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Report No. 09-07

Steps to Control Prison Inmate Health Care Costs Have Begun to Show Savings

at a glance

The Department of Corrections' health care costs have increased 37% in the past five years. Factors contributing to this trend are national medical cost inflation, growth in the inmate population and demand for health care, health care staff vacancies that have resulted in the use of more costly temporary employees, and the department's failure to provide adequate management control over contracted health care in Region IV.

Since January 2008, the department has initiated several cost-containment measures that have begun realizing savings. The department reports spending \$12.5 million less for inmate health care during the first half of Fiscal Year 2008-09 than during the same period of the previous fiscal year. These steps include utilization management, staffing initiatives, expanding secure hospital beds, changes to pharmaceutical purchasing and dispensing, and centralized contract procurement. In addition, the Legislature included proviso language in the Fiscal Year 2008-09 General Appropriations Act limiting hospital charges, which saved approximately \$3.6 million from July to October 2008.

To ensure value and adequacy of contracted inmate health care, the department should further strengthen its contract procurement and monitoring practices.

Scope

As directed by the Legislature, this report reviews the Department of Corrections' efforts to contain health care costs and identifies best practices in contracting for inmate health care.¹

Background

A federal court ruled in *Costello v. the State of Florida* that inmate health services are a constitutional right.² Consequently, when offenders are admitted to Department of Corrections' prisons, the state becomes responsible for providing their health care.³ The department provides medical, dental, mental health, and pharmaceutical services to over 91,237 inmates housed in 55 prisons and in 77 other facilities throughout the state.⁴ Inmates often arrive at Florida's correctional facilities with an array of medical problems, including chronic or infectious diseases, mental health conditions, and substance abuse or alcohol disorders.

¹ [Fiscal Year 2008-09 General Appropriations Act](#) (Ch. 2008-152, *Laws of Florida*, following specific appropriation 775AM) and s. 11.51(6), *F.S.*

² *Costello v. Wainwright* 430 U.S. 325, 51 L.Ed. 2nd 372, 97S.Ct. 1191 (1977), 506, led to 21 years of litigation against the Florida Department of Corrections and court oversight of inmate health services.

³ Section 945.025(2), *F.S.*

⁴ On January 1, 2009, the total inmate population was 99,585, including inmates housed at six private prisons.

The department provides a basic level of health services within its institutions.⁵ Each major correctional institution provides infirmary services for nursing level care, such as monitoring vital signs, administering intravenous fluids, changing bandages and dressings, stabilizing patients after procedures, and monitoring long-term patients who are not acutely ill but cannot live among the general population. For more serious medical procedures, such as surgeries and treatment for chronic diseases, the department operates a 153-bed hospital at the Reception and Medical Center in Lake Butler. Also at the prison hospital, a contracted mobile surgery unit provides ambulatory surgery services.

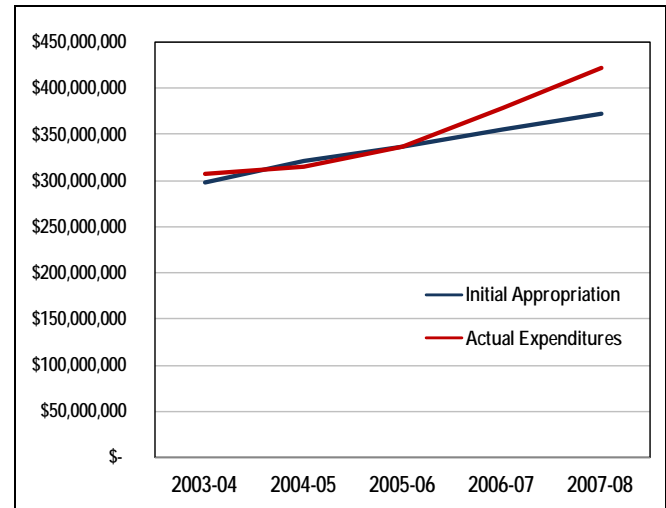
The department transports inmates to hospitals in the community when inmates have medical emergencies or require more specialized medical treatment than it can provide. The department negotiates contracts and price agreements with community hospitals and medical specialists for these services; in July 2008, the department had 159 contracts valued at \$335.7 million with health care providers.

The department's health care costs have increased nearly 37% over the past five years compared to 30% growth in total department appropriations. While the department's health care appropriation, as a percentage of its total appropriation, has remained constant at 15%, the department has spent more than initially appropriated in four of the past five fiscal years.⁶ See Exhibits 1 and 2.

⁵ Six private prisons provide their own health care to inmates. However, the department is responsible for hospital medical service charges over \$15,000 for these inmates. The department reports that in Fiscal Year 2007-08 it spent \$1,475,142 for these charges.

⁶ The department has typically covered shortfalls by requesting appropriation transfers from unfilled staff vacancies. Our prior report, *Corrections Experiences Turnover and Vacancies, But Performance Not Diminished*, OPPAGA Report No. 07-15, February 2007, noted that at the end of Fiscal Year 2005-06, the department had approximately 500 (5%) correctional officer vacancies as well as more than 200 vacant nurse, physician, and dentist career service positions at times during the year.

Exhibit 1 Inmate Health Care Costs Have Increased 37% Between Fiscal Years 2003-04 and 2007-08



Source: Florida LAS/PBS, July 23, 2008, September 28, 2008, and October 1, 2008.

Exhibit 2 Inmate Health Services Has Spent More Than Originally Appropriated Since Fiscal Year 2005-06

Fiscal Year	Initial Appropriation	Actual Expenditures	Difference
2003-04	\$297,096,464	\$307,626,417	\$(10,529,953)
2004-05	321,252,150	315,487,038	5,765,112
2005-06	335,588,990	336,339,039	(750,049)
2006-07	355,399,926	379,086,727	(23,686,801)
2007-08	372,402,325	421,381,540	(48,979,215)

Source: Florida LAS/PBS, July 23, 2008, September 28, 2008, and October 1, 2008.

The department has used privatization to attempt to control inmate health care costs with mixed results. As directed by the Legislature, in July 2001 the department contracted with Wexford Health Sources, Inc., to provide comprehensive health care to inmates at prison facilities in its Region IV (South Florida). After finding repeated noncompliance with contract requirements, the department re-bid the contract in 2005 and selected Prison Health Services, which took over services in Region IV on January 1, 2006. However, in August 2006, the vendor requested additional compensation citing higher than expected rates of hospitalization and resultant higher costs. The department rejected the request and Prison Health Services terminated its contract in November 2006.

The department subsequently solicited bids for a new health care contract, but found no bidders with sufficient financial resources to perform the duties of the contract.

In November 2006, the department implemented a hybrid model of health care in Region IV. By this model, the department contracts with numerous providers who deliver health care services in its institutions. The largest contract is with MHM Services, Inc., which delivers comprehensive mental health services and provides medical staffing at 13 institutions in South Florida and Taylor Correctional Institution in Perry.

As directed by the Legislature, this report addresses four questions.

- What factors have contributed to increased inmate health care costs?
- What steps have the department and Legislature taken to contain inmate health care costs?
- What issues should be considered when deciding whether to outsource inmate health services?
- What practices should the department follow when contracting for health services?

Questions and Answers —

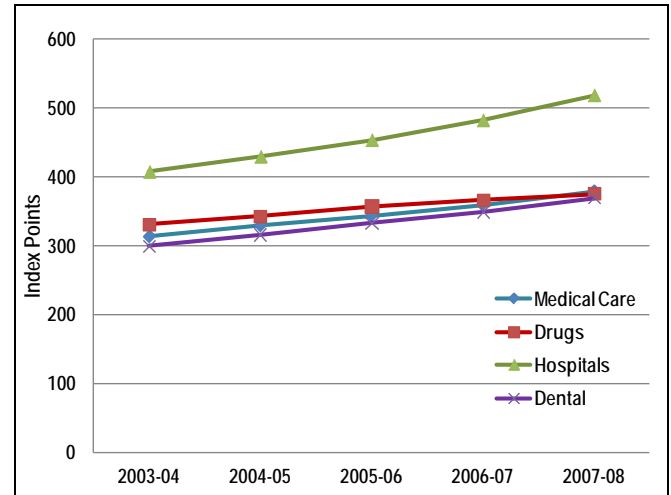
What factors have contributed to increased inmate health care costs?

Over the previous five fiscal years, several factors have contributed to the increased cost of the department's health services. These factors include national medical cost inflation, growth in the inmate population, higher proportions of elderly and female inmates, inmates' high demand for health services, use of costly temporary employees to cover persistent vacancies among department health care staff, and insufficient management control over contracted health care in Region IV.

Rising health care prices nationwide. A key driver of department costs is health care cost inflation. Average medical costs nationwide have grown by 21% over the past five years, as shown in Exhibit 3. Average prices for many key services that the department requires have increased more

sharply. For example, hospital service prices have increased 28% and dental service prices have increased 23% over the past five years, according to U.S. Department of Labor Consumer Price Indexes.

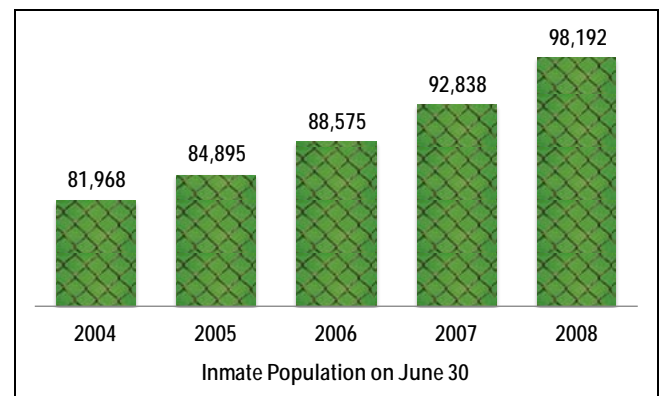
Exhibit 3
Health Care Costs Have Increased Nationwide



Source: OPPAGA analysis of data from the U.S. Department of Labor, Bureau of Labor Statistics.

Growth in the inmate population. Between Fiscal Years 2003-04 and 2007-08, Florida's inmate population increased by 20%, from 81,968 to 98,192, as shown in Exhibit 4.⁷ As all inmates require health care services, this growth in the inmate population leads to a corresponding increase in department health care costs.

Exhibit 4
Florida's Inmate Population Has Increased by 20% Since 2004



Source: Florida Department of Corrections.

⁷ These figures include inmates housed at private prisons.

Increase in the proportion of elderly and female inmate populations. The prison population has changed over time, with the department serving more older and female inmates. Over the past five years, the population of inmates classified as elderly, those 50 years of age and older, increased by 63% from 8,695 to 14,143.⁸ The number of female inmates increased by approximately 30% from 5,299 to 6,888 over this period.

Elderly inmates account for a disproportionately higher amount of health expenditures as they need more clinical visits, hospital admissions, and medications than the general inmate population. Similarly, female inmates tend to require more clinical visits and prescriptions due in part to illnesses related to the reproductive system, and greater mental health care due in part to psychological disorders resulting from trauma and physical and sexual abuse.

Inmates' high demand for health services. Inmates are generally less healthy than the general population, due in part to poverty, unemployment, inadequate nutrition, and failure to receive preventive health care services prior to entering prison. Studies also have shown inmates have a higher incidence of infectious diseases than the general public, and have a high occurrence of substance abuse-related disorders and mental illnesses. The department must send some inmates needing treatment for chronic and acute medical conditions to relatively expensive community hospitals and specialty clinics. In Fiscal Year 2007-08, the department spent \$78.7 million to treat inmates in community hospitals.

Some inmates also access health services for personal gains such as avoiding work, relieving boredom, talking to nurses and other medical staff, and obtaining transport out of the institution to a community hospital or to another institution. Some inmates describe false or exaggerated symptoms in an attempt to achieve such secondary gains.⁹

⁸ The Department of Corrections classifies inmates age 50 and older as aging or elderly. These inmates generally have poorer health status due to lack of health care prior to incarceration, personal habits such as smoking, alcohol, and drug abuse, the impact of the stress of isolation, and possible victimization experienced in prison.

⁹ *Review of Inmate Health Services Within the Department of Corrections*, [OPPAGA Report No. 96-22](#), November 1996.

Persistent vacancies in department health care positions. The department has persistently high vacancy rates among its health care staff. As the department is constitutionally required to provide health care services to inmates, it must hire temporary employees when staff vacancies occur. In Fiscal Year 2007-08, the department's average vacancy rate was 12.5% for health service full-time equivalent employee positions. As shown in Exhibit 5, the department had vacancy rates above that average in several key health care positions, including registered nurse specialists, senior physicians, advanced registered nurse practitioners, physicians, senior registered nurses, and senior psychologists.

Exhibit 5 The Department Had High Vacancy Rates in Key Health Service Positions in Fiscal Year 2007-08¹

Employee Class	Positions ²	Average Vacancies	Vacancy Rate
Registered nurse specialist	59.2	17.3	29.3%
Senior physician ³	98.2	27.9	28.4%
Advanced registered nurse practitioner	22.7	6.0	26.5%
Physician	31.8	7.8	24.6%
Senior registered nurse	177.3	38.6	21.8%
Registered nurse supervisor	26.3	4.8	18.1%
Health support technician	25.3	4.1	16.2%
Senior psychologist	60.5	9.0	14.9%

¹ Based on average monthly authorized positions. All positions, except physician and senior physician, are classified by the department as forensic/correctional. These positions are classified as special risk and subject to the 3% annual retirement rate.

² Full-time equivalent employees only.

³ Includes psychiatrists and general practitioners.

Source: OPPAGA analysis of Florida Department of Corrections' data.

The department attributes high vacancies in these positions primarily to salaries that historically have been lower than market rates. Also, there is a national shortage in health services personnel, and, according to the department, many health care professionals prefer employment in community settings that have a mission focused on patient care, rather than security. Finally, the department notes that prison settings and the

remote location of most institutions is unappealing to many prospective applicants.

When the department cannot fill its vacancies, it contracts with private employment agencies for temporary health care professionals at a higher cost. In Fiscal Year 2007-08, the department had an average of 39 vacancies a month in its senior registered nurse positions. Filling these positions at its contract payment rate would cost \$743,668 annually more than the department's average salaries and benefits for the positions.¹⁰

Insufficient management control over contracted health care in Region IV prior to 2008. The department failed to provide adequate contract management and medical oversight when it outsourced health care services in Region IV. This led to increased expenses and substandard inmate health care in some facilities in the region, according to the Correctional Medical Authority.¹¹

The department reported that its health leadership was deficient in Region IV after Prison Health Services cancelled its contract to provide health care in November 2006. The department responded to this cancellation by entering into emergency procurement agreements for private health services in the region. These contracts were not competitively procured and many lacked performance measures and penalties to hold contractors accountable. In addition, the Correctional Medical Authority and the department reported that in 2007 the department lacked needed medical oversight of its contractors and did not adequately monitor whether these providers delivered health care according to the department's policies. In the absence of this oversight, vendors did not maintain some inmate health records, admissions to community hospitals increased, and inmates received

medications that were not on the department's formulary.

The Correctional Medical Authority documented several deficiencies in the department's oversight in its June 2007 review of institutional medical care at Broward Correctional Institution. The authority identified delays in inmate evaluation, diagnosis, and treatment, and inadequate documentation of prescriptions written for inmates. The authority required the department to take emergency corrective action, which included reorganizing the medical records department to include a complete inventory of all medical records; instituting a new inmate medical record check-in/check-out system to provide for better inmate record tracking and accountability; and establishing a physician record review process. The department also revised its consultation process to facilitate more timely appointment follow-ups and specialty referrals.

The department has taken several steps to regain control of health care delivery and costs in Region IV. The department appointed a new assistant secretary of health services in January 2008 and assessed operations to identify ways to contain costs. Also, between October 2007 and April 2008, the department filled vacancies and replaced staff for all regional clinical and administrative director positions in Region IV with department staff to provide stronger management of its contracted health care providers.¹²

What steps have the department and Legislature taken to contain inmate health care costs?

As the department is affected by many external cost drivers for inmate health care, it must make special efforts to contain those costs that are within its control. The department's new health services administration reports that it has given an increased priority to controlling health care costs. Since January 2008, the department and the Legislature have initiated several cost containment measures, including establishing utilization management, implementing two staffing initiatives, expanding secure bed capacity,

¹⁰ For a senior registered nurse with up to three years of experience, the current department bi-weekly rate is approximately \$2,467 (including benefit costs); the temporary agency cost is approximately \$3,200 bi-weekly.

¹¹ The Correctional Medical Authority, housed in the Department of Health, assures that the Department of Corrections maintains adequate standards of physical and mental health care for inmates at all institutions, and provides an annual report to the Governor and Legislature on the status of the department's health care delivery system. The authority is an independent oversight body not under the control, supervision or direction of either the Department of Health or the Department of Corrections.

¹² Those positions included regional medical executive director, regional health services manager, and regional registered nurse, mental health, and pharmacy consultants.

revising its pharmaceutical practices, improving contracting, and limiting hospital charges to 110% of Medicare rates. These steps have begun to show savings. The department reports spending \$12.5 million less for inmate health care during the first half of Fiscal Year 2008-09 than during the same period of the previous fiscal year. However, the total savings impact cannot yet be determined.

The department established a hospitalization utilization management system. In this system, the department's nurses and doctors review each case referred for hospital admission to determine if treatment by a community hospital is necessary according to the department's guidelines. As of October 2008, the department reports that it has avoided 539 inmate admissions since it implemented the system in January 2008 and that hospital lengths of stay have been reduced, resulting in \$4.9 million in savings.

The department implemented two staffing initiatives to help contain costs. First, it replaced contracted staff with state employees to provide dental services statewide and pharmaceutical services in Region IV. The department estimates that it will save over \$4.5 million annually by bringing these services in-house.

Second, the department increased starting salaries to reduce vacancy rates for key health service positions. For example, in March 2008, the department raised its starting annual salary for dentists from \$68,153 to \$99,000. This, coupled with increases in starting salaries for other dental positions, reduced dental staff vacancies from 28% to 9%.¹³ The department projects that these entry salary enhancements will reduce its need to contract for more expensive temporary medical personnel. However, the department's median salaries for most health professions remain below market rates and the median salaries paid by other state agencies such as the Department of Children and Families, as shown in Exhibit 6.

Exhibit 6

The Department's Median Salaries for Health Professionals Are Below Those of the Department of Children and Families and Market Rates

Occupation	DOC Median	DCF Median	Market Median
Psychiatrists	\$ 138,569	\$ 145,000	\$145,030
Dentists	120,000	113,106	142,510
Physicians	100,099	125,542	NA
Registered Nurses	50,168	55,048	57,060
Psychologists	45,007	58,167	60,100
Licensed Practical Nurses	32,389	33,490	38,240

Source: OPPAGA analysis of data from People First (as of August 28, 2008), Florida Department of Corrections, and U.S. Department of Labor, Bureau of Labor Statistics.

The department should assess the impact of its starting salary enhancements on staff turnover, recruitment, vacancy rates, and use of contracted health care staff. The department should report the results of its assessment to the Legislature and seek authorization to raise salaries of existing staff if its assessment shows that this action would produce net cost savings to the state.

The department expanded secure hospital bed capacity. Secure hospital beds are located in community hospitals and consist of secure wings with locked passages, security cameras, and a complement of correctional officers. Treating inmates in secure beds reduces costs. Each inmate treated among a hospital's general patient population must be accompanied by two armed correctional officers at all times. Secure beds also reduce escape and public safety risks and avoid the need to transport inmates from South Florida to the department's hospital in Lake Butler.

The department has contracted with Memorial Hospital in Jacksonville and Larkin Community Hospital and Kendall Medical Center in Miami for secure inmate beds. The secure wing at Kendall Medical Center is currently under renovation and will house 24 beds, and is projected to be ready for inmates in spring 2009.

The department currently lacks data to evaluate savings from using secure beds in community hospitals, as it does not track its total costs for transporting inmates for medical purposes. The department should collect and analyze this data to determine whether it should continue to

¹³ The department has authority to increase starting salaries for new hires, but must obtain legislative approval to increase the salaries, other than merit increases, of existing employees.

expand the number of secure medical beds in community hospitals.

The department revised its pharmaceutical purchasing and dispensing practices. These actions include eliminating a separate purchase order for pharmaceuticals in Region IV, revising its pharmaceutical formulary, and partnering with the Florida Department of Health to obtain federal discounts for drugs to treat inmates with HIV and sexually transmitted diseases.

In July 2008, the department cancelled a purchase order agreement with a private vendor to provide pharmaceutical services in Region IV. The department consolidated these purchases with those of its other three regions and buys all pharmaceuticals through the Minnesota Multistate Contracting Alliance for Pharmacy.¹⁴ The department also began using its employees rather than contracted staff to dispense the drugs to inmates. The department estimates that this change will save over \$2.4 million annually.

The department has changed its drug formulary to make less expensive generic drugs the first and second choices for filling prescriptions. For example, the department removed Seroquel® from its formulary and replaced Risperdal® with a generic for the treatment of schizophrenia and bipolar I disorder. The department reports that between April and September 2008 it spent \$1.3 million less for anti-psychotic drugs than during the same period in 2007.

The department also began a pilot program in November 2008 with the Florida Department of Health to purchase high-cost drugs for inmates at substantially reduced prices under the federal

340B Drug Pricing Program.¹⁵ The department has entered into a memorandum of understanding with the Florida Department of Health whereby physicians with the county health departments will treat inmates who have been diagnosed with HIV/AIDS and sexually transmitted diseases.¹⁶ Since these inmates will be treated by Department of Health physicians, the drugs can be purchased at 340B pricing levels, which are expected cost approximately 30-50% less than drugs purchased through the Minnesota Multistate Contracting Alliance.

The department improved its contracting practices. Specifically, the department centralized procurement, pursued statewide contracts, and established and negotiated contracts with health care providers to reduce billing rates. The department has been working to replace contract procurement at the regional level with a centralized, statewide system to facilitate better contract negotiation and oversight, and to provide savings through volume discounts and economies of scale. The department also is establishing statewide contracts to negotiate better cost and service terms. For example, the department reports that it contracted with a single statewide provider to dispose of biomedical waste instead of renewing multiple contracts for separate regions. This allowed the department to contain the disposal costs despite an increase in usage demand.

The department also has negotiated contracts with some community hospitals and specialists for discounts. In June 2008, the department had contracts with 27 community hospitals and agreements with five others to charge less than standard billing rates for inmate care. For example, the department had an agreement with Shands at the University of Florida to charge 30% below its standard billing rates.

¹⁴ The Minnesota Multistate Contracting Alliance, created in 1985, is a voluntary, group-purchasing organization operated and managed by the State of Minnesota's Department of Administration for government health care facilities. The alliance's mission is to provide, through volume contracting and careful contract management, the best value in pharmaceuticals and related products to its members-eligible governmental health care facilities. Member facilities purchase over \$1 billion per year and have national account status with all of the major brand name and generic pharmaceutical manufacturers. The Bureau of Statewide Pharmaceutical Services at the Florida Department of Health manages purchases through the alliance for Florida agencies.

¹⁵ The 340B Drug Pricing Program resulted from enactment of Public Law 102-585, the Veterans Health Care Act of 1992, which is codified as Section 340B of the Public Health Service Act. Section 340B limits the cost of covered outpatient drugs to certain federal grantees, federally qualified health centers, and qualified disproportionate share hospitals for significant savings on pharmaceuticals.

¹⁶ The department has begun working with the Alachua and Jackson County Health Departments. The Alachua County Health Department will treat inmates at Hamilton, New River, Union, Columbia, and Lowell Correctional Institutions.

The Legislature included cost containment measures in proviso language in the General Appropriations Act for Fiscal Year 2008-09. These provisions require the department to pay no more than 110% of Medicare rates for health care charges. Other states such as Ohio, South Carolina, and Texas have similar requirements. Hospital charges are also limited to Medicare rates for certain federal prisoners and detainees. Medicare rates are significantly lower than the discounts and contract rates the department had previously negotiated. From July to October 2008, hospital charges based on 110% of Medicare rates were 69% lower than billed charges, which saved \$3.6 million.¹⁷

The Legislature also required the department to contract for pharmaceutical services statewide only if contracted costs are at least 3% below the department's costs to fill prescriptions in Fiscal Year 2007-08. To fulfill the requirements of the proviso language, the department has issued a request for proposals that is scheduled to close in March 2009. The department indicates that it will take one month to review the bids and make a decision on whether to award a contract. However, on September 17, 2008, TYA Pharmaceuticals filed a lawsuit against the Department of Corrections, alleging that the proviso is unconstitutional. The plaintiff is requesting that the proviso language be removed from the official records of the state and that the department cease its request for proposals for statewide comprehensive pharmaceutical services.

What issues should be considered when deciding whether to outsource inmate health services?

Outsourcing can be a viable option for providing adequate, cost-effective health services. It is critical for agencies to systematically plan privatization initiatives and develop business cases that identify the expected costs and benefits of outsourcing before carrying out these efforts.

¹⁷ According to the department, as of October 9, 2008, 10 hospitals have not renewed contracts and currently only accept emergency room admissions due to the reimbursement limitations of the proviso. These hospitals are Baptist Hospital (Pensacola), Baptist Medical Center (Miami), Jacksonville Plastic Surgery, Lee Memorial Hospital, Winter Haven Memorial, and Shands hospitals at Jacksonville, Lake Shore, Live Oak, Starke, and at the University of Florida (Gainesville).

The Legislature and department should consider several issues when deciding whether or not to contract for inmate health services.

Has the department established an adequate business case to assess outsourcing proposals? The 2006 Legislature required state agencies to develop business cases to ensure that their plans to outsource services would be efficient and cost-effective.¹⁸ However, the Department of Corrections' outsourcing efforts of health care services are exempt from the business case process.¹⁹

Despite this exemption, the department should evaluate its initiatives for feasibility, cost-effectiveness, and efficiency before it proceeds. The evaluation should include key aspects such as analyzing the agency's current performance, identifying the specific goals to be achieved, describing available options for achieving those goals, analyzing the advantages and disadvantages of these options, describing current market conditions, performing a cost-benefit analysis, and establishing a contingency plan for potential contractor nonperformance.

The department did not adequately plan or manage its outsourcing of health services in Region IV, resulting in higher costs when, in November 2006, the provider prematurely terminated its contract and the department contracted with multiple service providers without securing competitive proposals to obtain the best value.²⁰ In addition, the department continues to lack cost data needed to assess whether its contracts with community hospitals for secure treatment beds produce net savings.

¹⁸ The Council on Efficient Government was created in 2006 in response to a growing trend to outsource government services and jobs. The council's role is to review, evaluate, and issue advisory reports on outsourcing business cases as specified by legislation as well as investigate and recommend innovative ideas to increase efficiency and save taxpayer dollars.

¹⁹ Section 287.0571(4)(a), *F.S.*, provides exemptions from competitive bidding of certain contractual services including medical services, and thus, exemption from the review and evaluation of business cases to outsource as required by s. 287.0573(8)(b), *F.S.*

²⁰ *Inmate Health Care Consolidation Progressing; Privatization Requires Agency Vigilance*, OPPAGA [Report No. 04-61](#), August 2004.

How would contracting provide the department with needed technology? Privatization proponents contend that the private sector can provide access to equipment and technology that the department may not be able to otherwise afford. The Department of Corrections is limited in the services it can provide because of the age and condition of equipment in its hospital in Lake Butler, and it reported that its infirmaries are underutilized because they do not have basic medical equipment such as oxygen concentrators and intravenous pumps. Accordingly, the department should assess how privatization would affect these key technology deficiencies.

How would contracting provide access to medical specialists? The department frequently needs access to medical specialists because some inmates have acute, chronic, or otherwise serious illnesses and conditions that must be treated. Outsourcing can provide the department access to medical specialists that it cannot afford to hire as full-time employees or for which it has only occasional need, such as neurologists. The department should consider how outsourcing would affect its ability to obtain this necessary medical expertise.

How would contracting address staffing issues? The department, like many correctional agencies across the nation, has particular difficulty recruiting and retaining health professionals due to the nature of its work environment. Nonetheless, the department is constitutionally required to provide medical services to inmates and must have nurses on-site and physicians on-call 24 hours a day. Therefore, when critical positions such as nurses and physicians are unfilled, the department must use relief staffing agencies. Although this alternative is more expensive, it enables the department to meet its federal and statutory requirements. The department should consider how outsourcing proposals would affect its ability to obtain cost-effective medical staffing.

Has the department established a clear contingency plan? The department needs a contingency plan for providing services if a private provider terminates its contract early or is terminated for noncompliance. This was clearly demonstrated in November 2006 when Prison Health Services terminated its contract and the department was forced to find health care

providers on short notice in South Florida. Accordingly, it is critical for the department to establish plans to quickly and effectively respond if such problems recur in future contracts.

How will the department evaluate outsourcing outcomes? The department should establish qualitative and quantitative performance measures to assess whether its contractors are providing effective and efficient services, and establish a system for periodically reporting these data to management and the Legislature.

What practices should the department follow when contracting for health services?

When the department concludes that contracting is the best alternative, it should use sound practices to ensure that each contract saves the state money, provides adequate services, and avoids lawsuits.

The Council on Efficient Government has identified several key best practices for managing outsourcing initiatives. The department currently follows most of these best practices. However, it should strengthen its procurement and monitoring practices in some areas.

Conduct research to determine the best contracting alternatives. Researching potential vendors and market rates helps determine reasonable and fair pricing, best vendors, and performance/service standards. The department currently researches potential vendors and market rates when it is required to bid out services. This has enabled it in some cases to negotiate lower rates for services. For example, the department researched biomedical waste disposal market costs and determined that it could reduce costs by basing payments on the volume of waste generated rather than on the removal of waste containers.

Competitively bid for contracts to ensure the best value for the state. Competitive bidding is a way to ensure that contracts provide the best value to the state and are awarded equitably and without favoritism. Florida law exempts contracts less than \$25,000 and many aspects of health services from competitive bidding.²¹ Despite the exemption, the department now bids for major medical service contracts, such as comprehensive

²¹ Sections 287.057(5)(e) and 287.057(5)(f)7., F.S.

mental health care for Region IV, radiology, pharmaceutical delivery, and biomedical waste disposal.

Require contractors to adhere to federal and state law, and applicable department policies and procedures. Requiring contractors to have a clean service record and comply with federal and state laws and rules helps avoid lawsuits and early termination of contracts. The department could strengthen its current practices by ensuring that contracts clearly state that failure to adhere to laws can result in sanctions, including termination of contract. Contracts should also require contractors to provide notice within seven days of any filed complaints, investigations, warning letters, inspection reports, or disciplinary actions imposed and include related documentation with the notification. For example, in 2008, a contract bidder for radiology services bid lower than its competitor and was awarded the contract. The department later found that the contractor was acting illegally in not paying workers' compensation taxes, in addition to not performing agreed services, and it terminated the contract.

Clearly articulate the terms and conditions of the contract. Contracts should clearly specify the responsibilities of the contractor and the department, including penalties for noncompliance. While the department has tightened its contract language to clearly identify the services and responsibilities of each party, it should take additional steps. Currently, most health care contracts do not specify penalties for noncompliance other than termination for cause. The department does list specific penalties for persistent staff vacancies in its contract with MHM Solutions, Inc., for health staff in Region IV, and should include similar intermediate sanctions in other contracts when appropriate.

Establish performance measures and assess performance. Performance measures establish the state's expectations for contracted services. The department has improved its efforts in this area. Previously, performance measures were not a standard part of contracts, but the department now includes them in its major contracts and annually evaluates providers' performance.

Develop standardized training and a procedures manual for contract monitoring staff. Standardized training helps ensure that monitors are evaluating programs in a uniform and consistent manner. Training should be based on a procedures manual that addresses standards of conduct, assessing vendor risk, and preparing monitoring reports. The department does not have a manual but trains all of its monitors on state laws and rules and department procedures. The department should publish a manual that encompasses all aspects of contract monitoring responsibilities to ensure that all monitors are trained in a standardized manner.

Ensure that contractors adequately monitor subcontractors. The department contracts with private companies that sometimes subcontract with other companies to provide services. The department should strengthen its contracting practices by requiring contractors to monitor subcontractors to ensure that they meet all required standards. Subcontractor deficiencies were reported to be a problem in Region IV when health services were fully outsourced. Contracts now require that contractors ensure that all contract services are provided as specified, even if they use subcontractors.

Develop clear, measurable corrective action plans that address deficiencies and oversee implementation of those plans. Action plans must be clearly defined and measurable penalties must be defined for failure to correct deficiencies. Also, interim steps should be established so that monitors more quickly identify whether the vendor is making progress in correcting noncompliance. The department has improved its efforts in this area and its contracts are now written to require deficient providers to establish corrective action plans for all noted deficiencies within 10 days of receipt of the monitoring report. The department also developed a new monitoring tool, which includes action plans with dates for completion.

The department should assure that services are billed correctly. The department should ensure that the state does not pay for services it has not received and that it pays the correct amount for those that it has received. This includes determining accurate billing charges according to Medicare rates. An entity with expertise in health billing and Medicare rates should administer hospital and physician bill payment, but the department does not have expertise in this area. The department has recently strengthened its efforts in this area. In December 2008, the department awarded a contract to a claims reviewer to identify overpayment and ensure that charges are correctly calculated, discounts were correctly applied, and no charges were made for services that were not provided.

Recommendations —————

To strengthen the department's ability to provide cost-effective inmate health care, we recommend that the department

- determine the impact of its increased starting salary rates on staff turnover and vacancy rates and request legislative approval to increase salaries of other vital medical service staff if it would reduce long-term costs to do so;

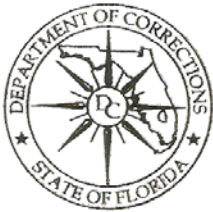
- track costs for the medical transport of inmates to determine whether it is less costly to contract for secure hospital beds and, if so, for how many should there be contracts issued;
- develop business cases that identify the expected costs and benefits of outsourcing before carrying out these efforts;
- include intermediate sanctions for noncompliance in its contracts; and
- publish a contract monitoring manual that establishes clear oversight responsibilities to ensure that all contract monitoring staff are trained in a standardized manner.

Agency Response —————

In accordance with the provisions of s. 11.51(5), *Florida Statutes*, a draft of our report was submitted to the Secretary of the Florida Department of Corrections for his review and response.

The Secretary's written response to this report is presented in Appendix A.

Appendix A



FLORIDA
DEPARTMENT of
CORRECTIONS

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Fax: (850) 922-2848

January 29, 2009

Gary VanLandingham
Director
Office of Program Policy Analysis
and Government Accountability
111 West Madison Street
Tallahassee, Florida 32399-1475

Dear Mr. VanLandingham:

Thank you for the opportunity to respond to OPPAGA's report on the Department of Correction's Office of Health Services (OHS). I couldn't agree more with your assessment that, since early 2008, OHS Management has made extensive efforts to greatly improve health care operations within the Department, both clinically and financially. Their experienced approach to managing health care operations has resulted in substantial cost savings, mirroring much of what you stated in your report.

Through the first six months of the fiscal year, OHS has spent \$12.5 million less than the same period a year ago. This is amazing considering, at the beginning of Fiscal Year 2008-2009 OHS was projected to spend \$44 million more than it was appropriated (Appropriation of \$425 million for FY 2008-2009 - Anticipated expenditures \$469 million). The OHS deficit on January 1st has come down to \$4 million, a \$40 million decrease in just six months.

This decrease in expenditures compared to last year was accomplished despite an increase in over 5000 inmates, more HIV inmates, more geriatric inmates, and an increase in the cost of health care (6.3% nationwide).

Put another way, the daily cost of inmate health care, or per diem rate, was \$13.03 per inmate per day at the end of FY2007-2008. On January 1, 2009, we reduced this rate to \$11.81; again, about a \$40 million cost avoidance in the first six months.

Director Gary Vanlandingham
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January 28, 2009

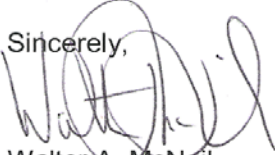
These cost savings measures were started by a new OHS management team, headed by Dr. Sandeep Rahangdale, who created a new "CAN DO" mission statement for Health Services that emphasized best practices and the ethical imperative of prompt and proper inmate care. It also focused on collaboration between State agencies, Universities, and national resources to provide the most cost efficient health care possible

Last, but not least, these cost savings measures were accomplished with the cooperation and efforts of our dedicated health services staff throughout the State of Florida. We instituted an aggressive Utilization Management program, de-privatized major contracts to reduce administrative healthcare costs, reduced more expensive temporary staffing, and aggressively negotiated to lower rates in many of our health services contracts.

Lastly, one of our most successful tools was the passing of 2008 Legislative proviso which allowed us to pay for hospital care, when no contract exists, at greatly discounted rates based on a percentage of Medicare. Prior to this proviso, we were forced to pay the full price of the claim. This will save the State approximately \$20 million during the current fiscal year. We are requesting that this proviso become permanent in law.

I want to thank you for the professional and courteous manner in which you and your staff conducted this review. They were a pleasure to work with. Responses to the recommendations contained in your report are shown on the following attachment.

Sincerely,

A handwritten signature in dark ink, appearing to read "Walter A. McNeil", written over a circular stamp or seal.

Walter A. McNeil
Secretary

Department of Corrections
Office of Health Services
Responses to OPPAGA Recommendations

Office of Health Services responses to the recommendations contained in the OPPAGA report are shown below.

Recommendation 1 – Determine the impact of its increased starting salary rates on staff turnover and vacancy rates and request Legislative approval to increase salaries of other vital medical service staff.

OHS Response – OHS recognizes that quality, dedicated health care staff is integral to efficient and effective operations. Historically, the starting salaries, hence current salaries, of many of our long-term staff have been substantially below comparable market rates. Current OHS management understands the fact that recruiting and obtaining competent, experienced staff actually saves the State money. That is why we requested and were successful in raising new-hire appointment rates across the board in health services.

As you can imagine, this has caused great concern among many current, long-term, dedicated staff who see new staff being hired at salaries above theirs. Therefore, we are requesting, for the second consecutive year, a \$14 million Legislative appropriation to bring most veteran salaries up to current appointment rates. We believe this is justified given the substantial cost savings staffs have realized.

Recommendation 2 – Track costs for the medical transport of inmates to determine whether it is less costly to contract for secure hospital beds and, if so, for how many should there be contracts issues.

OHS Response – We currently contract with Memorial Hospital Jacksonville (MHJ) and Larkin Hospital in Miami, who provide a secure hospital wing for Department inmates. We have also contracted with Kendall Hospital in Dade County, who is in the process of constructing, at their expense, about \$1 million in security improvements for a 24-bed wing in their existing hospital.

We believe it quite apparent that utilizing a secure wing, which is staffed using three 8-hour shifts, is much less costly than providing security at non-secure hospitals. At non-secure hospitals, at least two and sometimes more security staff are needed, on a 24-hour basis, to ensure each inmate is properly secured.

Recommendation 3 – Develop business cases that identify the expected costs and benefits of outsourcing before carrying out these efforts.

OHS Response – Before deciding whether to contract with individual physicians or hospitals, or whether to provide services through a regional or statewide contract, OHS management makes great efforts to analyze expected costs and benefits. In fact, we recently completed a business case analysis for the design, construction and operation of a Radiotherapy Treatment Center on the grounds of RMC Hospital.

Recommendation 4 – Include intermediate sanctions for non-compliance in its contracts.

OHS Response – The issues mentioned in the report pertaining to a contract with MHM Solutions for health care staffing in Region IV were a result of the 2006 comprehensive health services contract the Department previously had with Prison Health Services (PHS). Region IV staffing had been privatized since 2001. As a result of being required to re-bid the contract, and the fact that PHS substantially underbid in winning the contract, PHS decided to terminate the contract after just 9-months. This forced OHS to write emergency contracts with all of PHS's subcontractors, which MHM Solutions had for Region IV health services staffing. In fact, the contract does provide for liquidated damages for excessive staff vacancies.

Nonetheless, during 2009 OHS will be determining how best to provide medical staffing in Region IV. If the decision is made to continue contracting, we will ensure adequate penalties for non-compliance.

Recommendation 5 – Establish a contract monitoring manual that establishes clear oversight responsibilities to ensure all contract monitoring staff are trained.

OHS Response – In September 2008, the Bureau of Procurement and Supply (BPS) created Procedure 205.013, Contract Management and Monitoring, which provides guidelines and responsibilities for contract monitors throughout the Department. In addition, in mid-2008, OHS created a Contract Monitoring Section, which has improved contract monitoring efforts for its more than \$200 million in OHS medical services contracts. OHS contract monitors have received training from BPS. In addition, they are in the process of creating more specific monitoring guidelines for health services contracts.

The Florida Legislature

Office of Program Policy Analysis and Government Accountability



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