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FEDERAL PRISONS

Containing Health Care Costs for an Increasing Inmate Population

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Containing Health Care Costs For An Increasing Inmate Population

In conjunction with a rising federal inmate population, the Bureau of Prisons' (BOP) health care costs (not adjusted for inflation) for treating prisoners increased from $137.6 million in fiscal year 1990 to $372.1 million in fiscal year 1999, an average annual increase of about 8.6 percent. Adjusted for inflation, BOP's per capita inmate health care costs increased from $3,001 in fiscal year 1990 to a high of $3,703 in fiscal year 1996. However, per capita costs steadily decreased in subsequent fiscal years, declining to $3,242 in 1999. By way of comparison, the nation's per capita health care costs (adjusted for inflation) rose continuously during fiscal years 1990 through 1999.

Since the early 1990s, BOP has attempted to increase the efficiency and economy of health care delivery to prisoners through various cost-containment initiatives, such as restructuring medical staffing, obtaining discounts through quantity or bulk purchases, leveraging resources through cooperative efforts with other governmental entities, and even privatizing medical services at selected facilities. BOP reports that some of these efforts are starting to produce savings, as indicated by the decrease in per capita inmate health care costs from 1997 through 1999.

To further control medical costs, BOP has proposed two legislative provisions. One---a prisoner copayment provision—would authorize the Director of BOP to assess and collect a fee of not less than $2 for each health care visit requested by a prisoner**.** BOP officials expect that this copayment provision would serve primarily to reduce the number of unnecessary medical visits. The Congressional Budget Office (CBO) has concluded that this provision would also generate annual revenues of about $1 million. The second provision would build on the federal government's extensive experience in establishing payment rates for inpatient hospital services through Medicare's prospective payment system. That is, Medicare's prospective rates, which vary to reflect expected patient-care costs, could be adapted to serve as caps to BOP's payments to community hospitals for services provided to federal prisoners. The CBO has estimated that this legislative provision would save BOP about $6 million annually. Although we did not fully evaluate the advantages and disadvantages of these two legislative provisions, we believe that they would be helpful to BOP's efforts to control medical costs.

In addition, we identified an administrative option whereby BOP might achieve further savings by negotiating more cost-effective contracts with community hospitals that provide medical care for inmates. In late 1999, to provide a basis for identifying best value among competing proposed

contracts, one of BOP's six regions---the South Central Region---began using an innovative "benchmarking" approach. According to regional office contracting officials, if the benchmarking approach were applied to all contracts in the South Central Region, the estimated savings would be about $5.6 million annually in this one region alone. We are recommending that BOP (1) take steps to test the benchmarking approach and (2) if results validate the cost effectiveness of this approach, implement it BOP-wide.

Federal Prisons: Containing Health Care Costs for an Increasing Inmate Population

Mr. Chairman and Members of the Subcommittee:

I am pleased to be here today to discuss the results of our review of health care costs at the federal Bureau of Prisons (BOP). We undertook this work at the request of, and as agreed with the Subcommittee. We focused our work primarily on identifying (1) trends in BOP health care costs from fiscal year 1990 through fiscal year 1999, (2) BOP initiatives to contain rising medical costs, and (3) legislative and administrative options for helping to contain health care costs.

My statement is based on our analyses of BOP statistics and reports and on interviews with officials in BOP's central office and six regional offices and officials with the Department of Health and Human Services' (HHS) Health Care Financing Administration (HCFA), which administers the Medicare program. We performed our work from July 1999 to March 2000 in accordance with generally accepted government auditing standards. Regarding the various cost-containment initiatives or proposals discussed in this statement, we did not independently verify the savings estimates made by BOP and the Congressional Budget Office (CBO). Attachment I presents additional details about our scope and methodology in addressing the objectives.

In this statement, I make the following points:

- In conjunction with a rising federal inmate population, BOP's health care costs (not adjusted for inflation) increased from $137.6 million in fiscal year 1990 to $372.1 million in fiscal year 1999, an average annual increase of about 8.6 percent. Adjusted for inflation,[1] BOP's per capita inmate health care costs increased from $3,001 in fiscal year 1990 to a high of $3,703 in fiscal year 1996. The per capita costs steadily decreased in subsequent fiscal years, declining to $3,242 in fiscal year 1999. In contrast, the nation's per capita health care costs (adjusted for inflation) rose continuously during fiscal years 1990 through 1999.

- Since the early 1990s, BOP has attempted to increase the efficiency and economy of health care delivery to prisoners through various cost-containment initiatives, such as restructuring medical staffing, obtaining discounts through quantity or bulk purchases, leveraging resources through cooperative efforts with other governmental entities, and even

[1] Throughout this statement, when we present health care cost data adjusted for inflation, we used the gross domestic product (GDP) price index, with 1998 as the base year.

privatizing medical services at selected facilities. BOP reports that some of these efforts are starting to produce savings.

- To further control medical costs, BOP has proposed two legislative provisions. One—a prisoner copayment provision—would authorize the Director of BOP to assess and collect a fee of not less than $2 for each health care visit requested by a prisoner. BOP officials expect that a copayment provision would serve primarily to reduce the number of unnecessary medical visits. CBO's analysis also concluded that a copayment provision would reduce the number of unnecessary medical visits and would generate annual revenues of about $1 million. The second legislative provision would establish a Medicare-based cap on payments to community hospitals that treat inmates. CBO has estimated that this legislative provision would save BOP about $6 million annually. We believe that these two legislative provisions would be helpful to BOP's efforts to control medical costs.

- Finally, we identified an administrative option whereby BOP might achieve further savings by negotiating more cost-effective contracts with community hospitals that provide medical care for inmates. In late 1999, to provide a basis for identifying best value among competing proposed contracts, one of BOP's six regions---the South Central Region---began using an innovative "benchmarking" approach. According to regional office contracting officials, if the benchmarking approach were applied to all contracts in the South Central Region, the estimated savings would be about $5.6 million annually in this one region alone. We are recommending that BOP (1) take steps to test the benchmarking approach in other regions and (2) if results validate the cost effectiveness of this approach, implement it BOP-wide.

Background

BOP's responsibility for maintaining the federal prisoner population includes providing health care for all inmates in its custody. According to BOP's Health Services Manual, the health care mission of BOP is to provide the necessary medical, dental, and mental health services to inmates by a professional staff, consistent with acceptable community standards. BOP uses various medical care arrangements to provide health services to inmates. These arrangements include BOP's use of both internal and external health care providers.

Internally, each of BOP's 98 facilities has an on-site health service unit to provide routine, ambulatory medical care. For instance, these units are to provide care for moderate and severe illnesses, including hypertension and diabetes mellitus, as well as care for patients with HIV infection and AIDS.

A medical professional is to be either on-site or available for 24-hour continuous duty to handle medical problems that may occur during or after normal working hours.[2] According to a BOP official, inmate sick call is to be conducted on a weekly schedule at each facility, with urgent care services available at all times. If an inmate is found to have a health problem beyond the capabilities of the health service unit, BOP medical personnel are to refer the inmate to one of seven medical referral centers or, alternatively, to an outside community care provider (hospital).

To round out BOP's internal health care network, the seven medical referral centers provide hospital and other specialized services to inmates. According to a BOP Health Services Division official, the medical referral centers originally were intended to provide all of BOP's medical needs. However, despite still performing some major medical procedures (such as treatment for chronic diseases and mental illness), the centers have evolved to focus on postsurgical recovery and aftercare for inmates who have received medical treatment from outside community care providers. The change in focus was due to rapid changes in medical technology and procedures, in addition to the limited capacities of the medical centers.

BOP's health service units and medical referral centers are staffed by a combination of Public Health Service (PHS) and BOP health care employees, consisting of physicians, dentists, physician assistants/nurse practitioners, nurses, pharmacists, psychiatrists, psychologists, and laboratory and x-ray personnel. The Joint Commission on Accreditation of Healthcare Organizations has accredited all of BOP's health service units and medical referral centers.

In certain instances, BOP's internal resources cannot fully meet inmates' medical needs. If an inmate requires special medical expertise that is not available internally, BOP personnel are to seek it from an external medical provider. In addition, according to a BOP official, a continual rise in BOP's inmate population caused six of the seven[3] medical referral centers to exceed their rated capacities for patients during 1999, and this situation will likely continue in view of the projected rising prison population**.** For these reasons, in future years, according to a BOP official, community medical providers can be expected to play a larger role in meeting the health care needs of a growing and aging inmate population---and, in turn,

[2] In some BOP facilities, after hours care may be provided by the local community hospital.

[3] According to a BOP official, the seventh medical referral center (Ft. Devens, MA) was in the process of opening during the time of our review and, therefore, was not operating at full capacity.

this trend will increase the importance of negotiating cost-effective contracts.

Generally, secure transportation and guard escort services are required for prisoners referred from BOP facilities to community providers. Costs for transportation and guards represent additional health care expenses borne by BOP in obtaining community-based medical services for inmates. However, according to a BOP official, in some cases the community providers can visit and treat inmates inside BOP's facilities, which eliminates the need for secure transportation and guard escorts.

Trends in Health Care Costs

In conjunction with a rising federal inmate population, BOP's health care costs increased during the 1990s. According to BOP data, the federal inmate population increased from 64,936 at fiscal year-end 1990 to 133,689 at fiscal year-end 1999. Further, BOP officials estimate that the total federal inmate population will reach approximately 198,700 by fiscal year-end 2006.[4]

BOP data show that the number of inmates 46 years of age and older increased each year from 1995 to 1999**.** For example, the number of inmates between the ages of 46 and 50 rose from 7,937 in 1995 to 9,854 in 1999, an increase of 24 percent. Inmates 66 years of age and older rose from 881 in 1995 to 1,225 in 1999, an increase of 39 percent. A BOP official attributed the "aging" of the inmate population, in part, to changes in sentencing laws that are intended as get tough on crime measures—laws involving, for example, mandatory minimum sentences and repeat offender provisions. According to the BOP official, older inmates place greater demands on the health care system than do younger inmates.

BOP's health care costs (not adjusted for inflation) increased from $137.6 million in fiscal year 1990 to $372.1 million in fiscal year 1999, an average annual increase of about 8.6 percent.[5] However, BOP's health care costs as a percentage of total operational costs were fairly stable, averaging 13 percent annually during this period.

During fiscal years 1990 through 1999, BOP's cumulative health care costs for inmates totaled about $2.7 billion. For this 10-year period, table 1 shows the following:

[4] Attachment II presents more information about BOP inmate population trends.

[5] These figures represent operational costs. BOP categorizes its costs as operational costs (primarily salaries and other operating expenses) and capital costs (building and construction expenditures).

- Almost three-fourths of BOP's cumulative health care costs involved three categories: BOP medical personnel salaries (38 percent), community provider services (24 percent), and PHS associated costs (10 percent). Four other categories (at 5 to 8 percent each) accounted for the remainder of the cumulative costs.
- Per capita inmate health care costs (adjusted for inflation) increased from 1990 to 1999 in all of the categories except two (community provider services and miscellaneous).

Table 1: BOP Health Care Costs by Category, Fiscal Years 1990 Through 1999

Cost category	Percentage of cumulative health care costs (1990-99)	Per capita health care costs (1990)[a]	Per capita health care costs (1999)	Percentage change in per capita health care costs from 1990 to 1999
BOP medical personnel salaries	38%	$1,066	$1,225	+14.9%
Community provider services	24	741	728	-1.8
PHS associated costs	10	336	367	+9.2
Supplies	8	289	307	+6.2
Consultants	8	255	281	+10.2
Guard escort services	7	155	198	+27.7
Miscellaneous[b]	5	159	135	-15.1
Total	**100%**	**$3,001**	**$3,241**	**+8.0%**

[a]Per capita costs for 1990 are adjusted to 1999 dollars using the GDP price index.

[b]The miscellaneous category includes headquarters expenses, equipment purchases, HIV testing, transportation charges (including airlift costs), printing costs, and interest.

Source: Developed by GAO based on BOP data.

On the other hand, it must be recognized that the limited or point-to-point (1990 and 1999) comparisons in table 1 are insufficiently detailed to show trends for the intervening years. BOP's per capita inmate health care costs, adjusted for inflation, were $3,001 in fiscal year 1990, increased to a high of $3,703 in fiscal year 1996, and then decrea*sed* annually to $3,242 in fiscal year 1999. In contrast to the decrease in BOP's per capita health care costs in recent years, national per capita health care costs—that is, data for all adults and children in the United States—show a steady increase annually during fiscal years 1990 to 1999. Adjusted for inflation, national per capita health care costs progressively increased from $3,059 in 1990 to $3,970 in 1998 and to $4,140 (estimated) in fiscal year 1999.

Per capita data for selected BOP cost categories (adjusted for inflation) show the following:

- BOP medical personnel salaries: Per capita costs decreased steadily from a peak of $1,399 in 1996 to $1,225 in 1999.

- Community provider services: Per capita costs decreased from a high of $952 in 1993 to $728 in 1999.
- PHS associated costs: Per capita costs were $378 in 1997 and $379 in 1998, and then decreased to $367 in 1999.
- Guard escort services: Per capita costs decreased from $289 in 1995 to $198 in 1999.

Overall medical costs, however, are likely to continue to rise in future years, according to BOP officials. In explaining this anticipated trend, the officials noted the following reasons:

- Projections of the number of inmates incarcerated in federal facilities show continued increases.
- Felony inmates transferred to BOP from the District of Columbia Department of Corrections generally have disproportionately more medical needs than other BOP inmates.
- From the Immigration and Naturalization Service (INS), BOP is receiving increasing numbers of long-term, nonreturnable detainees.
- BOP's expenditures for pharmaceuticals likely will rise due to the increasing prevalence of illnesses such as HIV and hepatitis.

Attachments III and IV present more information about trends in BOP's health care costs.

Cost-Containment Initiatives

A BOP Health Services Division official stated that the recent downward trend in per capita inmate health care costs was due to implementation of various cost-containment initiatives. In the last several years, BOP has put into place a number of initiatives to address health care costs. In response to our inquiries, BOP officials identified a total of 23 ongoing and/or planned cost-containment initiatives. We grouped these initiatives into five categories: (1) cooperative efforts with other federal agencies to acquire medical services, equipment, and supplies; (2) other acquisition-related initiatives involving BOP only; (3) staffing-related initiatives; (4) initiatives concerning the delivery of services; and (5) health care privatization and other initiatives. Examples of initiatives in each category are discussed in the following sections.[6] As indicated, BOP has reported that some of the ongoing initiatives have resulted in cost savings.

Cooperative Acquisitions

BOP has various cooperative initiatives—either ongoing or planned—with the Department of Defense (DOD), the General Services Administration, the U.S. Marshals Service (USMS), and/or the Department of Veterans

[6] Attachment V lists all of the 23 ongoing and/or planned initiatives.

Affairs (VA). The purpose of BOP's cooperative efforts with other agencies is to save money through bulk purchasing and resource sharing. In 1993, for example, VA began including BOP in contracts to obtain discounts on high-volume purchases of pharmaceuticals. As a result of this effort, BOP has cited average annual savings of approximately $760,000. One example of resource sharing is a pilot project that began in the New York City area in 1998. Under the terms of an interagency agreement, VA physicians work in medical specialty clinics at BOP facilities to treat both BOP and USMS prisoners.

Other Acquisition-Related Initiatives

An example of another type of acquisition-related initiative is a precertification program that BOP began in 1995. That is, precertification is required before inmates are sent to community providers for inpatient surgery, other inpatient hospitalization services, or outpatient surgery. In the precertification process, BOP headquarters officials, including both policy and medical personnel, are to review and approve community-provided medical treatment being requested by BOP field personnel. According to a BOP official, it appears that precertification has led to field institutions recommending treatment only for those cases deemed to be medically necessary or medically indicated. As a result of this initiative, BOP reported savings of $785,000 in 1998.

Staffing-Related Initiatives

Regarding staffing initiatives, in 1994, wardens at some BOP prisons began eliminating 24-hour medical staff coverage, if emergency care was readily available in the community. BOP reports that this initiative has generated cost savings averaging about $1.6 million per year. A BOP official acknowledged that this initiative was implemented as a result of our 1994 report on inmate health care.[7]

Also, partly as a result of our 1994 report, BOP began restructuring its health care staff to allow for more efficient operations. For example, one staffing initiative focused on using qualified, lower-salaried medical personnel---instead of more highly paid physicians and physicians' assistants---for certain nonprimary health care duties, such as routine laboratory and pharmacy services. According to BOP, this initiative has generated annual savings of about $5.5 million.

A BOP Health Services Division official added that both the reductions in 24-hour medical staff coverage and staff restructuring caused the downward trend in BOP's health care salary costs since 1997. Also,

[7] Bureau of Prisons Health Care: Inmates' Access to Health Care Is Limited by Lack of Clinical Staff (GAO/HEHS-94-36, Feb. 10, 1994).

according to this official, the restructuring initiative has had a positive effect on BOP's second highest health care cost category (after salaries)---community provider services. That is, restructuring has reduced the number of trips to community medical providers by emphasizing the proper roles of BOP's own internal medical staff. For example, the number of occurrences of community hospitalization decreased from 5,247 in fiscal year 1997 to 5,166 in 1999. The annual number of inmate inpatient days in community hospitals also decreased over the last 5 years, from 23,257 in fiscal year 1995 to 23,107 in fiscal year 1999. The official added that the reduced number of trips to community medical providers—a result of BOP's restructuring initiative—has also resulted in reduced guard escort costs.

Delivery of Services Initiatives

In 1996, BOP began a telemedicine initiative that involves using video teleconferencing to exchange health information and provide health care services. BOP's stated goals for this program are to reduce costs, improve access to medically necessary resources, and enhance security, while delivering quality medical care to the inmate population.

In 1999, Abt Associates, Inc., performed an evaluation of this initiative and concluded that telemedicine was a widely accepted and viable cost-containment strategy.[8] Based upon the demonstration project and additional research, BOP personnel presented a proposal, in March 1999, to the BOP executive staff to implement telemedicine throughout BOP. The executive staff approved the proposal. As of November 1999, BOP had eight facilities equipped with telemedicine, with plans to add the technology to all facilities by the end of calendar year 2000.

According to a BOP official, the success of the telemedicine initiative partly accounts for the downward trend in the costs of guard escort services. As previously mentioned, BOP's per capita costs for guard escort services decreased from $286 in fiscal year 1995 to $199 in fiscal year 1998.

Privatization Initiative

BOP has an ongoing privatization project, among other health care cost-containment initiatives. Specifically, in response to a Senate Appropriations Committee report, BOP is experimenting with the delivery of health services through privatization at its facilities located in Beaumont, TX. The University of Texas Medical Branch (UTMB) is

[8] Telemedicine Can Reduce Correctional Health Care Costs: An Evaluation of **a** Prison Telemedicine Network (NCJ 175040), March 1999, prepared by Abt Associates, Inc., for the Joint Program Steering Group, Office of Science and Technology, National Institute of Justice.

providing all the health services for four separate prison facilities located in Beaumont.

Under the terms of its contract with BOP, UTMB was to provide medical services at the rate of $5.12 per inmate, per day in fiscal year 1998. In comparison, BOP's overall per inmate rate was $9.21 a day during the same time period. Thus, the contract rate for the Beaumont facilities seemingly represented daily savings of $4.09 per inmate, when compared with the rest of BOP.

However, according to BOP officials, the Beaumont pilot was not fully operational until the middle of fiscal year 1998, and the first full year of data for the pilot was not completed until fairly recently, that is, the end of fiscal 1999. Therefore, BOP does not expect a detailed evaluation of the Beaumont project to be completed until June 2001. BOP's Beaumont evaluation plan notes that the evaluation will include comparisons with other correctional programs to show whether privatization at Beaumont offers better value for the taxpayer**,** while providing the required quality of care. Also, BOP officials told us that replication of the Beaumont privatization model is a concern, particularly with respect to remote locations that do not have access to major community medical centers or teaching medical centers.

BOP Proposals for Legislation

BOP has proposed two legislative provisions to help further control health care costs. One provision would authorize the Director of BOP to assess and collect a prisoner copayment. Another provision would establish a Medicare-based cap on payments to community hospitals that treat inmates.

Proposal For Prisoner Health Care Visit Copayment

Requiring federal prisoners to help defray the cost of their health care by paying even a nominal fee for medical visits could help BOP control health care costs. Recognizing the potential for cost savings, the Senate passed S. 704 on May 27, 1999, authorizing the Director of BOP to assess and collect a fee of not less than $2 for certain health care visits requested by a prisoner. The Senate referred S. 704 to the House. A similar bill (H.R. 1349) has been introduced in the House in March 1999, and hearings were held September 30, 1999. As of March 9, 2000, there had been no further action in the House on this bill.

BOP Expects More Efficient Use of Medical Resources With a Copayment Fee Set at $2 Per Visit

If the legislation passes, BOP anticipates setting the copayment fee at $2 per visit[9], excluding indigent inmates who are unable to pay. According to BOP, a copayment fee can be expected to result in more efficient use of medical resources. Specifically, BOP anticipates the copayment fee of $2 per visit will result in more efficient use of medical resources by (1) reinforcing BOP's efforts to teach prisoners personal responsibility, (2) reducing the wait-time of genuinely ill prisoners to receive medical attention, (3) diverting fewer valuable staff hours unnecessarily, and (4) allowing medical staff to more appropriately spend their time evaluating and treating those prisoners who have legitimate medical needs.

In short, BOP anticipates that a copayment provision will discourage frivolous demands on finite medical resources—such as the practice of prisoners signing up for sick call to avoid required activities**.** While BOP anticipates that a copayment provision will not generate a net gain in revenue, BOP still endorses such a provision for the several previously mentioned reasons.

CBO Estimates Additional Revenue of $1 Million From Prisoner Copayments in the First Year

A May 1999 CBO analysis of the proposed $2 health care service fee estimated that BOP might generate additional revenue of at least $1 million in fiscal year 2000. CBO projected that the potential savings would increase annually in subsequent years as initial fixed or start-up costs were recovered, but also noted that actual savings would be realized only to the extent that appropriations were reduced.

Under the Senate version of the proposed copayment legislation, all fees collected from prisoners subject to restitution orders would be paid to victims. In the remaining cases, 75 percent of the fees collected would be deposited into the Crime Victims Fund, and the other 25 percent would be available to the Attorney General to help defray BOP's costs of administering a copayment fee provision and making appropriate distributions of collections. CBO estimated that administrative costs would be about $170,000 annually. BOP has suggested that the proposed legislation be modified to mandate that 100 percent of collected fees go to the Crime Victims Fund.

CBO has noted that a copayment provision would discourage some prisoners from unnecessary health care visits, perhaps reducing overall visits by up to 25 percent. CBO based its projection on the results of similar prisoner copayment programs that have been adopted in 36 states

[9] BOP supports copay fee exemptions for emergency visits, mental health visits, obstetric care, scheduled physical exams, and chronic care visits.

or local jurisdictions. The states and localities using prisoner copayment fees have, according to CBO, realized average reductions in sick call visits of 16 to 50 percent.

Proposal for Medicare Rate Cap on Hospital Payments

According to BOP, inmate health care costs could be further controlled by building on the federal government's extensive experience in establishing payment rates for inpatient hospital services through Medicare's prospective payment system.[10] That is, Medicare's rates, which vary to reflect expected patient-care costs, could be adapted as caps to BOP's payments to community hospitals for services provided to federal prisoners. A BOP official told us that no appreciable costs would be incurred in implementing a Medicare-based cap for BOP's payments to community hospitals.

In this regard, BOP (with HCFA assistance) has drafted legislative language, that is currently included in the administration's draft crime bill as the "Prisoner Medical Payment Efficiency Act of 1999." Under the proposed legislation, community hospitals that choose to treat BOP inmates would be required to accept payment rates as prescribed in regulations to be issued by the Attorney General and the HHS Secretary---payments that would be tied to the Medicare program's rate structure. BOP's National Health Care Systems Administrator explained that the language is intended only to ensure that those hospitals that agree to treat federal prisoners do so at the rates specified by the Attorney General and HHS Secretary.

As of early March 2000, the administration's draft crime bill had not been introduced in Congress. However, what follows, is our presentation of cost-benefit and other perspectives on the Medicare-based cap proposal.

CBO and BOP Have Estimated That Substantial Savings Would Result From a Cap Based on Medicare Rates

In September 1999, CBO analyzed the Medicare-based cap proposal[11] and estimated that the proposal would save about $6 million annually, assuming appropriations were reduced accordingly. CBO concluded that the annual savings would result from contracts that could be negotiated using Medicare rates. More specifically, CBO arrived at the $6 million-savings estimate by considering the following information:

[10] The prospective payment system is the mechanism by which the Medicare program calculates payments to hospitals for services rendered, at predetermined rates, specific to patient diagnoses.

[11] CBO's analysis involved a preliminary review of section 6508 ("Medicare Rate Enforcement Mechanism") of S. 899, which contained a proposal similar to that in the administration's draft crime bill.

- In 1998, BOP spent $82 million under contracts with community hospitals that treated federal prisoners.
- Of this total, about $30 million (or 37 percent) involved services provided under contracts that were "not negotiated" because of factors such as company or hospital location, underwriting issues, or one-bidder-only responses to BOP's solicitations.
- Approximately 20 percent of the $30 million resulted from nonnegotiated contracts that had prices higher than applicable Medicare rates.

Thus, CBO concluded that bringing the nonnegotiated contracts' costs in line with Medicare rates would save about $6 million annually, which is an amount equal to 20 percent of $30 million. By design, CBO's methodology (a broad overview or "macro" approach) was intended to provide an order-of-magnitude estimate of savings that could be expected from having a Medicare-based cap on BOP payments to community hospitals.

In addition, BOP recently analyzed a nonprojectable sample of actual billings received by BOP from community hospitals and concluded that a Medicare-based cap would generate substantial savings. In its analysis, BOP summarized actual cost data from the nonprojectable sample (217 of 3,362**)** of hospital bills received for the prisoners' care in 1998. Then, for this sample, BOP calculated what the medical care would have cost at applicable Medicare rates. A comparison[12] of the actual billings and the constructed Medicare-based rates showed that BOP paid about $1.3 million for services that would have cost about $662,000 at Medicare rates—representing lost potential savings for BOP of nearly 50 percent.

HCFA Supports a Medicare-Based Rate Cap for BOP

BOP collaborated with HCFA—the Medicare program administrator—in developing the legislative proposal to use a Medicare-based cap to better control federal prisoners' health care costs. According to HHS' Legislative Affairs Office, HCFA officials were closely involved in developing the legislative language and fully support BOP's efforts. Both HHS and BOP officials noted that the proposed legislative language requires further collaboration by the Attorney General and the HHS Secretary to establish implementing regulations. The process of establishing regulations, according to BOP officials, would allow for the consideration of special circumstances or interests, such as the continued stability of the Medicare program, the potential impact on rural hospitals, and possible extraordinary expenses for prisoners' medical care.

[12] Attachment VI presents more details on BOP's sample analysis.

DOD and VA Already Use Medicare Rates in Paying for Civilian Hospital Care

Under existing provisions[13] of the Medicare statutes, community hospitals that agree to treat DOD and VA civilian beneficiaries are required to accept certain payment rates. These rates are prescribed by regulations[14] required by the federal Medicare statutes and issued by the Secretary of HHS and the Secretaries of DOD and VA, respectively. As a result, DOD and VA are paying community hospitals for medical care for civilian beneficiaries based on Medicare rates. BOP patterned its legislative proposal on these existing provisions for DOD and VA. Regarding the period before DOD began using Medicare-based rates in its health care program for civilian military dependents,[15] we reported that DOD's medical reimbursement rates were significantly higher—50 percent higher on average—than those for similar services under the Medicare program.[16]

Recent Legislation Reflects the Use of a Medicare-Based Rate Cap on Payments to Hospitals

In November 1999, Congress passed legislation establishing a Medicare/Medicaid-based cap on health care payments to community hospitals for treating prisoners under the custody of USMS and the Immigration and Naturalization Service (INS), both of which are component agencies of the Department of Justice, as is BOP. The legislation was enacted as part of the Department of Justice's fiscal year 2000 appropriation (P.L. 106-113). Language included in the appropriation amended title 18 of the U.S. Code to limit the amount that the Attorney General can pay for certain federal prisoners' heath care, stating that:

"Payment for costs incurred for the provision of health care items and services for individuals in the custody of the United States Marshals Service and the Immigration and Naturalization Service shall not exceed the lesser of the amount that would be paid for the provision of similar health care items and services under—(A) the Medicare program …or (B) the Medicaid program…" 18 U.S.C. 4006.

Attachment VII presents more information about this legislation and USMS efforts to contain costs for health care provided to detainees.

Contracting for Health Care Services Could Be Improved

Irrespective of whether the legislative proposals suggested by BOP are enacted, another option for controlling health care costs involves negotiating more reasonably priced contracts with community providers (hospitals). In this regard, to help identify best value among competing

[13] 42 U.S.C. section 1395cc (a)(1)(J),(L).

[14] DOD and VA regulations, respectively, are located at 32 C.F.R. 199.14 and 38 C.F.R. 17.55.

[15] The Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) is DOD's medical program for active duty dependents and retirees and their dependents.

[16] Defense Health Care: Reimbursement Rates Appropriately Set; Other Problems Concern Physicians (GAO/HEHS-98-80, Feb. 26, 1998).

bidders, one of BOP's six regions (the South Central Region) recently began using a benchmarking approach in contract solicitations. According to regional office contracting officials, if the benchmarking approach were applied to all contracts in the South Central Region, the estimated savings would be about $5.6 million annually in this one region alone. Thus, wider testing and use of the benchmarking approach—throughout all six of BOP's regions—might produce even greater cost savings.

Current Pricing Structures Not Adequate for Identifying Best Value

At the time of our review, BOP had 112 contracts with community hospitals to supplement its health service units and medical referral centers. Typically, a contract had a 5-year term consisting of a base year and 4 option years. BOP's costs under these contracts totaled about $82 million in fiscal year 1998.

Of BOP's 112 contracts with community hospitals, about 63 percent had pricing structures based on nonbenchmarked Medicare rates, about 23 percent had pricing structures based on fee schedules, and the remaining 14 percent were based on per diem rates or other pricing structures. BOP officials acknowledged that current contract-solicitation practices---as reflected in the pricing structures of competing contract proposals and the resulting contracts---generally have not provided an adequate basis for BOP to identify the lowest price for medical treatment**.** To illustrate the lack of price comparability among bids, BOP officials noted the following:

- Contract proposals that use nonbenchmarked Medicare rates: Under general practices, each applicable bidder has proposed that its contract be based on its own unique Medicare rate. Because these rates are unique to the respective hospital, this type of pricing proposal does not lend itself to the easy comparing of hospitals—not even to the comparing of hospitals located in the same urban and/or rural geographic area. For example, regarding viral meningitis treatment provided by five hospitals in the El Paso, Texas, area—after adjusting or otherwise identifying the specifically applicable Medicare factors—BOP found that the Medicare rates had a variance among the five hospitals of almost 43 percent, ranging from a low of about $7,000 to a high of about $10,000.
- Contract proposals that use fee schedules: Fee schedules are exceedingly difficult to use for comparative purposes. For instance, a fee schedule can be quite voluminous, with hundreds of pages and thousands of individual line items. In fact, it is not unusual for the printed pages of a fee schedule to be several inches thick. Moreover, comparison difficulties are further compounded in that fee schedules tend to change frequently. For these reasons, when contract competitions have been based on fee schedules, BOP generally has been unable to adequately identify the lowest-priced

and highest-priced bidders. Rather, BOP has tried to compare randomly selected line items, but comparison results have not been projectable to entire fee schedules.

- Contract proposals with a mixture of rate structures: In responding to a given solicitation, some community hospitals may bid their own unique Medicare rate, and other hospitals may bid with fee schedules. BOP's experience is that comparing these bids is very difficult. Thus, as a general practice, BOP has tended to automatically select a Medicare-rate bidder without determining whether such selection offered the best value.

In summary, BOP had 112 contracts with community hospitals at the time of our review. However, BOP officials readily acknowledged that—given the difficulties in comparing rate structures in competing bids—BOP cannot readily determine whether or not these contracts represent best values.

One Region Reported Savings Based on a New Contracting Approach

Community medical providers can be expected to play an even larger role in the future to meet the health care needs of a growing and aging inmate population---and, in turn, this trend would increase the importance of negotiating cost-effective contracts.

Recently, to provide a basis for identifying best value among competing proposed contracts, one of BOP's six regions---the South Central Region---began using an innovative "benchmarking" approach. Specifically, in soliciting contracts, the region required bidders to use a common or standard benchmark rate—that is, the "Medicare federal rate" for relevant Medicare diagnosis-related groups (DRG)—and to separately show (if applicable) a proposed percentage markup or percentage discount to that benchmark rate.

While South Central Region officials are convinced the benchmarking approach solves BOP's difficulties in comparing prices among bids, the officials acknowledge that data are not available to demonstrate agencywide that price reductions would result in every renegotiated contract that uses the benchmarking approach. Such data could take years to accumulate.

As of January 2000, BOP's South Central Region had used the benchmarking approach twice. Based on this experience, the region undertook a price analysis comparing (1) the region's most recently awarded contract based on the benchmarking approach, and (2) another contract recently awarded under BOP's traditional approach. The region reported estimated cost savings of about 32 percent annually from the

contract awarded under the benchmarking approach compared with the contract negotiated under BOP's traditional approach. According to regional office contracting officials, if the benchmarking approach were applied to all contracts in the South Central Region, the estimated savings would be about $5.6 million annually in this one region alone.

Possible Opportunity for BOP-wide Savings

In November 1999, after a series of meetings with South Central Region officials, we contacted BOP's other five regional offices to obtain views on the benchmarking approach. Contracting officials in all five regions told us that the benchmarking approach has merit and that they may consider using it in the future.

In addition, contracting officials at BOP headquarters commented that use of the benchmarking approach for contracting is best viewed as a supplement to, rather than a replacement for, BOP's efforts to obtain legislation placing a Medicare-based cap on payments to community hospitals for treating inmates. The officials noted, for instance, that benchmark contracting is a bottom-up approach designed to encourage competition—and, in turn, stimulate price reductions—whereas the legislative cap proposal is a top-down approach to set a maximum payment amount.

Nonetheless, under BOP's decentralized management structure for contracting, BOP headquarters officials told us that they would prefer to obtain full "buy-in" from each of the regions before implementing a benchmarking approach agencywide. South Central Region officials acknowledged that sufficient data are not available to demonstrate that price reductions would result from using the benchmarking approach to renegotiate every contract. However, South Central Region officials are convinced that the benchmarking approach solves BOP's difficulties in comparing prices among bidders and, thus, should be a preferred contracting approach. Although BOP currently has no plans to implement the benchmarking approach agencywide, headquarters officials told us that a training seminar on this approach is to be provided to representatives of all regional contracting offices by summer 2000.

Each year—given the typical terms of its contracts (a base year, plus 4 option years)—BOP is to review each of its contracts for price reasonableness and decide whether to exercise the option or to solicit a new contract. According to South Central Region officials, wider use of the benchmarking approach may help to make these decisions and realize significant cost savings. BOP headquarters officials noted, however, that the cost effectiveness of the benchmarking approach should be further

validated before deciding whether to implement this approach throughout the agency.

Conclusions

BOP's inmate population was 133,689 at fiscal year-end 1999, more than double the number at fiscal year-end 1990. In conjunction with an aging and growing inmate population, BOP's health care costs increased during this decade, to a cumulative total of $2.7 billion during fiscal years 1990 through 1999. In recent years, however, available data show some signs of a positive trend. For example, BOP's per capita inmate health care costs (adjusted for inflation) decreased in 1997, 1998, and 1999. A BOP official attributed the recent downward trend to various cost-containment initiatives, such as working with other federal agencies to leverage available resources, restructuring health care staff to allow for more efficient operations, and making greater use of telemedicine technology.

In the future, BOP anticipates that the federal prison population will continue to age and to grow, reaching an estimated 198,700 inmates by fiscal year-end 2006. To help further control medical costs, BOP has proposed two legislative provisions. One provision would authorize the Director of BOP to assess and collect nominal fees for certain health care visits requested by a prisoner. According to CBO, 36 states or local jurisdictions already have such a provision. BOP endorses a fee provision as a means of using limited medical resources more efficiently. BOP anticipates that a fee provision would not generate an increase in net revenue, even though CBO has estimated that a $2 fee would generate savings of at least $1 million in fiscal year 2000 and that future years would show even greater savings as initial fixed or start-up costs were recovered. However, CBO also noted that actual savings would be realized only to the extent that appropriations were reduced.

The second proposed legislative provision would establish a Medicare-based cap on payments to community hospitals that treat BOP prisoners. CBO has estimated that this legislative provision would save about $6 million annually. The Medicare program's administrator, HCFA, supports BOP's efforts to secure passage of this legislative provision. Two other federal agencies, DOD and VA, already have statutory authority to use Medicare rates in paying for civilian hospital care. Moreover, legislation enacted in November 1999 utilized a Medicare/Medicaid-based rate cap for community hospitals that treat prisoners under the custody of USMS and INS.

In our opinion, these two legislative provisions seem to be steps in the right direction. That is, we think that these provisions would be helpful to BOP's efforts to control medical costs.

An administrative option whereby BOP might achieve further savings involves focusing on contract negotiations, that is, negotiating more cost-effective contracts with community hospitals that provide medical care for inmates. In 1999, to provide a basis for identifying best value among competing proposed contracts, one of BOP's six regions, the South Central Region, began requiring bidders to use a common or standard baseline rate (the Medicare federal rate for relevant DRGs) and to separately show, if applicable, a proposed percentage markup or percentage discount to that rate. According to regional office contracting officials, based on actual experience with two recent contracts, if this benchmarking approach were applied to all contracts in the South Central Region, the estimated savings would be about $5.6 million annually in this one region alone. Thus, by not implementing the benchmarking approach agencywide, BOP may be foregoing an opportunity to save potentially millions of dollars annually in health care costs.

Recommendation to the Attorney General

We recommend that the Attorney General require the BOP Director to test the benchmark contracting approach currently being used in BOP's South Central Region. If test results validate the cost effectiveness of the benchmark contracting approach, the BOP Director should require its implementation for health care contracts throughout BOP.

Mr. Chairman, this concludes my prepared statement. I would be pleased to answer any questions that you or other Members of the Subcommittee may have.

Contacts and Acknowledgements

For further information regarding this testimony, please contact Richard M. Stana on (202) 512-8777 or Danny R. Burton on (214) 777-5600. Individuals making key contributions to this testimony included Ronald J. Salo, David P. Alexander, Fredrick D. Berry, Laura A. Dummit, Ann H. Finley, Michael H. Harmond, and Mary K. Muse.

Objectives, Scope, and Methodology

Objectives

At the request of the Chairman, Subcommittee on Criminal Justice Oversight, Senate Committee on the Judiciary, our objectives were to identify (1) trends in the federal Bureau of Prisons (BOP) health care costs from fiscal year 1990 through 1999, (2) BOP initiatives to contain rising medical costs, and (3) legislative and administrative options for helping to contain health care costs.

Scope and Methodology

Initially, to obtain an overview understanding, we reviewed various reports, studies, and articles about correctional health care costs and related issues. These documents included the most recent health services evaluation reports completed (in 1997, 1998, or 1999) by BOP's Program Review Division—-that is, reports evaluating health services at BOP's medical referral centers.

Also, we obtained (1) overall statistics on the BOP inmate population and health care expenditures, (2) descriptive information about BOP's cost-containment initiatives and claimed savings, and (3) general data about applicable hospital payment rates under the Medicare program and rates in BOP's contracts with community hospitals. We discussed the sources of data with applicable agency officials, and we worked with the officials to reconcile any mathematical or other discrepancies that we identified in the data.

The following four sections discuss more specifically the scope and methodology of our work in addressing the respective objectives.

Cost Trends

To identify trends in BOP health care costs since fiscal year 1990, we obtained BOP inmate population data and health care cost information from BOP's Administration Division. For example, the Administration Division provided us data showing the actual growth and/or the projected growth of the federal inmate population for fiscal years 1990 through 2006. To provide a relative perspective of BOP's health care costs, we calculated these costs as a percentage of the agency's total operational costs for fiscal years 1990 through 1999.

Also, using data provided by BOP's Administration Division, we calculated the annual changes in BOP's health care cost categories (salaries, supplies, etc.) during fiscal years 1990 through 1999. To determine and discuss the reasons for changes or trends in the various cost categories, we interviewed the Administrator of BOP's National Health Systems.

Further, for comparative purposes, we obtained national health care cost data from the Health Care Financing Administration's (HCFA) Office of the

Actuary. Using HCFA and BOP data, respectively, we calculated per capita annual health care costs for both the nation and BOP for fiscal years 1990 through 1999. Using the standard gross domestic product (GDP) price index, we adjusted all per capita costs for inflation. That is, we adjusted all per capita cost data to 1999 dollars, using the GDP price index.

Cost-Containment Efforts

To identify BOP's initiatives for containing health care costs, we interviewed officials at BOP headquarters and BOP's six regional offices. In so doing, we obtained information about ongoing as well as planned initiatives. We reviewed documents on BOP's health care contracting practices and on BOP's pilot project involving privatization of the delivery of health care services at the prison complex in Beaumont, TX. In addition, we reviewed a November 1996 report—-prepared by the Department of Justice's Office of the Inspector General—-on inmate health care costs.[1]

We contacted the U.S. Marshals Service (USMS) to obtain information about a cooperative or joint (BOP and USMS) initiative to contain health care costs. We interviewed relevant USMS headquarters officials and reviewed relevant documentation, including a 1994 Department of Justice report on medical services for USMS detainees.[2]

We did not independently verify the savings cited by BOP regarding its various cost-containment efforts. Further, we did not analyze or confirm the relationship between the trends in BOP's per capita health care costs and BOP's cost-containment initiatives.

Legislative Options

As suggested by the requester's office, we focused on two BOP proposals—-one calls for establishing a prisoner copayment requirement for medical service, and the other calls for establishing a Medicare-based cap on payments to community hospitals that treat inmates. We discussed these proposals with Department of Justice, BOP, USMS, and HCFA officials in Washington, D.C. We also interviewed a representative of the American Hospital Association in Washington, D.C.

Prisoner Copayments

Regarding a possible requirement for prisoner copayments, we reviewed relevant legislative bills—-S. 704 and H.R. 1349—-that were introduced in the 106th Congress. Also, we reviewed the Congressional Budget Office's (CBO) analysis of a copayment provision.

[1] Inspection of Inmate Health Care Costs in the Bureau of Prisons, Report Number I-97-01, November 1996.

[2] Management Report: Review of the U.S. Marshals Service Detainee Medical Services, Department of Justice, Justice Management Division, December 1994.

Cap on BOP Payments to Community Hospitals

We obtained the views of HCFA and BOP officials on the merits of a legislative proposal—included in the administration's draft crime bill—to establish a Medicare rate cap on BOP payments to community hospitals that treat inmates. In addition, we reviewed a Department of Justice policy options paper[3] on the advantages and disadvantages of such a cap. Further, regarding estimates of cost savings calculated by CBO and BOP, we contacted applicable staff of the respective agencies to discuss the methodology and data sources used to make the estimates.

BOP's Health Care Contracts With Community Hospitals

To obtain a general overview of BOP contracting, we reviewed BOP's Acquisition Policy Manual and excerpts from the Federal Acquisition Regulations related to solicitations, and we discussed contracting practices with responsible BOP officials at headquarters and the six regional offices.

Regarding a benchmark contracting approach used by BOP's South Central Region, we discussed this approach with regional contracting officials and also reviewed relevant documents. For example, we reviewed the region's first benchmark solicitation package, which led to a health care contract being awarded in September 1999 for the newly opened Federal Detention Center in Houston, Texas.

Also, the region's contracting officer provided us a briefing on the benchmark contracting approach, including its advantages in comparing bid prices and its potential for achieving price reductions. Further, regional office contracting staff provided us a detailed analysis comparing the prices of two health care contracts recently negotiated by the region. One contract was awarded under the benchmark approach, and the other was awarded under BOP's traditional approach. According to BOP regional office officials, this was a reasonably designed comparison in that

- both contracts were awarded within 14 months of each other,
- the estimated amount for each contract was in the range of $25 million to $30 million,
- the same contractors bid in both solicitations,
- the BOP facilities involved in both solicitations were medical referral centers, and
- the BOP facilities were located in the same city (Fort Worth, TX).

[3] Legislative Options – Medicare Rates for Detainee Health Services, Department of Justice, Justice Management Division, December 1996.

We discussed with BOP staff the methodology and data sources used to make the analysis, and we examined the supporting documentation.

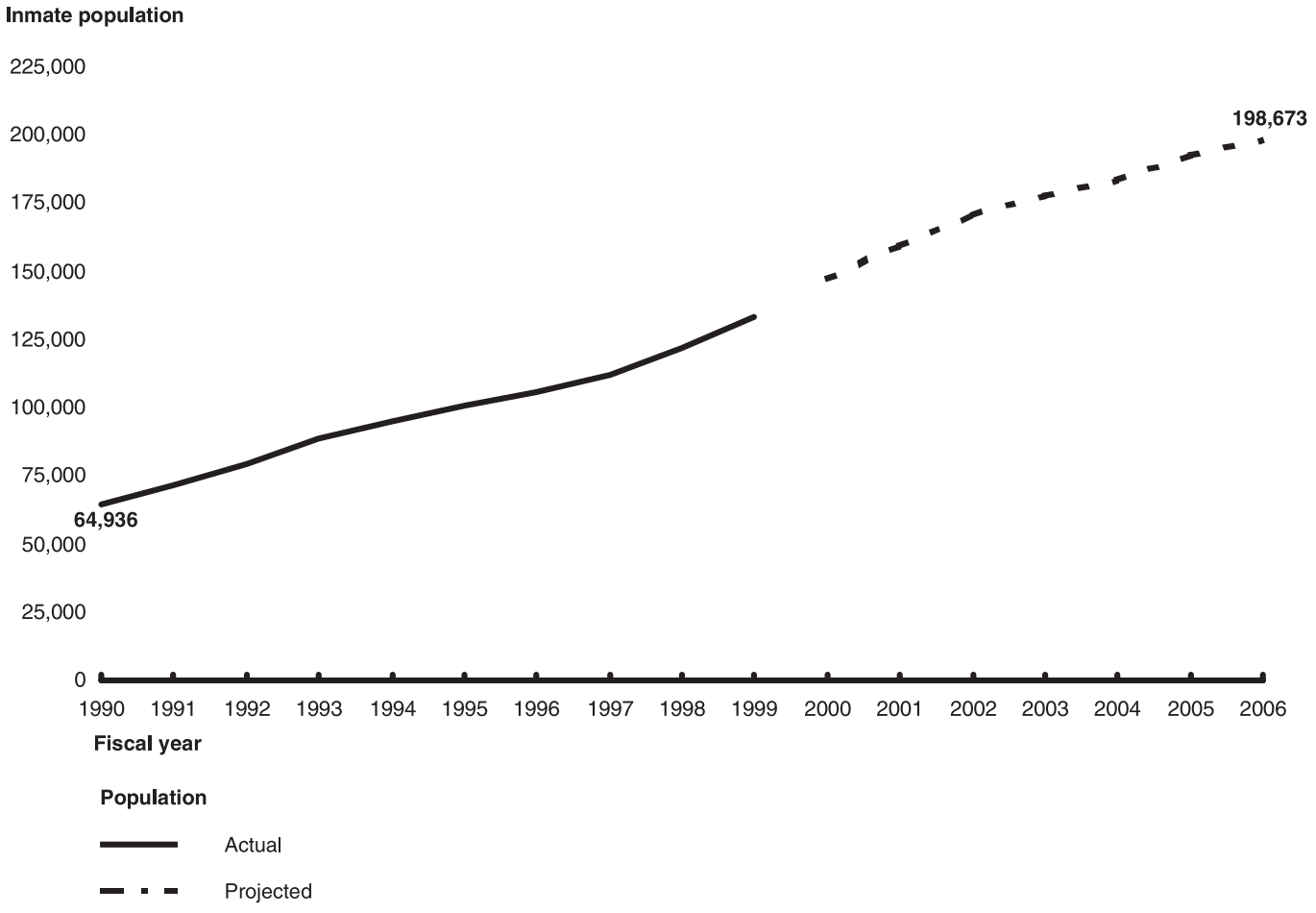
To understand the difficulties BOP has experienced in trying to compare price proposals under BOP's traditional approach to medical care solicitations, we reviewed examples of actual bid proposals—-some based on hospital fee schedules and some based on Medicare rates. Also, we obtained the views of contracting officials in the South Central Region.

To obtain a broader spectrum of views on the benchmark contracting approach and on BOP's traditional contracting approach for health care, we interviewed BOP contracting officials from headquarters and from the agency's six regional offices. From BOP headquarters, we obtained cost data that compared medical payments under BOP's traditional health care contracts to Medicare rates. From each of BOP's six regional offices, we obtained data on the rates or pricing structures in the respective region's contracts with community hospitals.

BOP Inmate Population Trends

As figure II.1 shows, the federal inmate population steadily increased during the 1990s. According to BOP officials, the primary cause of the population growth in recent years has been the number of federal drug case convictions. Moreover, this population growth appears likely to continue through fiscal year 2006.

Figure II.1: BOP Inmate Population Growth, Fiscal Years 1990-1999, and BOP Projected Inmate Population Growth, Fiscal Years 2000-2006



Source: BOP data.

Table II.1 shows the specific numbers that constitute the trend line in figure II.1.

According to BOP officials, in addition to the impact from the continuing prosecution of drug cases, the projected inmate population will increase because of two other factors:

- Projected increases during fiscal years 2000 through 2002 are due, in part, to BOP's congressionally mandated assimilation of approximately 7,200 District of Columbia inmates.[1]
- Projected increases during fiscal years 2003 through 2006 include the anticipated transfer of about 4,000 inmates from the Immigration and Naturalization Service detention.

Table II.1: Actual Inmate Population, Fiscal Years 1990-1999, and Projected Inmate Population, Fiscal Years 2000-2006

Fiscal year	Inmate population	Number change from previous year	Percent change from previous year
1990	64,936	—	—
1991	71,508	6,572	10%
1992	79,678	8,170	11%
1993	88,565	8,887	11%
1994	95,162	6,597	7%
1995	100,973	5,811	6%
1996	105,432	4,459	4%
1997	112,289	6,857	7%
1998	122,316	10,027	9%
1999	133,689	11,373	9%
2000	147,674[a]	13,985	10%
2001	159,859[a]	12,185	8%
2002	171,223[a]	11,364	7%
2003	177,890[a]	6,667	4%
2004	183,846[a]	5,956	3%
2005	193,254[a]	9,408	5%
2006	198,673[a]	5,419	3%

[a]Projected population at end of fiscal year.

Source: BOP data.

[1]The National Capital Revitalization and Self-Government Improvement Act of 1997 (enacted as title XI of the Balanced Budget Act of 1997, P.L. 105-33) requires the transition of both male and female D.C. felony offenders to BOP.

Health Care Cost Trends

BOP categorizes its costs as operational costs (primarily salaries and other operating expenses) and capital costs (building and construction expenditures). This attachment presents information about BOP's operational costs regarding health care for inmates.

Health Care Costs Compared With Total Operational Costs

As table III.1 shows for fiscal years 1990 through 1999, BOP's health care costs as a percentage of total operational costs were fairly stable throughout the 10-year period, averaging 13 percent annually. However, in conjunction with a rising federal inmate population in the 1990s, BOP's inmate health care costs increased annually during this decade. Overall, BOP's health care costs (not adjusted for inflation) increased from $137.6 million in fiscal year 1990 to $372.1 million in fiscal year 1999, an average annual increase of about 8.6 percent. Nonetheless, as indicated in table III.1, this increase has not been disproportionate to the trend in BOP's total operational costs. That is, as previously mentioned, BOP's health care costs as a percentage of total operational costs were fairly stable, averaging 13 percent annually during fiscal years 1990 through 1999.

Table III.1: BOP's Health Care Costs and Total Operational Costs, Fiscal Years 1990-1999 (Dollars in Millions)

Fiscal year	Health care costs	All other operational costs	Total operational costs	Health care as a percentage of total operational costs
1990	$137.6	$1,008.6	$1,146.2	12%
1991	174.4	1,185.7	1,360.1	13
1992	211.1	1,347.4	1,558.5	14
1993	235.7	1,566.7	1,802.4	13
1994	262.4	1,742.3	2,004.7	13
1995	300.8	2,021.5	2,322.3	13
1996	327.1	2,135.6	2,462.7	13
1997	341.3	2,247.6	2,588.9	13
1998	354.7	2,414.8	2,769.5	13
1999	372.1	2,495.5	2,867.6	13

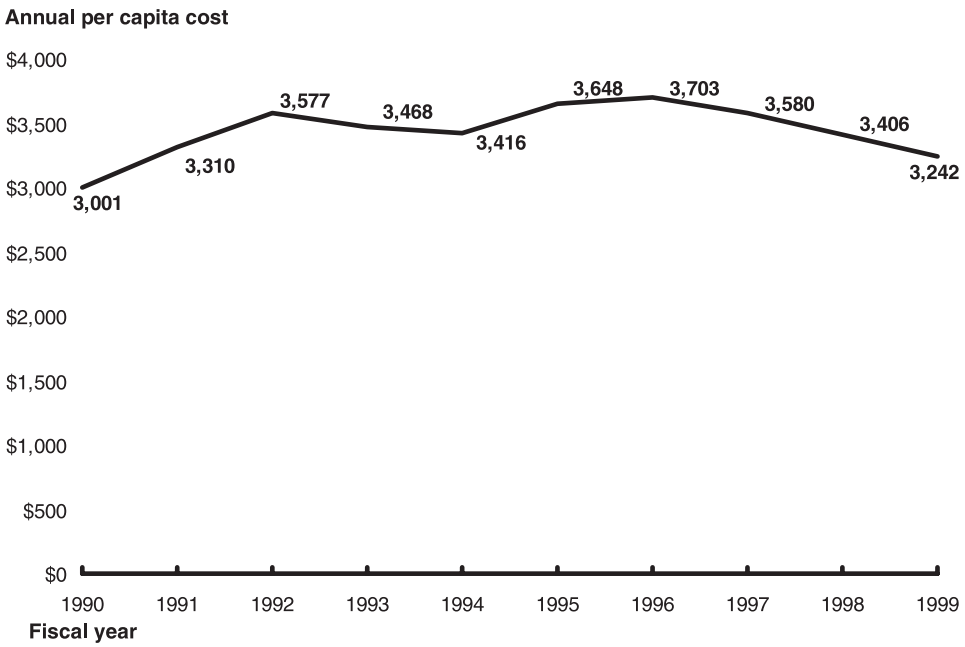
Note: All dollar amounts are in then-year dollars (i.e. not adjusted for inflation).

Source: Developed by GAO based on BOP data.

Per Capita Health Care Costs Adjusted for Inflation

For fiscal years 1990 through 1999, figure III.1 shows the trend in BOP's per capita inmate health care costs adjusted for inflation, using 1999 as the base year. As shown, the per capita costs increased from $3,001 in 1990 to a peak of $3,703 in 1996, and then decreased to $3,242 in 1999.

Figure III.1: Annual Per Capita Cost of Inmate Health Care, Adjusted for Inflation, Fiscal Years 1990-1999

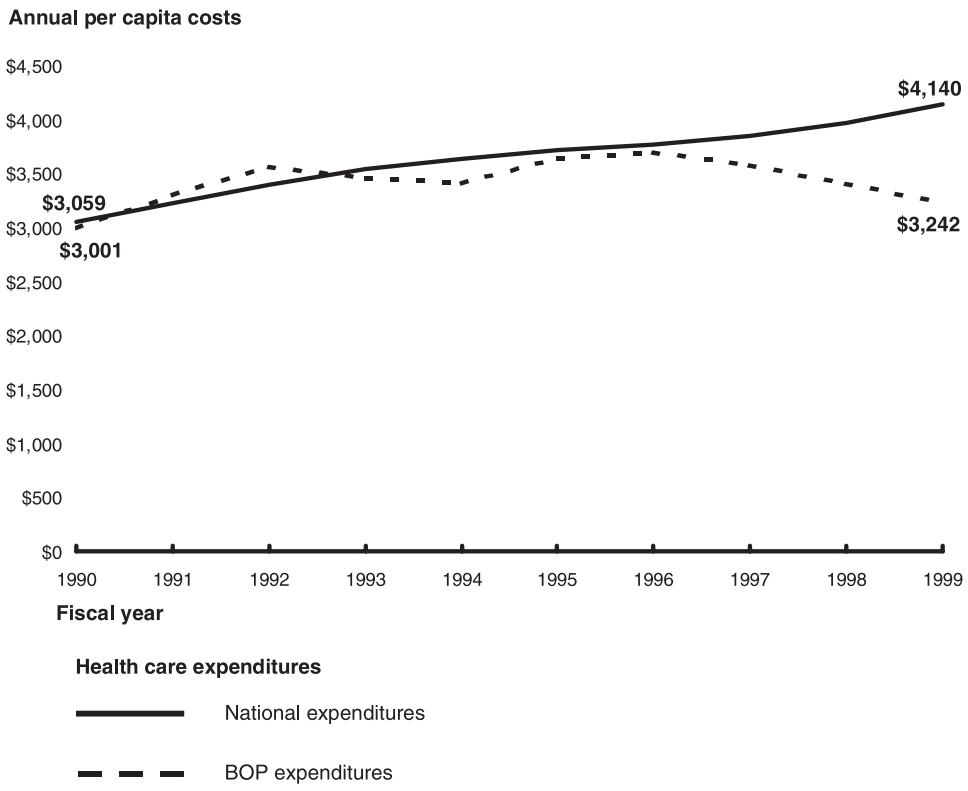


Note: All data are adjusted to fiscal year 1999 dollars, using the GDP price index.

Source: BOP data.

For fiscal years 1990 through 1999, figure III.2 compares national per capita health care costs with BOP's per capita health care costs, adjusted for inflation. In contract to the continuing upward trend in national per capita health care costs through 1999, BOP's per capita health care costs decreased in 1997, 1998, and 1999.

Figure III.2: Comparison of Annual Per Capita Health Care Cost for the United. States and BOP, Adjusted for Inflation, Fiscal Years 1990-1999



Note: All data are adjusted to fiscal year 1999 dollars, using the GDP price index.

Sources: Developed by GAO based on data from BOP and HCFA.

Overall medical costs, however, are likely to continue to rise in future years, according to BOP officials. In explaining this anticipated trend, the officials noted the following reasons:

- Projections of the number of inmates incarcerated in federal facilities show continued increases.
- Felony inmates transferred to BOP from the District of Columbia Department of Corrections generally have disproportionately more medical needs than other BOP inmates.
- From the Immigration and Naturalization Service (INS), BOP is receiving increasing numbers of long-term, nonreturnable detainees.
- BOP's expenditures for pharmaceuticals likely will rise due to the increasing prevalence of illnesses such as HIV and hepatitis.

Health Care Cost Categories

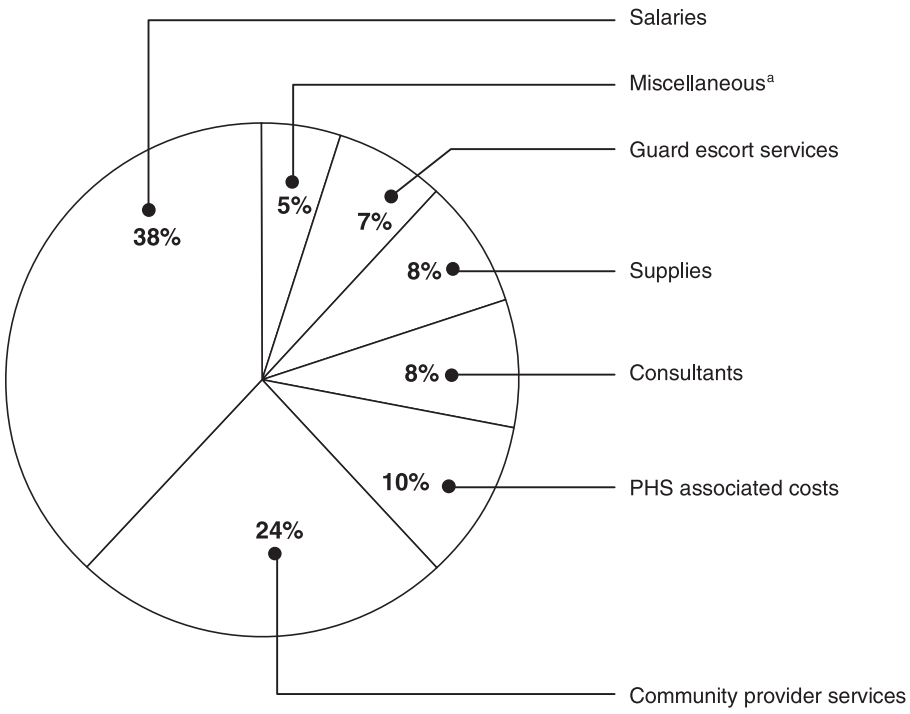
This attachment presents information about trends in BOP's costs of providing health care for inmates during fiscal years 1990 through 1999. For this 10-year period, the information presented covers BOP's cumulative or total health care costs, as well as the various categories or components of the total costs.

Cumulative Health Care Costs

BOP's cumulative health care costs for inmates totaled about $2.7 billion during fiscal years 1990 through 1999. Of these total cumulative costs, figure IV.1 shows that

- 38 percent pertained to salaries of on-site medical personnel;
- 24 percent consisted of contract payments to physicians and hospitals for medical services inmates received outside the prison facility (community provider services);
- 10 percent was for compensation of Public Health Service medical employees (PHS associated costs);
- 8 percent involved purchases of small equipment items and drugs (supplies);
- 8 percent involved payments to physicians who contracted with BOP to treat inmates inside the prisons (consultants);
- 7 percent primarily involved overtime payments to guards who escorted inmates being transported to outside medical facilities (guard escort services); and
- 5 percent involved payments for various miscellaneous items, including airlift costs, headquarters expenses, and equipment purchases.

Figure IV.1: BOP Cost Categories for Inmate Health Care Expenditures, Fiscal Years 1990-1999



[a]This category includes headquarters expenses, equipment purchases, HIV testing, transportation charges (including airlift costs), printing costs, and interest.

Source: Developed by GAO based on BOP data.

Trends in Major Health Care Cost Categories

As figure IV.1 shows, BOP's three largest health care cost categories are salaries, community provider services, and PHS associated costs. For each of these categories, figure IV.2 shows BOP's per capita costs (adjusted for inflation) during fiscal years 1990 through 1999.

As figure IV.2 shows, per capita salary costs for in-house medical personnel increased during most of this 10-year period. A BOP official attributed the rise to the high cost of in-house medical personnel. The official noted, for example, that a physician's compensation can easily exceed $100,000 annually.

The most recent years reflect a decrease in per capita salary costs. Specifically, this cost component peaked at $1,399 in fiscal year 1996, then steadily decreased annually declining to $1,225 in fiscal year 1999. According to BOP officials, these decreases can be attributed to various cost-containment initiatives implemented by BOP.[1] A BOP official cited,

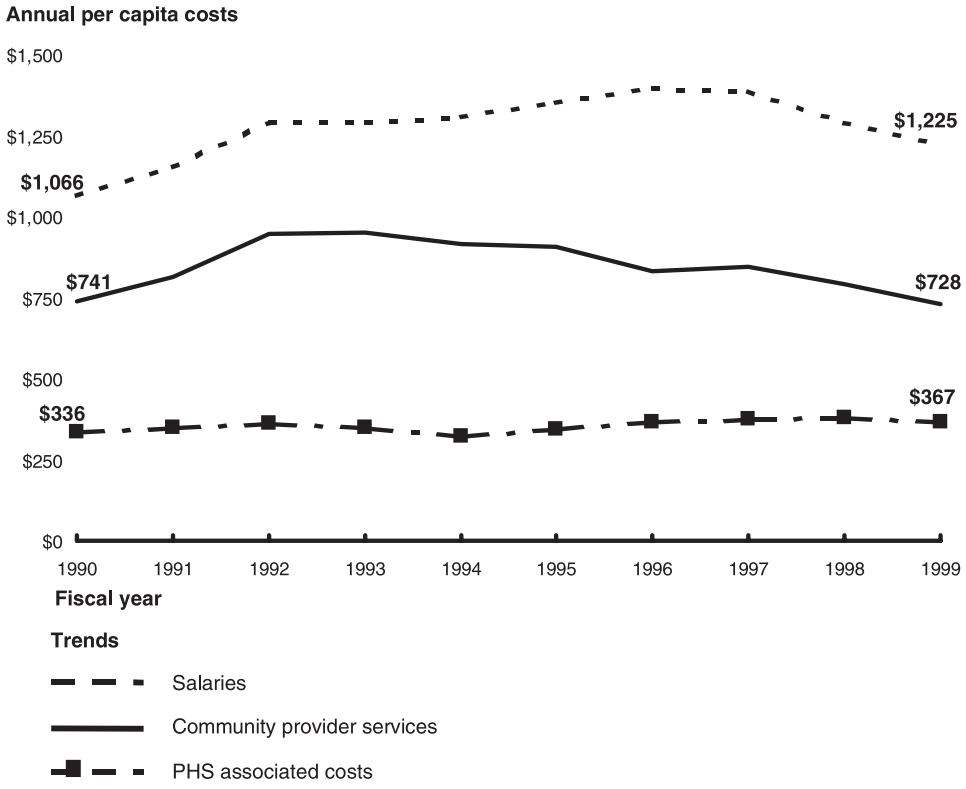
[1] Attachment V lists BOP's cost-containment initiatives.

for example, a staff-restructuring initiative that involved using lower-paid but qualified staff rather than higher-paid physicians to perform certain routine services, such as laboratory, pharmacy, and x-ray duties.

Regarding the per capita costs of community provider services, figure IV.2 shows that 1993 was the peak year during the 10-year period. These per capita costs decreased from $952 in fiscal year 1993 to $728 in fiscal year 1999. According to a BOP official, the policy has been to return the inmates as quickly as possible from external hospital facilities so that BOP could perform the rehabilitative and recuperative services in prison hospitals.

Figure IV.2 shows that PHS associated per capita costs increased gradually from $322 in fiscal year 1994 to $367 in fiscal year 1996, leveled off at $378 in fiscal year 1997 and $379 in fiscal year 1998, and then decreased to $367 in fiscal year 1999. A BOP official told us that this trend was due to high retention rates and increased tenure for PHS personnel.

Figure IV.2: Trends in Annual Per Capita Inmate Health Care Costs for Salaries, Community Provider Services, and PHS Associated Costs, Fiscal Years 1990-1999



Note: All data are adjusted to fiscal year 1999 dollars, using the GDP price index.

Source: Developed by GAO based on BOP data.

Trends in Other Health Care Cost Categories

In addition to the three major cost categories discussed above, BOP's other health care cost categories are (1) supplies, (2) consultants, (3) guard escort service, and (4) miscellaneous. For fiscal years 1990 through 1999, figure IV.3 shows the per capita costs for the first three categories and for equipment, which is a component of the fourth category (miscellaneous). For recent years, the reasons for changes in per capita are discussed below.

Per capita supply costs increased steadily from $262 in fiscal year 1996 to $307 in fiscal year 1999. According to a BOP official, supply costs began increasing in 1996 primarily due to bulk purchases for 10 prisons that opened in fiscal years 1997 and 1998. The official indicated that another contributing factor was the purchase of expensive drugs for treating inmates infected with AIDS or hepatitis C. For example, the drug Interferon, which is used to treat hepatitis C, costs $11,000 annually per inmate patient according to a BOP official. Further, as discussed below, the official noted that BOP made an accounting change in 1995 whereby more items thereafter were classified as "supplies" and not "equipment."

As figure IV.3 shows, per capita consultant costs rose steadily, from $212 in fiscal year 1994 to $320 in fiscal year 1998, before decreasing to $281 in fiscal year 1999. A BOP official said prison wardens were encouraged to use consultants (i.e., contract physicians) to treat inmates inside the prisons because this arrangement was less expensive than paying salaries and benefits for additional BOP or PHS personnel. A BOP official also said that efficiencies were gained by having contract physicians come to BOP facilities and treat multiple inmates on-site, as opposed to transporting the inmates to outside medical facilities.

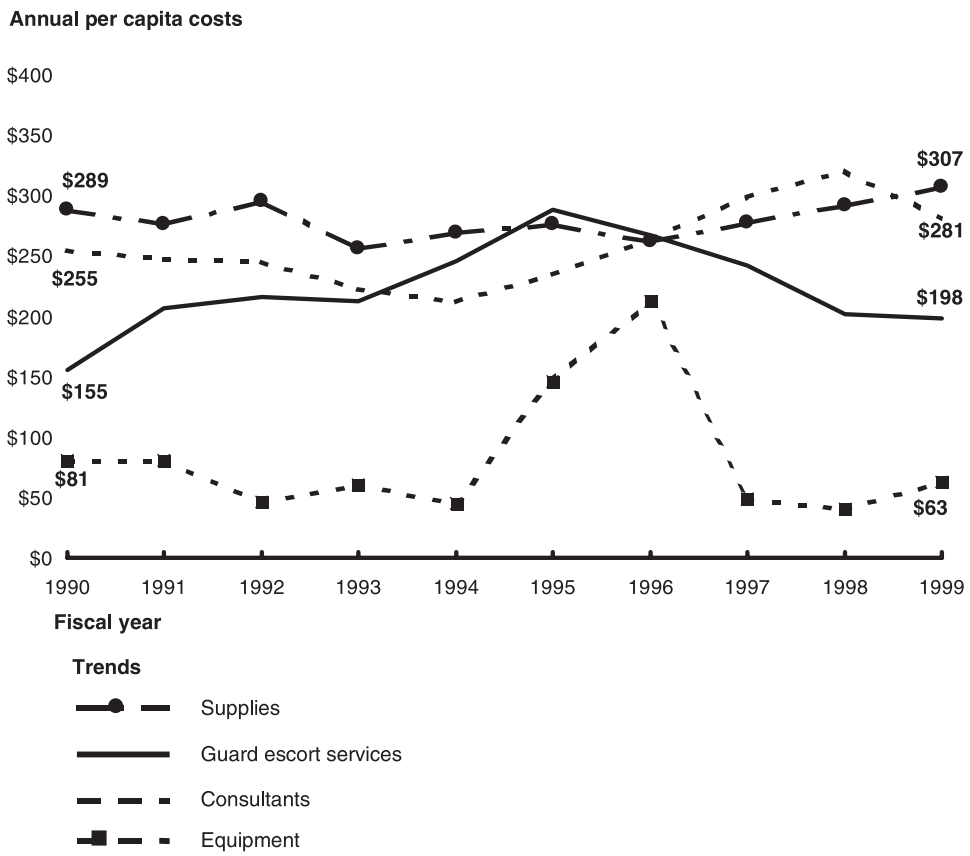
In contrast to increased consultant costs, per capita guard escort service costs progressively decreased from a high of $289 in fiscal year 1995 to $198 in fiscal year 1999. As indicated above, a reason for this trend is that more emphasis was placed on providing on-site treatment (e.g., by having contract physicians come to the prisons), which lessened the demand for guard escort services.

The miscellaneous category of BOP's health care costs include HIV testing, airlift costs, headquarters expenses, and equipment. Of the four categories shown in figure IV.3, per capita equipment costs reflect the widest fluctuation, particularly over the period from fiscal year 1994 to fiscal year 1999. These costs rose to $146 in fiscal year 1995, peaked at $212 in fiscal

year 1996, dropped to $49 in fiscal year 1997 and $40 in fiscal year 1998, and then increased to $63 in fiscal year 1999. According to a BOP official, per capita equipment costs likely increased in 1995 and 1996 as a result of advance purchases of equipment for 10 new prisons that BOP opened in fiscal years 1997 and 1998. Regarding the sharp decline in per capita equipment costs after 1996, a BOP official noted that an accounting change raised the dollar threshold for the equipment category to $25,000, which resulted in many items thereafter being classified as supplies.

A BOP official said he anticipated that all four cost categories would continue their current trends in the future; that is, supply and consultant per capita costs probably would continue to increase, while guard escort service and equipment per capita costs probably would continue to decrease.

Figure IV.3: Trends in Inmate Per Capita Health Care Costs for Consultants, Supplies, Guard Escort Service, and Equipment, Fiscal Years 1990-1999



Note: All data are adjusted to fiscal year 1999 dollars, using the GDP price index.

Source: Developed by GAO based on BOP data.

Summary of BOP Health Care Cost-Containment Initiatives by Type

BOP has implemented or is planning to implement various health care cost containment initiatives. BOP has 23 initiatives that are either currently ongoing or are in the planning stages.[1] As shown in table V.1, these initiatives fall into five categories: (1) cooperative acquisition efforts with other agencies, (2) other acquisition efforts, (3) staffing reforms, (4) delivery of services, and (5) others. The dollar savings shown are BOP's figures, either realized or estimated cost savings. We did not verify any savings reported by BOP on specific initiatives. In addition, where applicable, the year shown in parentheses indicates when BOP implemented the particular health care cost-containment initiative.

Table V.1: Health Care Cost-Containment Initiatives

Initiatives	Description
Cooperative acquisitions	
Pharmacy prime vendor (1993)	BOP "piggybacks" on Department of Veterans Affairs (VA) pharmaceutical contracts. The savings realized by BOP are through bulk purchases on these contracts. BOP cites average annual savings of approximately $760,000.
Federal resource sharing	BOP has existing contracts with VA for various local services at the facility level, such as lab services, telemedicine where VA facilities are involved, HIV tests, etc.
U.S. Marshals Service New York Managed Care Network Pilot Project (1998)	An interagency agreement between USMS and the VA hospitals in Manhattan and Brooklyn calls for VA physicians to come inside the BOP facilities to provide medical specialty clinics. The use of the two VA hospitals for outpatient appointments and medical tests saves time and money and enhances prisoner security, while reducing the number of outside locations for prisoner medical appointments.
Consolidation Pilot Project with the U.S. Marshals Service	In response to a congressionally mandated Department of Justice study, BOP will be consolidating outside medical services for both BOP and USMS prisoners housed in BOP facilities. This project is to begin in early calendar year 2000 at three BOP pilot sites in New York City, Miami, and Oklahoma City. Under this project, according to USMS, BOP physicians will order outside care, when needed, for USMS prisoners. BOP will also pay for the medical and transportation expenses. Initially, BOP will enter into an agreement with the USMS to be reimbursed for its prisoners' medical-related expenses. After 2001, BOP will be requesting budget increases from Congress to cover the expenses of the USMS prisoners.
Mandatory national contracts	BOP piggybacks on VA contracts for various generic drugs not included in the "Pharmacy Prime Vendor" initiative discussed above. BOP estimated annual savings of $770,000 in 1998 that would have been realized had this initiative been in place. As of December 1999, BOP was beginning to award some of these contracts.
Medical equipment	BOP intends to require Central Office approval of purchases of medical equipment, valued at $1,000 or more, while taking advantage of bulk purchasing with VA, the Department of Defense, and the General Services Administration. This initiative is in its formative stages and has yet to be developed.
Other acquisition-related initiatives	
Precertification (1995)	Under this initiative, before inmates are sent to community providers for inpatient surgery, other inpatient hospitalization service, or outpatient surgery, precertification is required. In the precertification process, BOP headquarters officials, including policy and medical personnel, are to review and approve BOP field institutions' requests that inmates be treated by community providers. BOP cites savings of about $785,000 in 1998.

[1] BOP expects many of the initiatives in the planning stages to be reviewed by BOP's executive staff in the spring of 2000. At that time, the staff will either approve or reject the proposals.

Initiatives	Description
Pharmacy over-the-counter (1994)	By allowing inmates to purchase drugs over-the-counter (OTC) with their own funds, BOP has experienced savings in pharmaceuticals. BOP expects this project will also reduce the number of inmate sick calls. A BOP official from the Health Services Division stated that savings from this initiative were approximately $1.2 million for fiscal year 1999. He added that, as of October 1999, BOP had 36 OTC drugs available to prisoners. BOP will continue to add drugs to the OTC program to increase savings further. Also, BOP is considering adding vending machines to this initiative, which would allow inmates access to some OTC drugs 24-hours a day, 7 days a week. Currently, inmates can purchase OTC drugs only one time a week at the commissary.
Pharmacy national formulary initiative (1992)	BOP officials determine the most cost-effective mix of drugs they will authorize. BOP's emphasis is on generics and limiting medical personnel from prescribing newer, more expensive drugs when the old ones are effective. BOP officials could not provide any overall cost savings for this initiative.
Laboratory	BOP will perform a cost-benefit analysis of the options for obtaining laboratory services. These options include (1) keeping all laboratory services in-house, (2) contracting out all laboratory services, or (3) engaging in resource sharing for laboratory services with another agency, such as VA. This initiative is in its formative stages and has yet to be fully developed.
Staffing-related initiatives	
Elimination of 24-hour medical staff (1994)	Prison wardens at some facilities have eliminated 24-hour medical staff coverage as long as emergency care was readily available in the community. The individual prison wardens make these decisions. BOP is reemphasizing this initiative by stressing to wardens that they should plan for this change, if feasible, at their respective facilities. BOP expects this initiative will continue to lower staff costs and estimates that its cost savings have averaged $1.6 million annually.
Medical staff restructuring (1994)	BOP has utilized lower-paid medical personnel to perform certain services they are qualified to perform, instead of having more highly paid physicians' assistants or other medical personnel perform the same services. BOP estimates an annual savings of $5.5 million from this initiative.
Staffing ("provider teams")	This effort focuses on the right mix of staff ("health care provider teams") at each facility to provide the best care in the most efficient and economical manner. Specifically, within the provider teams, the same medical professionals see the same inmates on an ongoing basis, resulting in a degree of familiarity with their conditions. This improves efficiency through continuity of care. Provider teams will oversee the delivery of health services during inmate sick call, in addition to dental and mental health services. This initiative is in its formative stages and has yet to be fully developed.
Delivery of services initiatives	
Telemedicine (1996)	Telecommunications technologies exchange health information and provide health care services across geographic, time, social, and cultural barriers. The technology, as applied in BOP, involves video teleconferencing, modified with the addition of peripheral devices to produce images of diagnostic quality. As of November 1999, telemedicine was utilized at eight BOP facilities. During calendar year 2000, BOP expects to equip all of its remaining facilities with telemedicine. This initiative helps avoid guard escort costs for outside medical trips.
Levels of care	BOP will place inmates already incarcerated with special medical needs at facilities that have staff and funding to address their specific conditions, thereby eliminating duplicated health care resources at numerous facilities. Savings will be realized BOP-wide through more efficient health care operations and savings on staff costs. Some facilities may increase their costs, while others will decrease theirs. This initiative is still in the planning stages.
Scope of services	BOP will make decisions on the scope of services to be provided to inmates. A BOP official stated that this initiative is linked to the aforementioned staffing initiative on health care provider teams and concerns the types of services the teams will perform. This initiative has yet to be fully developed.
Pharmacy	BOP plans to explore options for restructuring pharmacy services, including consolidating staff for multiple facilities in the same location. This initiative is in its formative stages and has yet to be fully developed.

Initiatives	Description
Other initiatives	
Beaumont Privatization Project (1998)	This project involves the privatization of the entire health care operation at BOP's facilities in Beaumont, TX. The project has been fully operational since the middle of fiscal year 1998. As of October 1999, no results of this project had been reported to BOP's executive staff. BOP expects an evaluation report on this project by June 2001.
Health promotion and disease prevention	A three-person team will actively seek ways to keep inmates healthy by encouraging healthy lifestyles. This initiative will help prevent health care costs from rising through preventative means. BOP has not done an impact assessment.
Combined 325/350 Project (FY 1997)	BOP will combine funds for inside (code "350) and outside (code "325") medical care at the facility level, thereby increasing local wardens' authority and responsibility in the fiscal management of health care and requiring them to manage health care within a budget. BOP could not provide any estimated cost savings from this initiative.
Special program needs of physically disabled, chronically and terminally, and geriatric offenders	Under this ongoing initiative, BOP screens inmates when they enter the prison system to determine the best and most cost-effective arrangements for their care. All inmates entering into the system are screened for disabilities, and appropriate assignments are made for these inmates. Certain medical problems can be staff intensive (ventilator patients, for example), and BOP must do proper planning to provide the best care for the inmate in the most cost-effective manner. BOP could not provide any estimated cost savings from this initiative.
Automation of medical records	Automation of medical records is planned for the second quarter of fiscal year 2000. Currently, all medical records are kept manually. No one in BOP can immediately access medical records; therefore, efficiency is adversely impacted. According to BOP, this effort is not likey to be completed in the next 2 or 3 years. This initiative is in its formative stages and has yet to be fully developed.
Decentralized training	BOP plans to decentralize review and approval authority for local medical training from BOP's Central Office to the field. The plan was to be implemented at the beginning of fiscal year 2000. By doing this, BOP is putting the responsibility on the local wardens to make the most cost-effective decisions on continuing education training for their medical personnel. BOP expects this effort to eliminate at least two staff positions in the Central Office, that is, staff who have been responsible for reviewing and approving requests from wardens for local training.

Source: Developed by GAO based on BOP data.

In addition to the 23 initiatives presented in table V.1, our statement discusses the following:

- BOP has proposed two legislative provisions to further control medical costs. One provision---a prisoner copayment provision---would authorize the Director of BOP to assess and collect a fee of not less than $2 for each health care visit requested by a prisoner. The second provision would establish a Medicare-based cap on payments to community hospitals that treat inmates.
- Also, we identified an administrative option whereby BOP could achieve further savings by negotiating more cost-effective contracts with community hospitals that provide medical care for inmates.

BOP Inmate Care In Community Hospitals In 1998: Sample Data Comparing Actual Billings To Constructed Medicare-Based Billings

This attachment compares (1) data that BOP collected on actual hospital billings received for prisoners' care in community hospitals in 1998 with (2) data developed by BOP on what Medicare-based billings would have been. BOP's analysis was based on a nonprojectable sample of 217 inpatient billings, about 7 percent of the bills that BOP received for various hospital services across the country in calendar year 1998. The sampled billings covered 55 hospital discharge classifications or DRGs. For each of the 55 DRGs, table VI.1 presents the actual hospital billings to BOP from the 7-percent sample, the constructed Medicare-based billings, and the billing differences. The data are arrayed by billing differences, beginning with the largest difference.

BOP's analysis found that actual hospital billings exceeded the constructed Medicare-based billings for 50 of the 55 DRGs. Overall, the comparative analysis showed that BOP paid about $1.3 million (actual hospital billings) for services that would have cost about half that amount ($662,000) at Medicare rates.

BOP used HCFA's online, Internet personal computer software program, PPS PC Pricer-1998,[1] to calculate what the billings would have been at the relevant Medicare rates for the services provided by the hospitals. We did not review the actual hospital bills in BOP's sample and did not verify BOP's Medicare billing calculations.

Table VI.1: BOP Inmate Care In Community Hospitals In 1998: Sample Data (Grouped by DRG) Comparing Actual Billings with Constructed Medicare-Based Billings

DRG	DRG description	Actual hospital billing to BOP	Constructed Medicare–based billing	Billing difference
145	Other Circulatory System Diagnosis Without Complications	$114,713	$29,286	$85,427
203	Malignancy of Hepatobiliary System or Pancreas	97,211	31,885	65,326
175	G.I. Hemorrhage Without Complications	77,296	16,351	60,945
143	Chest Pain	47,472	14,883	32,589
208	Disorders of the Biliary Tract Without Complications	36,321	6,450	29,871
14	Specific Cerebrovascular Disorders Except TIA	48,122	22,591	25,531
198	Cholecystectomy Except Laparoscope Without C.D.E. Without Complications	$48,431	$24,594	$23,837

[1]The PPS PC Pricer software calculates the amount that a hospital is to be paid for each patient discharged in a particular hospital discharge classification or DRG. Software updates are released quarterly during the fiscal year. BOP used the 1998 version in developing its constructed Medicare billings.

DRG	DRG description	Actual hospital billing to BOP	Constructed Medicare–based billing	Billing difference
503	Knee Procedure Without PDX of Infection	30,043	9,377	20,666
231	Local Excision & Removal of Int Fix Devices Except Hip & Femur	28,707	8,268	20,439
395	Red Blood Cell Disorders Age >17	23,119	5,140	17,979
165	Appendectomy With Complicated Principal Diag Without Complications	27,907	10,463	17,444
122	Circulatory Disorders With AMI Without C.V. Comp Disch Alive	21,370	3,957	17,413
280	Trauma To The Skin, Subcut Tiss & Breast Age >17 With Complications	19,202	2,257	16,945
127	Heart Failure & Shock	29,128	13,611	15,517
209	Major Joint & Limb Reattachment Procedures of Lower Extremity	28,166	12,904	15,262
489	HIV With Major Related Condition	18,118	4,995	13,123
232	Arthroscopy	21,043	7,925	13,118
160	Hernia Procedures Except Inguinal & Femoral Age >17 Without Complications	17,553	5,911	11,642
158	Anal & Stomal Procedures Without Complications	15,469	4,240	11,229
290	Thyroid Procedures	16,811	6,122	10,689
189	Other Digestive System Diagnoses Age >17 Without Complications	27,088	16,769	10,319
53	Sinus & Mastoid Procedures Age >17	17,067	7,730	9,337
124	Circulatory Disorders Except AMI, With Card Cath & Complex Diag	12,957	3,752	9,205
135	Cardiac Congenital/Valvular Disorders Age >17 Without Complications	21,192	12,005	9,187
281	Trauma to the Skin Subcut Tiss & Breast Age >17 Without Complications	12,132	3,335	8,797
153	Minor Small/Large Bowel Procedures Without Complications	15,099	6,394	8,705
449	Poisoning & Toxic Effects of Drugs Age >17 With Complications	11,774	3,279	8,495
275	Malignant Breast Disorders Without Complications	14,458	6,141	8,317
174	G. I. Hemorrhage With Complications	13,856	5,588	8,268
138	Cardiac Arrhythmia & Conduction Disorders With Complications	23,117	15,133	7,984
125	Circulatory Disorders Except AMI, With Card Cath Without Complex Diag	14,377	6,805	7,572
162	Inguinal & Femoral Hernia Procedures Age >17 Without Complications	11,328	3,990	7,338
136	Cardiac Congenital & Valvular Disorders Age >17 Without Complications	14,673	7,553	7,120
335	Major Male Pelvic Procedures Without Complications	14,430	7,637	6,793
306	Prostatectomy With Complications	14,248	8,388	5,860
256	Other Musculoskeletal System & Connective Tissue Diagnoses	$20,219	$14,772	$5,447

Attachment VI

BOP Inmate Care In Community Hospitals In 1998: Sample Data Comparing Actual Billings To Constructed Medicare-Based Billings

DRG	DRG description	Actual hospital billing to BOP	Constructed Medicare–based billing	Billing difference
270	Other Skin Subcut Tiss & Breast Proc Without Complications	11,341	6,151	5,190
415	O.R. Procedure for Infectious & Parasitic Diseases	19,092	14,376	4,716
316	Renal Failure	14,142	10,268	3,874
7	Periph & Cranial Nerve & Other Nerv Syst Proc Without Complications	11,654	7,835	3,819
416	Septicema Age >17	11,543	7,853	3,690
197	Cholecystectomy Except Laparoscope Without C.D.E. No Complications	16,864	13,346	3,518
76	Other Resp System O.R. Procedures With Complications	27,833	24,335	3,498
243	Medical Back Problems	12,193	9,314	2,879
120	Other Circulatory System O.R. Procedures	17,346	14,613	2,733
172	Digestive Malignancy With Complications	12,723	10,654	2,069
142	Syncope & Collapse Without Complications	21,159	19,102	2,057
188	Other Digestive System Diagnoses Age >17 With Complications	11,480	9,572	1,908
369	Menstrual & Other Female Reproductive System Disorders	14,988	13,912	1,076
183	Esophagitis Gastroent/Misc Digest Disorders Age >17 No Complications	13,480	12,893	587
171	Other Digestive System O.R. Procedures Without Complications	15,854	16,296	(442)
423	Other Infectious & Parasitic Diseases Diagnoses	16,051	17,630	(1,579)
75	Major Chest Procedures	21,952	23,700	(1,748)
148	Major Small/Large Bowel Procedures With Complications	31,087	33,099	(2,012)
107	Coronary Bypass Without Cardiac Cath	11,500	26,540	(15,040)
Total		**$1,336,499**	**$661,969**	**$674,529**

Note: All billing amounts are rounded to the nearest dollar.

Source: Developed by GAO based on BOP data.

U.S. Marshals Service: Efforts to Contain Costs for Health Care Provided to Detainees

Background

The U.S. Marshals Service (USMS), a component agency of the Department of Justice, is responsible for housing federal pre-trial detainees, who are remanded to its custody until sentenced and designated to a BOP facility to serve time. In fiscal year 1999, USMS maintained an average monthly population of 32,119 pre-trial detainees and housed about 70 percent of the detainees in local jails under contractual arrangements whereby USMS paid per diem rates for bed space. The remaining 30 percent of USMS detainees were housed in BOP detention centers.

Health Care Delivery and Cost

USMS' responsibility for maintaining detainees includes covering the cost of their health care. USMS is different from BOP in two aspects of health care: delivery and coverage. Unlike BOP, USMS does not provide medical care directly to its detainees. Instead it is entirely dependent upon the provision of such services from medical staff in local, state, and federal facilities that house USMS prisoners or from community hospitals. Another difference between BOP and USMS is the average length of stay. For an individual held by USMS, custody can range from a matter of days to as long as a year. Since confinement is relatively short, USMS' health care policy is limited to reasonable and medically necessary care and does not extend to elective or preventative health care. By contrast, since BOP prisoners are confined for longer periods, BOP practices preventative health care.

For the 70 percent of USMS detainees housed in jails, delivery of medical services varies widely. Generally speaking, USMS detainees held in local jails normally receive the same medical care that the local jails provide to other inmates. The expenses for medical services provided within local jails are incorporated in the per diem rate charged. USMS is billed directly by community medical care providers for the cost of medical services provided outside the jails. Larger county jails may have enhanced medical services as a part of their infrastructure and may use county staff and facilities. In these situations, the county may provide more comprehensive medical services, including inside care, transportation and guard services for community hospital care, and bill review and payment. USMS would in such situations reimburse the county for outside care. Smaller jails provide medical care on an as needed basis by local professionals. The diversity in health care delivery by county jails complicates efforts by USMS to manage a medical program and to take proactive steps to contain costs.

As with detainees in jails, the USMS detainees in BOP centers have access to the same medical services and staff provided by BOP to its prisoners. These medical services are provided by Public Health Service staff in clinic-type facilities on site to treat routine medical problems at no cost to

USMS. Instead these services are funded as part of the BOP institution's operating costs. When USMS detainees need medical treatment outside a BOP facility, USMS is charged the rate contracted by BOP with the outside facility (community hospital). Physicians' fees are billed separately, usually at full cost. Further, regarding instances when USMS detainees need medical treatment in community hospitals, secure transportation and guard escort services are required. These costs are also paid by USMS.

The business practice for USMS has been to pay all outside medical bills at the full price rather than at a reduced rate. The Justice Department reported in a 1996 review[1] that USMS did not know how to get price discounts, interpret medical bills, or price them properly at Medicare rates even if the vendor agreed to Medicare prices. USMS also lacked professional medical staff with the technical expertise to develop medical care policy, determine medical necessity, or assist field staff when medical care issues arose.

In addition to USMS' business practice of paying at full price, both the size of the detainee population and the cost of outside medical treatment have been increasing. As a result, the need for medical care outside secured facilities has become a significant expense to USMS and in fiscal year 1998 totaled $25 million, an increase of over 30 percent since 1993.

Cost-Containment Initiatives

In the mid-1990s, USMS began developing a formal Prisoner Medical Services Program in order to contain increasing medical costs for a rapidly growing prisoner population. One example of how this program has contained medical costs is a pilot project in New York City. The objective of the project was to reduce medical costs to Medicare rates by creating a managed care network. In implementing this project, USMS established a managed care network of local hospitals and physicians' associations that agreed to charge Medicare rates. USMS' network also gained access to secured hospital beds at Medicaid rates.

A related aspect of the New York City pilot project is guard service. USMS obtained county jail security guard service at only $130 per day. Prior to this, if a USMS detainee had to be hospitalized, two contract hospital guards on a 24-hour schedule would cost the USMS about $1,000 per day. USMS reports that this pilot project in the New York City area saved $15 million in prisoner medical care costs covering approximately a 4-year period (February 1996 to December 1999).

[1] Justice Performance Review, New York City Managed Care Network, U.S. Department of Justice, February 1996.

USMS also developed an in-house prototype medical claims system that helped in processing medical claims while at the same time collecting vital program data to help USMS identify cost trends. At the time of our review, USMS was surveying its 1998 medical diagnoses to establish a profile of medical need and was working with the VA to obtain managed care services through the Veterans Integrated Service Networks (VISN).

VISNs offer medical services and support, such as medical contracts, diagnostics, and laboratory services, throughout the nation. For example, USMS negotiated an interagency service agreement with a VISN in New York City to provide medical specialty clinics inside federal detention facilities in Manhattan and Brooklyn to reduce outside prisoner medical trips that were costly and represented a prisoner security risk to the local population. The VISN also provided USMS with outpatient services at its hospitals in New York City at Medicare rates that reduce USMS' medical costs.

Legislative Cap on Costs

In 1999, recognizing the need to reduce the cost of health services still further, USMS and the Immigration and Naturalization Service (INS) coordinated with the Health Care Financing Administration (HCFA) to develop proposed legislative language setting a maximum amount that USMS and INS would pay for community medical care. That proposed cap was based on using the Medicare rate structure. In November 1999, Congress passed legislation establishing such a cap on future health care payments made by the USMS and INS. The legislation was enacted as part of the Department of Justice's fiscal year 2000 appropriation.[2] Language included in the appropriation amended Section 4006 of Title 18, U.S. Code, to limit the amount that the Attorney General can pay for certain federal prisoners' heath care, stating that:

"Payment for costs incurred for the provision of health care items and services for individuals in the custody of the United States Marshals Service and the Immigration and Naturalization Service shall not exceed the lesser of the amount that would be paid for the provision of similar health care items and services under—(A) the Medicare program …or (B) the Medicaid program…" 18 U.S.C. 4006.

[2] P.L. 106-113 (Nov. 29, 1999).