Georgia Department of Audits and Accounts
Performance Audit Division
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# Inmate Health Contract

## Requested Information on Spending Trends

### Why we did this review

This review of the inmate health contract between the Georgia Department of Corrections and Georgia Regents University was conducted at the request of the House Appropriations Committee.

The Committee asked for a review of expenses related to the contract, primarily focusing on monthly and year-end changes. In addition, a review of the historical trends of costs per inmate and a comparison to other states was requested. This review did not examine the quality of care provided through the contract.

### About GDC

The Georgia Department of Corrections began contracting with Georgia Regents University (then known as Medical College of Georgia) in 1997 to provide physical healthcare services to inmates in state corrections facilities. The contract has been renewed every fiscal year since. The Department of Corrections Office of Health Services oversees the contract management.

Georgia Correctional HealthCare manages the contract at Georgia Regents University. It provides inmates with physical healthcare services at all state prisons as well as some smaller state facilities. The contract does not cover mental health, most dental health, nor does it cover services for private prisons or county correctional institutions.

### What we found

In July 1997, the Georgia Department of Corrections (GDC) began contracting with the Medical College of Georgia (now known as Georgia Regent's University (GRU)) to provide physical health care services to inmates in its facilities. GRU created the Georgia Correctional HealthCare (GCHC) unit to operate the contract.

GDC has renewed the contract with GRU each year. Over the past five fiscal years (2010-2014), GDC has based the contract amount on the prior year contract expenses and made adjustments as necessary to meet budgetary directives. According to GDC, there is currently no formula or projection used to predict the next year's expenses. During the period reviewed, the contract amount decreased by 7%.

We found that GDC's contract amount has not always matched the expenses incurred by GCHC to provide the services. For example, in fiscal year 2008, GCHC expended approximately $178 million for physical health care services while the contract covered $163 million, leaving a $15 million deficit. However, in fiscal year 2009, GCHC expended $171 million while the contract was $178 million, a $7 million surplus. Because of these types of discrepancies, GDC has made a practice of rolling deficits or surpluses forward to the next fiscal year. From fiscal year 2010 to 2014, the deficit or surplus amount ranged from −0.05% to +4.1% of the total contract amount.

On average, we found the expenses were 35% higher in June, the last month of the fiscal year, and 25% lower in July, than the average monthly spending. Contract spending is subdivided into six categories, with three – staffing, direct care and

pharmaceuticals – making up 96% of the total expenses. We analyzed the data to determine where the fluctuations were occurring, how large they were, month over month as well as at the end of the year and identified the drivers of the fluctuations where possible. Fluctuations in billings and expenses, particularly at the end of the year, are occurring primarily in the three largest categories. According to GDC, direct care expenses fluctuate because inmates' need for services provided outside the facilities is variable. The staffing fluctuations are attributable to year-end accruals, and fluctuations in pharmaceutical expenditures occur because GCHC stocks up on medications at the end of the year. However, to isolate the reasons why fluctuations occur and determine if they are reasonable would require a detailed analysis of operations and programmatic information to determine how decisions are made and how services are being provided at the individual facility level.

While expenses fluctuate, we found that overall physical health care costs per inmate have been stable at or near $3,500 per inmate per year, between fiscal years 2003 and 2013. Total health care costs (which include physical, mental, and dental health care) per inmate have historically been stable as well, at or near $4,000 per inmate per year. The audit team surveyed twelve other states to determine their costs per inmate for fiscal year 2013. We found that Georgia spends less per inmate than most other states.

Finally, we found that all of the cost containment practices identified in previous DOAA reports are still in effect. Staff noted that they have increased the number and type of medical procedures available within the facilities, which results in lower costs than if the inmate had to be treated offsite. GCHC also indicated it has accessed Medicaid benefits for those inmates who are eligible as defined by the Georgia Department of Community Health. Because of legislation enacted in 2011, GCHC now pays the Medicaid rate to non-contracted hospitals when emergency services are provided to inmates. Finally, in addition to the group pharmacy benefits it was already receiving, GCHC now participates in the federal 340B program which allows it to purchase HIV/AIDS medications at a reduced rate. GDC and GCHC are currently working to expand the program to include Hepatitis C medication and certain cancer medications.

## What we recommend

This report is intended to provide answers to questions posed by the House Appropriations Committee. We hope that this report provides pertinent information to help inform policy decisions.

***Report Revision:*** *On January 12, 2015, a change was made to the 4th sentence of the 3rd paragraph of the What We Found section to more precisely clarify the Agency's actions. This editorial change did not affect the remainder of the report or any of the information provided.*

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## Purpose of the Special Examination

This review of the inmate health contract between the Georgia Department of Corrections and Georgia Regents University was conducted at the request of the House Appropriations Committee. The Committee asked that we address the following questions:

1. How is the Georgia Regents University (GRU) contract amount determined annually?
2. What causes fluctuations in monthly spending, and in particular, year-end spend down?
3. What are historical trends on the cost of care per inmate?
4. How do these costs per inmate compare to other states?
5. Are the cost containment practices identified in the 2004 and 2007 inmate health reports released by DOAA still in operation? If not, why not? Have any been added?

This special examination did not evaluate the quality of health care provided to inmates through the contract with GRU. A full description of the objectives, scope, and methodology used in this review is included in Appendix A. A draft of the report was provided to GDC for its review, and pertinent responses were incorporated into the report.

## Background

### History

Inmates in the custody of state, federal, or local correctional systems are entitled to a constitutionally required level of health care, which includes physical, mental, and dental health services. GDC's Office of Health Services (OHS) oversees the provision of this care. OHS's purpose is to ensure adequate health care is provided to state inmates in the most efficient, cost-effective, and humane manner possible, while protecting the public health and safety of the rest of the state's citizens. OHS does this by working with other divisions within GDC to ensure inmates are housed in facilities that meet their security requirements as well as their medical needs.

Georgia's 51,000 inmates are housed in 93 facilities across the state, including state prisons, private prisons, county correctional institutions, substance abuse centers, transitional centers, probation detention centers, and integrated treatment facilities. Approximately 45,000 (89%) inmates receive healthcare services through the GCHC contract. While the standard of care for inmates housed in the state's four private prisons and 23 county correctional institutions is the same as those for inmates in GDC-operated facilities, the operators of these facilities are responsible for providing the health services up to a certain point.[1]

[1] County facilities cover the first $1,000 and private prisons are responsible for the first $24,999 of health care costs incurred. Private prisons' contribution decreases to 50% up to $49,999 and 25% up to $99,999. GDC is responsible for 100% of costs above $100,000.

## Physical Health Care Contract

In July 1997, GDC began contracting with Medical College of Georgia (now known as Georgia Regent's University (GRU)) to provide physical health care services to inmates in its facilities. GRU created the Georgia Correctional HealthCare (GCHC) unit to operate the contract. OHS retains responsibility for determining whether specialized services are appropriate, determining what medications are available through the drug formulary, identifying inmates (based on medical criteria) the Board of Pardons & Paroles can consider for medical reprieve, and transporting inmates, as necessary, to receive services. GCHC is responsible for:

- Managing physical health care operations in GDC facilities;
- Providing intake services at GDC's diagnostic facilities;
- Conducting physical health care clinics addressing urgent illnesses and injuries, non-urgent illnesses and injuries, and chronic illnesses;
- Negotiating and managing contracts with health care service providers throughout Georgia (hospitals, specialty clinics, ambulance services, etc.) for health care services that cannot be provided by resources within GDC facilities; and
- Managing the drug formulary along with OHS.

### Provision of Physical Health Care

Generally inmates receive physical health care through on-site clinics within the prison. Inmates requiring services that are not available at their facilities can be transferred to other state facilities that provide such services or can be seen by a community health care provider. Emergency services are also available to all inmates.

Primary care services such as clinics, sick call, and pill call are available at all state prison facilities. Specialized services are located in certain prison facilities throughout the state. For example, upon entrance into the correctional system, inmates are housed in one of the two diagnostic state prisons where personnel administer a battery of tests to diagnose medical problems, establish treatment needs and determine an inmate's physical capabilities. These assessments then determine the inmates' placement. In addition, the state operates regional infirmaries in 12 prisons and Helms Medical Facility to care for inmates who need skilled nursing care but are not in need of hospitalization. The state also operates regional pharmacies in nine prisons; these pharmacies manage the bulk purchase and distribution of pharmaceuticals to the other prisons.

There are also state prisons specifically equipped to provide specialized medical care. For example, acute and specialized medical services, including surgeries, are provided at Augusta State Medical Prison (ASMP). In addition, ASMP houses an infectious disease clinic, which provides care to inmates through the federal 340B drug program. The program allows the state to obtain drugs at a reduced rate. The Georgia State Prison also has a surgical unit and the Helms Medical Facility houses pregnant female inmates as well as male inmates undergoing cancer treatment.

When necessary, inmates may also receive care outside GDC facilities. Currently, GCHC has agreements with over 200 outside providers. The majority of subcontracts are for hospital care, emergency services, surgeons or other specialized physicians, pharmacies, and physical therapy. While GCHC manages these subcontracts, GDC must first authorize the care through its Utilization Management process.

Currently, GCHC provides 682 staff for physical health care services, 95 mental health nurses, 4 dental staff, and 211 staff categorized as "other."[2] According to GCHC labor reports, there is a 19% vacancy rate.

According to GDC, Georgia's inmate population is growing older, and therefore requiring more medical care. In addition, GDC facilities, rather than private prisons, house the more ill and aged inmates. GDC also notes that, if inmates in private prisons require more intense medical treatment, it transfers these individuals to a GDC facility.

## Contract Expenses

Inmate health care is funded through GDC's health appropriation of approximately $200 million per year. Most of GDC's healthcare funding (approximately 80%) is for physical health through the contract with GRU **(Exhibit 1)**. Mental health and dental health services are also provided through the health budget; the majority of these services are provided separately from the GRU contract.

**Exhibit 1**
**Expenses for Physical Health Contract Represent Majority of GDC's Total Health Expenses, Fiscal Years 2010 - 2014**

| Fiscal Year | Total Health Expenses | Total Contract Expenses | % of Total Health Expenses |
|---|---|---|---|
| **2010** | $209,042,530 | $166,316,922 | 80% |
| **2011** | $208,103,267 | $162,260,524 | 78% |
| **2012** | $201,921,554 | $164,762,369 | 82% |
| **2013** | $200,252,056 | $156,079,919 | 78% |
| **2014** | $202,233,729 | $161,745,714 | 80% |

Source: GCHC history report, agency Teamworks data

Based on spending data from fiscal year 2010 through fiscal year 2014, physical health care costs have decreased. While the total contract expenses have decreased 3% since fiscal year 2010 ($4.6 million), expenses year-to-year have fluctuated.

Contract spending is subdivided into several categories as shown in **Exhibit 2**. Direct care, staffing and pharmaceuticals represent the largest categories of expenses. Direct care expenses primarily include payments for outpatient care, physician fees, as well as professional, dialysis, laboratory, radiology, and optometry services. Staffing expenses include all permanent and temporary employees. Pharmaceuticals expenses include all drug purchases. Operating expenses, which include office supplies, medical supplies, repairs and maintenance as well as freight and storage, also include the $500,000 management fee. GCHC noted that this fee does not cover the office space, utilities, campus-related services (such as shuttle

[2] Other includes management, admin/support, and clerical staff.

services) provided by GRU. GCHC also administers subcontracts for administrative services, including claims administration, and temporary staffing.

**Exhibit 2**
**Total Contract Spending and Inmate Population Have Decreased between Fiscal Years 2010 and 2014**

| Category | FY 2010 | FY 2011 | FY 2012 | FY 2013 | FY 2014 |
|---|---|---|---|---|---|
| **Staffing** | $66,092,316 | $68,373,316 | $71,099,840 | $72,458,138 | $76,696,617 |
| **Travel** | 282,285 | 254,797 | 285,965 | 279,083 | 275,616 |
| **Operating Expenses** | 5,606,620 | 5,665,253 | 5,910,821 | 6,504,639 | 6,554,688 |
| **Pharmaceuticals** | 28,454,287 | 29,807,131 | 31,886,553 | 25,977,846 | 28,464,572 |
| **Direct Care** | 65,695,076 | 57,741,449 | 54,910,249 | 50,413,297 | 49,354,873 |
| **Equipment** | 186,340 | 418,605 | 668,941 | 446,916 | 399,347 |
| **Total Expenses** | **$166,316,922** | **$162,260,524** | **$164,762,369** | **$156,079,919** | **$161,745,714** |
| **Inmate Population**[1] | 48,182 | 46,791 | 46,094 | 45,270 | 45,110 |

[1]This number indicates the subset of the GDC's total inmate population that receives physical healthcare services from GCHC.

Source: GCHC history report and financial statements

The biggest changes in spending occurred in the staffing and direct care categories, the two largest. Over the five-year period reviewed, spending on staffing increased $10.6 million while spending on direct care decreased $16 million. The remaining categories remained relatively stable. Over the same period, the number of inmates decreased by 6%.

# Requested Information

## How is the contract amount determined annually?

GDC bases the GRU contract amount on previous year's expenses. According to GDC, there is currently no formula or projection used to predict the next year's expenses.

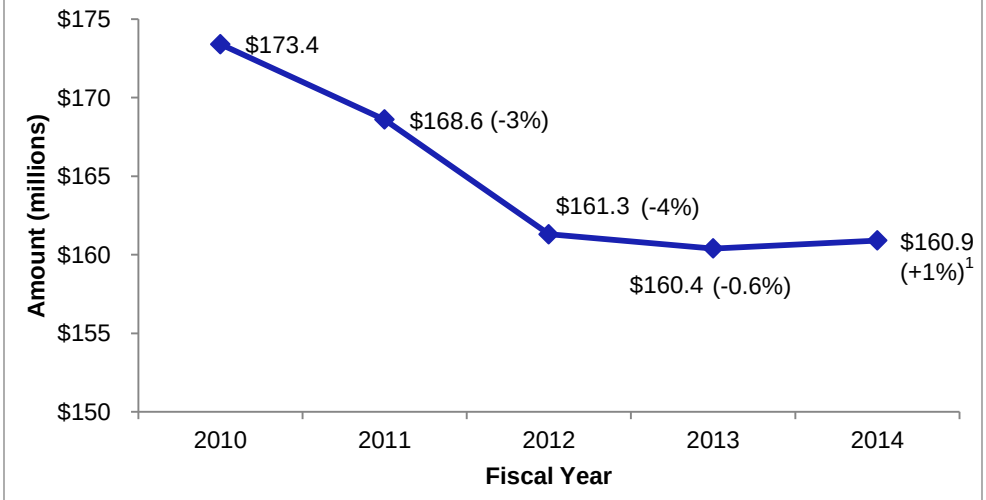
*The State of Georgia's fiscal year is July 1 – June 30*

While the contract amount has generally decreased each year, GCHC's actual expenses varied above and below the contract budget. According to GDC, the unpredictability of healthcare costs motivates it to pay forward any surplus in the contract to "spread the burden out" over the following fiscal year. The contract is cost-based. As noted earlier, GDC is required by law to provide a constitutional level of care. Therefore, catastrophic cases can result in higher than anticipated expenses that must be absorbed. According to GDC, they work closely with GCHC to identify such cases and make adjustments to other expenses where possible. These areas are discussed in more detail below.

### Changes in the Contract Amount

While the medical consumer price index (CPI) has increased each year from 2010 to 2014, on average, Georgia's inmate healthcare costs have decreased (see **Exhibit 14** on page 16 for a graphical representation). The contract amount decreased by 7% ($12.5 million) between fiscal year 2010 and 2014. These adjustments included reductions and additions that reflected facility closures, program reductions and general decreases in operating costs, as well as new programs and new treatment beds. Fiscal year 2014 was the only year since 2010 that saw an overall increase in funding for the contract. **Exhibit 3** shows the change from year-to-year.

**Exhibit 3**
**The Contract Amount Decreased 7% from Fiscal Year 2010 to 2014**




[1]In FY2014, the contract amount was amended mid-year. The original contract amount was $158.9 million. $2 million was added to compensate for the temporary loss of 340B pricing.
Source: Agency agreements and budget documents, fiscal years 2010-2014

From fiscal year 2010 to 2011, the contract amount decreased by $4.8 million (3%) because of cuts to annualize facility closures and transfer funds to the Jail Subsidy program. From fiscal year 2011 to 2012, the contract amount decreased another $7.3 million (4%) because facilities were closed, operating funds were reduced and funds were transferred to Medicaid. From fiscal year 2012 to 2013, the contract amount decreased by $900,000 (0.6%) because of changes within a specific facility. From fiscal year 2013 to 2014, the contract amount actually increased by $500,000 (1%). During this year, the federal government forced the state to cease participation in the 340B program, resulting in a significant increase in drug pricing. At mid-year, GDC requested and received $2 million in supplemental funding to cover these increased costs. Because the original contract amount reflected a reduction of $1.5 million due to increased program efficiencies, the overall increase was $500,000. Subsequent to the supplemental appropriation, the federal government reinstated GDC's participation in the 340B program.

As noted earlier, the contract is funded through the Health appropriation line item and represents approximately 80% of that appropriation ($161 million of the $202 million Health appropriation). Therefore, the majority of cuts to the Health appropriation will be realized within the contract. However, GDC indicated that if funding is available within the Health appropriation, it can be moved to the contract to offset some planned reductions.

***Agency Response:*** *In its response to the report, GDC noted its opinion that "the adjustments listed as the reasons for cost reductions are primarily global initiatives by the GDC to reduce its overall expenditures and were not necessarily the initiatives GDC/GCHC underwent to reduce health care costs. Rather, we think the health care reductions from 2010 to 2014 were a result of:*

- *Enhancing internal services at prison sites such as ASMP ambulatory surgeries and the addition of the Modular Surgical Unit (MSU) at the Georgia State Prison*
- *Improved contract terms with hospitals and physician groups.*
- *Utilization management. (inpatient admissions went down steadily in that period)*
- *Reduction in census at the GEOCare (formerly "JustCare") facility by enhancing mental health capabilities at ASMP."*

## Contract Amount Compared to Expenses

Over the past five fiscal years, the contract amount has declined by 7%; during the same period, the actual expenses have declined 3%. **Exhibit 4** shows the change over time in both the contract amount and actual expenses. As a result, when compared year-by-year, there appears to be a deficit in some years and a surplus in others. In either case, over the past six years, the difference was consistently less than 5% of the budgeted contract amount each year.

**Exhibit 4**
**Difference Between Contract Expenditures and Expenses has been Less Than 5% for the Past Six Years, Fiscal Years 2007 - 2014**

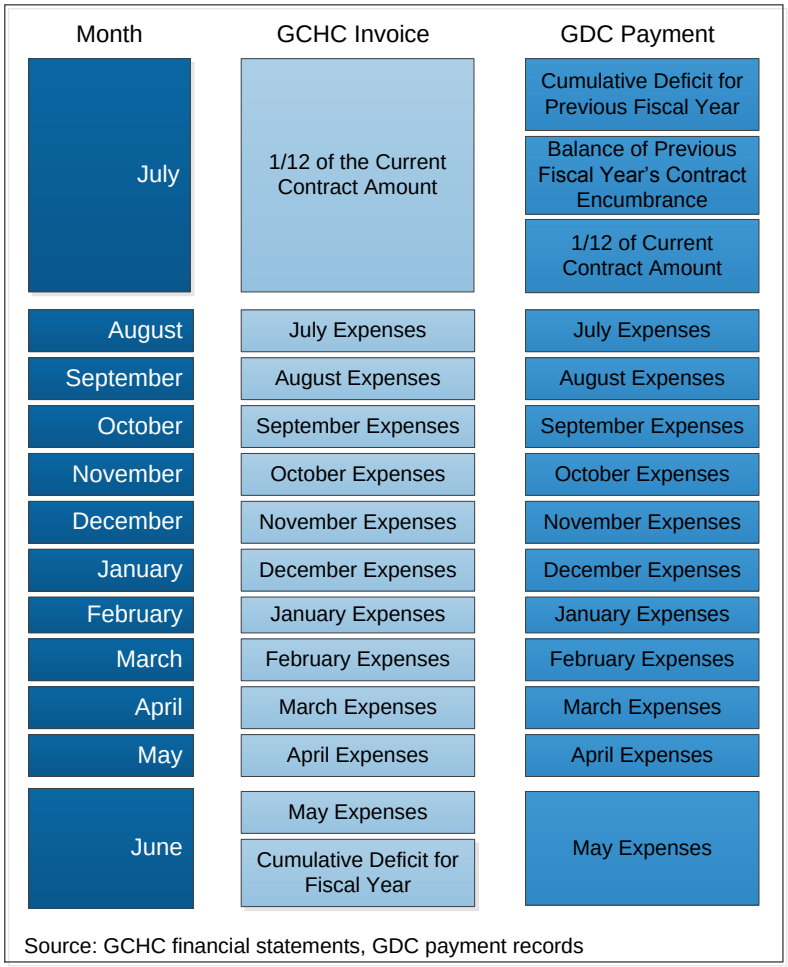
| Fiscal Year | Contract Expenditure | Expenses Billed by GCHC | Surplus/Deficit | % of Contract Amount |
|---|---|---|---|---|
| **2007** | $148,000,000 | $157,900,523 | $9,900,523 | 6.7% |
| **2008** | $163,420,684 | $177,485,900 | $14,065,216 | 8.6% |
| **2009** | $177,686,944 | $170,902,331 | $6,784,613 | 3.8% |
| **2010** | $173,420,721 | $166,316,922 | $7,103,799 | 4.1% |
| **2011** | $168,609,228 | $162,260,524 | $6,348,704 | 3.8% |
| **2012** | $161,281,687 | $164,762,369 | $3,480,682 | 2.2% |
| **2013** | $160,381,687 | $156,079,919 | $4,301,768 | 2.7% |
| **2014** | $160,881,687 | $161,745,714 | $864,027 | 0.5% |

Source: Agency Teamworks data, GCHC history report

At the beginning of the fiscal year (July 1), GDC encumbers the entire contract amount. Throughout the year, it issues payments against that encumbrance until the balance is zero. **Exhibit 5** outlines the schedule of payments GDC follows. According to the contract, GCHC's July invoice reflects 1/12 of the contract amount. The invoices for August through June must be submitted by the 10th of the month and reflect the actual expenses incurred in the prior month. A final invoice is submitted at the end of June to reconcile any outstanding balance due resulting from actual expenses versus payments made.

As shown in Appendix B, in June 2013, GDC paid $10.2 million budgeted for the fiscal year 2013 contract towards fiscal year 2014 expenses. The payment represented 6% of the total contract amount and covered approximately 23 days of contract costs. In other years, the contract has not covered all expenses, and a deficit was rolled forward. According to GDC, it pays any surplus to the following fiscal year as a precautionary measure due to the unpredictability of healthcare costs and to avoid asking for mid-year budget adjustments. In order to make this process more transparent, consideration could be given to allowing GDC to carry a fund balance to control for the volatility of health care expenses. Appendix B shows the payment details for fiscal years 2012 through 2014.

**Exhibit 5**
**GDC Pays the Surplus Forward to the Next Fiscal Year**



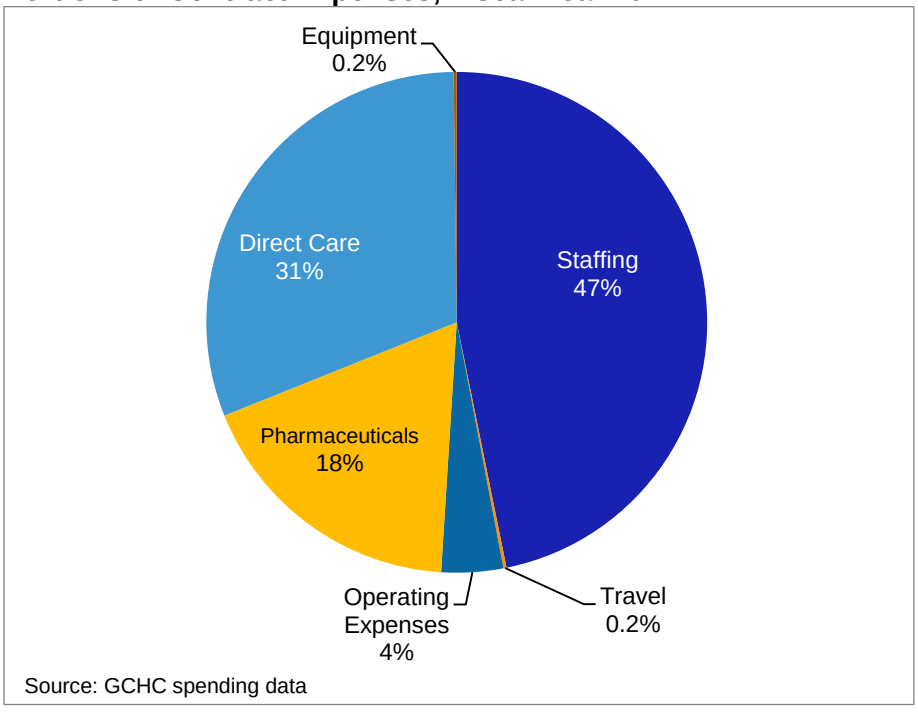

Source: GCHC financial statements, GDC payment records

## What causes or explains fluctuations in monthly billings and expenses, particularly relating to year-end spending?

As shown in **Exhibit 6**, staffing, direct care and pharmaceuticals account for approximately 96% of the contract expenses. Fluctuations in billings and expenses, particularly at the end of the year, are primarily occurring in these same three categories. According to GCHC, direct care expenses fluctuate because inmates' need for services is variable. The staffing fluctuations are attributable to payroll accruals at the end of the year and GCHC stocks up on pharmaceuticals at the end of the year, resulting in year-end increases in this category.[3]

On average, we found the expenses were 35% higher in the June and 25% lower in July than the average monthly spending. As discussed in the following sections, we analyzed the data to determine how large the fluctuations were, month over month as well as at the end of the year. We also identified the drivers of the fluctuations where possible. However, in order to isolate the reasons why the fluctuations occur or whether they are reasonable would require a more detailed analysis of operations and programmatic information to determine how decisions are being made and how services are being provided at the individual facility level.

**Exhibit 6**
**Direct Care, Staffing and Pharmaceuticals Represent the Largest Portions of Contract Expenses, Fiscal Year 2014**




Source: GCHC spending data

[3] At year-end, a portion of payroll for non-exempt staff has been earned but not paid out due to payroll cycles. For accounting purposes, the payroll is accrued (charged) to the year in which it was earned and paid out in the subsequent year.

### Monthly Fluctuations

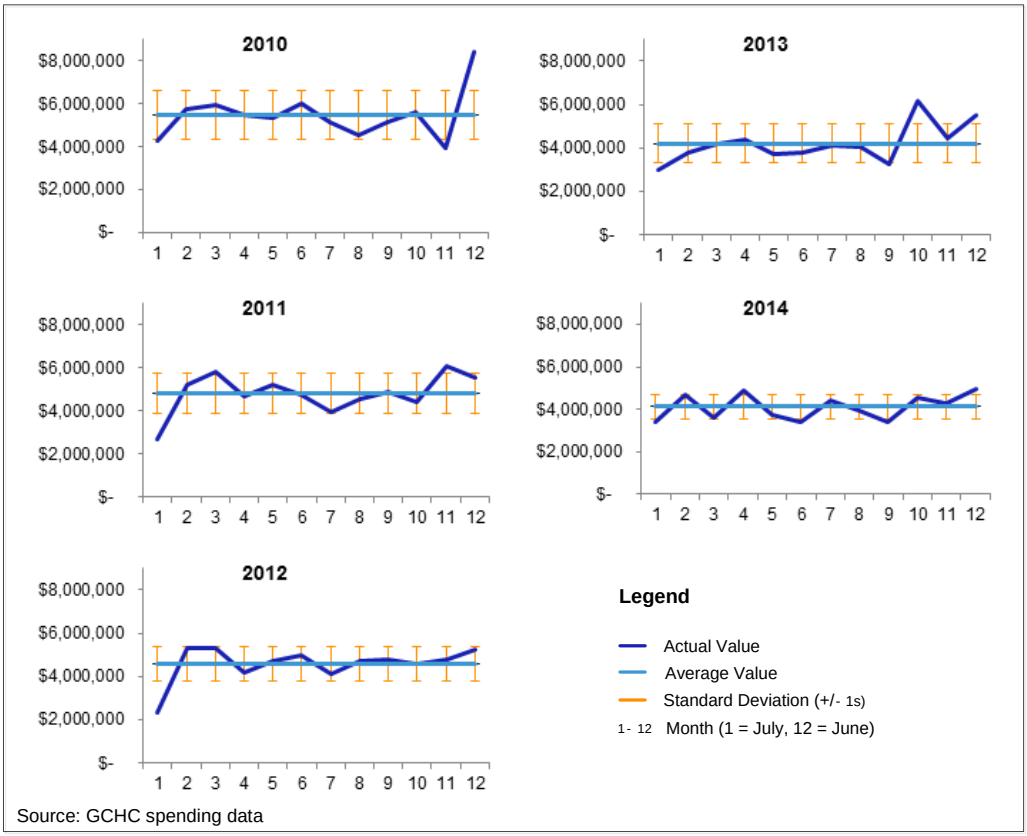
The majority of expenditure categories within the contract fluctuate on a monthly basis. In order to identify where significant fluctuations were occurring, the audit team calculated the average expenses per month by spending category and the standard deviation for each fiscal year from 2010-2014. The variance was calculated by comparing the actual spending for each category to the average to identify categories for further review.[4] The categories with the most significant changes were: direct care, staffing and operating expenses.

- Direct Care – We identified several factors that explained the fluctuations in the monthly direct care expenses. Variations occurred in subcategories related to laboratory and inpatient services. According to GDC, these subcategories reflect actual inmate needs and, therefore, are not constant across months. Variations also occurred when smaller prison facilities used services. GDC noted that the smaller facilities use services sporadically, again, as needed by the inmates. Staff attributed larger monthly variations towards the end of the year to "invoice push." GCHC stated that, while providers are required to submit invoices throughout the year, it has established a practice of contacting vendors to ensure payments have been received to ensure there are no outstanding invoices due. Therefore, even though services are consumed throughout the year, the costs are paid at the end of the year.

  **Exhibit 7** shows the monthly fluctuations in total direct care costs for each fiscal year, as compared to the average. The orange bars represent a range of standard deviation below/above the average. **Exhibit 7** shows that most monthly fluctuations in direct care occur within a "normal" range. Only a few months of each year are outside that range.

[4] While two standard deviations above/below the average are generally used to identify outliers, the audit team was comparing variations in each category or month relative to other categories; therefore, we determined that one standard deviation was adequate for our purposes.

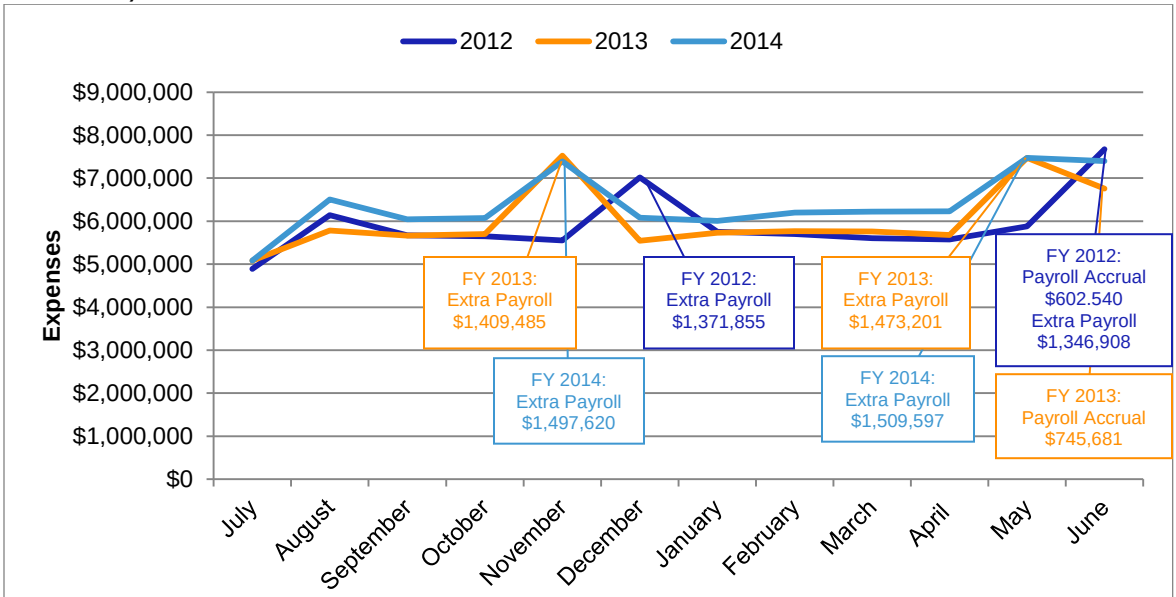
**Exhibit 7**
**Direct Care Monthly Fluctuations Generally Fall Within One Standard Deviation, Fiscal Years 2010 - 2014**




Source: GCHC spending data

- Staffing – The shifts in personal services (permanent employees) occurred due to year-end payroll accruals as well as extra payrolls each year; the timing of those changes every year. These expenses also change if facilities open or close. The shifts in temporary employees occur as additional staff are needed. GCHC officials said their use may increase during holiday months, and those invoices would be paid in January or February. **Exhibit 8** shows that the primary fluctuations in total costs can be described by one-time expenses throughout the year. In addition, several subcategories under staffing fluctuated from month-to-month. Temporary clerical staff expenses were lower in July than other months. Agency physician expenses were higher in February than other months. Agency mid-level staff expenses were higher in May as well.

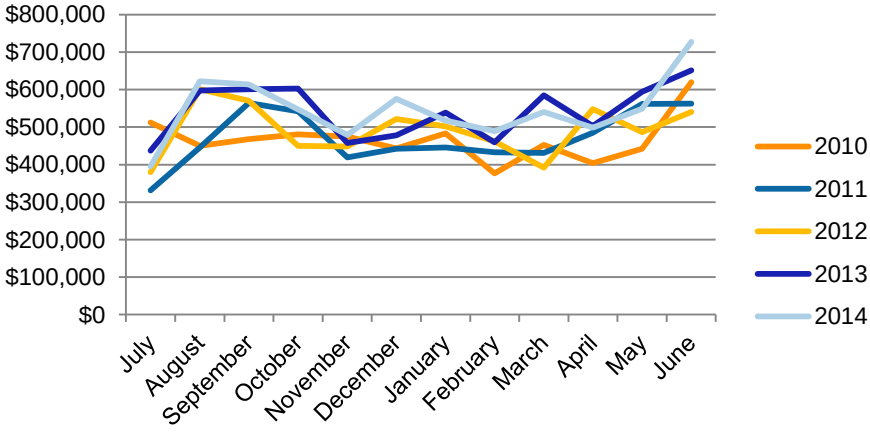
**Exhibit 8**
**Fluctuations in Staffing Costs Occurred due to Extra Payrolls and Payroll Accruals, Fiscal Years 2012 - 2014**



Source: GCHC spending data

- Operating Expenses - Fluctuations in operating expenses primarily occurred because of invoice timing issues, according to GCHC staff. They noted that vendors do not always submit invoices promptly, pushing some to other months. **Exhibit 9** below shows the monthly fluctuations by fiscal year for all operating expenses. Most years show lower expenses in July and higher expenses in June, with inconsistent year-to-year changes in other months. The largest subcategory is medical supplies, which also had higher expenses in June. According to GCHC, these fluctuations are not systematic and occur when storage, repairs or maintenance is needed.

**Exhibit 9**
**Operating Expenses Fluctuate Most at the Beginning and End of Fiscal Years 2010 - 2014**

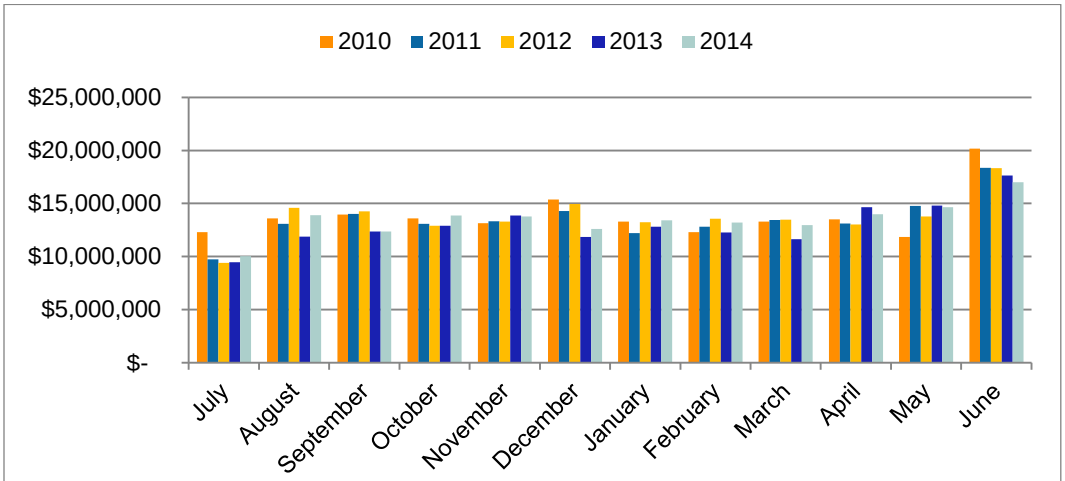


Source: GCHC spending data

### Year-end Spending Increases

GCHC's expenses are generally lower in July and higher in June (see **Exhibit 10**). In order to identify categories with the largest change at the end of the year, the audit team compared June spending data to the average spending in August through May spending.[5]

**Exhibit 10**
**Expenses are Generally Lower in July and Higher in June, Fiscal Years 2010 - 2014**




Source: GCHC spending data

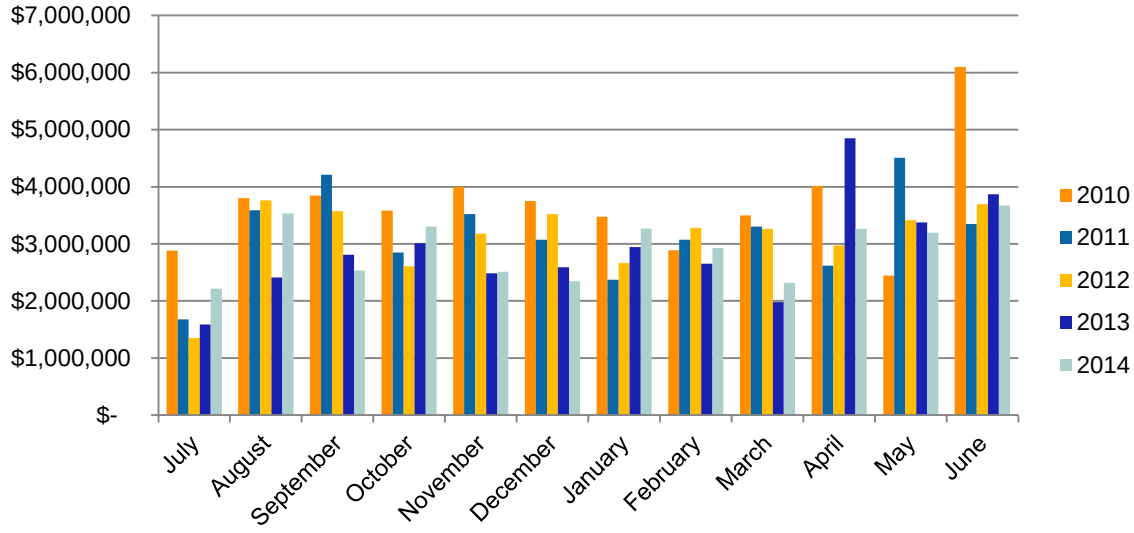
The largest year-end variances occurred in three categories: direct care, staffing and pharmaceuticals. The average June variance for each and the reasons identified are discussed below.

- Direct Care – The average June variance was 27% ($1.3 million). During the period reviewed, inpatient costs, which includes claims payments for inmates receiving outside services, accounted for 79.5% of the direct care costs ($221 million of $278 million). This subcategory showed a June variance of 26%. Staff initially indicated that, because it pays more claims at the end of the fiscal year, the expenses are higher. While analysis confirmed more claims are paid in the last quarter of the fiscal year (April – June), expenses were not similarly higher. Therefore, the number of claims paid at the end of the year does not explain the year-end increase in direct care spending.

  **Exhibit 11** is based on GCHC's actual expenditure data. With the exception of fiscal year 2010, the monthly fluctuation over the period does not show a distinct pattern of year-end increases. The high payment totals occur at varying points throughout each fiscal year. As noted earlier, to fully explain the reasons for the fluctuations within the categories would require further analyses of programmatic and facility level data.

[5] July was excluded from the calculation of the average because its expenses are generally significantly lower than the other months.

**Exhibit 11**
**Monthly Claims Spending Increases Are Not Consistent Over Several Years, Fiscal Years 2010 - 2014**



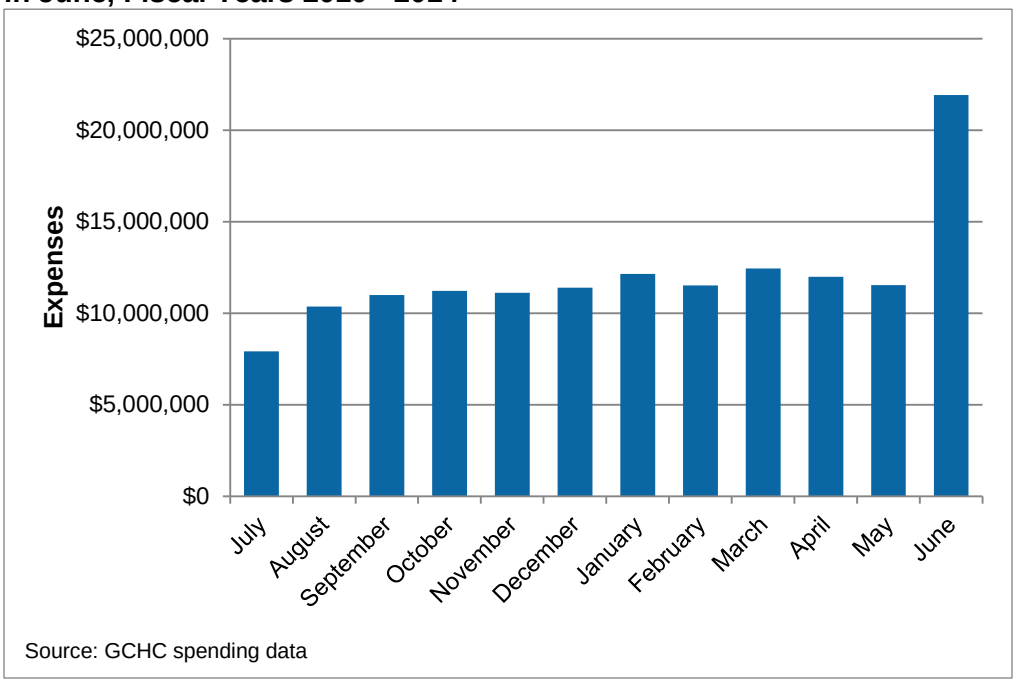

Source: GCHC spending data

During the period, laboratory services accounted for 5.2% ($14.4 million of $278 million) of direct care expenses, making it the second largest subcategory. Approximately 74% of the prison facilities with laboratory services expenses doubled their average monthly spending in June. GCHC staff stated that this increase was not operational or systematic; meaning there is not a push for lab work to be completed at certain times in the year. Staff also noted that the increase could reflect a high number of inmate admissions at a certain point in the year, but it does not track that information.

- Staffing – The average June variance was 25% ($1.4 million). The variances showed up in two sub-categories: agency clerical and agency travel. Three facilities paid for "agency clerical" expenses only in June. These expenses are for temporary clerical workers. In addition, approximately 25% of facilities had high June variances in agency travel. Travel occurs throughout the year, but until recently employees had until the end of the fiscal year to submit expenses.

- Pharmaceuticals – Pharmaceuticals' average June variance was 92% ($2.1 million). GDC currently operates nine regional pharmacies that purchase and distribute the bulk of the medications. As of 2010, there were 12 regional pharmacies in operation. Of the 12 regional pharmacies, 10 had high June variances, over all five years. GCHC officials stated that the facilities stock up on certain medications at the end of the year. Based on the analysis, the largest variances occur in HIV/AIDS, mental health, and hepatitis-C medications. We also saw a large variance in the general medicine category "drugs and pharmaceuticals," which includes medications for: dialysis, tuberculosis, blood altering, hypertension, and respiratory illness. **Exhibit 12** shows the increase in Regional Pharmacies' June expenditures compared to other months across the five-year period reviewed.

**Exhibit 12**
**Regional Pharmacies' Pharmaceutical Expenses Increase Significantly in June, Fiscal Years 2010 - 2014**




Source: GCHC spending data

## What are the historical trends on the cost of care per inmate? How does Georgia's cost per inmate compare benchmarked against other states?

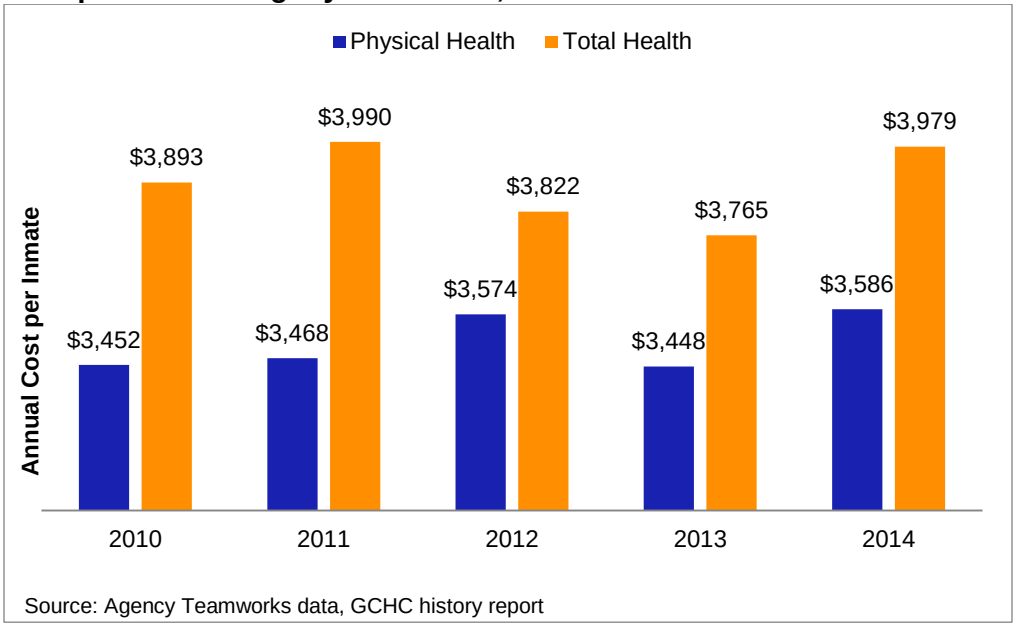
*Total healthcare costs include all health care services for inmates – physical, mental and dental. Physical healthcare costs include only those provided by GRU/GCHC through this contract.*

Physical healthcare costs per inmate have historically been stable at approximately $3,500 per inmate per year. Total healthcare costs per inmate have historically been stable as well, at approximately $4,000 per inmate per year. The audit team surveyed twelve other states to determine their costs per inmate for fiscal year 2013. We found that Georgia spends less per inmate than most other states. We did not assess quality of care, type of services available, or the model used, all of which may affect cost.

### Historical Trends in Georgia

The cost per inmate for physical health care has increased slightly between fiscal years 2010 and 2014. The cost per inmate for total health care has also increased slightly between fiscal years 2010 and 2014, as shown in **Exhibit 13**.

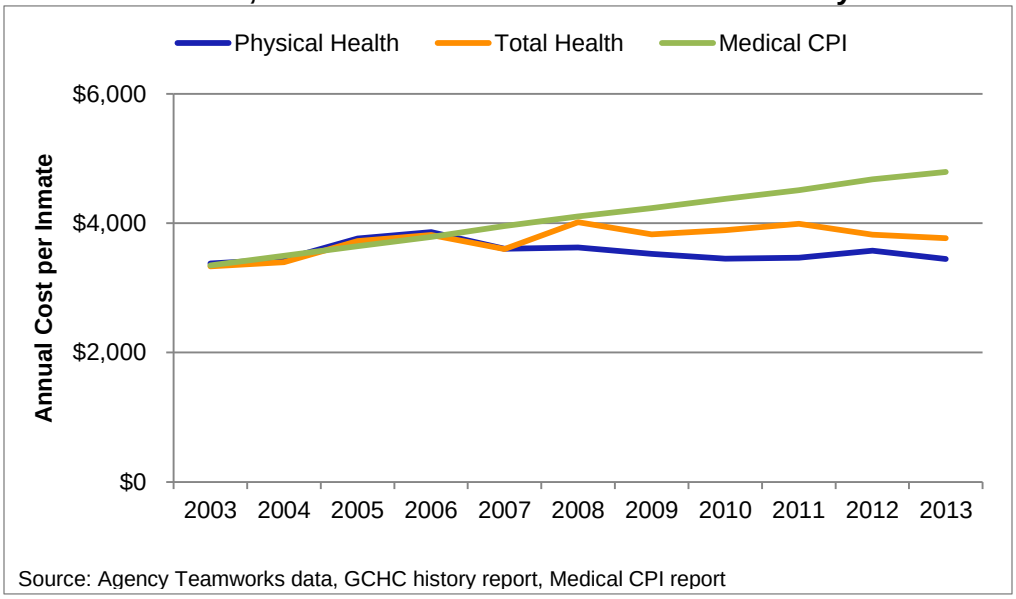
**Exhibit 13**
**Physical Healthcare Cost per Inmate Increased While Total Healthcare Cost per Inmate Slightly Decreased, Fiscal Years 2010 - 2014**




Source: Agency Teamworks data, GCHC history report

Going back further to fiscal year 2003, we see that physical healthcare cost per inmate, as well as total healthcare cost per inmate, has been stable over time. **Exhibit 14** shows that physical healthcare cost has been at or near $3,500 per inmate, and total healthcare cost per inmate around $4,000. While medical costs in the United States have increased annually, changes in Georgia's cost per inmate for physical healthcare has varied.

**Exhibit 14**
**Physical Health and Total Health Costs per Inmate Were Stable Fiscal Years 2003 - 2013, While Medical CPI has Increased Annually**

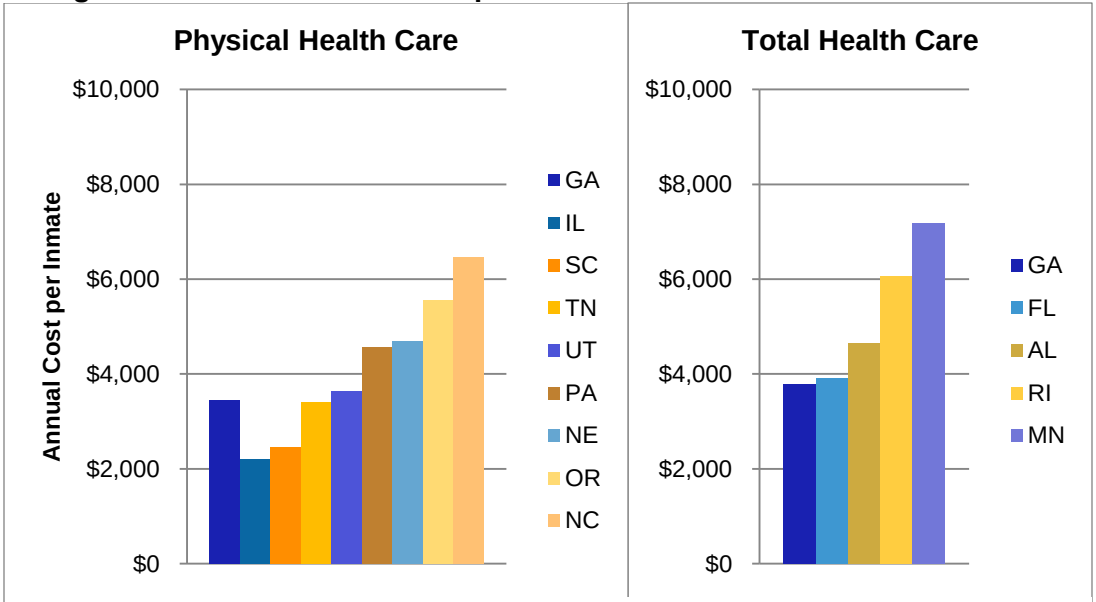



Source: Agency Teamworks data, GCHC history report, Medical CPI report

### Compared to Other States

A recent PEW report (data reported from 2007 and 2011) found nine states spending less than Georgia per inmate in 2011. In addition, the audit team's other states survey found that most states spent more than Georgia in physical health care and total health care in fiscal year 2013. Some states were not able to provide physical health care costs only, so total health care costs are compared in those cases, see **Exhibit 15**.

**Exhibit 15**
**Georgia's Fiscal Year 2013 Costs per Inmate Were Lower than Most States**




Source: Agency Teamworks data, GCHC history report, other states survey

Most states surveyed spent more than Georgia in fiscal year 2013 in either physical healthcare or total healthcare. Two states surveyed spent less (Illinois and South Carolina), two spent approximately the same (Tennessee and Utah), and four spent more. Pennsylvania, Nebraska, Oregon and North Carolina spent over $4,000 per inmate for physical health in fiscal year 2013. Florida spent approximately the same in total healthcare per inmate. The other three respondents (Alabama, Rhode Island and Minnesota) spent significantly more.

## Are the cost containment practices identified in the 2004 and 2007 inmate health reports released by DOAA still in operation? If not, why not? Have any been added?

All of the cost containment practices identified in previous DOAA reports are still in operation. In addition, because of HB 197, Medicaid rates now apply when inmates receive emergency services in hospitals. As noted earlier, because of the relationship between GRU and GDC, the Georgia Regents Health System was able to establish a satellite clinic at ASMP, which allows it to purchase certain medications through the federal 340B program. According to GDC staff, costs have remained low partially because GDC and GCHC both continue to work to offset increasing overall healthcare costs by using cost containment practices.

### Preexisting Cost Containment Practices

In earlier audit reports (2004 and 2007), DOAA documented several cost containment measures that GDC and GCHC were implementing. All of those cost containment practices are still in place today.

- Telemedicine and tele-mental health – Telemedicine and tele-mental health allow inmates to receive medical and mental health consultations from physicians in different locations. Physicians can also order tests as deemed necessary after seeing the patient via video conference. Most telemedicine occurs at ASMP. Tele-mental health is managed by a subcontractor. These practices help to lower costs by allowing physicians to forego travel expenses.

- Inmate copayments – Inmates are charged for certain medical services. The copayment for self-initiated sick call visits is $5 and the copayment for prescriptions is $5. The money comes out of the inmate's commissary account. Inmate copayments originated from a legislative initiative. According to GDC, this practice intends to keep costs low by ensuring inmates take healthcare expenses seriously.

- Negotiated rates with outside providers – Part of GCHC's contract responsibility is to obtain and manage contracts with outside providers. GCHC currently contracts with over 200 hospitals, specialist physicians, temporary staffing, claims administration, ambulance services and more. Previous DOAA reviews found that these contract rates were competitive and helped to lower GCHC's costs.

- Medical reprieve for terminally ill inmates – This program allows parole-eligible inmates, who meet established criteria, to be considered by the Board of Pardons & Paroles for compassionate release.[6] GDC and GCHC employees identify candidates and GDC manages the process to get inmates approved. According to GDC officials, approximately 40 inmates per year are approved for medical reprieve, which equals about 65% of submissions. This practice lowers costs by allowing inmates who meet the criteria to be released from GDC's custody. Once released, these inmates are responsible for their own care and living expenses. They may also be eligible to receive coverage from other entities such as Medicaid, Medicare, or private insurance.

- Utilization Management – Largely managed by GDC, this process ensures that all outside services received by inmates are pre-approved. Utilization Management nurses review requests for inmates to see specialists or other care at hospitals. Emergency care services received are reviewed after the fact. Nurses also monitor inmates while admitted to a hospital to ensure that they can transition care efficiently. This practice lowers costs by ensuring that only medically necessary services are provided.

[6] Criteria include: 1) a terminal illness with less than 12 months life expectancy; 2) a condition that requires frequent, extensive, and specialized care that is not reversible with current medical therapy; or, 3) dementia.

- Drug formulary – GDC and GCHC together manage a strict list of acceptable prescriptions for inmates. If drugs are not on the formulary, providers must request to use the drug. This practice lowers costs by having generic or less expensive medications on the formulary. GCHC is also able to bulk purchase some medications through a certain vendor.

### Additional Cost Containment Practices

GCHC also reported new measures they believe help contain costs.

- In-house capability – Staff noted that they have increased the number and type of procedures available within the facilities, which results in lower costs than if the inmate had to be treated offsite.

- Federal Funding Participation– GCHC also indicated it has accessed Medicaid benefits for those inmates who are eligible as defined by the Georgia Department of Community Health.

- Medicaid rates at hospitals – Previously hospitals that would not enter contracts with GCHC were able to impose full charges on inmate care. Because of legislation enacted in 2011, hospitals are required to treat inmates requiring care at rates that are no more than the Medicaid rate.

- 340-B Program – In addition to group pharmacy benefits, GCHC was able to obtain 340B pricing for certain prescription drugs (HIV/AIDS). The 340B Drug Pricing Program requires drug manufacturers to provide outpatient drugs to eligible health care organizations at significantly reduced prices. The program required the Georgia Regents Health System, in partnership with GDC and GCHC to open a clinic for inmates in ASMP. All inmates receiving the medications must individually qualify to participate in the program. GDC and GCHC are currently working to expand the program to include Hepatitis C medication and certain cancer medications.

# Appendix A: Objectives, Scope, and Methodology

## Objectives

This report examines the Georgia Department of Corrections' (GDC) inmate health contract with Georgia Regents University (GRU). Specifically, our examination set out to determine the following:

1. How is the contract amount determined annually?
2. What causes or explains fluctuations in monthly billings and expenses, particularly relating to year-end spending?
3. What are the historical trends on the costs of care per inmate?
4. How does Georgia's cost per inmate compare benchmarked against other states?
5. Are the cost containment practices identified in the 2004 and 2007 inmate health reports released by DOAA still in operation? If not, why not? Have any been added?

## Scope

This audit generally covered activity related to GDC's inmate health contract with GRU that occurred during fiscal year 2010 through 2014 with consideration of earlier or later periods when relevant. Georgia Correctional HealthCare (GCHC) is the unit of GRU administering the contract. Information used in this report was obtained by reviewing relevant laws, rules, regulations, contract documents, interviewing agency officials and staff from GDC and GRU, analyzing data and reports of spending, comparing spending data within and across fiscal years, reviewing existing studies by other organizations, and conducting a survey of other states. Contract spending data was used to inform multiple objectives. This data was provided from GRU's TeamWorks financials. We also received additional data from GCHC including annual financial statements summarizing spending data. We compared the two data sets to ensure consistency.

## Methodology

**To determine how the contract amount is determined annually,** we interviewed GDC staff and GCHC staff. We obtained and reviewed contract documents (fiscal years 2010-2014) that show changes in the contract amount each year. Through additional interviews we were able to match changes to those reflected in budget documents for each fiscal year. In addition, we obtained and analyzed invoice and payment data for fiscal years 2012 – 2014 from GDC and GCHC in order to analyze contract payments.

**To determine the causes or explanations fluctuations in monthly billings and expenses and year-end spending increases,** we obtained spending data for fiscal years 2010 through 2014 from GCHC. We conducted three sets of analyses of spending data. The first identified monthly fluctuations, the second identified year-end (June) variances at the spending category level, and the third identified monthly and year-end variances in claims spending data. We obtained claims spending data for fiscal years 2012 - 2014, which is held separately from GCHC spending data. While we concluded that the information was sufficiently reliable for the purposes of our review, we did not independently verify the data. We conducted interviews with the data administrator to determine the appropriate usage of data fields.

In order to conduct the monthly fluctuations analyses, we summarized each year's spending by category. We then calculated the monthly average for each category in each fiscal year as well as the standard deviation. We compared the monthly spending totals in each category to the average using plus/minus one standard deviation as the threshold. We marked any months/categories outside of one standard deviation as outliers. In order to see trends over the period (fiscal years 2010 – 2014), we created a summary matrix showing outliers for each year. From this summary, three categories were chosen and analyzed further by subcategory and facility as appropriate.

In order to conduct the year-end variance analyses, we summarized each year's spending by category. We then calculated the average for August through May spending; July and June spending was excluded as they were generally lower and higher than other months, respectively. We calculated the variance by comparing June spending to the average. We calculated the percent variance (June variance divided by the average) to identify outliers. We defined outliers here as having a percent variance of 50% or more. From this analysis, we identified three categories of spending to further analyze by subcategory and facility as appropriate.

In order to conduct the claims spending analysis, we used information obtained in interviews with GCHC and Covenant to determine which fields to use. We added columns to include month and year paid. We summarized the data by month paid to show the number of claims paid each month as well as the total paid to providers.

After each set of analyses was completed, we conducted interviews with GCHC staff and GDC officials to obtain explanations for the changes we found.

**To determine the historical trends on the costs of care per inmate**, we interviewed GDC officials/staff and GCHC staff about changes in spending over time. We also reviewed GCHC reports that showed spending for fiscal years 2010 – 2014, as well as changes in inmate population. Using GCHC spending data, GDC budget reports and inmate population data, we calculated an annual cost per inmate for both physical healthcare (specific to the contract) and total healthcare (all GDC Health costs and inmates). We also acquired medical CPI rates for fiscal years 2003 – 2014 for comparison.

**To obtain information on how Georgia's cost per inmate compares benchmarked against other states**, we reviewed national studies on inmate healthcare costs. The PEW Research Center's study entitled *State Prison Health Care Spending: An examination* included detailed spending information for a subset of states. We built our survey sample around those states as well as contiguous states. We then contacted officials and staff from twelve other states about their physical and total healthcare costs per inmate in fiscal year 2013, and other aspects of their inmate healthcare system.

**To obtain information on cost containment practices currently in operation**, we reviewed DOAA previously published reports on inmate healthcare in Georgia. After constructing a list of previously documented cost containment practices, we interviewed GDC staff and GCHC staff about each. In addition, we noted any cost savings efforts implemented since those reports had been published.

For information included in the report background, the audit team reviewed contract documents, previous DOAA reports, and PeopleSoft financial data to determine basic program information. Basic program information includes total contract spending per year and the scope of services for GCHC and GDC.

This special examination was not conducted in accordance with generally accepted government auditing standards (GAGAS) given the timeframe in which the report was needed. However, it was conducted in accordance with Performance Audit Division policies and procedures for non-GAGAS engagements. These policies and procedures require that we plan and perform the engagement to obtain sufficient, appropriate evidence to provide a reasonable basis for the information reported and that data limitations be identified for the reader.

# Appendix B: FY 2012-2014 Detail of Contract Payments Made

| Transaction Date | GCHC Actual Expenses | GCHC Invoice Amount | GDC Payment Amount | GDC Contract Balance | Surplus/Deficit (Payment compared to Expenses) |
|---|---|---|---|---|---|
| **Fiscal Year 2012** | | | | | |
| | | | | $161,281,687.00 | |
| **July 2011 - Prior FY funds** | | | **$9,405,121** | | |
| July 2011 | $9,391,106 | $13,440,140 | $4,035,019 | $157,246,668 | $4,049,034 |
| August 2011 | $14,598,523 | $9,391,106 | $9,391,106 | $147,855,562 | ($1,158,383) |
| September 2011 | $14,258,197 | $14,598,523 | $14,598,523 | $133,257,039 | ($818,057) |
| October 2011 | $12,890,981 | $14,258,197 | $14,258,197 | $118,998,841 | $549,159 |
| November 2011 | $13,280,185 | $12,890,981 | $12,890,981 | $106,107,860 | $159,955 |
| December 2011 | $14,940,063 | $13,280,185 | $13,280,185 | $92,827,675 | ($1,499,922) |
| January 2012 | $13,235,014 | $14,940,063 | $14,940,063 | $77,887,612 | $205,127 |
| February 2012 | $13,563,025 | $13,235,014 | $13,235,014 | $64,652,599 | ($122,885) |
| March 2012 | $13,474,842 | $13,563,025 | $13,563,025 | $51,089,574 | ($34,702) |
| April 2012 | $13,013,851 | $13,474,842 | $13,474,842 | $37,614,731 | $426,290 |
| May 2012 | $13,782,535 | $13,013,851 | $13,013,851 | $24,600,881 | ($342,395) |
| June 2012 | $18,334,046 | $13,782,535 | $13,782,535 | $10,818,345 | ($4,893,906) |
| July 2012 | | | $4,893,906 | $5,924,439 | $0 |
| July 2012 | | | $5,924,439 | ($0) | $5,924,439 |
| **Totals** | **$164,762,369** | | **$161,281,687** | | |
| **Fiscal Year 2013** | | | | | |
| | | | | $160,381,687 | |
| **July 2012 - Prior FY funds** | | | **$5,924,439** | | |
| July 2012 | $9,454,996 | $13,365,141 | $7,440,702 | $152,940,985 | $3,910,145 |
| August 2012 | $11,882,555 | $9,454,996 | $9,454,996 | $143,485,989 | $1,482,586 |
| September 2012 | $12,370,912 | $11,882,555 | $11,882,555 | $131,603,434 | $994,230 |
| October 2012 | $12,892,196 | $12,370,911 | $12,370,911 | $119,232,523 | $472,945 |
| November 2012 | $13,856,003 | $12,892,196 | $12,892,196 | $106,340,327 | ($490,862) |
| December 2012 | $11,831,670 | $13,856,003 | $13,856,003 | $92,484,324 | $1,533,471 |
| January 2013 | $12,795,052 | $11,822,670 | $11,822,670 | $80,661,653 | $561,089 |
| February 2013 | $12,259,944 | $11,831,670 | $11,831,670 | $68,829,983 | $132,815 |
| March 2013 | $11,643,700 | $13,232,326 | $13,232,326 | $55,597,658 | $1,721,441 |
| April 2013 | $14,663,982 | $11,643,700 | $11,643,700 | $43,953,958 | ($1,298,841) |
| May 2013 | $14,789,819 | $14,663,982 | $14,663,982 | $29,289,976 | ($1,424,679) |
| June 2013 | $17,639,090 | $13,490,978 | $13,490,978 | $15,798,998 | ($5,572,790) |
| July 2013 | | | $2,558,857 | $13,240,141 | ($3,013,933) |
| July 2013 | | | $13,240,141 | ($0) | $10,226,207 |
| **Totals** | **$156,079,919** | | **$160,381,687** | | |
| **Fiscal Year 2014** | | | | | |
| | | | | $160,881,687 | |
| **July 2013 - Prior FY funds** | | | **$10,226,207** | | |
| July 2013 | $10,030,171 | $13,240,141 | $3,013,933 | $157,867,754 | $3,209,970 |
| August 2013 | $13,909,115 | $10,030,171 | $10,030,171 | $147,837,583 | ($668,975) |
| September 2013 | $12,360,349 | $13,909,115 | $13,909,115 | $133,928,468 | $879,791 |
| October 2013 | $13,865,415 | $12,485,349 | $12,485,349 | $121,443,119 | ($500,274) |
| November 2013 | $13,761,100 | $13,740,415 | $13,740,415 | $107,702,704 | ($520,960) |
| December 2013 | $12,610,049 | $13,761,100 | $13,761,100 | $93,941,604 | $630,091 |
| January 2014 | $13,415,369 | $12,610,049 | $12,610,049 | $81,331,555 | ($175,229) |
| February 2014 | $13,188,619 | $13,415,369 | $13,415,369 | $67,916,186 | $51,521 |
| March 2014 | $12,950,311 | $13,188,619 | $13,188,619 | $54,727,567 | $289,829 |
| April 2014 | $13,999,684 | $12,950,311 | $12,950,311 | $41,777,256 | ($759,543) |
| May 2014 | $14,648,079 | $13,999,684 | $13,999,684 | $27,777,573 | ($1,407,938) |
| June 2014 | $17,007,453 | $14,648,079 | $14,648,079 | $13,129,494 | ($3,767,313) |
| July 2014 | | | $9,362,181 | $3,767,313 | $5,594,868 |
| July 2014 | | | $3,767,313 | $0 | $9,362,181 |
| **Totals** | **$161,745,713** | | **$160,881,687** | | |

The Performance Audit Division was established in 1971 to conduct in-depth reviews of state-funded programs. Our reviews determine if programs are meeting goals and objectives; measure program results and effectiveness; identify alternate methods to meet goals; evaluate efficiency of resource allocation; assess compliance with laws and regulations; and provide credible management information to decision-makers. For more information, contact us at (404) 656-2180 or visit our website at www.audits.ga.gov.