



Office of the Inspector General
U.S. Department of Justice



The Federal Bureau of Prisons' Reimbursement Rates for Outside Medical Care

EXECUTIVE SUMMARY

Introduction

The Federal Bureau of Prisons (BOP) relies on outside medical services to provide care for inmates that cannot be provided by institution staff.¹ From fiscal year (FY) 2010 to FY 2014, BOP spending for outside medical services increased 24 percent, from \$263 million to \$327 million, while BOP's overall budget increased at less than half that rate, 11 percent, from \$6.2 billion to \$6.9 billion.

We found that the BOP is the only federal agency that pays for medical care that is not covered under a statute or regulation under which the government sets the agency's reimbursement rates, usually at the Medicare rate. Instead, the BOP solicits and awards a comprehensive medical services contract for each BOP institution to obtain outside medical services. At the end of FY 2014, all of the BOP's comprehensive medical services contracts paid a premium above the applicable rates paid by Medicare for medical services. The Office of the Inspector General (OIG) conducted this review to examine the rates the BOP pays for outside medical care and potential legislative changes that could help contain medical costs.

Results in Brief

The BOP Spent at Least \$100 Million More than the Medicare Rate in FY 2014 on Outside Medical Care

We analyzed outside medical spending data at 69 of the 97 BOP institutions.² We found that all 69 institutions paid reimbursement rates higher than those paid by Medicare. The actual reimbursement rates ranged from 115 percent to 385 percent of the Medicare rate, with the majority of reimbursement rates between 126 percent and 200 percent of the Medicare rate.

Our analysis further found that these 69 institutions spent approximately \$241 million for outside medical care in FY 2014, but that this figure would have dropped to \$143 million, a \$98 million dollar (41 percent) decrease, if the BOP had capped its medical fees at the Medicare rate. Given that this analysis necessarily excluded more than one-quarter of the BOP's institutions, we concluded that it was likely the BOP as a whole spent at least \$100 million more for outside medical care than the applicable rates paid by Medicare in FY 2014.

Although the BOP believes that increased competition has helped it recently obtain more competitive rates at some institutions, we were unable to assess this

¹ For the purposes of this review, we refer to outside medical services as any medical services provided by non-BOP staff at a location other than the BOP institution.

² We had to exclude 28 BOP institutions from our analysis because of limitations in BOP spending. The BOP considers correctional complexes (multiple institutions that are co-located) to be a single location for the purpose of obtaining outside medical care. When complexes are counted as a single location, there were 97 institutions in FY 2014 instead of 121.

claim over the 5-year period we assessed and, similarly, we could not determine consistent factors that influenced the rates the BOP paid. Ultimately, we found that local factors, such as cost of living, often influenced the reimbursement rates at a given institution.

The Department of Justice and the BOP Have Not Fully Explored Legislative Options That Could Reduce the BOP's Outside Medical Spending

The BOP has historically opposed being added to the statute (18 U.S.C. § 4006(b)(1)) that requires other federal law enforcement agencies, including the Department of Homeland Security, the Federal Bureau of Investigation, and the U.S. Marshals Service, to pay no more than the applicable Medicare rate for inmate and detainee medical care. The BOP told us that because its inmates are generally incarcerated for longer periods than detainees held by other federal law enforcement agencies, the BOP provides both acute and chronic (long-term) medical care for its inmates, while other federal law enforcement agencies provide only acute care. Both BOP officials and institution staff expressed concern that adding the BOP to the list of agencies in 18 U.S.C. § 4006(b)(1) could result in fewer medical providers being willing to treat BOP inmates.

However, we found that the BOP has not fully explored other legislative options that might help it control its medical costs without compromising provider access. For example, another federal law (42 U.S.C. § 1395cc) provides that hospitals must treat patients whose care is paid for by the Department of Defense, the Department of Veterans Affairs, or the Indian Health Service, and must accept the rates established by those agencies. For all three agencies, the established rate is the Medicare rate. We found that neither the BOP nor the Department of Justice has explored whether the provisions of this statute could be extended to the BOP. As a result, while federal law requires that medical providers who treat members of the military and their dependents, Veterans, Native Americans, federal pre-trial detainees, and immigration detainees accept the Medicare rate when reimbursed by the federal government, those same providers are allowed to charge the BOP a premium above the Medicare rate when treating BOP inmates. Further, the BOP officials we interviewed had not engaged with states to learn more about how their prison systems address similar challenges, or other federal agencies to discuss strategies for better ensuring access to medical care.

Recommendations

We make three recommendations in this report to assist the BOP in exploring legislative and other options for providing medically necessary care while maintaining access to providers and better controlling medical costs.

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INTRODUCTION

Background

The Federal Bureau of Prisons (BOP) provides medical care to federal inmates as part of its mission to confine inmates in environments that are safe, humane, cost-efficient, and appropriately secure. Though the number of federal inmates has declined for a second year in a row, the BOP's medical spending continues to increase, both in general and disproportionately compared to its overall spending. From fiscal year (FY) 2010 to FY 2014, the BOP's overall budget increased 11 percent: from \$6.2 billion to \$6.9 billion. In the same period, medical spending increased nearly twice as much: 22 percent, from \$905 million to \$1.1 billion. To supplement the care the BOP medical staff provides inside its institutions, the BOP enters into contracts with outside hospitals, physicians, and other medical professionals. Medical spending on these contract services has increased 24 percent: from \$263 million in FY 2010 to \$327 million in FY 2014.

The Office of the Inspector General (OIG) conducted this review to examine the BOP's reimbursement rates for outside medical care and potential legislative changes that could help contain medical costs. In this introduction, we describe trends in the BOP's medical spending, how the BOP negotiates its outside medical services contracts, the rates other entities pay, and previously considered legislative changes related to limiting spending for outside medical services.

Medical Costs Are a Significant and Increasing Portion of the BOP's Budget

Due to the BOP's large inmate population (171,868 inmates in 121 institutions as of September 2014), medical spending constitutes a significant and increasing portion of its annual budget.³ Specifically, the BOP spent \$905 million of its \$6.2 billion budget (15 percent) in FY 2010 on inmate medical care. This increased to \$1.1 billion of its \$6.9 billion budget (16 percent) in FY 2014. The majority, \$952 million, or 87 percent, of medical costs in FY 2014 were for medical care provided both inside and outside the institutions.⁴ Inside medical costs are incurred to treat inmates within institutions, and include salaries for BOP medical staff, medical supplies, prescription drugs, and costs to pay outside providers to come to the institution and treat patients. Outside medical costs are incurred to treat inmates at private physicians' offices or at hospitals, and include costs to transport inmates to those locations.

³ This reflects the pre-trial and sentenced population in BOP-managed institutions only, exclusive of inmates in contract institutions and residential reentry centers.

There are currently 122 BOP-managed institutions, but there were only 121 during the scope of our review.

⁴ The remaining medical costs include salaries for U.S. Public Health Service employees, who staff many institution medical clinics, medical transport costs, costs of handling unforeseen medical events at institutions, and medical referral laboratory costs. These costs, when combined with inside and outside medical services, total the BOP's medical budget.

The increase in medical costs can be attributed, in part, to the growth in the aging inmate population and an increase in inmates with medical needs. In May 2015, the OIG reported that aging inmates (inmates age 50 and older) were the fastest growing segment of the BOP population, increasing 25 percent from FY 2009 to FY 2013, while the population of inmates 49 and younger decreased by 1 percent.⁵ We also found that aging inmates on average cost 8 percent more to incarcerate than inmates age 49 and younger, due to increased medical needs. In conjunction with the growth of the aging inmate population, BOP staff told us that they have seen an increase in the number of sicker inmates with more complex illnesses even in institutions not designated to house more seriously ill inmates. Because resources are limited inside institutions, the BOP must contract with physicians and outside hospitals to provide for inmates' medical needs.⁶

The BOP Generally Negotiates Separate Comprehensive Medical Services Contracts for Each Institution with Outside Providers

Although the BOP purchases outside medical care for more than 170,000 inmates nationwide, and spends over \$300 million annually on that outside medical care, it has not leveraged this potential nationwide purchasing power by developing contracts on a national or even regional basis. Instead, the primary way the BOP obtains outside medical care for inmates is through comprehensive medical services contracts negotiated on an institution-by-institution basis. These contracts are generally negotiated with third-party administrators who are responsible for creating a network of hospital and physician providers who meet an institution's medical needs. The BOP's Field Acquisition Office (FAO) is responsible for negotiating each institution's individual contract.

The reimbursement rates under most comprehensive medical services contracts are negotiated using the Medicare rate as a benchmark, and establish reimbursement rates for inpatient and outpatient care provided by physicians and in hospitals.⁷ Currently, all BOP comprehensive medical services contracts have reimbursement rates at least 15 percent above the Medicare benchmark rate.⁸

⁵ Department of Justice (DOJ) OIG, *The Impact of an Aging Inmate Population on the Federal Bureau of Prisons*, Evaluation and Inspections Report 15-05 (May 2015), <https://oig.justice.gov/reports/2015/e1505.pdf> (accessed March 1, 2016).

⁶ The OIG recently released a report examining the BOP's medical staffing challenges. See DOJ OIG, *Review of the Federal Bureau of Prisons' Medical Staffing Challenges*, Evaluation and Inspections Report 16-02 (March 2016), <https://oig.justice.gov/reports/2016/e1602.pdf> (accessed April 13, 2016).

⁷ Medicare rates are set by the federal government and establish the amount a provider will receive from Medicare to provide medical services. The Medicare rate for a service can differ depending on locality and provider.

Some institutions have contracts in which the rates are based on a discount from the provider's prices rather than a premium over the Medicare rate.

⁸ According to BOP Contract Specialists, the third party administrator keeps a portion of this rate as payment for its services and pays the rest to the medical providers. Due to the contracting

(Cont'd.)

All comprehensive medical services contracts are competitively bid according to standard federal contracting regulations. When looking to award a comprehensive medical services contract for an institution, the FAO will issue a solicitation, which includes information regarding the medical services that institutions want the vendor to fulfill. For example, the FAO can solicit for a specific service, such as cardiology, and the estimated number of visitation hours and patients per contract year for that service. Typically, the FAO receives bids from multiple vendors. The bids include pricing information, as well as details regarding how the vendor will provide the services that the BOP requested in the solicitation. The FAO evaluates the bids on three criteria: (1) technical factors, (2) pricing, and (3) past performance of the vendor. Technical factors include security aspects, as well as the distance from an institution to the provider and the diversity of medical services offered by providers. The FAO evaluates pricing as the amount and the rate that an institution pays for a service in accordance with the local market as well as technical factors. Finally, the FAO evaluates the quality of the vendor's past performance. The FAO can award the contract by selecting among the original bids or can ask the vendors to submit revised bids before it awards the contract.⁹ Officials in the FAO may also elect not to award the contract if they believe the BOP would be better served by procuring medical care outside of a comprehensive medical services contract.

State Departments of Corrections Face Similar Challenges to Contain Medical Costs

Like the BOP, state departments of corrections use community hospitals and physician providers to supplement the medical care provided inside state institutions. State departments of corrections also have experienced a substantial increase in inmate medical costs. According to a 2014 report, correctional medical spending rose in 41 states by a median of 13 percent from FY 2007 to FY 2011.¹⁰ While the system to provide medical care for inmates varies among states, many state departments of corrections utilize state legislation or the Medicaid program to limit the rates that they pay for some medical care. We discuss the way some states are addressing rising inmate medical costs in the results section below.

Scope and Methodology of the OIG Review

Our review analyzed BOP comprehensive medical services rates and spending data from FY 2010 through FY 2014, as well as applicable Department of Justice (Department) and BOP policies, procedures, and studies and federal laws and

structure, the BOP does not know the rate kept by the third party administrator and the rate paid to the providers.

⁹ If the FAO requests revised bids, it can describe the original bids as weak, significantly weak, or deficient on each of the three selection criteria. It may not, however, make a specific counteroffer or request specific revisions. See 48 C.F.R. § 15.306.

¹⁰ Pew Charitable Trusts and the John D. and Catherine T. MacArthur Foundation, *State Prison Health Care Spending* (July 2014), <http://www.pewtrusts.org/en/research-and-analysis/reports/2014/07/08/state-prison-health-care-spending> (accessed March 1, 2016).

regulations. Specifically, our review focused on contract medical spending that occurred outside the institutions.

Our fieldwork, conducted from April 2015 through January 2016, included interviews, data collection and analyses, and document reviews. We conducted six video teleconferences to five BOP institutions and the BOP's FAO. Our video teleconferences included institutions with and without a comprehensive medical services contract at the end of FY 2014. We also interviewed BOP officials, including the Assistant Directors responsible for two Central Office divisions.¹¹

To understand the role of Department management in helping the BOP address its medical cost challenges, we interviewed officials with the Office of the Deputy Attorney General and the Justice Management Division. We also interviewed an official from the Office of Management and Budget. To understand how other federal law enforcement agencies pay for inmate and detainee medical care, we interviewed officials from the U.S. Marshals Service and Immigration and Customs Enforcement. To understand Medicare rules and how other agencies pay for medical services, we interviewed officials with the Department of Health and Human Services' Centers for Medicare and Medicaid Services and the Department of Defense Office of the Inspector General.

Finally, to understand how states are addressing rising inmate medical costs, we interviewed officials from 10 state departments of corrections: Kentucky, Louisiana, Minnesota, New Hampshire, New Jersey, New York, North Carolina, Pennsylvania, Texas, and Washington. A detailed description of the methodology of our review is in Appendix 1.

¹¹ The BOP's Central Office is located in Washington, D.C. We interviewed the Assistant Directors of the Administration and Health Services Divisions.

RESULTS OF THE REVIEW

The BOP is the only federal agency that is obligated to provide medical care that is not covered by legislation establishing maximum reimbursement rates for those medical services. For example, under 18 U.S.C. § 4006(b)(1), Department of Justice (Department) components, including the U.S. Marshals Service (USMS) and the Federal Bureau of Investigation (FBI), as well as the Department of Homeland Security (DHS), are required to pay no more than the Medicare rate for medical services provided to inmates and detainees.¹² In 2011, a Department of Justice employee submitted an entry to the President's SAVE Award contest suggesting that the BOP could save \$241 million annually if 18 U.S.C. § 4006(b)(1) was amended to include the BOP, thereby capping the rate the BOP pays for inmate medical care at the Medicare rate.¹³ The Department analyzed the viability of this proposal and found that while the \$241 million estimate was too high, its analysis suggested that the BOP could save up to \$131 million annually from such a change.¹⁴ The OIG estimated as a result of the data examined during this review that BOP outside medical spending was at least \$100 million more in FY 2014 than it would have been if the BOP had paid at the applicable Medicare rate. While amending 18 U.S.C. § 4006(b)(1) to include the BOP would help the BOP obtain lower rates, the Department and the BOP are concerned that this would negatively affect the BOP's ability to obtain medical care at its institutions. We found that neither the Department nor the BOP has fully explored other legislative options that would likely substantially lower the BOP's medical costs and also mitigate their concerns.

The BOP Spent at Least \$100 Million More than the Medicare Rate in FY 2014 on Outside Medical Care

We estimated that the additional cost to the BOP by contracting for outside medical services at rates greater than the applicable rates paid by Medicare was at least \$100 million in FY 2014. We originally sought to include all 97 BOP institutions in our analysis.¹⁵ However, we had to exclude 28 BOP institutions from our analysis because limitations in BOP data left us unable to determine how those

¹² The statute establishes only the maximum rates that these federal agencies would spend on inmate or detainee outside medical care. Medicare does not provide coverage to inmates.

¹³ Between 2009 and 2013, a program called the SAVE Award solicited ideas from federal employees that would yield cost savings for the government while also improving government operations. Winning ideas were incorporated into the President's Budget.

¹⁴ DOJ Justice Management Division (JMD), *Managing Medical Costs in the Bureau of Prisons: Feasibility of Applying the Medicare Rate*, Issue Paper (July 2012).

We requested a copy of this issue paper from JMD in June 2015, but they were unable to locate a copy. The Office of Management and Budget provided us with a copy of the final issue paper. JMD Budget Staff officials confirmed for us that JMD wrote the issue paper.

¹⁵ The BOP considers correctional complexes (multiple institutions that are co-located) to be a single location for the purpose of obtaining outside medical care. When complexes are counted as a single location, there were 97 institutions in FY 2014 instead of 121.

institutions' medical spending would have changed if they had paid the applicable Medicare rates.¹⁶ Therefore, we analyzed medical spending at the 69 BOP institutions for which data was available and calculated that at their contracted rates they paid \$98 million more than the applicable rates paid by Medicare in FY 2014. Given that our analysis excluded more than one-quarter of the BOP's institutions, we concluded that it was likely the BOP as a whole spent at least \$100 million more than the applicable rates paid by Medicare in FY 2014. In the remainder of this section, we focus only on medical spending at the 69 institutions we analyzed.

Our analysis of these 69 institutions found that they spent approximately \$241 million for outside medical care in FY 2014.¹⁷ Using BOP medical spending data on outside medical care and the lowest rate for each institution we analyzed, we estimated that these institutions would have spent \$143 million if they had paid the Medicare rate, a reduction of \$98 million, or 41 percent.¹⁸ We also found that this spending gap has persisted over time. For example, we calculated that, in FY 2010, 67 institutions spent \$205 million on contracted outside medical care, but would have spent \$116 million if they had paid the Medicare rate, a difference of approximately \$89 million (see Figure 1 below).¹⁹

¹⁶ We excluded 14 institutions because they were in the process of awarding a comprehensive medical services contract at the end of FY 2014, 8 institutions because the BOP reported that they were unable to obtain a comprehensive medical services contract due to local market conditions, 5 institutions whose contracted rates were not based on the Medicare rate, and 1 institution that did not report any contract medical spending in FY 2014. The BOP further told us that an example of a local market condition that prevents the BOP from obtaining a comprehensive medical services contract would be a local hospital that does not want to sign a long-term contract with the BOP. For more information on our methodology, please see Appendix 1.

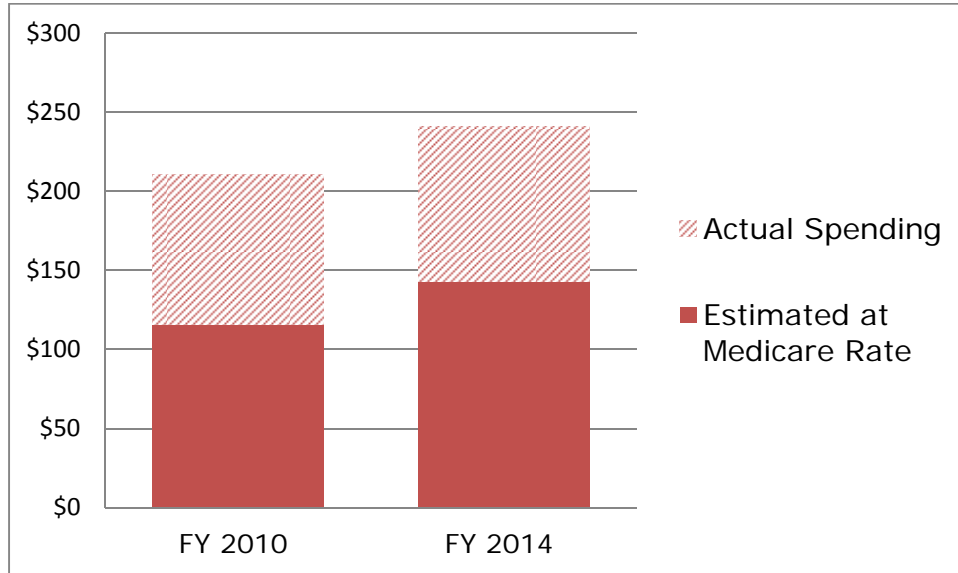
¹⁷ Outside medical spending refers to contract medical spending that occurred outside the institution. Our estimate does not include contract spending that may have occurred inside the institution. See Appendix 1 for more details on our methodology.

¹⁸ Each comprehensive medical services contract typically has set, negotiated rates for different categories of medical care, depending on whether the care is inpatient or outpatient and whether it is billed by a hospital or a physician. The BOP may award a comprehensive medical services contract that pays the same rate for every category or a different rate for each category. If a contract paid a different rate for each category, we assumed for the purposes of our analysis that all spending under the contract was at the lowest rate. For more details, see Appendix 1.

¹⁹ At the end of FY 2010, 67 institutions had comprehensive medical services contracts.

Figure 1

OIG Estimate of the Difference between Actual Spending and Estimated Spending Using Medicare Rates by Fiscal Year, in Millions



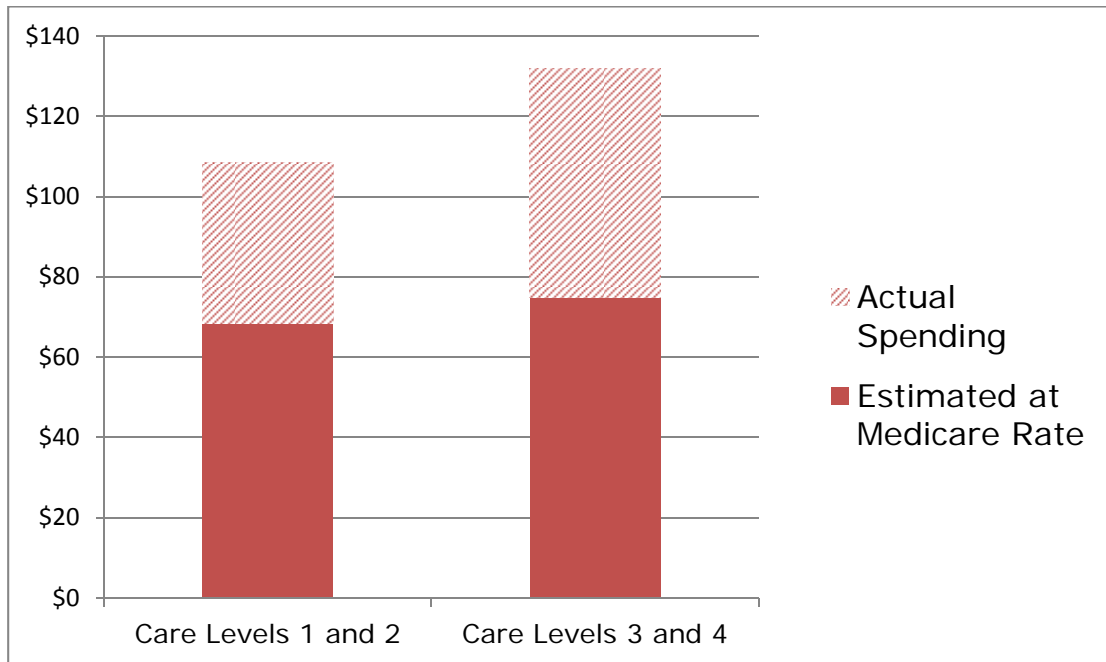
Source: OIG analysis of BOP medical spending data and reimbursement rates in BOP comprehensive medical services contracts

We found that the impact of paying above the Medicare rate in FY 2014 was greatest for Care Level 3 and Care Level 4 institutions, where the BOP incarcerates inmates with the most significant medical needs.²⁰ In the same year, we found that the 10 Care Level 3 and 4 institutions we analyzed made up 55 percent, or \$132 million, of the \$241 million spent for outside medical care. If these institutions paid at the Medicare rate, their outside medical spending would have been reduced 44 percent, from \$132 million to \$74 million. Although Care Level 1 and Care Level 2 institutions do not individually spend as much on outside medical care than higher care level institutions, medical spending in lower care level institutions is still significant. For example, in FY 2014, Care Level 1 and 2 institutions, which represent 59 of the 69 institutions in our analysis, spent approximately \$40 million more than the Medicare rate. One Care Level 2 institution paid more than triple the Medicare rate for all outside medical spending under its comprehensive medical services contract. We estimated that this institution would have spent \$1.9 million if reimbursement rates were capped at the Medicare rate, \$4.2 million less than the \$6.1 million it actually spent. See Figure 2 for our estimates based on each care level in FY 2014.

²⁰ The BOP designates a care level for each institution, ranging from Care Level 1 for institutions that house the healthiest inmates to Care Level 4 for the BOP's medical institutions that house the sickest inmates. Inmates are assigned a care level based on documented medical history, and designated to an institution with a corresponding care level. For more information, see DOJ OIG, *The Federal Bureau of Prisons' Efforts to Manage Inmate Health Care*, Audit Report 08-08 (February 2008).

Figure 2

OIG Estimate of the Difference between Actual Spending and Estimated Spending Using Medicare Rates by Care Level, in Millions



Source: OIG analysis of BOP medical spending data and reimbursement rates in BOP comprehensive medical services contracts

We found wide gaps between what BOP institutions actually paid and the Medicare rate because all 69 institutions we analyzed had reimbursement rates above that paid by Medicare. The actual reimbursement rates ranged from 115 percent of Medicare to 385 percent of Medicare. The majority of reimbursement rates were between 126 percent and 200 percent of the Medicare rate.

While the BOP Reports that Increased Competition Has Helped It Obtain More Competitive Rates, Its Spending Data Shows that It Continues to Pay Nearly 70 Percent Above the Medicare Rate for Outside Medical Care

While all 69 institutions we analyzed paid above the Medicare rate, BOP officials and staff told us that they have had some success lowering reimbursement rates primarily due to increased competition. The Field Acquisition Office (FAO) Section Chief told us that, in the past, they would be “lucky” to receive two proposals for a contract but now receive anywhere between five and seven proposals. Similarly, a Contract Specialist told us that in the past there was sparse competition, with typically two contractors competing against each other. According to BOP data, an average of five vendors bid to provide institutions with

their current comprehensive medical services contract.²¹ Several FAO staff stated that in more competitive environments, the BOP has better leverage to obtain lower reimbursement rates.

However, we found that increased competition did not always result in lower reimbursement rates. According to BOP data, 20 institutions experienced an increase in their reimbursement rates in at least one of their services after signing a new comprehensive medical services contract after FY 2010, even with multiple bids for the contract. One institution's inpatient facility and outpatient facility rates increased on average 82 percent over its previous contract rates despite receiving eight bids. Another institution's inpatient facility and outpatient facility rates increased on average 98 percent over its previous contract rates despite having 10 bids. FAO staff told us that they believe local market factors also influence proposed rates, in addition to the amount of competition. As a result, the BOP continues to spend nearly 70 percent above the applicable Medicare rate and significantly higher rates than other federal agencies who provide medical care, as discussed later in the results.

The BOP Is Concerned that Prohibiting It from Paying More than the Medicare Rate Could Affect Its Ability to Obtain Medical Care

As discussed, Department components, such as the USMS and the FBI, as well as DHS agencies, including Immigration and Customs Enforcement (ICE), are required under 18 U.S.C. § 4006(b)(1) to pay no more than the Medicare rate for medical services provided to inmates and detainees.²² We found that the BOP's need to provide chronic care for numerous inmates over a long period of time makes its medical care needs more complex than those of these law enforcement agencies. The BOP told us that amending 18 U.S.C. § 4006(b)(1) to include the BOP could significantly limit the BOP's ability to obtain outside medical services given that medical providers have the choice not to treat inmates.²³ The BOP believes that this situation could be exacerbated by capping the amount it pays to hospitals. In reviewing the viability of the employee's SAVE Award proposal, the Department cited similar concerns, and concluded that the "BOP did not want to be

²¹ Our data covered a 5-year period, from FY 2010 to FY 2014. Because comprehensive medical services contracts are generally for 5 years, our data did not show how many institutions saw an increase in competition for their contracts over time.

²² Under 18 U.S.C. § 4006(b)(1), the Medicare rate is established as the maximum rate that these federal agencies could spend on outside medical care for inmates or detainees. Medicare does not provide coverage to inmates.

The FBI reported that its spending on inmate medical care was about \$1,000 in FY 2014 and that it spent nothing in FY 2015. Because the FBI spends so little on medical care, we did not further analyze the impact of 18 U.S.C. § 4006(b)(1) on its budget and operations.

²³ The only exception is the *Emergency Medical Treatment and Active Labor Act of 1986*, 42 U.S.C. § 1395dd, which requires all hospitals to provide a medical screening exam to any patient who comes to the emergency room and to stabilize any emergency medical conditions that may exist, without regard to the patient's ability to pay. Officials from the Centers for Medicare and Medicaid Services (CMS) told us that this statute does not require hospitals to treat non-emergencies.

included under this legislation because of concerns about provider access in rural areas where the Medicare rate would not be competitive enough to attract bids from service providers.”

The BOP's Need for Chronic Care Over the Long Term May Affect Its Ability to Obtain Medical Care Under 18 U.S.C. § 4006

The BOP is required to treat chronic conditions over a long period of time in addition to providing care for acute conditions. BOP officials and staff told us that, unlike ICE and USMS detainees, BOP inmates are generally incarcerated for long periods of time, with the majority ranging from 3 to 15 years.²⁴ For example, a 2009 ICE report stated that its detainees were held on average for 30 days.²⁵ The USMS reported to us that in FY 2015, USMS detainees were held on average for 100 days.

Due to the longer stays of the BOP's inmate population, its medical mission must address more than simply acute care. The BOP's policy on patient care encompasses an extensive range of medical care, focusing primarily on acute care, medically necessary non-acute care, and certain elective care that is not always medically necessary but would improve an inmate's quality of life.²⁶ In contrast, the USMS's policy states that it has the authority to pay for reasonable and medically necessary care for detainees in its custody.²⁷ Since the USMS's detainees are held for shorter, less predictable periods of time, by policy the USMS does not provide either elective or preventive medical care.²⁸ Further, if the USMS must provide treatment for a detainee's chronic medical condition, it needs to do so for a shorter period of time compared to the BOP. Thus, the USMS states that treatment of many non-emergency medical situations and pre-existing conditions that are not life-threatening should be delayed until the individual is released or transferred to prison.²⁹

²⁴ The USMS is responsible for the custody of individuals in pre-trial detention.

Statistics regarding BOP sentence length are as of December 2015. See BOP, “Sentences Imposed,” December 26, 2015, https://www.bop.gov/about/statistics/statistics_inmate_sentences.jsp (accessed March 1, 2016).

²⁵ ICE is responsible for the administrative detention of aliens who are subject to removal for violations of immigration law.

Dora Schriro, *Immigration Detention Overview and Recommendations* (Washington, D.C.: Department of Homeland Security, October 6, 2009), 6, <https://www.ice.gov/doclib/about/offices/odpp/pdf/ice-detention-rpt.pdf> (accessed March 1, 2016).

²⁶ Examples of acute care include treatment for a heart attack or trauma. Examples of medically necessary non-acute care include treatment for diabetes, heart disease, HIV, or cancer. Examples of elective care include joint replacement and reconstructive knee surgery. See BOP Program Statement 6031.04, Patient Care (June 3, 2014).

²⁷ USMS, “Prisoner Health Care Standards,” <http://www.usmarshals.gov/prisoner/standards.htm> (accessed March 1, 2016).

²⁸ USMS, “Prisoner Health Care Standards.”

²⁹ USMS, “Prisoner Health Care Standards.”

The USMS Chief of the Office of Medical Operations for the Prisoner Operations Division told us that the USMS had discussions for the BOP to join its national managed-care contract but that the BOP was not particularly interested due to the difference in population.³⁰ The BOP's Assistant Director for Administration told us that USMS contracts are primarily for acute care because of the short amount of time the USMS holds detainees and, as a result, would not meet the needs of BOP institutions.

Cost Is One of Several Factors the BOP Considers When Awarding Comprehensive Medical Services Contracts

The BOP considers a number of factors in addition to cost when weighing options for comprehensive medical services contracts because it relies on outside providers to perform diverse and long-term medical services. BOP officials and staff said that they consider the distance inmates must travel to providers and the range of medical services that the contract offers, both outside and inside the institution. This is particularly important given the remote location of a number of BOP institutions. As a result of these additional factors, the BOP told us that it must agree to pay above the Medicare rate in order to have close access to appropriate care while mitigating security risks.

The BOP told us it is concerned that amending 18 U.S.C. § 4006 to include the BOP could lead to several negative consequences. First, and most significant, the BOP is concerned that it would lose many of its current providers, particularly at higher care-level institutions since many of those inmates need access to hospitals and specialists to treat complex medical issues. For example, the BOP strategically placed its federal medical centers near populated, metropolitan areas so that inmates with specialized medical needs could access a number of hospitals in that area. However, BOP staff told us that using reputable providers in these areas often makes it difficult to obtain lower rates because of the extensive services that the providers deliver to inmates and the surrounding community. Further, BOP staff told us that inmates provide only a very tiny portion of the hospitals' volume and, therefore, the BOP has little leverage during rate negotiations. A Warden at a federal medical center stated that "if we are paying the minimum rate, I think it will open the door for many [providers] to say 'I think we can make it without your business.'"

Second, if the BOP lost access to providers closest to its institutions, it would increase the distance required to transport inmates to providers willing to accept the Medicare rate. One institution's Health Services Administrator told us that its local hospitals were in the same network and, if one of the hospitals did not want to accept the Medicare rate, the institution would lose access to the entire network, requiring greater travel distances to receive care. According to the BOP's National Health Services Administrator, there is a correctional aspect to escorting inmates

³⁰ The USMS obtains care for its detainees through a national managed care contract that gives them access to providers across the country. As of June 2015, the contract covered about two-thirds of the country.

outside the institution.³¹ Institution staff does not want to escort inmates long distances to hospitals and increase security risks for the community. For example, an FAO Contract Specialist told us that she worked on a comprehensive medical services contract for an institution located in a remote area. The institution had one nearby hospital that proposed extremely high reimbursement rates and another hospital over 65 miles away that proposed cheaper reimbursement rates. She told us that the institution's Warden expressed concerns about transporting inmates to far distances and, as a result, the BOP chose the nearby hospital despite the higher rates.³² Further, the National Health Services Administrator said that many institutions make multiple medical trips each day, including both scheduled trips and emergencies. She said that if correctional staff cover these medical trips, staff from other program areas have to cover correctional posts and are unable to perform their other duties.

Finally, the BOP negotiates for diverse services, including having outside medical providers treat inmates at the institutions' medical clinics rather than bringing inmates to the providers' offices. BOP officials and staff believe that a Medicare cap would decrease the willingness of medical providers to travel to the BOP's institutions. An FAO Section Chief went further, stating that he believes a Medicare cap would prevent nearly all providers from being willing to treat inmates inside BOP institutions. Institution staff told us that their institutions benefit from having providers come inside the institution because it reduces (a) the safety and security concerns of transporting inmates into the community, (b) the amount of staff leaving the institution to escort inmates, and (c) the transportation and overtime costs associated with outside medical trips.³³ Additionally, the Warden of a federal medical center told us that his staff tries to find providers willing to come inside the institution to see multiple inmates during a visit, so that the institution does not incur the transportation costs associated with taking inmates to outside providers. BOP officials and staff further acknowledged that reimbursement rates are higher for outside providers to travel to institutions to account for time lost while unable to treat patients at their primary locations. The BOP's National Health Services Administrator told us that the BOP must offer higher reimbursement rates to make it worthwhile for providers to travel to institutions and leave their offices.

In a 2012 issue paper, the Department raised concerns similar to those stated by BOP officials and staff during our review, finding that the institutions would be unable to negotiate services at the Medicare rate and could lose access to providers as a result.³⁴ It further reported that if nearby providers refuse to accept the Medicare rate, institutions would have to transport inmates greater distances,

³¹ According to BOP policy, correctional staff is required to escort inmates to outside medical appointments. See BOP Program Statement 5538.07, *Escorted Trips* (December 10, 2015).

³² This institution currently has the highest reimbursement rates of the institutions with comprehensive medical services contracts.

³³ We estimated that in FY 2014 the BOP spent approximately \$60 million in overtime pay to transport inmates to outside medical providers.

³⁴ DOJ JMD, *Managing Medical Costs in the Bureau of Prisons*.

resulting in additional costs. The Justice Management Division (JMD) ultimately recommended that the Department not seek to have 18 U.S.C. § 4006 amended to include the BOP, citing provider access concerns and the complexity of contracting medical services for over 200,000 inmates. A JMD official told us that the report's conclusion was based on the BOP's strong preference not to cap reimbursement rates at the Medicare rate, as well as a lack of evidence to allow JMD officials to be comfortable recommending a cap.³⁵

The Department and the BOP Have Not Fully Explored Other Legislative Options That Could Reduce the BOP's Outside Medical Spending

Although the Department did not recommend that 18 U.S.C. § 4006 be amended to include the BOP for these reasons, it did recommend that the BOP consider proposing alternative legislative options to increase the BOP's leverage and to better contain outside medical spending. Specifically, the Department recommended that the BOP explore amending the *Social Security Act of 1935* so that it could lower its reimbursement rates without compromising provider access. However, we found that neither the Department nor the BOP has taken steps to pursue this option. As a result the BOP remains the only federal agency that is obligated to provide medical care where federal law or regulation does not establish the rate it pays for those medical costs. Meanwhile, states have made changes to control their inmate medical costs and have achieved cost savings as a result. The BOP officials we interviewed said they had not engaged with state or federal agencies that regularly pay for medical care to discuss healthcare management. The BOP told us that it has explored possible non-legislative mechanisms for managing medical costs; but its efforts are ongoing and therefore it is difficult to judge the impact on BOP's overall medical spending.

The Department and the BOP Should Consider Legislation to Amend the Social Security Act to Cover the BOP

One section of the *Social Security Act of 1935*, 42 U.S.C. § 1395cc, describes the provider agreement that hospitals must file with the government in order to be eligible to receive Medicare payments. Officials from the Centers for Medicare and Medicaid Services (CMS) told us that other federal agencies that pay for medical care are included in the *Social Security Act's* provider agreement and Medicare regulations, which means that hospitals must accept patients at the rate those agencies pay. Specifically, the standard Medicare provider agreement requires hospitals to accept patients paid for by the Department of Defense's (DOD) TRICARE program, the Department of Veterans Affairs (VA), and the Indian Health Service.³⁶ We found that these three agencies base their rates on Medicare's rates.

³⁵ JMD provides advice and assistance to senior management officials relating to basic Department policy for budget and financial management; personnel management and training; facilities; procurement; equal employment opportunity; information processing; records management; security; and all other matters pertaining to organization, management, and administration.

³⁶ TRICARE is the medical insurance system for current and former members of the military and their dependents. See 42 U.S.C. § 1395cc(a)(1)(J) (DOD), 42 U.S.C. § 1395cc(a)(1)(L) (VA), and
(Cont'd.)

For example, the DOD's TRICARE program generally reimburses at the Medicare rate, following direction from Congress to bring these costs in line with Medicare beginning in FY 1991.³⁷ The VA and the Indian Health Service both reimburse health services at the Medicare rate.³⁸

In 1999, legislation was introduced in the Senate to amend the provider agreement to require hospitals "to be a participating provider of medical care for prisoners and detainees in the custody of the Attorney General, in accordance with the practices, payment methodology, and amounts prescribed under regulations issued by the Attorney General."³⁹ While the legislation was never enacted, the Department's 2012 analysis reasoned that such legislation could benefit the Department by giving it the authority to set payment rates without limiting provider access because a hospital would be required to treat inmates if it wanted to continue receiving payments from Medicare. Thus, this legislation is substantially different from 18 U.S.C. § 4006(b)(1), which limits the USMS's and the DHS's reimbursement rates to the Medicare rate, because that statute does not require hospitals to accept these patients as a condition of remaining in the Medicare program. A JMD official told us that amending the *Social Security Act* to cover the BOP, if enacted, would be a "game changer" for the BOP. In response to a working draft of this report, a JMD official stated that amending the *Social Security Act* to cover the BOP, if enacted, would have a significant positive effect on the BOP by reducing medical costs.

CMS officials told us that because the BOP is not specifically identified in the standard Medicare provider agreement, hospitals are not required to accept a particular reimbursement rate when treating BOP inmates.⁴⁰ The officials also told us that the only way to require hospitals to accept BOP inmates would be to amend the provider agreement. Finally, they told us that the BOP is the only federal agency that pays for medical care that is not covered under a statute or regulation in which the government sets the agency's reimbursement rate. As a result, while federal law requires medical providers who treat members of the military and their dependents, Veterans, Native Americans, federal pre-trial detainees, and

42 U.S.C. § 1395cc(a)(1)(U) (Indian Health Service). See also 42 C.F.R. §§ 489.25, 489.26, and 489.29.

³⁷ See P.L. 101-511, § 8012. See also Civilian Health and Medical Program of the Uniformed Services (CHAMPUS); TRICARE Program; Reimbursement, 63 Fed. Reg. 175, 48439 (September 10, 1998).

³⁸ The VA's reimbursement rates are established at 38 C.F.R. § 1755(a). According to a Government Accountability Office (GAO) report, in FY 2011 the VA adopted the Medicare rate for medical care delivered by non-VA providers. The GAO concluded that a slight drop in VA medical spending from FY 2011 to FY 2012 was likely due to this decision. See GAO, *VA Health Care: Management and Oversight of Fee Basis Care Need Improvement*, GAO-13-441 (May 2013), 11.

The Indian Health Service's reimbursement rates are established at 42 C.F.R. § 136.30(c).

³⁹ *21st Century Justice Act of 1999*, 106th Cong., 1st sess., S. 899, sec. 6508.

⁴⁰ As noted above, the only exception is the *Emergency Medical Treatment and Active Labor Act of 1986*, 42 U.S.C. § 1395dd.

immigration detainees to accept the Medicare rate when reimbursed by the federal government, those same providers are allowed to charge the BOP a premium above the Medicare rate when treating BOP inmates.

CMS officials also noted that the standard Medicare provider agreement applies only to hospitals and facilities, and nearly all hospitals sign Medicare provider agreements in order to remain economically viable. Physician participation in the Medicare program is voluntary, and physicians are not required to sign a provider agreement or equivalent document. As a general matter, hospitals participating in Medicare must ensure that they are able to provide the care their patients need. We therefore believe that inmate care in hospitals would not be greatly affected, because hospitals could ensure that a physician who accepts the Medicare rate is available to treat inmates.⁴¹ We could not determine by reviewing the BOP's medical cost data how much of its spending was on payments to hospitals and physicians for inpatient hospital care as opposed to payments to physicians for care outside a hospital setting. We recognize that changing the *Social Security Act* provider agreement (42 U.S.C. § 1395cc) would not be binding on physicians and therefore would not be a method for lowering the rates the BOP pays for physician care provided outside a hospital setting.

States Have Taken a Variety of Actions to Address the Rising Cost of Providing Outside Medical Care

Similar to the BOP, many state correctional systems have also experienced a significant increase in outside medical costs. We interviewed officials from 10 state departments of corrections regarding steps their states have taken to contain these costs and identified two approaches that states are taking similar to the legislative options available to the BOP discussed above. State officials we spoke to credit these two approaches with helping reduce outside medical costs.

In general, individuals who are inmates of a public institution such as a prison or jail are excluded from Medicaid.⁴² In 1997, the Center for Medicaid and State Operations issued a memorandum to all Associate Regional Administrators clarifying that Medicaid covers inpatient care in hospitals, nursing facilities, juvenile psychiatric facilities, and intermediate care facilities if an inmate would have been Medicaid eligible had he or she not been incarcerated.⁴³ Officials we interviewed

⁴¹ For example, physicians employed by hospitals generally accept the Medicare rate. According to the Physicians Foundation's 2014 Survey of America's Physicians, 31 percent of physicians were employed by hospitals. See Physicians Foundation, *2014 Survey of America's Physicians* (September 2014), 11.

⁴² Section 1905(a)(27)(A) of the *Social Security Act of 1935* excludes "any such payments with respect to care or services for any individual who is an inmate of a public institution (except as a patient in a medical institution)" from coverage under the Medicaid program. See 42 U.S.C. § 1396d.

⁴³ Robert A. Streimer, Director, Disabled and Elderly Health Programs Group, Center for Medicaid and State Operations, Department of Health and Human Services, memorandum to All Associate Regional Administrators, Division for Medicaid and State Operations, December 12, 1997, 2-3.

(Cont'd.)

from all 10 states reported that their states relied on this policy to obtain the Medicaid rate for inpatient care of their Medicaid-eligible inmates.⁴⁴ Initially, this policy applied to only a small portion of inmates, such as juveniles and pregnant women. However, beginning in 2014, the *Affordable Care Act* gave states the option to expand Medicaid to all Americans under age 65 with incomes up to 133 percent of the poverty level.⁴⁵ In states that expanded Medicaid, most state inmates who are U.S. citizens qualify under the guidelines. An official from a state that expanded Medicaid in 2014 estimated that 97 percent of her state's inmates now qualify for Medicaid, and were therefore eligible to have their inpatient care covered at the Medicaid rate.

Separate from the Medicaid policy described above, four states that we spoke to have laws that cap the reimbursement rates for state inmate medical care.⁴⁶ The laws in these four states are more similar to 18 U.S.C. § 4006(b)(1) than to the Medicare provider agreement in that the state laws do not contain explicit language requiring providers to accept inmate patients. Further, the laws use different approaches to implementing a cap, such as establishing different caps for inpatient and outpatient care, or establishing caps above the state's Medicare rate and giving the state department of corrections authority to negotiate for rates lower than the cap. Officials told us that these laws led to significant cost savings.⁴⁷ One official reported that cost savings from her state's statute, as well as other initiatives, were so significant that its 2014 spending on outside medical care was less than its 2005 spending.⁴⁸ Officials from two of these states further reported that their state laws also contained provisions that allowed their agencies to negotiate rates slightly above the statutory cap in limited circumstances when they are unable to contract for medical care at the capped rate. For example, one official reported that his

42 C.F.R. § 435.1010 defines an inpatient as one who has been admitted to a medical institution and receives room, board, and professional services for at least 24 hours.

⁴⁴ In addition to obtaining the Medicaid rate, this policy also means that inpatient stays qualify for the Medicaid program's federal cost sharing. The federal government covers between 50 percent and 84 percent of the cost of Medicaid. CMS officials told us that the federal government covers a higher proportion of Medicaid costs in less affluent states.

⁴⁵ As of March 14 2016, 31 states and the District of Columbia had expanded Medicaid eligibility under the *Affordable Care Act of 2010*. See the Henry J. Kaiser Family Foundation, "Status of State Action on the Medicaid Expansion Decision," <http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act> (accessed March 31, 2016).

⁴⁶ The specifics of each state's law vary but are generally tied to the Medicare or Medicaid rates in that state. For example, Pennsylvania's statute caps inpatient care at the Medicaid rate and outpatient care at the Medicare rate. North Carolina's statute caps payments at either double the Medicaid rate, or 70 percent of hospital bill charges, whichever is less.

⁴⁷ One state official told us that the budgetary impact of his state's legislation was difficult to assess because the state has a separate contract with each hospital that treats inmates. We note that this is similar to the BOP's practice of awarding separate comprehensive medical services contracts for each institution.

⁴⁸ In response to a working draft of this report, this official estimated that her state avoided approximately \$1 million per month in medical costs due to the statute.

state paid approximately 10 percent more than the Medicare rate cap to a small number of hospitals in a remote part of the state, and that this was still lower than the rate his agency paid prior to the state legislation being enacted.

The BOP Has Not Engaged with Other Agencies That Pay for Medical Care

While the BOP's specific responsibility to provide medical care for inmates incarcerated for long periods of time may be unique among federal agencies, its need to consider ways to contain costs for medical services is not. However, we found that the BOP has not engaged with outside entities that might be able to offer guidance or technical expertise on medical care pricing when making contract award decisions. For example, the BOP has not engaged with state departments of corrections, which have the same medical mission, to discuss options for managing the costs of inmate medical care. The BOP's FAO staff told us that they do not consider what states are paying when making contract award decisions. FAO staff also told us that they have not sought guidance from agencies with medical care or insurance expertise when evaluating contracts. For example, the Department of Health and Human Services (HHS) has been collecting and publishing data on the prices hospitals charge throughout the country, but the BOP has not reviewed this data or considered the implications of providers' prices when making contract award decisions.⁴⁹ A Health Services Administrator from one institution recommended that the FAO work with an expert in medical care payments because such knowledge could help the FAO in its contract negotiations.

The BOP officials we interviewed also said they have not engaged with other federal agencies to discuss options for addressing medical costs in ways other than through their current comprehensive medical services contracting model. For example, the Assistant Director for Health Services told us that the BOP is interested in the outcome of ongoing HHS research into new medical care payment models but also said that to her knowledge the BOP has not requested the results of that research. An official from the Office of Management and Budget also observed that to her knowledge the BOP does not reach out to other agencies to get better insight into medical care management. She suggested multiple areas where such collaboration might benefit the BOP, such as establishing a partnership with the HHS to improve release planning for inmates who need nursing home care or seeking guidance from the DOD on access to medical providers in remote areas.

⁴⁹ See Centers for Medicare and Medicaid Services, "Medicare Provider Utilization and Payment Data," April 30, 2015, <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Medicare-Provider-Charge-Data/index.html> (accessed March 1, 2016). As of March 1, 2016, the HHS had released data through calendar year 2013.

The BOP Is Considering Some Actions to Try to Address the Cost of Outside Medical Care, but the Financial Impact of These Actions Is Unknown

In 2012, the Department recommended that the BOP explore alternative pricing and contracting approaches, and the BOP has taken some steps in this direction.⁵⁰

BOP officials told us that the BOP is studying the viability of awarding comprehensive medical services contracts on a regional basis, rather than awarding separate contracts for each institution, and is currently seeking pricing information from vendors to determine whether such an approach could result in cost savings. The vendors have requested data from the BOP on past utilization of outside medical care, such as the number of inmate trips and the frequency of various procedures, in order to develop price estimates. While BOP officials have told us that they are working to collect the data the vendors requested, and hope to make a decision on regional contracting within a year, the effort has been complicated by the fact that the BOP does not require all of its providers to submit their claims electronically or even mandate the use of standard Medicare paper claims forms. In fact, only 23 of the institutions require outside medical providers to submit medical bills electronically. The submission of paper claims, particularly those that differ from standard Medicare claim forms, greatly limits the ability of the BOP to obtain and analyze the kind of claims data that might allow it to achieve greater efficiencies and reduce the cost of medical care.⁵¹ As a result, the BOP cannot easily generate the information from its recordkeeping systems that it needs to provide vendors to help the BOP effectively weigh whether a regional approach to contracting for medical services would be beneficial. We are concerned this data deficit could further delay BOP's ability to lower the cost of outside medical care.⁵²

Additionally, Department and BOP officials told us that the BOP is experimenting with alternative pricing techniques in its contract solicitations to divide high- and low-cost physician specialties into separate rate categories.⁵³ The FAO Section Chief told us that one upcoming contract solicitation will ask vendors to price anesthesiology services separately because these rates are believed to be typically higher and, in effect, make the overall negotiated rate higher than it would otherwise be. However, the FAO Section Chief also told us that the BOP does not currently know how often it uses anesthesiology services because it does not track

⁵⁰ DOJ JMD, *Managing Medical Costs in the Bureau of Prisons*, 15.

⁵¹ Although the BOP has indicated that it is working toward expanding the number of BOP institutions that require providers to submit electronic medical bills, between January 2015 and April 2016 no additional institutions adopted the practice.

⁵² The BOP's inability to effectively use a data-driven, performance-based management approach because it lacked the proper metrics to do so, is a recurring challenge for the Department. See the OIG's *Top Performance and Management Challenges for 2015*, at <https://oig.justice.gov/challenges/2015.pdf>.

⁵³ In the BOP's comprehensive medical services contracts, the BOP currently has only two rate categories for physician services: one for inpatient care for all specialties and another for outpatient care for all specialties.

how much it uses each type of physician specialty. A Department official told us that the BOP is creating separate rate categories with the goal of lowering the rates for other specialties such as cardiology.

We found that the BOP would benefit from collecting and analyzing utilization data for inmate medical care, particularly as it explores alternative options to contain outside medical spending. Further, we believe the BOP would benefit from the collection and analysis of utilization data even if the *Social Security Act* was amended to include the BOP in the standard Medicare provider agreement. This is because any amendment to the Medicare provider agreement would apply only to hospitals, and not to physician care provided outside hospital settings. Therefore, the BOP would still need deeper analysis of utilization data for specific physician services in order to better understand the actual costs and reduce the rates for various physician specialties.

CONCLUSION AND RECOMMENDATIONS

Conclusion

As the cost and need for medical care increase, every federal agency except the BOP has statutory mechanisms in place to establish reimbursement rates for outside medical care and help contain medical spending. Because the BOP is not covered under any statute, it has no mechanism to effectively and practically establish and enforce its own uniform reimbursement rates across all, or even a geographic subset, of its institutions. This has led to the BOP paying rates much higher than other federal agencies. Specifically, all BOP institutions with comprehensive medical services contracts have reimbursement rates above the applicable rates paid by Medicare, with some institutions spending two to three times more than the Medicare rate. Institution staff told us that inmates provide only a small portion of each provider's patient volume, which we believe leaves the BOP without a strong negotiating position when awarding these contracts. Further, some institutions cannot obtain comprehensive medical services contracts and must accept rates at the provider's discretion when a need arises for this care. Otherwise, the institution would not have access to that provider and would have to search for alternatives. We estimated that, as a result, the BOP spent at least \$100 million more on outside medical services than the applicable Medicare rate and paid higher reimbursement rates than all other federal agencies.

We recognize the concerns expressed by the Department and the BOP that amending 18 U.S.C. § 4006(b)(1) to include the BOP could negatively impact the BOP's ability to obtain necessary medical care for its inmates. Although this statute limits the rates that the U.S. Marshals Service and the Department of Homeland Security must pay, it does not require medical providers to accept patients those agencies bring them. Given the potential that limiting the BOP's reimbursement rate without guaranteeing access could decrease providers' willingness to treat BOP inmates, both at BOP institutions as well as at community hospitals and physicians' offices, we do not believe this is the optimal solution to the BOP's medical care cost issue. If providers closest to BOP institutions began declining inmate patients due to lower reimbursement rates, it could lead to increased costs to transport inmates greater distances and increased security and logistical challenges associated with those longer trips. As noted in the report, we found that two states addressed this risk by establishing caps slightly above the Medicare rate, or providing a limited exception to their law capping medical reimbursement at the Medicare rate.

We believe that any attempt by the BOP to set uniform reimbursement rates for outside medical care must incorporate a mechanism to guarantee inmate access to such care. However, we found that the Department and the BOP have not fully considered alternatives that could potentially address these concerns while simultaneously controlling medical spending. In particular, if the standard Medicare provider agreement described in the *Social Security Act* (42 U.S.C. § 1395cc) were amended to include the BOP, hospitals that participate in the Medicare program would be required to treat BOP inmates at a rate the federal government had established. The Department of Defense (DOD), the Department of Veterans

Affairs (VA), and the Indian Health Service are already included in the *Social Security Act* provider agreement, and all have enacted regulations to reimburse care at the Medicare rate. While this proposed legislation would cover only hospital care and not outpatient physician care that BOP inmates require, it would go a long way in helping the BOP contain its medical spending while maintaining access to hospitals. We believe the Department and the BOP should explore what would be necessary to expand the *Social Security Act* to provide similar authority to the BOP, so that the BOP could establish its own uniform reimbursement rates without worrying that doing so would limit its access to hospitals.

We also believe that the Department and the BOP could do more, and would benefit from discussing other strategies for managing these costs with officials at state corrections departments and other federal agencies that have expertise in these areas, such as the Department of Health and Human Services and the DOD. For example, the BOP could reach out to other agencies with greater expertise in the acquisition of and payment for medical care to help determine whether there are other options beyond changes to medical care reimbursement rates that could help the BOP address medical costs. This can help enable the Department and the BOP to obtain a better understanding of alternate strategies outside of considering potential legislative options and the advantages and challenges faced by those agencies who also provide medical care.

Recommendations

To assist the BOP in exploring legislative and other options for providing medically necessary care while maintaining provider access, we recommend that it:

1. Convene a working group of officials from the Department, BOP, and other federal agencies, as necessary, to consider potential legislative options to improve the BOP's ability to manage reimbursement rates for medical care, including potential amendments to the *Social Security Act*.
2. Convene a working group of officials from the Department, the BOP, and other federal and state agencies that pay for medical care, as necessary, to consider additional guidance and expertise as the BOP seeks to manage its medical costs.
3. Improve the collection and analysis of utilization data for inmate medical care to better understand the services that inmates need and the impact it has on the BOP's medical spending.

EXPANDED METHODOLOGY

Data Analysis

To compare the difference between BOP spending on outside medical care and the applicable Medicare rate, we assumed that all spending at an institution was at the lowest rate allowable under its contract. The following paragraphs describe how we calculated that amount.

The BOP provided its FY 2010 and FY 2014 spending data, which can be filtered to show medical spending by institution. Medical spending can be further segregated into different categories, such as outside or inside medical spending and, within each category, even further delineated by sub-object codes such as contract spending. The BOP groups medical spending into six categories: (1) Airlift Medical, (2) Business Operations Medical, (3) Inside Medical (spending on medical care provided inside a BOP institution), (4) Outside Medical (spending on medical care provided outside a BOP institution), (5) Referral Lab Costs, and (6) Unforeseen Event – Medical. We limited our analysis to encompass only contract medical spending in the Outside Medical category, because that category accounts for over 80 percent of contract medical spending.⁵⁴ We then used two sub-object codes (25CN and 2515) as the contract medical spending for each institution.⁵⁵

The BOP also provided data on institutions that had comprehensive medical services contracts at the end of FY 2010 and FY 2014. At the end of FY 2014, 70 of the 97 BOP-managed institutions had comprehensive medical services contracts using Medicare as the benchmark rate.⁵⁶ Our analysis encompasses 69 of the 70 institutions since, according to BOP medical spending data, one institution did not report any contract medical spending in FY 2014. Each comprehensive medical services contract generally has rates based on the applicable Medicare rate for the following five services: (1) Inpatient Physician, (2) Outpatient Physician, (3) Inpatient Facility, (4) Outpatient Facility, and (5) Outpatient Institution Services – Other Physicians.⁵⁷ A contract may establish the same rate for each service, or a different rate for each service. For example, one institution that we included in our analysis paid 125 percent of the applicable Medicare rate for each of the five services. Another institution in our analysis paid 121 percent of the

⁵⁴ Contract medical spending may also occur in the other categories, but we excluded these categories from our analysis. For example, if a contract physician travels to a BOP institution to see inmate patients in the institution's medical clinic, the BOP records this as "inside medical" contract spending.

⁵⁵ We chose these two codes because institution staff we interviewed identified them as the codes they used to record the spending we were interested in analyzing.

⁵⁶ As we noted in the Introduction, the BOP considers all institutions in a correctional complex to be a single institution for the purpose of awarding comprehensive medical services contracts. As a result, there were 97 institutions in FY 2014 rather than 121.

⁵⁷ Facility services refer to services provided at hospitals.

applicable Medicare rate for one service and 110 percent of the applicable Medicare rate for another.

Since the BOP did not have any data regarding how much each institution with a comprehensive medical services contract spends on each of the five services, we were not able to calculate an average reimbursement rate paid by each institution for all of its contract medical services. Instead, we assumed that all of an institution's contract medical spending was for the service with the lowest rate because that would represent the least amount an institution would have spent above the Medicare rate. To compare the difference between BOP spending and the Medicare rate, we applied the lowest reimbursement rate to the estimated contract medical spending for each of the 69 institutions.⁵⁸ For example, one institution's contract established rates of 234 percent, 182 percent, 178 percent, and 145 percent of the applicable Medicare rate for the different types of services. We therefore assumed that all contract medical spending by this institution was 145 percent of the Medicare rate. Since we assumed that all contract medical spending occurred at this rate, we divided the institution's contract medical spending by 1.45 to calculate what that institution would have paid at the applicable Medicare rate. To find the difference between the BOP's actual spending and our estimate of the amount the BOP would have spent at the applicable Medicare rate, we subtracted our estimated Medicare rate amount from the institution's contract medical spending. We repeated this methodology across all 69 institutions we analyzed to estimate the overall difference.

Interviews

We interviewed BOP Central Office officials, including the Assistant Directors of the Health Services and Administration Divisions, the National Health Systems Administrator, the Chief of the Office of Legislative Affairs, the Chief of Budget Execution, and budget staff from the Administration Division.

We conducted interviews at five institutions and the BOP's Field Acquisition Office (FAO) via video teleconference. At institutions, we interviewed senior management, as well as staff that provide medical care to inmates. We interviewed four Wardens, one Associate Warden, five Health Services Administrators, five Business Administrators, and clinical staff, to include: an Occupational Therapist, a Health Systems Specialist, four non-supervisory Registered Nurses, a Physician Assistant, a Nurse Practitioner, and two Pharmacists. At the FAO, we interviewed the Section Chief and six Contract Specialists in the Medical Contracting and Assistance Section.

We also interviewed officials in other Department agencies, including two officials from the Office of the Deputy Attorney General, three officials from the Justice Management Division, and three officials from the U.S. Marshals Service

⁵⁸ When selecting the lowest rate in the contract, we excluded the Outpatient Institution Services – Other Physicians rate because BOP officials and institution staff told us that this category was seldom used. The Department also excluded this category from its 2012 analysis.

(USMS). We interviewed Department officials to understand the Department's involvement in working with the BOP to control medical spending. We interviewed USMS officials to understand their experience with 18 U.S.C. § 4006(b)(1), which caps its rate for inmate and detainee medical services.

We interviewed officials in federal agencies outside the Department to gain additional perspectives on how the federal government pays for medical care. We interviewed an official from the Office of Management and Budget to understand its involvement with the Department and the BOP on strategies to manage medical spending. We interviewed officials and staff from the Department of Homeland Security's Immigration and Customs Enforcement to understand their experience with 18 U.S.C. § 4006(b)(1). We interviewed an official from the Department of Defense (DOD) Office of the Inspector General to understand how the rate the DOD pays for medical care compares to the applicable Medicare rate. Finally, we interviewed officials and staff from the Centers for Medicare and Medicaid Services to understand the requirements imposed on medical providers as conditions of participating in Medicare.

We interviewed officials from 10 state departments of corrections: Kentucky, Louisiana, Minnesota, New Hampshire, New Jersey, New York, North Carolina, Pennsylvania, Texas, and Washington. We chose these states based on combination of factors such as the number of federal prisons in each state and whether the state had legislation limiting the rate its department of corrections pays for inmate medical care.

Site Visits

The team conducted video teleconferences with the following institutions, representing all four medical care levels: Federal Medical Center Butner, Federal Correctional Institution Danbury, Federal Medical Center Rochester, Federal Correctional Institution Sandstone, and Federal Detention Center SeaTac. We selected these five institutions based on a combination of factors such as whether the institution had a comprehensive medical services contract, the reimbursement rates in the comprehensive medical services contract, and the level of outside medical spending.

THE BOP'S RESPONSE TO THE DRAFT REPORT



U.S. Department of Justice

Federal Bureau of Prisons

Office of the Director

Washington, D.C. 20534

June 1, 2016

MEMORANDUM FOR NINA S. PELLETIER
ASSISTANT INSPECTOR GENERAL
OFFICE OF THE INSPECTOR GENERAL
EVALUATION AND INSPECTIONS DIVISION

Thomas R. Kane

FROM: Thomas R. Kane, Acting Director

SUBJECT: Response to the Office of the Inspector General's
(OIG) FORMAL Draft Report: OIG Review of the Federal
Bureau of Prisons' Reimbursement Rates for Outside
Medical Care

The Bureau of Prisons (BOP) appreciates the opportunity to respond to the open recommendations from the formal draft report entitled OIG Review of the Federal Bureau of Prisons' Reimbursement Rates for Outside Medical Care.

Therefore, please find the BOP's responses to the recommendations below:

Recommendations

To assist the BOP in exploring legislative and other options for providing medically necessary care while maintaining provider access, we recommend that it:

Recommendation 1: "Convene a working group of officials from the Department, BOP and other federal agencies, as necessary, to consider potential legislative options to improve the BOP's ability to manage reimbursement rates for medical care, including potential amendments to the Social Security Act."

Response: BOP agrees with this recommendation and will coordinate with officials from the Department of Justice and other agencies, as necessary, to consider potential legislative options to improve the BOP's ability to manage reimbursement rates for medical care, including potential amendments to the Social Security Act.

Recommendation 2: "Convene a working group of officials from the Department, the BOP, and other federal and state agencies that pay for medical care, as necessary, to consider additional guidance and expertise as the BOP seeks to manage its medical costs."

Response: BOP agrees with this recommendation and will coordinate with officials from the Department of Justice and other federal and state agencies that pay for medical care, as necessary, to consider additional guidance and expertise as the BOP seeks to manage its medical costs.

Recommendation 3: "Improve the collection and analysis of utilization data for inmate medical care to better understand the services that inmates need and the impact it has on the BOP's medical spending."

Response: BOP agrees with this recommendation and will work to improve the collection and analysis of utilization data for inmate medical care, to better understand the services that inmates need and the impact it has on the BOP's medical spending.

If you have any questions regarding this response, please contact Steve Mora, Assistant Director, Program Review Division, at (202) 353-2302.

OIG ANALYSIS OF THE BOP'S RESPONSE

The OIG provided a draft of this report to the BOP for comment. The BOP's response is in Appendix 2. Below, we discuss the OIG's analysis of the BOP's response and actions necessary to close the recommendations.

Recommendation 1: Convene a working group of officials from the Department, BOP, and other federal agencies, as necessary, to consider potential legislative options to improve the BOP's ability to manage reimbursement rates for medical care, including potential amendments to the *Social Security Act*.

Status: Resolved.

BOP Response: The BOP concurred with the recommendation and stated that it would coordinate with officials from the Department and other agencies, as necessary, to consider potential legislative options to improve the BOP's ability to manage reimbursement rates for outside medical care, including potential amendments to the *Social Security Act*.

OIG Analysis: The BOP's planned actions are responsive to our request. By September 9, 2016, please identify the membership of the working group and describe the legislative options considered as well as the research conducted by the group to assess the potential impacts of each legislative proposal.

Recommendation 2: Convene a working group of officials from the Department, the BOP, and other federal and state agencies that pay for medical care, as necessary, to consider additional guidance and expertise as the BOP seeks to manage its medical costs.

Status: Resolved.

BOP Response: The BOP concurred with the recommendation and stated that it would coordinate with officials from the Department, as well as other federal and state agencies that pay for medical care, to consider additional guidance and expertise as the BOP seeks to manage its medical costs.

OIG Analysis: The BOP's planned actions are responsive to our request. By September 9, 2016, please identify the membership of the working group and describe the guidance and expertise considered as well as the research conducted by the group to assess the potential impacts of each proposed approach.

Recommendation 3: Improve the collection and analysis of utilization data for inmate medical care to better understand the services that inmates need and the impact it has on the BOP's medical spending.

Status: Resolved.

BOP Response: The BOP concurred with the recommendation and stated that it would improve the collection and analysis of utilization data for inmate medical care to better understand the services that inmates need and the impact it has on the BOP's medical spending.

OIG Analysis: The BOP's planned actions are responsive to our request. By September 9, 2016, please identify the services inmates need and how frequently those services are used, as well as the BOP's plan for how it intends to collect and analyze that data on an institutional, regional, and national basis. Please also provide an update on the BOP's efforts to award comprehensive medical services contracts on a regional basis and explore alternative pricing techniques in its contract solicitations.

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