amendment.” The Estelle Court noted that negligence alone did not amount to a constitutional violation. However, such cases tend to arise in the negative, when deficiencies in a correctional operation, such as the failure to deliver services to a prisoner in a reasonable time, reflect an unconstitutional level of care in particular situations.

Accreditation standards developed by NCCHC for medical services at jails set the minimum recommended requirements to achieve voluntary

⁵ 429 U.S. 97 (1976).

accreditation.⁶ The standards we reviewed include 33 “essential” requirements, such as inmate receiving screening, diet and exercise, and suicide prevention. They also include 36 “important” requirements, such as hospital and specialized ambulatory care, and pregnancy counseling for female inmates. In terms of staffing, the standards recommend that there be at least one FTE physician in jails with an average daily population of 500 or greater. However, the standards also state that the numbers and types of health care professionals required at a facility depend on a range of factors, including the type and scope of the medical services being offered.

The contract requires the D.C. Jail to be accredited by NCCHC or JCAHO within 12 months of the contract’s inception. BCDC and PGCCC are currently accredited by NCCHC, according to the Office of Corrections Trustee.

Possibilities Exist to Reduce Future Contract Costs

The current contract maintains levels of medical service and staffing that were already in place at the D.C. Jail, but possibilities exist to reduce future contract costs. The contract includes a provision under which the contractor is to return on a quarterly basis any unused funding to the District. In addition, the contract can be modified at any time or recompeted at existing or scaled-back levels when the first year ends.

The solicitation to acquire medical services for the D.C. Jail did not preclude offerors from submitting proposals that would reduce staffing and costs over the existing levels, as long as quality health care services would be provided. The solicitation encouraged each offeror to submit an “alternate” proposal for providing quality health care services differently or more economically than that specified in the comparison proposal. The solicitation indicated that the offerors should not feel constrained by the parameters of the comparison proposal, including the FTE levels and positions. Accordingly, each of the three offerors submitted an alternate proposal.

The Receiver, in consultation with District officials, made it a requirement that each offeror also submit a “comparison” proposal that would maintain the existing staffing levels and positions for at least 1 year. According to

⁶ NCCHC is a not-for-profit accreditation association that includes the American Medical Association and the American Jail Association. There also exist other accreditation organizations, such as the American Correctional Association and the Joint Commission on Accreditation of Health Care Organizations (JCAHO). We focused on NCCHC’s standards because, as noted in the text, the D.C. Jail contract requires the jail to be accredited by NCCHC or JCAHO, and we were only able to obtain the NCCHC standards within the time frame of this review.

the DOC Director and the Office of Corporation Counsel, they supported this decision because they felt that maintaining the existing service levels offered the best means for obtaining court approval to end the Receivership in August 2000 and return control of the Jail's medical facility to the District. The decision also sought to ensure that the quality of medical care would not decline and again result in litigation, according to District officials.

The evaluation committee initially rated all six of the proposals (three comparison and three alternate). The Receiver and committee concluded that none of the alternate proposals provided specific enough information to ensure that the alternate approaches would maintain the same level of medical services as did the comparison proposals. Accordingly, the alternate proposals were not evaluated by the committee in its final review of proposals. The committee recommended to the Receiver that he issue the contract to the top-rated company to implement its comparison proposal.

Receiver Employees Were Not Subject to D.C. Personnel Regulations

The firm that was awarded the contract to provide medical and mental health services at the D.C. Jail was constituted of employees working for the Receiver, not for the District government. Under D.C. Personnel Regulations, a District employee may not be a party to a contract with the District government unless a written determination has been made by the head of the procuring agency that there is a compelling reason for contracting with the employee. A District employee can make an offer on a contract, but generally cannot be awarded the contract while still in D.C. employment status. In this case, however, the winning firm was made up of employees of the Receiver rather than the District government, and they were awarded a contract with the Receiver. Therefore, the personnel regulation did not apply in this context.

We would note that the D.C. Contract Appeals Board (CAB) ruled in May 2000 on a protest by a losing offeror in this procurement. The protester asserted, among other things, that the Receiver showed bias in favor of the company (the awardee) formed by the incumbent Medical Director. The protestor did not specifically raise the issue of the employees' failure to resign prior to the award. CAB denied the protest, finding that there was not proof of bias sufficient to challenge the award. However, CAB noted that certain of the Receiver's actions gave an appearance not conducive to confidence in the fairness of this procurement.

Contacts and Acknowledgements

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