Health Care Study:
Florida Department of Corrections

November 13, 2019

Prepared by:

Table of Contents

Executive Summary

This report examines the use of the following alternative approaches to the delivery of inmate health care in the Florida Department of Corrections (FDC):

- Insourcing, in which Department staff are directly responsible for managing health care and delivering services in facilities, while still contracting out for services delivered by providers in the community;
- Outsourcing, in which the Department contracts a private company to provide health care service management, staffing, and coordination of off-site care;
- A hybrid insourcing/outsourcing approach which uses elements of both models; and
- University medical school management of correctional health care.

The report describes the current provision of inmate health care services in the Florida Department of Corrections and compares the cost-effectiveness of these alternative models in delivering inmate health care services. Key report findings include:

Florida has a high incidence of chronic medical and mental health illness in the inmate population. With the rapid growth in the geriatric offender population, growing awareness of the needs of mentally ill offenders, and changing standards in the treatment of infectious diseases such as Hepatitis C, the system has experienced growing pressure to increase the levels of service and program performance. This in turn is driving the cost of health care in the prison system higher.

The Florida Department of Corrections' (FDC) health care program design is consistent with contemporary professional standards. Health care policies and procedures are based upon generally accepted professional standards promulgated by the American Correctional Association, the National Commission on Correctional Health Care, the Florida Agency for Health Care Administration Licensure, and best practices developed in other state correctional systems. The FDC oversees delivery of a comprehensive set of medical, mental health, and dental services for state prison system inmates. The FY 2019-20 budget for health care services totals $566.9 million.

The FDC has previously used a hybrid approach in managing inmate health care. During the time in which state employees were used to deliver facility health care services, the Department still maintained an extensive network of contracts with practitioners, hospitals, and vendors to provide off-site health care services in the community.

The Department of Corrections has attempted outsourcing with mixed results over the years. While privatization provided costs savings in the short-term, vendors were unable to provide consistent service that met contract performance standards at the funding levels they had bid. This led to a turbulent period of vendor terminations, transitions, and multiple attempts to attract additional vendors. Service quality issues at the time produced high levels of staff vacancies, decreased access to off-site care, increased inmate grievances, and costly litigation. In its most recent procurement, the

FDC received one responsive proposal for medical services after issuing multiple Invitations to Negotiate.

The current contract for inmate health services follows a cost-plus model. Under the Department's contract with Centurion, the vendor is reimbursed for the actual costs of care provided and paid an additional fee in the amount of 11.5 percent of program costs that cover administration and profit. The annual contract is capped at $421 million for the three years from FY 2019-20 through FY 2021-22. Pharmacy services are not part of the contract but are instead managed directly by the Department.

Florida's spending on inmate health care is low relative to national averages but is comparable to per diem spending levels in six of the ten largest correctional systems. Per inmate spending levels in Florida are close to those of Texas, Illinois, Georgia, and Pennsylvania.

After declining in the period Fiscal Year 2010-11 through Fiscal Year 2014-15, inmate health care costs increased by 36 percent over the past four years, an annual average increase of 9 percent. The increases appear attributable to misalignment between contract funding and service requirements in the initial outsourcing initiatives. Recent litigation on mental health services, Hepatitis C treatment, and hernia repair accounts for nearly $39 million in increased funding in the Fiscal Year 2019-20 budget. The ongoing increase in the geriatric population also continues to increase demand for medical services. The projected annual cost of providing health care for an inmate in a state-managed facility is $6,511 for FY 2019-20.

Correctional systems with insourced delivery systems provide on-site care in prison with state employees in 18 states, including three of the five largest state correctional systems. However, these systems still contract for hospitalization, outpatient, and specialty services provided outside prison.

Outsourcing provides managed health care through contracted providers in 20 state correctional systems. The two primary forms of outsourcing are 1) capitated models in which the vendor assumes primary financial risk for required service delivery and is paid a per diem fee per inmate to cover all program costs; and 2) cost-plus models in which the state reimburses the vendor for program costs and assumes financial risk for required service delivery.

Hybrid models which combine different aspects of both insourcing and outsourcing to meet system needs are used in eight states. Basic hybrid models privatize the management of health care in select facilities while maintaining state management of health care in other system facilities.

University-managed systems rely on a state medical school or health sciences university to manage all or some significant component of correctional health care services. Four correctional systems use the university model, including the Texas prison system, the largest correctional system in the United States.

Insourcing inmate health care services in Florida is feasible and would produce savings from the current system. The FDC has the internal expertise and management infrastructure to adopt an

insourced model for inmate health care. However, recruitment and retention of health care staff would be a significant challenge requiring substantial advance planning. The Department would also require an improved approach in the management of off-site care. This could be accommodated by contracting with an insurance company or health care organization to manage all off-site care, utilization review, and claims management. Implementation of an insourced system could reduce FDC health care spending by an estimated $46 million, primarily through elimination of vendor profit and administration costs.

The current cost-plus approach used by the FDC appears to be the most realistic means available to outsource on a system-wide scale. The cost-plus model is currently used by the FDC because the only vendor in the last procurement cycle willing to work with the Department made it a condition of the contract. By most reports, the current vendor is performing reasonably well under the current cost-plus contract. However, this approach to privatization does not encourage efficiency and appears to be the most expensive service delivery model, as the FDC must pay a significant fee to the vendor to cover overhead and profit, in addition to paying all direct costs. However, the contract is capped at $421 million for the next three years and will provide the FDC with an electronic medical record system, which is a significant benefit.

A capitated approach to outsourcing could produce savings by incentivizing vendors to achieve efficiencies, particularly in the management of off-site care. However, this approach to outsourcing works best in a competitive procurement with multiple viable bidders competing on price and service quality. There are very few vendors who can provide services on the scale required in Florida with a record of acceptable service delivery. Moreover, the high degree of financial risk makes attracting enough bidders to facilitate a competitive environment difficult. Assuming vendors willing to work in Florida on a capitated basis, estimated annual savings of $5.5 million, largely in the management of off-site care, may be possible.

A hybrid insourcing/outsourcing approach would require outsourcing services on a capitated basis for a region or group of select facilities, while insourcing the rest of the system. This approach increases administrative complexity and creates potential issues of equity in apportioning risk and inmates in need of health care among multiple vendors and state facilities. It also assumes that credible vendors are willing to bid on capitated contract services for smaller groups of contracts. If viable, the limited experience with this approach in one of the few states that use this model suggests savings could be achieved roughly equivalent to the level achieved with insourcing.

The university model of health care management has attractive features but requires active cooperation from a medical school. Elimination of profit, reduced administrative costs, and discounted pharmaceutical prices could produce potential annual savings of over $40 million. However, no Florida medical school has indicated any interest in partnering with the FDC to manage inmate health care. One potential approach to building interest in such a model could be partnering with a university to take on one aspect of the correctional health care program, such as management of off-site care for a region or group of facilities.

1. INTRODUCTION

In July 2019, the Office of Program Policy Analysis and Government Accountability (OPPAGA), a joint entity of the Florida Legislature, was required to solicit a contract with an independent consultant for a Study of Correctional Health Care in the Florida Department of Corrections (FDC). The goal of the study was to fulfill requirements of proviso language in the 2019 General Appropriations Act (Ch. 2019-117, Laws of Florida). The language states:

From the funds in Specific Appropriation 2754, the Office of Program Policy Analysis and Government Accountability is directed to contract with an independent third party consulting firm to conduct a review of inmate health care services in order to compare the cost-effectiveness of alternative methods of delivering the services.

OPPAGA directed that the Study address the following key research tasks:

- Describe the current provision of inmate health care services in the Florida Department of Corrections.
- Assess alternative models of delivering inmate health care services in the Florida Department of Corrections.
- Compare the cost-effectiveness of alternative models of delivering inmate health care services.

The proviso language required the review to consider at least the following options: (a) full insourcing of inmate health services, (b) insourcing of outpatient health services provided within state operated correctional facilities and outsourcing inpatient services, and (c) continuation of full outsourcing with modified contract terms imposing appropriate cost controls.

Methodology

In support of our analysis, we requested FDC health care expenditure data, as well as information on service delivery, utilization, and system performance. We also requested performance and activity measure data, planning documents, management reports, and other documentation of operations and programs.

We supplemented the written documentation and data provided by the FDC with information gained from interviews with program administrators and on-site observation of daily operations at the key FDC facilities identified below.

Exhibit 1: On-Site Facility Reviews

Facility	Location	Capacity	Mission
Florida Women's Reception Center	Ocala	1,345	Female offender reception, general population, and in-patient mental health
Lake Correctional Institution	Clermont	1,093	Male offender general population and inpatient mental health
Lowell Correctional Institution	Ocala	1,456	Female offender general population
Reception & Medical Center (RMC)	Lake Butler	1,503	Male offender reception, 120-bed hospital, 34-bed infirmary, surgical unit, dialysis unit, and inpatient mental health
Suwanee Correctional Institution	Live Oak	1,502	Male Youthful Offender Unit, Close Management Unit, inpatient mental health

The CGL team conducted an in-depth tour of all medical/mental health functions at each visited facility. This included observation of sick call, dispensing of medication, observation of chemotherapy and dialysis treatment (at RMC), and group therapy. We toured all health care facilities at these institutions, including the 120-bed hospital at the Reception and Medical Center. Members of the project team observed the intake process, sick call, and mental health service planning.

We selected these facilities, with input from the FDC Office of Health Care Services, to observe the high level of health services and the operational challenges presented. Staff interviews included FDC central office administrators as well as direct service contract staff. These interviews centered on the challenges facing the FDC in delivering effective health care to the inmate population. Staff interviewed were open and candid regarding the challenges and issues associated with the provision of health care in the current system.

2. CURRENT SYSTEM OVERVIEW

A review of different models to provide inmate health care begins with developing an understanding of the current service delivery system. This first requires an analysis of the Florida Department of Correction's (FDC's) health care program goals and how these goals produce the professional standards and policies that guide the system. We next describe the FDC's current system of correctional health care services, utilization of services by the inmate population, and how inmate population characteristics drive service requirements. The final section of the chapter describes the history of the FDC's evolving approaches to management of inmate health care services.

Standards

The FDC bases its health care policies and procedures upon generally accepted professional standards promulgated by the American Correctional Association, the National Commission on Correctional Health Care, the Agency for Health Care Administration Licensure, and best practices developed in other state correctional systems. The Department regularly updates policies and standards to reflect care guidelines recommended by the Centers for Disease Control and other recognized public health research organizations.

The FDC organizes its health care policies in 162 Health Services Bulletins (HSBs). These bulletins include multiple memos, information sheets, forms, orientation information, appendices for clinical care, guidelines, fact sheets, and policies. These bulletins provide direction on topics such as chronic illness monitoring (HSB 15.03.05), conditional medical release (HSB 15.02.14), and medical emergency response planning (HSB 15.03.06). In addition to HSBs, the Department has 30 custody-related policies which pertain to services such as therapeutic diets, medical transfers, health services for inmates in special housing, nursing sick call, and medication administration.

The FDC is responsible for providing a level of health care service to inmates consistent with constitutional standards, as determined by the federal courts, in accordance with Sections 945.025(2), and 945.6034, Florida Statutes. These standards, as established by the United States Supreme Court in *Estelle v. Gamble*[1], provide inmates the right to be free from deliberate indifference to their health care needs and that inmates have a right to the same standard of health care as available in the community. In subsequent rulings and case law, the courts have established three key elements of constitutional health care in correctional facilities: 1) the right to access to care, 2) the right to care that is ordered, and 3) the right to a professional judgement.[2]

A 1972 class action lawsuit against the FDC, *Costello v. Wainwright*, resulted in a finding that inadequate health care in the correctional system amounted to cruel and unusual punishment. The case further refined standards for health care delivery in the FDC and resulted in the creation of the

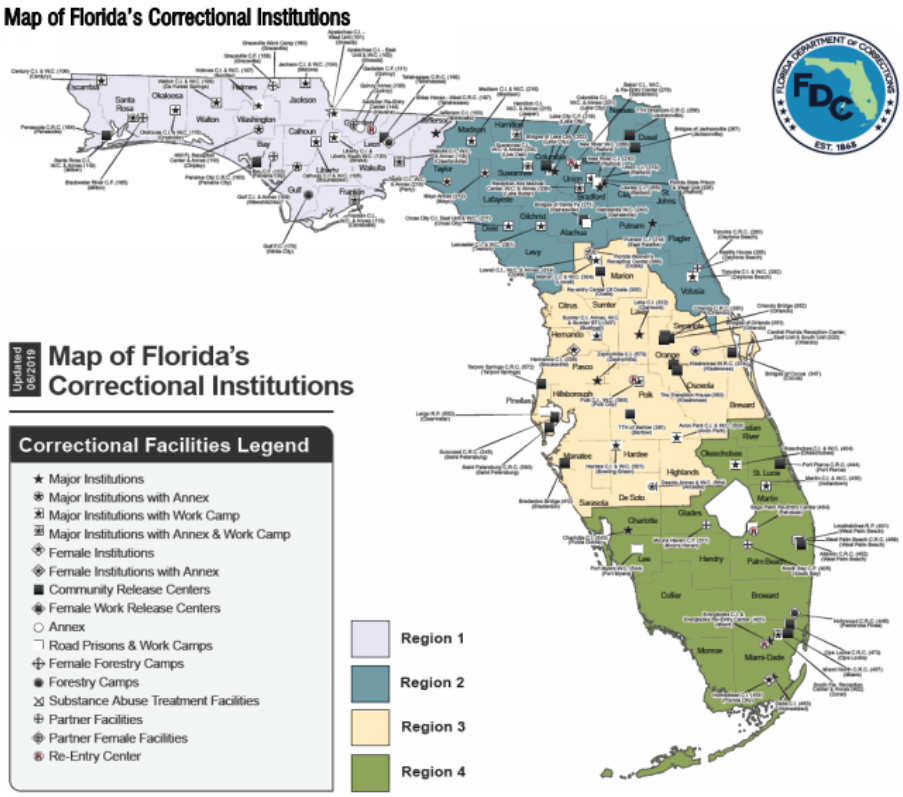
[1] *Estelle v. Gamble*, 420 U.S. 97, 97 S. Ct. 285, 50 L.Ed.2d 251(1978)
[2] B. Jaye Anno, Correctional Health Care: Guidelines for the Management of an Adequate Delivery System, National Commission on Correctional Healthcare, (2001:43).

Correctional Medical Authority (CMA) to provide independent monitoring of health care services.[3] The responsibilities of the CMA include inspection of the delivery of medical and mental health services in FDC facilities, annual reporting on inmate health care delivery to the Governor and the Legislature, and monitoring compliance with consent decrees. More recent litigation that has informed the development of FDC health care standards include *Osterbock v. McDonough*, *Disability Rights Florida, Inc. v. Jones*, *Hoffer v. Jones*, and *Copeland v. Jones*.[4] These cases addressed requirements for mental health programs, Hepatitis C treatment, hernia care, and other services.

Services

Consistent with these standards, the FDC oversees delivery of a comprehensive set of medical, mental health, and dental services for over 95,000 state prison system inmates in 145 facilities located in four regions throughout the state.

Exhibit 2: Florida Correctional Institutions



Source: Office of Program and Policy Analysis and Government Accountability, Florida Correctional Facilities, Report N0. 19-08, October 2019.

[3] *Costello v. Wainwright*, 3 430 U.S. 3425, 51 L.Ed.2d 372, 97 S. Ct. 1191 (1977)
[4] *Osterbock v. McDonough* 549 F.Supp.2d 1337 (M.D. Fla. 2008); *Disability Rights Florida, Inc. v. Jones*, Case No. 3:18-cv-179-J-25JRK; *Hoffer v. Jones* Case No. 4:17- cv-214-MW-CAS*; Copeland v. Jones* Case No. 4:IS—cv-452RH/CAS

The Department's *Comprehensive Health Services Plan*[5] describes the specific services provided. The FDC uses a managed care approach to provide these programs, contracting with a private vendor, Centurion of Florida, LLC.

Medical. The medical program at FDC institutions focuses on primary care. These services include sick call, infection control, immunizations, chronic disease clinics, health education, physical examinations, screenings, and urgent care services. Centurion provides full and part-time physicians, nurse practitioners, nurses and support staff in support of these functions at each state-run facility.

Like other states with large prison populations such as California and Texas, Florida operates a large, licensed hospital to provide inpatient care within a secure facility. Under Centurion management, the Reception and Medical Center (RMC) at Lake Butler supports 120 inpatient beds, as well as a licensed laboratory, same-day surgery center, dialysis treatment, chemotherapy and radiation treatment.

Inmates in need of more serious or advanced treatment may receive care from specialists subcontracted by Centurion, both in the facility or in the community. Inmates also receive inpatient and outpatient care in community hospitals as needed for emergency care or if the RMC has no beds available. Community hospitals are also utilized for specific types of specialty care such as orthopedics or cardiac care. If facility vendor staff cannot provide the services an inmate needs, the inmate is transported to a local hospital or provider's office for offsite care. The FDC has agreements with hospitals that receive a significant volume of inmates, establishing dedicated secure units to support FDC patients. These include Memorial Hospital of Jacksonville and Larkin Community Hospital in Miami. Use of other local community hospitals in non-secure wards requires 24 hour supervision of the inmate patient by two department correctional officers.

A Centurion Utilization Management team reviews all requests for specialty consults and hospital services, including those provided at the RMC. The team reviews and approves all hospital admissions and discharges using evidenced-based clinical criteria to ensure efficient use of resources.

Mental Health. Mental health treatment consists of a range of services dependent upon the care level required by the inmate. FDC policy establishes five levels of treatment, beginning with outpatient care and progressing through more intensive, structured inpatient programs to stabilize and treat inmates with more severe conditions. Inmates receiving inpatient mental health treatment all receive structured out-of-cell therapeutic services. Mental health program staffing provided by Centurion, includes psychiatrists, psychologists, licensed mental health professionals, nurses, and support staff. The FDC manages a continuum of mental health services with each facility's staffing scaled to meet its specific program needs. The FDC also operates a Cognitive Treatment Unit at the Wakulla Annex for inmates with dementia or traumatic brain injury.

Dental. Dental services include examinations, extractions, and emergency treatment at the time of their admission into the correctional system. On an as-needed basis, inmates with less than six months

[5] Florida Department of Corrections, Comprehensive Health Services Plan for the Continued Improvement of the Delivery of Health Care for Inmates, 2019-2024 (2019)

of time to serve may receive decay control, limited cleaning, and denture repairs. Inmates with more than six months to serve may receive dental exams with x-rays and periodontal screening. If clinically indicated, inmates with at least four months of incarceration time remaining may be provided dentures or non-emergent endodontic therapy. Advanced dental services are available on a limited basis depending upon need. Centurion provides dentists, dental assistants and dental hygienists in support of these services at all facilities except for reentry centers.

Pharmacy. The FDC manages the delivery of pharmacy services with 84 state employees, outside of the Centurion contract. The State pharmacy staff dispense over 1.5 million prescriptions annually from three regional pharmacies and the RMC in response to orders from medical staff at state prisons.[6] Centurion staff then administer medications to patients. Nurses provide unit dose prescriptions of prescribed medications at a pill line for general population inmates, at cell front for inmates in confinement or close management, and bedside in the hospital. Inmates are also allowed to keep common medications such as antihistamines or analgesics on their person (KOP) for use as specified by the prescription. Finally, inmates in dorms, special housing, and work squads may be provided over the counter medications (OTC) such as ibuprofen or antacid on an as-needed basis.

The FDC receives discounted medications for HIV/AIDs and STDs under the Florida Department of Health (DOH) through the 340b program. The 340b program is a US federal government pricing system that requires drug manufacturers to provide outpatient drugs to eligible health care organizations and covered entities at significantly reduced prices. The 340b program provides discounts of up to 40 percent from market rate prices. The Department also participates in the Minnesota Multi-State Contracting Alliance for Pharmacy (MMCAP), a purchasing organization for government institutions that negotiates reduced pharmaceutical prices for member organizations.

Due to the level of drug price purchasing discounts achieved by the FDC, past efforts at potential privatization of the pharmacy program have not shown savings, resulting in retention of the current system of state management of the program.

Exhibit 3 summarizes the key services available to inmates and where they are provided.

[6] Florida Department of Corrections, Comprehensive Health Services Plan for the Continued Improvement of the Delivery of Health Care for Inmates, 2019-2024 (2019).

Exhibit 3: FDC Health Care Service Summary

	Medical	Mental Health	Dental	Pharmacy
Prison On-Site Services	Primary care Chronic care Screenings Urgent care Inpatient care* Medication management Specialty clinics Surgery* Dialysis* Cancer treatment* Long-term care housing Physical therapy Respiratory therapy	Group counseling Individual counseling Medication management Crisis stabilization Infirmary Transitional Care Inpatient hospitalization	Examinations Extractions Cleaning Dentures & repair	Keep on Person (KOP) Unit dose Over the Counter (OTC)
Community Services	Specialist visits Emergency room visits Surgery Inpatient hospitalization	Psychiatric emergency care	Advanced dental surgery	

*Available only at Reception & Medical Center
Source: Florida Department of Corrections, Comprehensive Health Services Plan, 2019-2024, May 13, 2019.

The Department manages this system through the Office of Health Services (OHS). The OHS sets policy for the system, monitors contract performance, provides training, reviews grievance appeals, assesses clinical-legal issues, manages the overall budget for health care services, and reviews contractor spending. OHS has 62.5 employees assigned to these functions.

Inmate Patient Profile

The FDC provided health care to an average daily population of approximately 87,000 inmates in state-operated facilities in FY 2018-19.[7] This does not include health care services provided by vendors that operate the seven private correctional facilities under contract with the Department of Management Services (DMS)[8]. Over 28,000 inmates have been admitted to the state prison system in

[7] Florida Department of Corrections, Bureau of Research and Data Analysis.
[8] These facilities include Bay Correctional Facility, Blackwater River Correctional Facility, Gadsden Correctional Facility, Graceville Correctional Facility, Lake City Correctional Facility, Moore Haven Correctional Facility, and South Bay Correctional Facility.

the last 12 months.[9] Each new admission receives a thorough health screening and assessment, which may result in a prescribed treatment plan as indicated.

Inmates in U.S. prisons enter correctional systems with higher incidence of medical and mental health issues than found in the general population. Chronic disease is prevalent with higher rates of tuberculosis, HIV, Hepatitis B and C, arthritis, diabetes, and sexually transmitted disease compared to the general population.[10] Over half of prison inmates have a mental health disorder, and many of these offenders also have a history of substance abuse.[11]

The Florida correctional system population exhibits these same characteristics. In FY 2018-19, the FDC offender population included[12]:

- 57,826 inmates requiring treatment in chronic disease clinics
- 2,561 inmates diagnosed and treated for HIV
- 6,314 inmates diagnosed and treated for Hepatitis C
- 118 inmates with renal failure requiring dialysis treatment
- 4,000 inmates with hearing, mobility, or vision impairments or disabilities

In FY 2018-19, inmates had over 126,000 contacts with clinics for treatment of chronic conditions, with the largest number requiring cardiac or respiratory treatment.

---

[9] Florida Department of Corrections, Quarterly Inmate Admissions Reports, October 1, 2018 to September 30, 2019.

[10] National Institute of Corrections, "Solicitation for a Cooperative Agreement—Evaluating Early Access to Medicaid as a Reentry Strategy," Federal Register 76, no. 129 (2011): 39438-39443; Ingrid Binswanger, Nicole Redmiond, and LeRoi Hicks, "Health disparities and the criminal justice system: an agenda for further research and action," Journal of Urban Health 89*, no. 1* (2012): 98–107; and Laura Maruschak, Medical Problems of Prisoners (Washington, DC: US Department of Justice, Office of Justice Programs, Bureau of Justice Statistics, April 2008), , https://ww.bjs.gov/content/pub/pdf/

[11] Doris James and Lauren Glaze, Mental health problems of prison and jail inmates, (Washington, DC: US Department of Justice, Office of Justice Programs, Bureau of Justice Statistics, September 2006) , https://www.bjs.gov/content/pub/pdf/mhppji.pdf/

[12] Florida Department of Corrections, Bureau of Research and Data Analysis.

Exhibit 4: FY 2018-19 FDC Inmate Clinic Contacts

Type of Treatment	Number of Clinic Contacts
Cardiac	49,775
Endocrine	17,719
Gastro-intestinal	19,729
Immune System	8,516
Renal	12
Neurology	5,342
Cancer	1,785
Respiratory	12,166
Tuberculosis	6,316
Miscellaneous	4,723
TOTAL	**126,083**

Source: Florida Department of Corrections, Office of Health Services

Demographic characteristics of the population also contribute to health care service needs. The FDC incarcerates nearly 5,000 female offenders. Incarcerated women report histories of alcohol and drug abuse, sexually transmitted infection, sexual and physical abuse, and mental illness, at a much higher rate than incarcerated men, and as a result require a more intensive level of health care services. Moreover, female offenders also have gender-specific health needs such as gynecological care that create additional demands for health services. [13] In FY 2018-19 female offenders in Florida accounted for 12.8 percent of clinic encounters for chronic diseases despite representing 6.9 percent of the inmate population.[14]

The number of geriatric offenders in the correctional system also drives demand for health care services. Due to higher risk lifestyle choices and infrequent or irregular access to health care over their lives, many inmates physically age much more quickly than their chronological age would suggest. The National Commission on Correctional Healthcare and at least 20 state correctional systems define as geriatric any inmate over age 50.[15] Older prisoners cost approximately three times as much as younger prisoners to incarcerate, largely due to health care costs.[16]

---

[13] National Commission on Correctional Healthcare*, Women's Health Care in Correctional Settings,* 2019 https://www.ncchc.org/womens-health-care.

[14] Florida Department of Corrections, Office of Health Services.

[15] It's About Time: Aging Prisoners, Increasing Costs, and Geriatric Release. New York, NY: Tina Chiu, The Vera Institute of Justice; 2010. March, https://www.vera.org/publications/its-about-time-aging-prisoners-incresing-costs-and-geriatric-release

[16] Williams, B. A., Goodwin, J. S., Baillargeon, J., Ahalt, C., & Walter, L. C. (2012). Addressing the aging crisis in U.S. criminal justice health care. Journal of the American Geriatrics Society, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3374923.

As of June 30, 2019, over 27 percent of the FDC inmate population was age 50 or older. In fact, the system housed 1,775 inmates aged 70 or over. The proportion of the Florida inmate population that is geriatric exceeds that of the other three largest state correctional systems.

Exhibit 5: Geriatric Populations in Large State Correctional Systems

	Inmate Population	Number of Inmates Age 50+	Percent of Inmates Age 50+
Texas	145,019	31,876	22%
California	129,417	30,298	23%
Florida	95,502	25,732	27%
New York	52,344	10,140	19%

Sources: Texas Department of Criminal Justice, Fiscal Year 2018 Statistical Report; California Department of Corrections and Rehabilitation, Offender Data Points Report, June 2018; Florida Department of Corrections, Bureau of Research and Data Analysis; Office of the New York State Comptroller, New York's Aging Prison Population, April 2017.

The total number of geriatric inmates housed by the FDC has grown by 77 percent over the last ten years, despite a decline in the overall prison population during this period. Older inmates, like older individuals in society, have much greater health care needs than younger inmates. This change in the population has had a profound impact on the demand for health care services in the state correctional system.

Health Care Service Delivery History

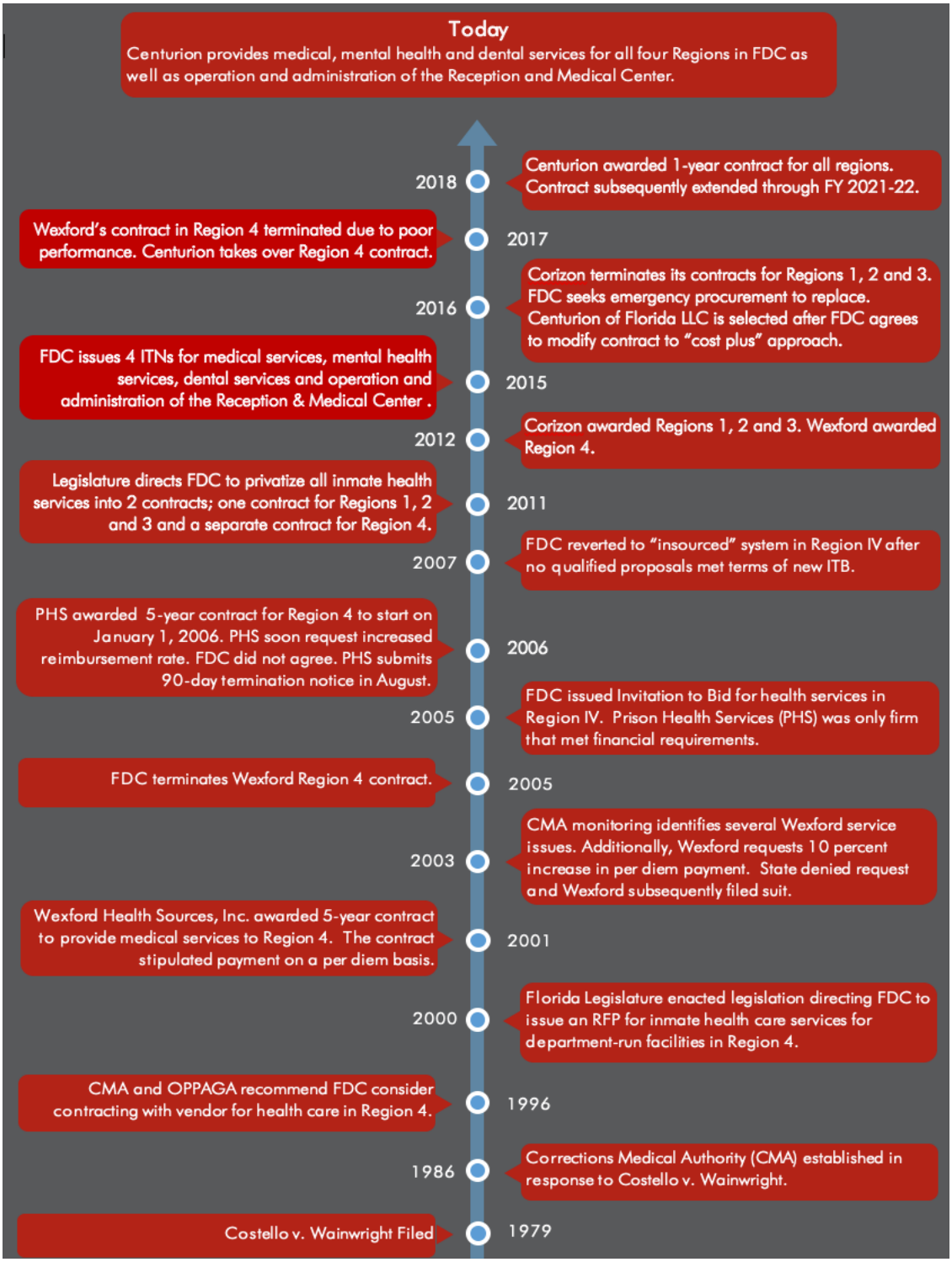
The FDC has a long and complicated history in contracting for the delivery of health care to inmates. Exhibit 6 summarizes past FDC health care contracts. Exhibit 7 presents a timeline for the Department's experience with outsourcing.

Exhibit 6: FDC Health Care Contract Summary

Contract Term	Vendor	Services
2001-2006	Wexford	Region 4 comprehensive health care
2006	Prison Health Services (PHS)	Region 4 comprehensive health care
2006-2007	Correctional Medical Services (CMS)	Region 4 staffing (after termination of PHS contract)
2006-2009	MHM	Region 4 mental health
2009-2014	Corizon (formerly CMS)	Region 4 mental health
2012-2016	Corizon	Regions 1, 2, & 3 comprehensive health care
2012-2017	Wexford	Region 4 comprehensive health care
2016-2017	Centurion (formerly PHS and MHM)	Regions 1, 2, & 3 comprehensive health care
2017-2018	Centurion	Add Region 4 comprehensive health care
2018-2019	Centurion	Statewide comprehensive health care
2019-2022	Centurion	Statewide comprehensive health care

Source: Florida Department of Corrections, Bureau of Procurement

Exhibit 7: Florida Department of Corrections Health Care Contracting History



Source: Florida Department of Corrections

Prior to and through the period of the *Costello v. Wainwright* litigation during the 1980's, the FDC managed health care services within the prison system with state employees, supplemented by individual contractors as needed. State-managed service included the management and staffing of the RMC's secure medical hospital. Private providers in the community and local hospitals or clinics provided specialty treatment, outpatient care, and inpatient hospitalization. The Department negotiated individual contracts and price agreements with these private providers.

One of the issues the system faced was difficulty in keeping health care staff positions filled, particularly in the Region 4, South Florida area. This is one of the primary challenges associated with insourcing correctional health care and has been a significant factor in the development of alternative approaches to staffing facility health care programs. That said, vendor performance in filling positions has been similar to that experienced by the state.

During this time, the first private company managed care providers specializing in correctional health care emerged onto the market, providing an alternative solution for systems seeking to improve prison health care services and/or reduce costs. In 1996 both the Correctional Medical Authority and the Office of Program Policy Analysis and Government Accountability (OPPAGA) recommended that the FDC consider privatizing correctional health care service for one region to better assess the viability and potential benefits of this approach.[17] The Department did not implement these recommendations, and in 2000, the Florida Legislature enacted legislation on the issue. The bill required the FDC to issue an RFP for inmate health care provided at all Region 4 correctional facilities, with an explicit goal of achieving cost savings.[18]

The subsequent RFP attracted bids from 4 vendors and resulted in the award of a five-year contract with Wexford Health Sources, Inc. for Region 4. The contract used a capitated model in which the vendor assumes financial risk in exchange for enhanced discretion in managing services to achieve efficiency. In this approach the vendor charges a per diem rate multiplied by the average monthly inmate population as compensation. The contract also called for 3 percent annual per diem rate increases.

Correctional Medical Authority (CMA) monitoring of health service delivery under the contract consistently indicated significant vendor service issues, including lack of internal management controls, poor or nonexistent tracking mechanisms, inadequate control and/or tracking of specialty consultations, and an unacceptable pharmacy system.[19] These issues eventually resulted in the FDC assessing financial penalties against Wexford. For their part, the vendor contended that the inmate population in the region contained a higher number of

[17] Corrections Medical Authority 1995-1996 Annual Report; OPPAGA Report No. 96-22, "Review of Inmate Health Services Within the Department of Corrections" (November 1996)
[18] Chapter 2000-166, Laws of Florida
[19] Florida Senate, Committee on Criminal Justice, Privatization of Prison Health Care Services, Issue Brief 2011-213, October 2010.

inmates with medical and mental health issues than their bid assumed, and as a result requested a 10 percent increase in the contract per diem rate. Litigation between Wexford and the FDC followed. While Wexford prevailed in the lawsuit, which forced an increase in payment, continued service quality issues resulted in the Department terminating the contract in 2005.

The Department then issued a new Invitation to Bid (ITB) for Region 4 health care services which produced three bids, including one from Wexford. The FDC awarded a five-year contract to Prison Health Services (PHS) in January 2006. The PHS bid was more than $80 million less than the next lowest bidder.[20] The vendor however soon indicated that they had underbid the contract due to the lack of adequate information on service volume during the bid process and requested an increase in contract compensation. In response to the Department's denial of this request, PHS provided notice and terminated the contract eleven months after its commencement.

The Department issued a subsequent ITB for Region 4 in 2007 which received no proposals that met the terms of the procurement. In response, the FDC reverted to an "insourced" system in Region 4, providing institution-based health care services with state employees, while contracting with a network of individual private providers for services provided in the community. This mirrored the approach used by the FDC in managing health care services in Regions 1, 2, and 3. Ultimately the number of contracts between the Department and private providers would exceed 200 across the state.

In 2011 the Legislature directed the FDC to privatize all inmate health services statewide into two contracts, one for Regions 1, 2, and 3; and a separate contract for Region 4.[21] The legislation specifically required that the contractor achieve cost savings of at least seven percent below the Department's FY 2009-10 health care expenditures.[22] The Department issued an RFP for comprehensive health services for all four regions, and in 2012 awarded contracts to Corizon, LLC for Regions 1, 2, and 3; and a contract to Wexford Health Sources, Inc. for Region 4. The total value of these contracts was $1.1 billion for Corizon for 2012-2016, and $237.9 million for Wexford for 2012-2017. The Department adopted a similar approach for these contracts as it had used for previous comprehensive health care contracts, in which the vendor assumes all financial risk and retains maximum flexibility in managing services; with compensation based on a per diem rate applied to the average daily inmate population.

The transition to statewide privatization was difficult. State employee unions sued the Department to block implementation of the contracts. The Department ultimately prevailed in court, but the case delayed contract implementation until 2013. During that time, many state health care staff resigned in

---

[20] Ibid.
[21] Laws of Florida, Chapter 2011-69.
[22] Florida Department of Corrections RFP, Comprehensive Healthcare Services in Regions I, II, and III, Solicitation 11-DC-8324, http://www.myflorida.com/apps/vbs/vbs_www.ad_r2.view_ad?advertisement_key_num=98603

anticipation of losing their positions, forcing the Department to rely on overtime and temporary staff to assure continued services. While both contracts achieved required savings levels (and in fact surpassed the seven percent savings requirement), the vendors in many cases initially reduced spending by maintaining lower health care staffing levels. According to FDC staff, this in turn led to serious performance issues in both contracts.

In response to these issues, the Department issued a new procurement solicitation for inmate health care services in December 2015. The Department adopted a new procurement model, an Invitation to Negotiate (ITN) for this solicitation. Under the RFP format, prospective bidders had limited information on contract scope and very little opportunity for questions and discussion on the services to be provided. Office of Health Services staff indicated that the prior vendors selected by the Department through the RFP process attributed their difficulties in providing services at the prices they bid to the lack of information available in the procurement process, which led them to underprice their proposals. The ITN process differs from an RFP procurement in that it specifically allows for sharing of information with the vendor and answering questions throughout the negotiation process. This generally results in a better understanding of the client's requirements on the part of the vendor.

The Department also made a substantial change in scope of work under the ITN approach. The scope of previous RFPs was for the comprehensive delivery of inmate health services in specific FDC regions. Through several rounds of RFPs this approach attracted a relatively small group of the same companies. None of the companies selected had performed at a level considered satisfactory by the Department. In a new approach under the ITN model, the Department defined scope by discipline, issuing four ITNs for statewide medical services, statewide mental health services, statewide dental services, and operation and administration of the Department's inpatient hospital at RMC. By dividing the scope of health care delivery in this manner the Department hoped to increase competition and attract new vendors. The ITNs also specified provisions to increase accountability and oversight of vendor performance.

As the Department entered into the ITN solicitation, Corizon provided notice that it was terminating their contract for health care services in Regions 1, 2, and 3 effective May 2016. In response to FDC concerns regarding staffing levels and vendor performance, Corizon indicated that the terms of its contract were too constraining to address the Department's concerns. This action forced the Department to seek an emergency procurement to replace Corizon. The procurement resulted in the selection of Centurion of Florida, LLC to provide services in the regions formerly under contract with Corizon. However, because of the risk in assuming this contract, Centurion required the Department to change the contract model to a "cost plus" approach. In this model, the vendor is reimbursed for all expenses related to the provision of required services and paid a management fee in addition to these costs. The cost plus approach effectively eliminates vendor financial risk. This initial contract with Centurion established the management fee at 13.5 percent of service costs.

As the FDC initiated the ITN process, CMA inspections in 2017 documented serious performance issues at the South Florida Reception Center, leading the Department to terminate Wexford's contract for Region 4. Due to the emergency nature of the circumstances, the Department added Region 4 to

the Centurion contract, resulting in the vendor assuming complete statewide responsibility for medical and mental health service delivery up through the original terms of the Corizon and Wexford contracts. This was an emergency action to assure continued service while the Department continued its attempt to procure new vendors through the ITN process.

The ITN solicitations attracted limited vendor responses.

- Medical Services ITN - produced two bidders, one of which (Wexford) dropped out of the process, leaving the Department with one vendor, Centurion, to negotiate a contract. The Department reissued the ITN to attract more responders, but again received only one proposal from Centurion.
- RMC Hospital ITN - resulted in one bidder, Centurion.
- Mental Health ITN - resulted in two bidders, Centurion and Correct Care Solutions.
- Dental Services ITN - attracted two responses from Centurion and Smallwood Prison Dental Services.

Based on the results of the ITNs, in 2018 the Department negotiated a one-year contract with Centurion in the amount of $375 million to provide statewide inmate health care services. The contract has since been amended to extend the term to three years through FY 2021-22.

Current Service Model

As described above, the FDC currently contracts with Centurion to provide inmate health care services at all FDC-operated facilities. Centurion supply the staff who provide treatment at the facilities, coordinates the care of inmates who must receive specialist or hospital services outside the facility, and manages the overall system of care through a system of regional administration, quality assurance, and utilization management.

The current system, however, is not completely outsourced. The Department retains management of the pharmacy system which provides medications to state inmates. Previous efforts to privatize this function failed to demonstrate cost savings, and in fact would have increased the cost of medications to the FDC. The Department's low costs for pharmacy service is primarily due to price discounts it receives for medications purchased through the Minnesota Multi-State Contracting Alliance for Pharmacy (MMCAP), a purchasing organization for government institutions that negotiates reduced pharmaceutical prices for member organizations. Other state correctional systems that participate in MMCAP include North and South Carolina. The Department also receives substantial discounts on medication for HIV/AIDS and sexually transmitted disease through interagency agreements with the Florida Department of Health and five local health departments for treatment of offenders with these conditions. Accordingly, the current service model is more accurately described as a hybrid, combining out-sourced vendor management and delivery of health care services with an in-sourced pharmacy program.

The contract is structured in a "cost plus" model. The vendor receives compensation in two components: 1) reimbursements for all approved health care expenditures; and 2) a percentage of

actual expenses to cover administrative expenses and profit. In effect, the contract passes through the cost of incurred health care expenses to the vendor, which receives a fee for administering the program. The administrative fee in the current contract is 11.5 percent of incurred expenses. The contract contains an overall annual cap on compensation paid out under the contract. The current contract compensation cap is $421 million for the current fiscal year and each of the next two fiscal years. Finally, as part of the services to be provided under the three-year contract term, the vendor will provide the FDC with an Electronic Medical Records system (EMR). This system will modernize FDC management of inmate health care information, enabling substantial efficiencies in patient care management and providing advanced metrics on health care work processes and management. The Centurion contract expires June 30, 2022.

The contract is "outcome-based" in that the vendor is held accountable through its level of achievement on a series of performance measures detailed in the contract. The contractor reports on their compliance with these performance measures quarterly. The level of compliance with performance measure requirements determines whether any financial penalties may be assessed against the vendor. While the vendor is reimbursed for actual expenses incurred, it may be subject to financial penalties if mandated outcomes are not achieved. The contract contains 70 performance measures and 135 pages of program standards covering every element of service and calls for an overall compliance rate of 80 percent for each standard as applicable, consistent with CMA standards. Each performance measure contains a specific financial consequence for non-compliance. Contract monitoring reports provide the basis for imposing these penalties.

Exhibit 8: Centurion Contract Performance Metrics

Measure No.	Description	Expectation	Measurement Duration	Financial Consequence
PM-007	From the time an inmate submits a sick call request form until the request form is triaged by an RN and determined to be either emergent, urgent or routine, shall be no longer than 24 hours.	80% compliance, per institution	Quarterly	For performance below 80%, consequences will be assessed as follows: 70%-79.99%: $2,000 per institution; 60%-69.99%: $4,000 per institution; Less than 60%: $6,000 per institution
PM-008	From the time the request is triaged, sick call requests categorized as emergent should be seen by a Licensed Nurse as soon as possible, not to exceed 60 minutes.	80% compliance per institution	Quarterly	For performance below 80%, consequences will be assessed as follows: 70%-79.99%: $3,000 per institution; 60%-69.99%: $6,000 per institution; Less than 60%: $9,000 per institution

Measure No.	Description	Expectation	Measurement Duration	Financial Consequence
PM-009	From the time the request is triaged, sick call requests categorized as urgent should be seen by a Licensed Nurse within 24 hours.	80% compliance per institution	Quarterly	For performance below 80%, consequences will be assessed as follows: 70%-79.99%: $2,000 per institution; 60%-69.99%: $4,000 per institution; Less than 60%: $6,000 per institution

Source: FDC Contract C2930, Amendment 2.

The FDC and the vendor jointly determine the staffing required to satisfy these performance measures, although this staffing pattern is not a part of the contract and vendor compliance is not monitored. Centurion's current staffing plan has 3,127.9 FTEs, assigned to the following disciplines:

Exhibit 9: Health Care Contract Staff by Discipline

	July 2019 Contract Staffing Plan	Percent of Total Staffing
Medical	1,531.3	49.0%
Mental Health	887.5	28.3%
Dental	228.2	7.3%
Administration	480.9	15.4%
Total	3,127.9	100%

Source: Florida Department of Corrections, Office of Health Services

Staffing levels, however, are not a part of the contract. While maintenance of adequate staffing levels is implicit in the required achievement of the contract performance measures, the contract does not specify staffing requirements or hold the vendor accountable for maintenance of program staffing levels. Provided they do not exceed the overall contract spending cap, the vendor is free to add staff if necessary, to reach standards, or conversely not fill positions without consequence, if they are able to meet the performance standards with lower staffing levels.

Office of Health Services

The FDC Office of Health Services administers the system's health care program. Responsibilities include development of policies, review of grievance appeals, budget management, contract management, and operation of the state pharmacy program. The OHS has 175 authorized positions assigned to Administration, Medical, Mental Health, Dental, Nursing, and Pharmacy offices.

Contract monitoring is a key OHS responsibility. The OHS has 18 monitors who perform contract monitoring. There are three teams each consisting of an administrator leader, two nurses, one mental health monitor, and one data analyst. On a state-wide basis there is one pharmacist and two dental

monitors. In addition, two teams of mental health professionals conduct risk management assessments to identify potential issues and provide solutions in mental health program delivery.

Monitoring visits can be scheduled or unscheduled, announced or unannounced. The monitors use several methodologies in monitoring contract performance including:

- Desk review of any records or documents related to service delivery; this can be a random or statistical sampling
- On-site review on any records
- Interviews
- Reviews of grievances
- Review of monitoring, audits, investigations, evaluations or other reviews of external agencies (CMA, DOH, ACA)

OHS audit teams conduct facility reviews in the first and third quarters of each fiscal year, with each facility self-reporting audit results in the second and fourth quarters. The Department changed its audit instrument in 2019. Where previously there were 262 performance measures, the new audit system contains 70 performance measures, consistent with contract requirements. These measures are similar in nature to prior measures albeit reduced in number. The FDC reduced the number of measures to facilitate more efficient monitoring of the contract.

These measures are Yes/No type compliance questions. The measures contain an outcome and an expected compliance rate for each measure. Ten to 20 records are reviewed based on a random sampling. Examples of monitoring metrics include:

- Within 10 calendar days of arrival at a reception center, an inmate received on medication from county jail will be evaluated by psychiatry.

- A baseline Mammography study will be performed for female inmates at 50 years of age, and every two (2) years thereafter until the age of 74.

- Acute illness patients were assessed by a nurse every eight (8) hours, including vital signs, and documented the evaluation on form DC4-684, Infirmary/Hospital Daily Nursing Evaluation.

3. HEALTH CARE COSTS

This chapter describes the cost of correctional health care in Florida, including the different elements of health care spending, trends, and key drivers of current and future costs. We also look at how Florida costs for health care compare nationally.

Spending on Inmate Health Care

The FDC appropriation for inmate health care services in FY 2019-20 totals $566.9 million. Appropriations for health care make up 21 percent of the FDC budget, ranking second behind correctional staffing in magnitude of spending. Assuming a stable inmate population through the current fiscal year, this will roughly equate to a cost of $17.84 per day per inmate, or $6,511 annually. Exhibit 10 summarizes the FY 2019-20 budget for inmate health care.

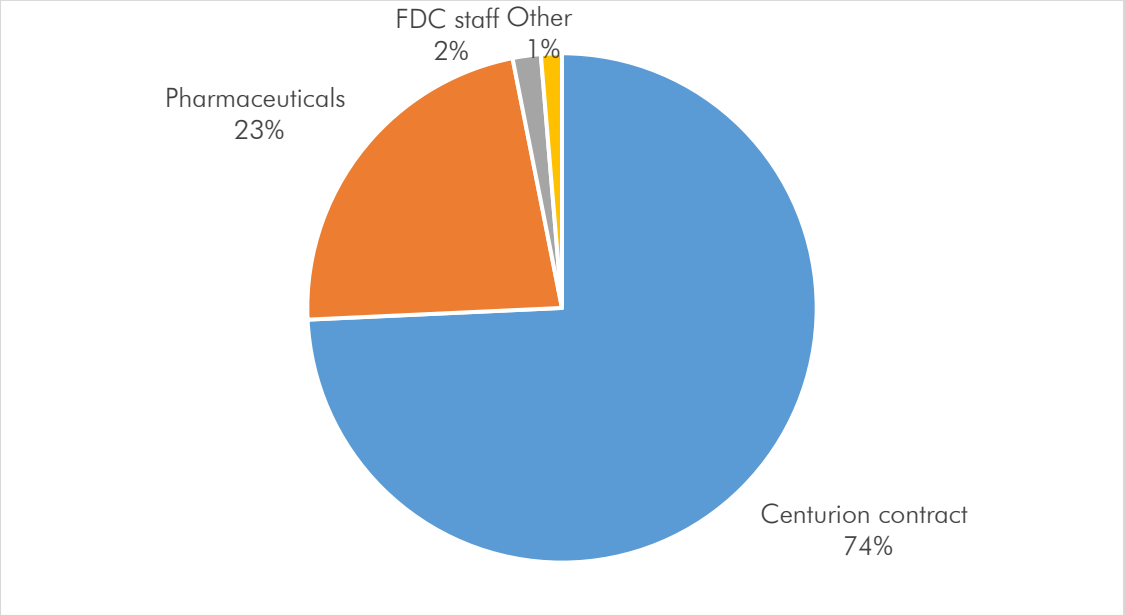
Exhibit 10: FDC FY 2019-20 Inmate Health Care Appropriations

Office of Health Services	FY 2019-20 All Funds Appropriations ($ 000)
Centurion Contract	421,000.0
Pharmaceuticals	128,222.9
OHS Employee Salaries & Benefits	9,721.6
Contracts	4,367.2
Other	3,554.9
TOTAL	566,866.7

Source: Florida Department of Corrections

The state's contract with Centurion for statewide facility health care services makes up 74 percent of health care spending. FDC expenditures for infectious disease, psychotropic, and general medications make up another 23 percent of the budget. The cost of state employees to administer the system and manage the pharmacy program is roughly 2 percent of the budget.

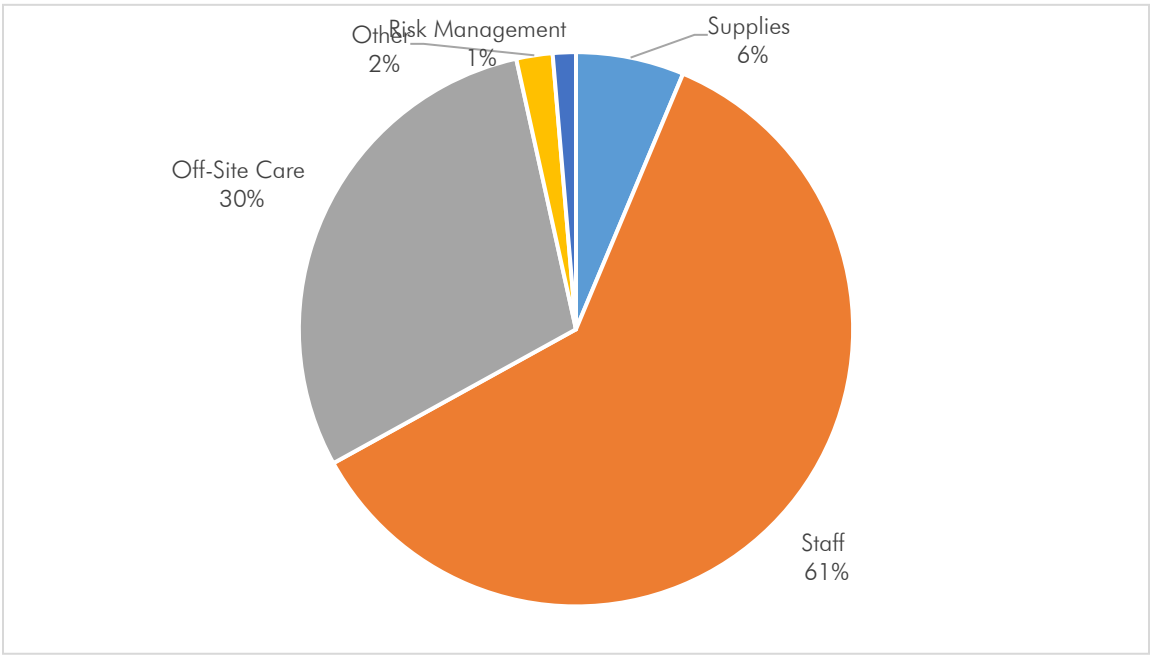
Exhibit 11: Inmate Health Services Expenditures Components



Source: Florida Department of Corrections

In FY 2018-19 Centurion expenditures under the contract for inmate health care totaled $355 million. Approximately 61 percent of expenditures were for health care staff in FDC facilities. Off-site care by hospitals and specialist clinicians made up 30 percent of vendor spending, with supplies and other expenses accounting for less than 10 percent of expenses.

Exhibit 12: FY 2018-19 Centurion Health Care Expenditures

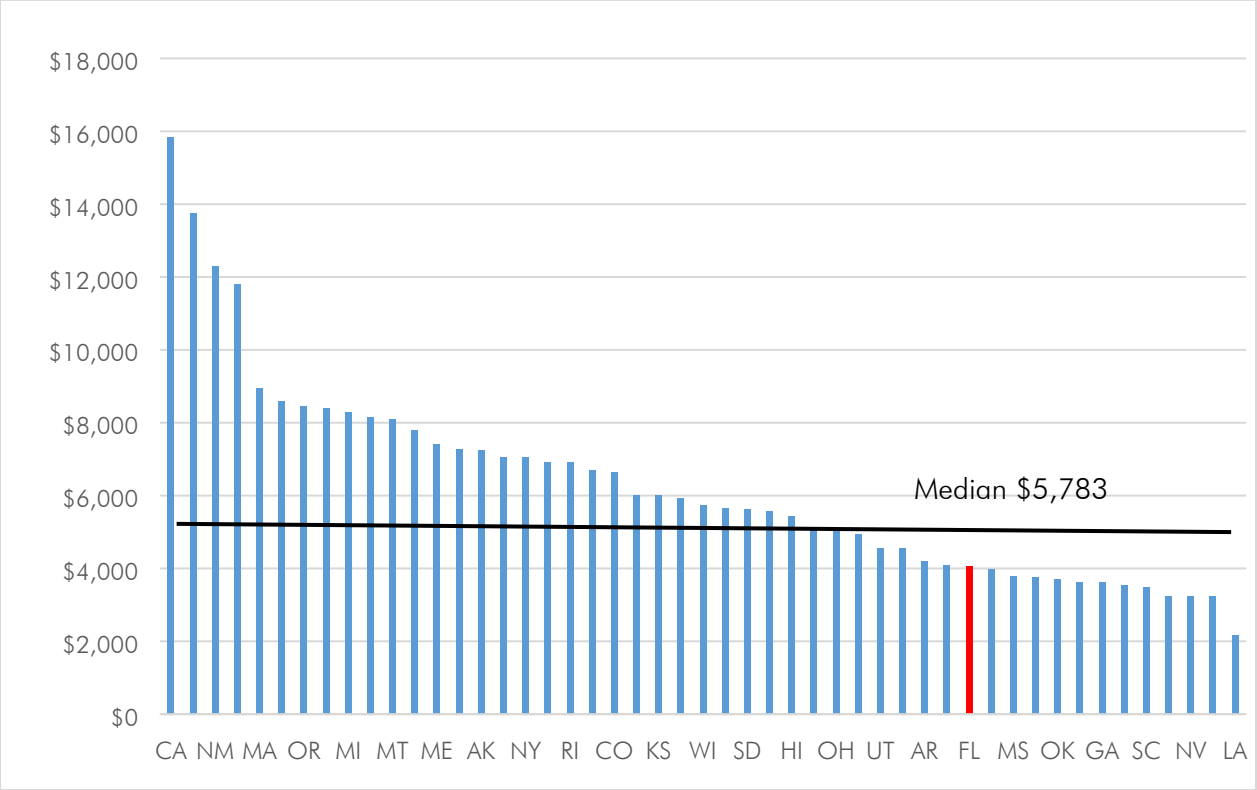


Source: Florida Department of Corrections

Comparison with Other States

A comparison of Florida's spending with the most recent data available for other state correctional systems shows FDC expenditures per inmate for health care in the bottom quartile of states with the lowest spending levels. A comprehensive review of 2015 correctional system spending in 49 states[23] by the Pew Charitable Trusts documented that annual spending on correctional health care ranged from a high of $15,827 in California to a low of $2,173 in Louisiana.[24]

Exhibit 13: State Spending Per Inmate on Correctional Health Care in 2015

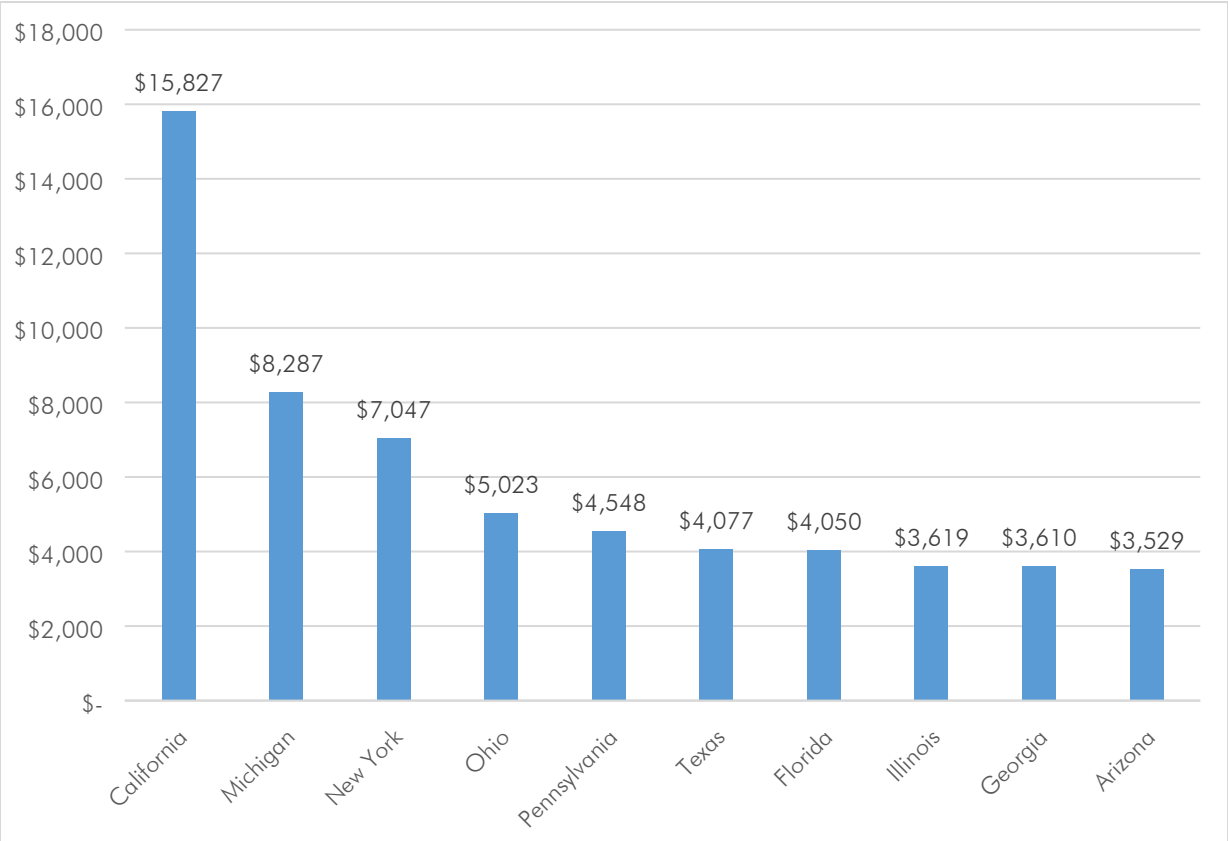


Source: Pew Charitable Trusts, Prison Health Care: Costs and Quality, 2017

Although California is an outlier, most of the states with relatively high spending levels are very small, and their higher costs may reflect a lack of resources or economies of scale. Spending levels for the ten largest correctional systems showed Florida ranked seventh. However, the degree of difference in spending level among the six systems with the lowest average spending level was small. The data shows Florida to have a somewhat lower spending level that is however still comparable to most large state correctional systems, as shown in Exhibit 14.

[23] Pew Charitable Trusts conducted a national survey of state correctional systems. All states except New Hampshire responded to the survey.
[24] Pew Charitable Trusts, Prison Health Care: Costs and Quality, October 2017, https://www.pewtrusts.org/en/research-and-analysis/reports/2017/10/prison-health-care-costs-and-quality.

Exhibit 14: 2015 Correctional Health Care Spending – Ten Largest State Prison Systems

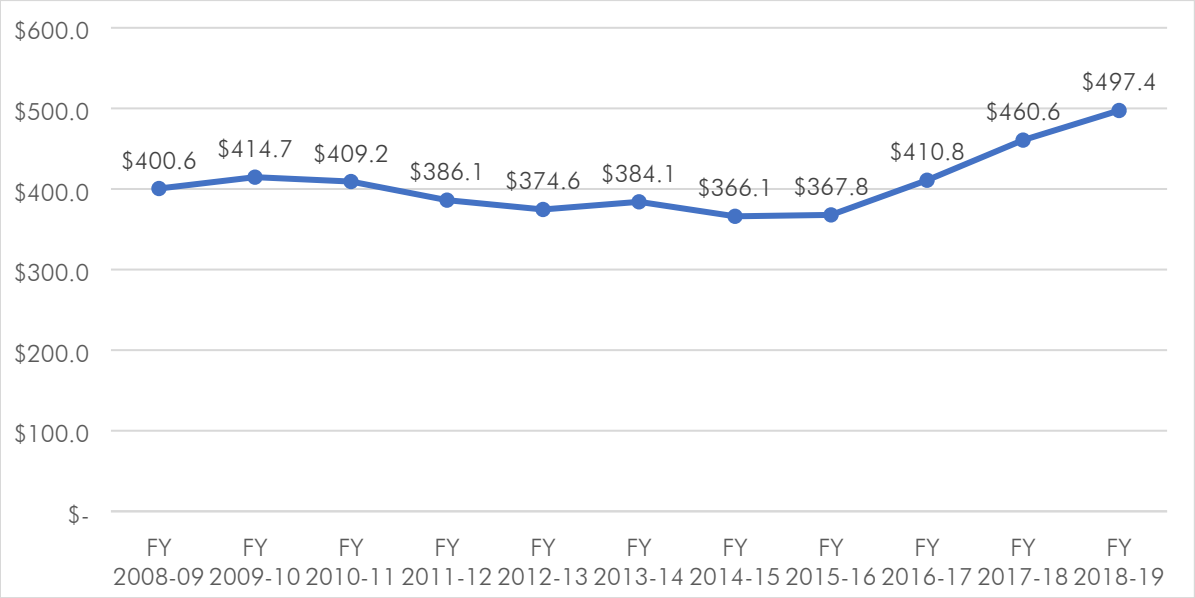


Source: Pew Charitable Trusts, Prison Health Care: Costs and Quality, 2017

Cost Trends

More recent trends show the level of FDC spending on inmate health care accelerating since 2016. As shown in Exhibit 15, the amount of funding allocated to inmate health care dropped by 9 percent in the period from FY 2008-09 through FY 2014-15 but has since steadily escalated. The FY 2019-20 budget represents a 54 percent increase over FY 2015-16 spending.

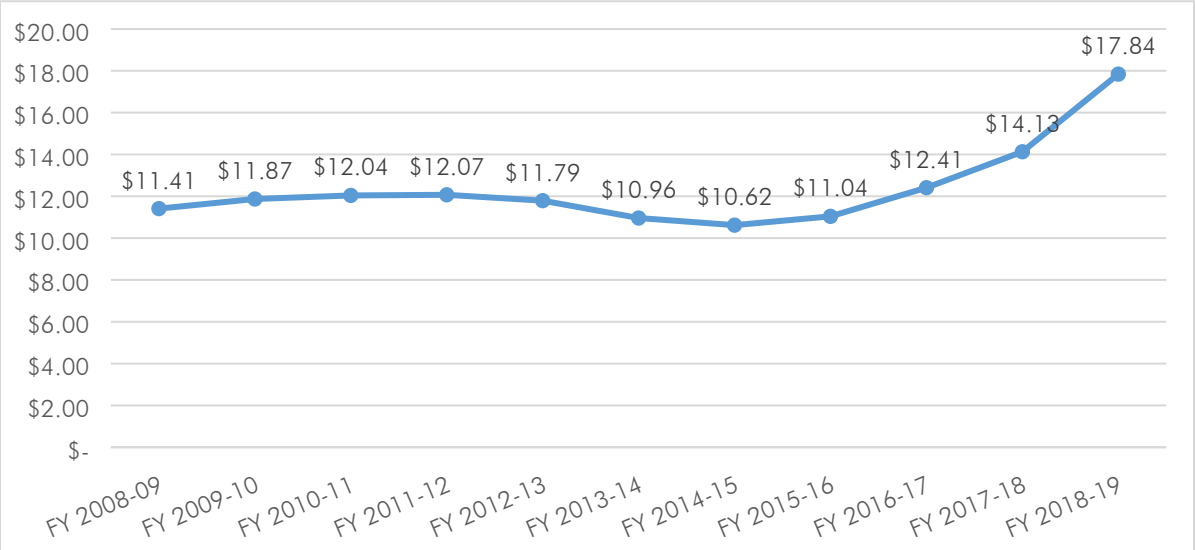
Exhibit 15: Inmate Health Services Spending FY 2008-09 to FY 2018-19



Source: Florida Department of Corrections

Examining per diem spending levels factors in the impact of changes in the average daily inmate population on total health care expenditures. This is a significant factor in evaluating cost trends as the actual average daily inmate population in the Florida correctional system has declined by 6.7 percent since FY 2008-09 from an average daily population of 93,270 in state-operated facilities in FY 2008-09 to 87,032 in FY 2018-19. The per diem cost trend, shows a steady decline through FY 2014-15, followed by significant increases.

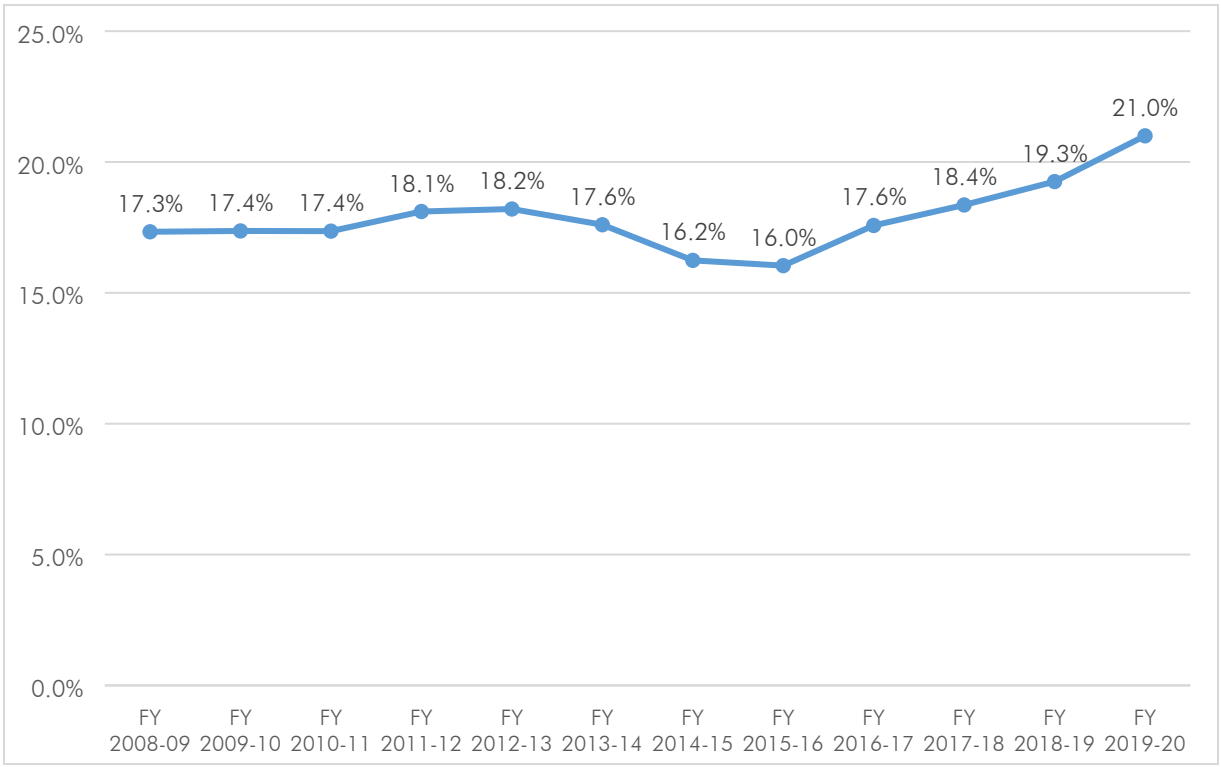
Exhibit 16: Inmate Health Services Per Diem Costs FY 2008-09 to FY 2018-19



Source: Florida Department of Corrections

The proportion of the FDC budget allocated to inmate health care reflects the increase in reported spending in the last four years. Following several years of decline, by FY 2015-16 the Department was spending 16 percent of its budget on inmate health care. The proportion of the budget allocated to health care has grown more recently in parallel with recent increases in spending.

Exhibit 17: Inmate Health Services as a % of FDC Spending

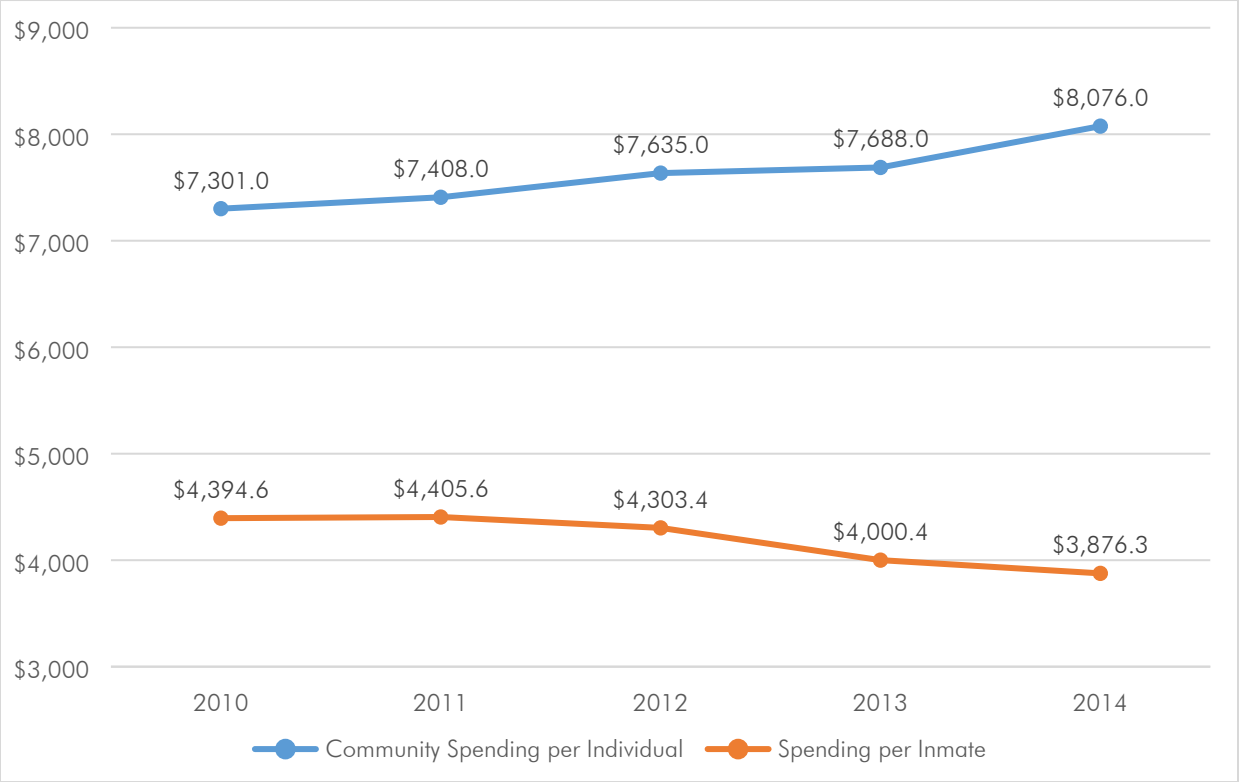


Source: Florida Department of Corrections

The two most notable factors from this review of spending trends are the significant decline in health care spending from FY 2008-09 to FY 2015-16, followed by the rapid growth in spending that has occurred since that time. This pattern does not follow the overall trend for health care costs in Florida. Annual spending for health care per inmate in the FDC dropped by 12 percent from FY 2008-09 to FY 2014-15. By contrast, according to the Centers for Medicare and Medicaid (CMS), the average cost for personal health care in the state increased by 13 percent over the same period.[25] In 2010, annual per inmate spending on health care was approximately 60 percent of the average level of spending on personal health care. By 2014, inmate health care spending had dropped to 48 percent of the level of personal spending on health care.

[25] Centers for Medicare and Medicaid Services, Health Expenditures by State of Residence, 2017, https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsStateHealthAccountsResidence.html.

Exhibit 18: Annual Community and Inmate Per Diem Spending for Health Care, Florida 2010-2014



Source: Centers for Medicare and Medicaid; Florida Department of Corrections

The primary factor driving this reduction in per inmate spending appears to be the privatization of inmate health care and subsequent decline in the quantity and quality of care provided during this period. The health care contracts with Wexford and Corizon in total reduced the cost of services by 11.2 and 12.9 percent respectively from the Department's FY 2011-12 and FY 2010-11 expenditures. Implementation of these contracts resulted in reductions in staffing, dramatic decreases in episodes of outside care, and increases in the number of grievances submitted by inmates about the poor quality of health care service. CMA inspections noted extensive system-wide areas of concern with the level of medical and mental health care provided.[26] Both vendors later claimed they were not provided enough information to accurately project costs, which resulted in the service issues that developed. Both vendors were unable to provide the level of service required by the Department and did not complete the terms of their contracts.

[26] Correctional Medical Authority, Annual Report and Update on the Status of Elderly Offenders in Florida's Prisons, 2014-15, 2015-16, https://fleog.sharepoint.com/sites/CMA/Documents/Forms/AllItems.aspx?originalPath=aHR0cHM6Ly9mbGVvZy5zaGFyZXBvaW50LmNvbS86Zjovcy9DTUEvRWdpbjdpWDNUTHhHanR5ekU2bzVCNEFCREIBbGVpVTI2VjBZcTdPMDlsNW5qdz9ydGltZT1LSy1SNTZ0YjEwZw&id=%2Fsites%2FCMA%2FDocuments%2FCMA%2FAnnual%20Reports%2FCorrectional%20Medical%20Authority%20%2D%202015%2D2016%20Annual%20Report%2Epdf&parent=%2Fsites%2FCMA%2FDocuments%2FCMA%2FAnnual%20Reports.

Cost Drivers

After declining in the period FY 2010-11 through FY 2014-15, inmate health care costs increased by 36 percent over the next four years, an annual average increase of 9 percent. Several factors appear to be driving this trend, including a misalignment between contract funding and service requirements, litigation, the increasing number of geriatric inmates, and increased pharmaceutical spending.

Misalignment between Contract Funding Amounts and Service Requirements. As described above, the Corizon and Wexford contracts reduced state funding for inmate health care. However, this lower funding level did not support a minimally adequate level of service. Accordingly, the reduced levels of spending achieved under these contracts are not an appropriate basis for comparison for contemporary budgets. Increases in funding from the levels required by these contracts need to be viewed in the context of restoring resources to get back to acceptable program performance levels.

Spending on inmate health care by the FDC in FY 2017-18 totaled $460.6 million. Although this represents a substantial $93 million increase from FY 2015-16, using a longer timeframe produces a different conclusion. As shown in Exhibit 15, the FY 2017-18 spending level is only $46 million more than the Department experienced in FY 2009-10. This represents annual growth of 1.3 percent over the eight year period compared with an annual increase in the cost of medical care nationally of 3.6 percent from July 2009 through June 2018.[27]

Much of the apparent increase in spending for inmate health care is attributable to an artificially low baseline spending level experienced by the Department after privatization. Costs went down to levels that could not sustain an adequate level of service. Subsequent increases in spending largely represent a return to levels necessary to support required service levels. Using a longer historical period to evaluate spending levels shows that recent growth in spending levels since FY 2015-16 represents a moderate overall rate of growth in the context of Department spending on health care prior to the privatization initiative of 2013. Further, misalignment between service needs and services provided by the vendors led to a backlog of medical/mental health issues, contributing to subsequent litigation and increased health care spending.

Litigation. Consent decrees and judgements from ongoing litigation on the adequacy of health care services have escalated Department resource needs. The following exhibit summarizes litigation-related increases in the Department's FY 2019-20 budget from the most significant cases that the Department has settled.

[27] U.S. Bureau of Labor Statistics, Chained Consumer Price Index for Medical Care, All Urban Consumers, 1999-2019.

Exhibit 19: Impact of Litigation on FY 2019-20 Inmate Health Care Budget

Case	Description	Funding Increase ($ millions)
Disability Rights Florida, Inc. v. Jones; Year 2 implementation of Inpatient Mental Health consent decree	308 staff phased in through the year, including Psychiatric staff, Nursing, Psychologists, Mental Health Professionals, Behavioral Health Technicians and clerical support for expansion of the Suwanee inpatient mental health units.	$16.6
Disability Rights Florida, Inc. v. Jones; Copeland et al v. Jones; Keohane v. Jones; additional staffing	139 staff needed to comply with litigation related to hernia treatment (2 FTEs), gender dysphoria treatment (3 FTEs), the treatment of inmates with disabilities (40 FTEs), as well as additional mental health positions (94 FTEs) included outpatient and inpatient services. In addition, this funds market rates adjustments needed to fill certain positions, such as psychiatrists and psychologists.	$13.4
Hoffer et al v. Jones; Hepatitis C treatment	16 FTEs to provide labs and other medical tests such as Genotyping, Liver Ultrasounds, and Endoscopies. Up to 45,000 screenings and subsequent follow up tests for those testing positive. This does not include the cost of medication.	$8.7

Source: Florida Department of Corrections

Increasing Number of Geriatric Inmates. The number of inmates over the age of 50 has increased from 14,486 on June 30, 2009 to 25,732 on June 30, 2019, an increase of 78 percent over the ten years. As in the community, geriatric patients are disproportionate users of health care. As shown below, despite composing 27 percent of the total inmate population, elderly inmates make up most hospital admissions, inpatient days, outpatient events, and prescriptions dispensed. Department data indicate that when admitted to a hospital, geriatric inmates have a 22 percent longer length of stay than inmates under the age of 50.

Exhibit 20: Department of Corrections FY 2018-19 Health Care Utilization

	50 Years & Older		Under 50 Years	
	Number	% of Total	Number	% of Total
Total Population	25,732	26.9%	69,770	74.1%
Hospital Admissions	1,496	53.7%	1,290	46.3%
Inpatient Days	10,084	63.7%	5,736	36.3%
Outpatient Events	18,319	57.8%	13,370	42.2%
FDC Prescription Dispensed	746,931	57.3%	573,917	42.7%
DOH Prescriptions Dispensed*	18,937	52.3%	17,241	47.7%
Cardiovascular Clinic Contacts	15,163	55.0%	12,360	45.0%
Endocrine Clinic Contacts	5,290	58.5%	3,751	41.5%

*DOH dispense prescriptions for HIV/AIDS and STDs under the 340b program
Source: Florida Department of Corrections

Nearly every prison system in the United States faces this same issue of increasing health care costs driven by the growth in the geriatric inmate population. As described earlier, the size of this population in Florida appears larger and growing at a faster rate than that of other large state correctional systems. This trend will continue to place strong upward pressure on inmate health care spending.

Drug Costs. Another significant cost driver is the increasing cost of prescription medications. The FY 2019-20 budget contains a $34.6 million increase for Hepatitis C medications, bringing total Department spending for these drugs to $48.4 million in the upcoming fiscal year. Price increases for other medications account for a $13.9 million increase in the budget. Higher drug costs are a significant growth factor in other state correctional systems as well. For example, increased spending on medications accounted for 33 percent of the growth in spending by the Virginia Department of Corrections from FY12-FY17.[28]

[28] Joint Legislative Audit and Review Commission, Commonwealth of Virginia, Spending on Inmate Health Care, 2018.

4. Alternative Service Delivery Models

This chapter examines alternative models for delivering correctional health care and their relative utility for the FDC. Models reviewed include insourcing inmate health services, insourcing of outpatient health services provided and outsourcing inpatient services, continuation of the current model of full outsourcing with modified contract terms imposing appropriate cost controls, and management by a third-party public health institution or agency.

Insourcing

An insourced approach to inmate health care management retains management and staffing of the health care services program internally in a state correctional agency and provides as much treatment as possible within the secure facilities of the correctional system. However, not all health care can be provided within a prison. An inmate in need of treatment by a specialist not on staff at the prison will require off-site care with a physician contracted to provide that care, or a contracted specialist to come on site. Similarly, diagnostic procedures that require equipment not maintained in a prison health care unit such as an MRI, will require outpatient care outside the correctional system. Finally, advanced procedures such as heart surgery must be provided in community hospitals that can safely support such treatment. As a result, a completely insourced inmate health care system is not feasible, and in fact virtually all correctional systems since the 1970's have relied on some level of contracting to provide required inmate health care.[29] Accordingly, for the purposes of this analysis, an "insourced" model refers to an approach that maximizes the use of government management and staff in the delivery of services, but still retains the use of contracts for specific services and treatment.

The degree to which a correctional system may rely on insourcing depends upon available resources. Systems that maintain prison hospitals or ambulatory surgical facilities, such as the Federal Bureau of Prisons, Texas Department of Criminal Justice, and California Department of Corrections and Rehabilitation have the capability to provide more services in-house. Florida falls in this category as well. The availability of internal resources reduces the need to take inmates out into the community for health care, diminishing a significant burden on custody staff.

Today, 18 state correctional systems use a primarily insourced model for health care delivery.

Exhibit 21: States with Insourced Delivery Systems

Alaska	North Carolina	Oregon
California	North Dakota	South Carolina
Connecticut	Nevada	South Dakota
Hawaii	New York	Utah
Iowa	Ohio	Washington
Nebraska	Oklahoma	Wisconsin

Source: Pew Charitable Trusts

[29] Pew Charitable Trusts

Insourcing is used by large correctional systems (California, New York, Ohio) as well as systems with very small inmate populations (Alaska, Hawaii, North Dakota), in every part of the United States. While these systems do contract for inpatient and outpatient care in the community, services in correctional facilities are primarily provided by state employees. The typical exception is for advanced mental health treatment. In almost all cases, psychiatric services are provided by independent contractors, as state personnel systems do not accommodate hiring specialized professionals in high demand.

An insourced system requires substantial internal expertise in correctional health care management and service delivery. Maintaining effective performance in an insourced system requires that a correctional system establish professional care protocols, retain a staff complement with adequate capacity and expertise, and design rigorous systems for monitoring cost and quality of services provided. If these requirements are met, insourcing can meet required standards for correctional health care and provide the following benefits:

- Stability. Use of government employees as service providers and managers provides greater assurance of continuity and consistency in staffing and service approach. The benefit package, particularly for retirement, for a state employee is typically superior to the benefits offered by private companies and acts as an incentive for long-term careers as a correctional system employee. Administrators in insourced systems such as California, Alaska, and Washington report relatively low turnover rates for facility health care staff. A recent report from Arizona indicates health care workers may prefer employment with a state agency, as opposed to a vendor.[30]

  Insourcing also avoids the disruptive transitions in management and employment status that can occur in the change from a government-run health care program to one managed by a private contractor, or in the transition from one vendor to another. In Florida, prior to each privatization initiative, the Department suffered a significant loss of experienced health care staff due to uncertainty regarding their employment status and future compensation level under a vendor. During each subsequent change in vendors, facility health care staff had to transition to a new employer and in most cases lost benefits they had accrued with their prior employer. Moreover, such transitions are highly complex events that place added strain on assuring continuity of adequate care. An insourced system avoids these issues.

- Accountability. The lines of accountability for assuring adequate health care delivery are quite clear in an insourced system, running directly from state employee facility staff and managers up through central office administrators. Contracting, however, transfers operational control to vendors, even while the state retains ultimate liability and responsibility for providing services. This adds a layer of complexity to system management. Similarly, lines of communication and

[30] Marc Stern, Federal Rule 706 Expert, Case 2:12-cv-00601, Report to the Court in the Matter of *Parsons v. Ryan, et al.*, October 2, 2019.

direction are straightforward in a government-run system. Coordination with custody staff is simpler when both health care staff and correctional officers are in the same command structure. Moreover, vendor staff are not directly accountable to state administrators, which can hamper responsiveness.

Problems inherent with insourcing relate to the relative lack of flexibility of government organizations compared to the private sector regarding personnel management. If, for example, a facility experiences chronic high staff vacancy levels, a private vendor generally has the discretion to quickly adjust salary levels or offer signing bonuses to adjust to market conditions. Private vendors generally have more sophisticated staff recruitment systems and a wider range of incentives in attracting employees. Staff with specific skillsets for critical functions such as utilization review and quality assurance may not be readily available within government. Vendors also may quickly redeploy staff as needed to meet operational needs. Finally, private vendors have much greater discretion in terminating staff that do not meet performance standards. State agency deficiencies in hiring and deploying staff to meet correctional system needs is one of the most often cited arguments for privatization.[31]

Another issue with insourcing is that while state agencies may have some expertise in managing facility health care staff and programs, the degree of difficulty associated with effective management of all the various facets of health care delivery is substantial. Few correctional systems have the level of in-house administrative resources and experience required to coordinate outside care and manage multiple contracts with outside providers. Specialized functions such as utilization management and invoice review are far outside the core competency of most state correctional agencies and add a layer of complexity that many systems may have difficulty in managing.

Outsourcing

An outsourced service model relies on a contracted vendor to manage and provide inmate health care services for the state correctional system. In its purest form, the state turns over all aspects of health care service delivery to the vendor.

Until the late 1970s, every state provided prison health care directly in an insourced delivery model. However, widespread litigation following *Estelle v. Gamble* produced judgements that required many states to immediately address significant deficiencies in correctional health care, often requiring that additional clinicians and nurses be hired as soon as possible. Private companies were formed to meet this need. In Illinois for example, in order to meet the need to hire additional staff required under the *Lightfoot v. Walker* consent decree, Illinois Department of Corrections administrators actively solicited a physician's group to help them meet their needs. The company formed by these physicians ultimately became Correctional Medical Services, one of the first companies to specialize in correctional health care, and one of the founders of Corizon Health.

[31] Pew Charitable Trusts.

These early companies soon moved beyond simply providing staffing to provide comprehensive services on a managed care model to both prison systems and jails throughout the United States. Today, 20 states provide most of their inmate health care services using an outsourcing model.

Exhibit 22: States with Outsourced Delivery Systems[32]

Alabama	Kansas	Tennessee
Arizona	Kentucky	Vermont
Arkansas	Massachusetts	West Virginia
Delaware	Maryland	Wyoming
Florida	Maine	
Idaho	Missouri	
Illinois	Mississippi	
Indiana	New Mexico	

Source: Pew Charitable Trusts.

The approach to service delivery in these states differs in terms of the range of services provided, the extent to which they provide system management in addition to clinical services, and whether one or multiple vendors provide services throughout the system. For example, Maryland contracts with separate private companies to provide different services: medical, dental, behavioral health, and pharmaceutical. Illinois has contracted with different vendors to provide comprehensive services to different regions of the state. Massachusetts requires vendors to use a state-managed hospital and pharmacy procurement system. Florida purchases medications and provides pharmacy services with state employees.

There are many specific approaches to outsourcing. The basic distinction lies in how to manage risk, both in terms of service quality and cost. Most outsourced contracts follow either a capitated or cost-plus approach.

Capitated Contracts. The most common approach to outsourcing is the use of a capitated contract. In this model, the state and the vendor agree to a fixed per-person payment rate for all individuals under their care. This vests all risk with the vendor. The intent of the model is to leverage vendor expertise to provide required services at a lower, stable cost.

The fixed per-person rate covers direct care at the facility as well as any specialty or off-site services that may be required. The vendor is responsible for providing contracted services for the number of inmates covered at the agreed rate, regardless of the actual cost. The capitated rate must cover all regular projected costs, a risk premium to cover potential additional liabilities, and a fee to cover administrative costs and profit. If the vendor can reduce costs, it can directly increase profits. If, however, the rate does not account for projected expenses and risks, or if the number of persons covered under the contract falls, the vendor stands to lose money. The state, for its part receives a predictable, stable price for inmate health care.

[32] Pew Charitable Trusts.

A capitated approach requires that the vendor be able to accurately assess the health status of the inmate population, their need for service, and risk factors that may drive up costs. Absent this information, the vendor in a competitive procurement may underbid the contract. The long-term consequences of underbidding are typically either unanticipated requests for additional contract funding, reduced services, or termination of the contract. Outsourcing initiatives in Florida using a capitated model have encountered all these issues.

Cost-Plus Contracts. In this approach the vendor manages health care services but passes through all costs of these services to the state, plus an additional charge for administration and profit. The state assumes all financial risk, while at the same time ceding management control over the program to the vendor. Florida, Pennsylvania, Montana, and Vermont report using the cost-plus model.[33]

This model is often used in systems that either lack data to provide projections of future costs or which have high perceived risks for unforeseen costs. Where the capitated model encourages an aggressive approach to managed care, the cost-plus is more akin to a "fee-for-service" model. The vendor simply manages the health care program and passes along the cost to the state. The primary advantage to the state is the transparency provided in that it reviews and approves all expenses. The contract can also more explicitly focus on service quality and performance as primary objectives. The disadvantage is that it provides little incentive for the vendor to control costs.

In either outsourcing approach, the primary challenge for the state is monitoring the contract to ensure compliance with performance requirements and other contract provisions. In effect outsourcing changes the focus from managing health care operations and services, to managing the contract and vendor performance.

Outsourcing Benefits and Challenges. Both approaches to outsourcing can provide benefits to clients, as well as certain issues. Commonly described benefits of outsourcing include:

- Professional Expertise. For systems that lack internal resources or professional staff, outsourcing provides a means to leverage the professional expertise of a vendor that specializes in correctional health care. Health care is not a core competency of many correctional systems, particularly in areas such as utilization review, quality assurance, network management, and electronic medical records systems. Contracting for health care services provides a relatively straightforward strategy to import these skills, improving performance and allowing correctional administrators to focus on other issues.

- Economies of Scale. Outsourcing can allow small correctional systems to access the economies of scale and more flexible procurement systems used by large, national companies in purchasing pharmaceuticals and supplies. This however is not a significant benefit for larger systems.

[33] Pew Charitable Trusts.

- Staffing. As described in the section on insourcing, private companies often have much more flexibility in setting salary and benefit levels to reflect market conditions in specific areas, and so can more effectively recruit and hire health care staff. This is particularly true in specialized areas such as mental health treatment. To the extent that civil service systems slow hiring or do not offer competitive salary levels, outsourcing provides a potential means to better keep service provider positions filled.

- Cost Savings. At least in the case of capitated contracts, outsourcing provides strong incentives for vendors to reduce costs in order to assure profits. The competitive bidding environment for an outsourcing procurement also tends to promote efficiency and attention to cost savings strategies.

Challenges associated with outsourcing generally revolve around managing performance goals in context with the imperative to control costs. With the capitated model, the vendor will always have the incentive to reduce costs to increase profits. To the extent that cost reduction is achieved through reduced services rather than increased efficiency, the model does not support overall correctional system goals. The disconnect between the vendor responsible for providing care and the state which is legally accountable if care is not adequate can lead to system dysfunction and contract failure. State systems that have experienced serious service issues with outsourced services under capitated contracts include Arizona, Virginia, Illinois, Idaho, and Florida. These issues include excessive number of staff vacancies, failure to refer inmates for off-site treatment, and long wait times for on-site treatment. Strong contract monitoring systems with clear performance metrics are essential to manage these issues.

The cost-plus approach by contrast presents issues of efficiency. The state pays the vendor to manage the system without any offsetting incentives to achieve efficiencies in service delivery. The state must maintain staff to monitor vendor performance against the contract and in addition will typically have an administrative office to provide overall program direction. The vendor however also has a cadre of administrative staff to oversee and coordinate service delivery, in some cases duplicating positions maintained by the state. In a cost-plus contract the state pays for its own administrative staff, covers the cost of the vendor administrative staff assigned to the contract, and then pays the vendor a fee to cover overhead and profit.

A recent review of the Arizona Department of Corrections highlighted this issue. "The vendor has monitors to make sure they comply with the Performance Measures and other requirements of the contract; the Arizona Department of Corrections has monitors to do the same. The vendor has a contract manager and statewide medical director; the Arizona Department of Corrections has a contract overseer and a medical director. The vendor has staff to follow and manage the costs of the contract; the Arizona Department of Corrections has staff to follow and manage the costs of the

contract. The vendor has lawyers to draw up, modify, and deal with issues related to the contract; the Arizona Department of Corrections has lawyers to do the same."[34]

Hybrid Insourcing/Outsourcing

A hybrid service delivery model combines different aspects of both insourcing and outsourcing to meet system needs. As noted earlier, all insourced correctional systems rely on some use of contracts to provide community outpatient services, specialist care, and hospitalization. Hybrid systems go beyond this limited approach to develop more blended systems. Basic hybrid models include outsourcing all care that takes place outside of a secure correctional facility, privatizing the management of health care in select facilities while maintaining state management of other facilities, mixing facility vendor and state staff under the management of state health care administrators, and designating specific disciplines such as mental health, pharmacy, or dental as either state or vendor managed within the context of a outsourced or insourced system.

Historically, hybrid models have evolved as systems experimented with outsourcing on a limited basis to address specific systemic or facility issues. Currently the eight states that use hybrid models which mix state employee and vendor management of health care include Colorado, Louisiana, Michigan, Minnesota, Montana, Pennsylvania, Rhode Island, and Virginia.

The variety of different approaches to hybrid insourced/outsourced models and the relatively small number of states that use this model makes it difficult to draw conclusions as to specific advantages or disadvantages to the approach. Rather, it appears that each state has attempted to develop a customized approach to best meet its unique needs. Michigan for example had a specific challenge in contracting with clinicians and managing off-site care. Their model uses state employee nurses and dentists, while contracting for doctors, psychiatrists, and off-site care with a capitated approach. Colorado uses state employees to provide on-site services but outsources all off-site care. Virginia outsources all health care at select facilities that are difficult to staff or that provide specialized services such as dialysis, while insourcing health care services in its other facilities.

University Management

A final alternative model for the delivery of inmate health care is contracting system management to a state medical school or health sciences university. The model is like more conventional outsourcing but removes the cost of profit and relies on existing university administrative infrastructure to reduce expenses. Currently Texas, Georgia, and New Jersey contract with state universities to manage inmate health care. In these cases, the state approached the medical schools for assistance in response to lawsuits mandating improvement in the delivery of inmate health care services. Connecticut, Louisiana, and Massachusetts have also recently experimented with forms of this approach, ranging from full university management of inmate health care services, to providing certain specified services.

[34] Stern.

Illinois and Virginia maintain more limited contracts for use of state medical school hospitals with secure inpatient units.

This model offers several advantages to state correctional systems. Affiliation with a recognized medical school signals a commitment to service quality and provides state correctional health programs with increased credibility. Medical school partnership also provides much improved access to qualified clinicians. Recruiting physicians to work for a state medical school is often easier than recruiting a physician to work for a prison health care company. In New Jersey, the vacancy rate for correctional facility physicians dropped well below 10 percent following establishment of a contract with Rutgers University.[35] University medical schools also generally have well-developed quality assurance programs, excellent access to contemporary data on best practices in treatment, and well-developed electronic medical records programs. The contracts are generally structured in a cost-plus model, but absent the private vendor profit margin, thereby reducing cost. Finally, affiliation with a university can facilitate access to 340b discount pricing on pharmaceuticals. As described earlier the 340b program provides outpatient drugs to covered entities at significantly reduced prices.

For universities, the primary benefit of such a relationship is the delivery of treatment to a historically underserved population, inmates. The fact that nearly all inmates eventually reenter the community also makes treatment of chronic and infectious diseases in prison a significant component of a comprehensive approach to public health promotion. Also, the inmate population, with its high incidence of pathology provides a medical school with unique professional training opportunities.

[35] R. Reeves, A. Brewer, L. DeBillo, C. Kossof, and J. Dickert, "Benefits of a Department of Corrections Partnership with a Health Sciences University: New Jersey's Experience," Journal of Correctional Health Care, 2014. Vol. 20(2), https://www.researchgate.net/publication/261035318_Benefits_of_a_Department_of_Corrections_Partnership_With_a_Health_Sciences_University_New_Jersey's_Experience/link/5592c71a08ae1e9cb42978ef/download.

5. Alternative Service Delivery Models in the FDC

This chapter assesses the application of each of the service models described in Chapter 4 to the delivery of inmate health care services in the Florida Department of Corrections (FDC). There is no consensus in current research on which model is most effective in supporting effective system performance while containing costs.[36] Instead, it appears that each model can work well depending upon the specific characteristics of the correctional system. This analysis examines the degree to which each of these alternatives provides an effective approach to managing the issues and needs of the FDC.

Insourcing

The feasibility of insourcing inmate health care services in the FDC is well established through the history of the Department. Except for an outsourced contract for Region 4 facilities from 2001-2007, the FDC managed a largely insourced system until the privatization of the system in 2013. The effectiveness of insourcing as a future service delivery model for the Department depends upon the Department's internal resources to effectively manage and support this approach.

FDC Internal Capacity to Support Insourcing

Requirements for successful management of an insourced correctional health care system include internal subject matter expertise, readily available data on key system metrics, an effective management infrastructure, and understanding of program spending and cost drivers.

Subject Matter Expertise. The lack of in-house clinical and management experts in correctional health care is a primary factor motivating correctional systems to privatize their health care delivery systems. The FDC does not have this problem. Senior leadership in the Department's Office of Health Services (OHS) has extensive correctional health care management experience dating back to the period of FDC insourcing of health care, and has taken an aggressive, hands-on approach to monitoring contractor performance. Staff are well-versed in contemporary professional standards and best practices as prescribed by the National Commission on Correctional Health Care and the American Correctional Association.

On the clinical side, OHS employs a Chief of Medical Services, a Senior Physician, a Chief and Assistant Chief of Dental Services, a Chief of Mental Health Services with two Assistant Mental Health Chiefs, a Chief of Nursing Services, and a Chief of Pharmacy Services. The Department also has a Chief Clinical Advisor that serves as the final professional authority for clinical decisions.

The Department appears to have ample in-house management and clinical expertise to support an insourced delivery system.

[36] Pew Charitable Trusts.

Data. Modern health care systems rely heavily upon ready access to data to facilitate effective patient treatment and for use of performance analytics to more effectively manage system outcomes. This requires systemwide use of an Electronic Medical Record (EMR) system. Unfortunately, the FDC relies on a legacy system of non-integrated databases that do not communicate with each other, are cumbersome to use and maintain, and that falls far short of contemporary standards. This can impair treatment (e.g. lack of standardization of the record, issues with continuity of care) and quality reviews.

With an EMR, information required for quality reviews, statistics, and audit data could be easily gathered. Currently, due to the number of audits (e.g. American Correctional Association (ACA), legal settlement agreement monitoring) staff spend a great deal of time gathering information to provide to the auditors. This paperwork burden could potentially be reduced with an EMR. In addition, an EMR would allow for benefits such as easier scheduling, alerts regarding the need for follow up appointments, and medication specific protocols so that required laboratory examinations are not missed. The lack of an EMR would impair the effectiveness of any future insourced system, but also handicaps the Department in managing vendors in any type of outsourced model.

Under the current Centurion contract, the vendor has committed to developing a comprehensive EMR for the Department within its contracted annual budget of $421 million for each of the next three years. This project will commence in June 2020 and should be completed by June 2022. Continued support and development of this project will be a key to future improvements in system performance and should be a top Department priority.

Management Infrastructure. The OHS has well-developed systems for oversight, policy development, and contract monitoring. The 18 staff assigned to contract monitoring could readily be reassigned to operational oversight and compliance in an insourced system. The Department's existing Quality Management (QM) program would also transition well to insourcing. The QM program supports ongoing reviews performed by institutional and regional staff to ensure efficient operations by the contractor. Activities include chart reviews of clinical functions such as chronic illness clinics, care reviews, medication/treatment administration, dental care, and mental health care; as well as site visits to monitor and assure proper health care system performance.

The Department also maintains a Behavioral Risk Management Team to provide operational stabilization and clinical integrity of the mental health delivery system. Multidisciplinary committees established at the institution, region, and statewide levels make recommendations for program service improvements, and evaluate corrective actions. It appears that the Department has ample administrative infrastructure to support management of an insourced system.

The primary administrative impact of insourcing would be in personnel management. The Department's Office of Human Resources would require 12 additional positions to support the hiring and personnel actions required to add and maintain over 2,000 new staff. This estimate is based on the increased workload across all areas of Human Resources and Staff Development and the number

of positions dedicated to these functions that were abolished after privatization. These staff would be assigned to recruitment, labor relations, classification, payroll, and staff development. The estimated annualized cost of these additional staff is $774,371.

Exhibit 23: Additional FDC Human Resource Staff Required for Insourcing

Title	Duties	FTE	Salary/Benefit Annual Cost
Human Resource Specialist	Manage position movement, shift changes, supervisor changes and classification	1	$ 67,086
Personnel Services Specialist	Labor/Employee Relations	1	$ 59,546
Personnel Services Specialist	Recruitment	4	$ 238,186
Personnel Technician III	Payroll	2	$ 114,191
Research & Training Specialists	Staff Development	3	$ 205,073
Human Resource Manager	Staff Development	1	$ 90,288
TOTAL		12	$ 774,371

Source: Florida Department of Corrections, Humans Resources Bureau

Insourcing could also potentially affect procurement workload, depending upon the approach taken by the Department in managing those contracts for off-site care that would still be required in an insourced model. The Department's past practice of establishing and managing over 200 individual contracts for off-site services created substantial internal procurement and management workload. An alternative approach, centralizing coordination and management of off-site care under a single contract is discussed later in this analysis.

Budget Management. Lack of information on spending components and inadequate understanding of cost drivers is a significant risk faced by systems transitioning from an outsourced model to insourcing. While capitated models provide low risk and predictable funding requirements for clients, they do not typically offer any detail on their actual costs for the components of service they provide, such as outpatient treatment, hospitalization, and medication. This deprives correctional systems of detailed knowledge of the characteristics of their spending requirements.

However, the cost-plus model used in the current Centurion contract provides near total transparency on costs, as the Department reviews and approves every expenditure made by Centurion under the contract. This provides excellent data on spending trends and equips the Department with an understanding of projected costs in an insourced system.

Impact of Insourcing Inmate Health Care Performance and Cost

As the Department appears to have the internal capability to manage an insourced health care program, an argument can be made for insourcing as a superior model of service delivery if it provides improved performance and/or lower costs in the core functional areas of inmate health care: on-site facility health care services and treatment, off-site care, and pharmacy services.

Facility Health Care Services. The central element of the inmate health care services provided on-site is the health care staff who manage the program and provide treatment. As of July 2019, Centurion's staffing plan included 2,953.4 FTEs. The key dimensions of an analysis of the FDC's ability to transition to insourced inmate health care include staff retention and recruitment, staff resources requirements, and staffing costs.

Staff Retention/Recruitment. When a correctional health care vendor transition occurs, the employees of a prior vendor typically remain. If the state chose to insource, it is likely most current staff would prefer to remain. Anecdotal reports indicate that many current facility health care staff are former state employees who transitioned to working for vendors with the implementation of privatization. FDC management indicates that many of the staff would welcome an opportunity to return to state employment. Facility managers reported that staff have told them they would take a pay cut to return to state employment. State employment, particularly due to the health insurance and retirement benefits, appears to be an attractive option for at least some vendor staff. The Reception and Medical Center (RMC) in fact lost many medical staff when the first outsourcing occurred as state employees left to find employment in other state agencies.

However, the fact is that the vendor currently pays higher salaries than the state for many staff positions, and still has trouble competing with local hospitals and community health care providers in hiring staff. Centurion has particular difficulty in recruiting and retaining nursing and mental health staff. During our visit to Lowell Correctional Institution, we noted the facility staffing plan called for four psychiatrists and two psychiatric nurse practitioners. Instead the facility had two full time psychiatrists working on the inpatient program and one psychiatric nurse practitioner splitting time between the inpatient and outpatient programs.

The challenge of recruiting and retaining staff will be a significant concern in an insourced service delivery model. If insourcing appears a viable option, the FDC needs to devote significant attention to a strategy to address the issue of recruiting and retaining professional staff. Financial pay differentials and bonuses may be required to sustain required staffing levels. In addition, the FDC would require development of a sophisticated recruitment strategy that includes nursing schools, social media, and community job fairs. A major difficulty will be in hiring and maintaining qualified professional physician and psychiatric staff. Realistically, many of these positions will require salary levels well beyond what is available to a state employee. As a result, even under an insourced service delivery model, many of these positions will have to be contracted out to individual practitioners.

Staffing Levels. Current facility staffing levels have been determined by the current vendor, in consultation with the Department, as the number needed to enable achievement of the service level

and program outcomes required by the contract. A high level review of current facility staffing does not indicate any apparent opportunities to reduce employee levels, given the number of inmates served and the level of services required. To test this conclusion, we compared overall health care program staffing levels in Florida with national staffing trends.

A 2017 nation-wide review of health care staffing in state prisons documented a median staffing level of 40.1 FTEs per 1,000 inmates[37]. The July 1, 2019 staffing plan for Centurion shows total contract staffing of 2,831.4 employees. Adding in OHS management and pharmacy staff of 168 positions, total correctional health care staffing in Florida is 2,999.4 staff. Based on the FDC's reported average daily inmate count of 87,032 for FY 2018-19 in state-operated facilities, this equates to 34.5 FTEs per 1,000 inmates in 2019, 14% below the national median number of FTEs per 1,000 inmates in prisons nationwide.

Correctional Medical Authority (CMA) audits for FY 2017-18 included 16 institutions with a total inmate population of 24,333.[38] These facilities had 16 physician positions. This equates to one doctor for every 1,520 inmates. CGL team member physicians, recognized as national experts in correctional health care, indicate a more typical ratio in most prison systems would be one doctor for every 800 inmates. CMA noted understaffing as a concern in their annual report as indicated by failure to follow up on diagnostic testing on a system wide basis, and recommended reviewing staffing levels for physical health staff including physicians, mid-level practitioners, and nursing staff as a possible cause of these failures.

Health care staffing is a complicated issue and the observations noted above are not conclusive regarding specific FDC staffing needs. However, a high level review shows no evidence of opportunities to reduce facility health care staffing under an insourced model. This is further supported by the increased staffing required of the Department under recent litigation to raise service levels to meet constitutional requirements. Prior to any change in service delivery models, the FDC should commission a detailed analysis of facility health care staffing to determine the level and composition of staffing required to meet performance expectations.

However, a transition to an insourced model would enable the elimination of many vendor administrative positions which are paid for under the contract. In most cases these positions either duplicate existing department OHS staff positions, have duties which can be absorbed by OHS, or would no longer be necessary. We reviewed Centurion regional and statewide administrative staffing and identified 37.5 statewide administrative positions that could potentially be eliminated under an insourced model:

	FTE
Statewide Dental Director	1.0
Regional Dental Director-Region I	0.5
Regional Dental Director-Region II	0.5

[37] Pew Charitable Trusts
[38] CMA

Regional Dental Director-Region III	0.5
Regional Dental Director-Region IV	0.5
Quality Management Program Director	1.0
Data Analyst	0.5
Administrative Coordinator	1.0
Administrative Assistant	2.0
Offender Based Information Specialist	1.0
Continuous Quality Improvement Program Director	1.0
Continuous Quality Improvement Program Coordinators	4.0
Pharmacy Director	1.0
Reentry Director	1.0
Regional Reentry Coordinators	4.0
Data Analyst	1.0
Administrative Coordinator	1.0
Administrative Assistants	7.0
Referral Specialist	3.0
Human Resource Administrator	2.0
Senior Human Resource Business Partner	1.0
Human Resource Business Partner	3.0

Elimination of these positions under an insourced service model would save an estimated $3.2 million. We do note that some vendor administrative FTEs should be retained, including those assigned to the electronic medical record (EMR) project, Information Technology, Utilization Management, Health Education, Infection Control, and Regional Mental Health.

Staffing Cost. Assuming the same level of facility staffing as provided under the current contract, the cost to the state of these staff will change somewhat, given the FDC's lower salary scale and higher benefit package. To determine the impact of such a change, using the payroll titles that were used by the FDC when it last insourced health care services, we attempted to convert existing vendor staff titles to comparable Florida state position titles. Using the midpoint of the pay grades as a salary assumption and applying the state's benefit package for Career and Selected Exempt Service (SES) employee categories, we developed an estimate of the annual cost of the current facility vendor staff if converted to state employees. We then added a 2 percent differential to address potential issues of recruitment and retention in a competitive market for health care workers. We made a separate calculation for the cost of senior clinical positions such as psychiatrists on the assumption that these positions would have to be contracted out to meet market compensation levels.

The results of this analysis show a projected cost of insourced facility health care staffing of $199.2 million. This compares to a Fiscal Year 2018-19 payroll and benefit cost for vendor staff under the Centurion contract of $209 million. Adjusting the Centurion payroll amount to take out the administrative positions recommended for elimination reduces Centurion's cost to $205.7 million, approximately $6.5 million or 3.3 percent above projected insourced costs for the same staffing plan. While this cost estimate will require further refinement, the level of cost difference is consistent with reports of the variance between vendor and state salary and benefit levels. The following tables summarize our projected cost of insourcing current vendor health care staff.

Exhibit 24: Projected Cost of Insourcing Facility Staff

Contract Title	State Title	FTEs	State Salary	Salary + Benefits	State Cost
Medical					
Administrative Assistant	Secretary Specialist	67.0	$ 28,303	$ 40,541	$ 2,716,253
Advanced Registered Nurse Practitioner	Advanced Practice Registered Nurse	80.8	$ 67,502	$ 96,691	$ 7,812,595
Assistant Health Services Administrator	Executive Nursing Director	1.0	$ 67,502	$ 96,691	$ 96,691
Clerk	Clerk Specialist	36.0	$ 25,029	$ 35,852	$ 1,290,668
Director of Nursing	Executive Nursing Director	69.0	$ 67,502	$ 96,691	$ 6,671,647
Registered Nurse Supervisor	Registered Nurse Supervisor	20.0	$ 67,502	$ 96,691	$ 1,933,811
Health Support Aide	Health Support Aide	45.0	$ 24,282	$ 34,781	$ 1,565,158
Licensed Practical Nurse	Licensed Practical Nurse	348.6	$ 35,330	$ 50,607	$ 17,641,445
Medical Technician	Health Support Technician	282.5	$ 28,303	$ 40,541	$ 11,452,859
Health Information Specialist	Health Information Specialist	1.0	$ 37,000	$ 52,998	$ 52,998
Medical Director	Medical Executive Director	92.2	$ 155,854	$ 223,246	$ 20,583,249
Medical Records Clerk	Clerk Typist Specialist	88.4	$ 26,049	$ 37,313	$ 3,298,452
Medical Records Supervisor	Health Information Systems Supervisor	59.0	$ 38,217	$ 54,742	$ 3,229,798
Assistant Director of Nursing	Registered Nurse Supervisor	15.0	$ 67,502	$ 96,691	$ 1,450,358
Registered Nurse Educator	Registered Nurse	1.0	$ 45,039	$ 64,513	$ 64,513
Registered Nurse-Infusion/Chemotherapy	Registered Nurse Specialist	3.0	$ 56,185	$ 80,479	$ 241,437
Emergency Medical Technician	Health Support Specialist	1.0	$ 33,628	$ 48,169	$ 48,169
Respiratory Therapist	Respiratory Care Specialist	4.2	$ 43,401	$ 62,167	$ 261,101
Laboratory Technician	Laboratory Technician	4.0	$ 30,878	$ 44,230	$ 176,920
Clinical Risk Manager	Clinical Associate	1.0	$ 63,635	$ 91,150	$ 91,150
Lead Inventory Coordinator	Clerk Specialist	4.0	$ 25,029	$ 35,852	$ 143,408

Contract Title	State Title	FTEs	State Salary	Salary + Benefits	State Cost
Nurse Manager	Registered Nurse Supervisor	7.0	$ 67,502	$ 96,691	$ 676,834
Registered Nurse/CQI	Registered Nurse	372.5	$ 45,039	$ 64,513	$ 24,031,155
Secondary Screener	Clerk Specialist	10.0	$ 25,029	$ 35,852	$ 358,519
Executive Nursing Director	Executive Nursing Director	1.0	$ 67,502	$ 98,284	$ 98,284
Hospital Administrator	Program Administrator	1.0	$ 79,624	$ 114,053	$ 114,053
Infection Control Nurse	Advanced Practice Registered Nurse	1.0	$ 67,502	$ 96,691	$ 96,691
Phlebotomist	Med Tech 1	4.0	$ 37,000	$ 52,998	$ 211,993
Resp. Therapist Supervisor	Resp. Care Specialist	1.0	$ 43,401	$ 62,167	$ 62,167
Registered Nurse-CQI-Medication Practice	Registered Nurse	1.0	$ 45,039	$ 64,513	$ 64,513
Scheduler	Clerk Specialist	6.0	$ 25,029	$ 35,852	$ 215,111
Transcriptionist	Clerk Typist Spec.	2.0	$ 26,049	$ 37,313	$ 74,626
	subtotal	1,630.2			$ 106,826,627
Mental Health					
Advanced Registered Nurse Practitioner/Physician Assistant- Mental Health	Advanced Practice Registered Nurse	32.70	$ 67,502	$ 96,691	$ 3,161,781
Behavioral Health Activity Technician	Behavioral Specialist	44.00	$ 48,894	$ 70,035	$ 3,081,556
Certified Nursing Assistant - Mental Health	Medical Technician 2	34.80	$ 38,839	$ 55,632	$ 1,936,009
Mental Health Clerk	Clerk Specialist	96.40	$ 25,029	$ 35,852	$ 3,456,122
Mental Health Director	Psych I Services Director	16.00	$ 80,584	$ 115,429	$ 1,846,859
Mental Health Licensed Practical Nurse	Licensed Practical Nurse	68.20	$ 35,330	$ 50,607	$ 3,451,367
Mental Health Professional	Human Services Counselor	290.60	$ 41,036	$ 58,780	$ 17,081,606
Mental Health Registered Nurse	Registered Nurse Specialist	100.80	$ 56,185	$ 80,479	$ 8,112,286

Contract Title	State Title	FTEs	State Salary	Salary + Benefits	State Cost
Mental Health Administrator	Program Administrator	1.00	$ 79,624	$ 114,053	$ 114,053
Mental Health Assistant Director of Nursing	Senior Registered Nurse	4.00	$ 67,502	$ 96,691	$ 386,762
Mental Health Director of Nursing	Registered Nurse Supervisor	4.0	$ 67,502	$ 96,691	$ 386,762
Reentry Specialist	Human Services Counselor	29.70	$ 41,036	$ 58,780	$ 1,745,780
Mental Health subtotal		**722.20**			**$ 44,760,944**
Dentist	Dentist	72.35	$ 105,214	$ 150,709	$ 10,903,786
Dental Assistant	Dental Assistant	126.75	$ 29,505	$ 42,264	$ 5,356,901
Dental Hygienist	Dental Hygienist	26.50	$ 37,000	$ 52,998	$ 1,404,454
Dental subtotal		**225.60**			**$ 17,665,141**
Infection Control	Registered Nurse Specialist	4.0	$ 56,185	$ 80,479	$ 321,916
Dental Director North	Senior Dentist	1.0	$ 111,646	$ 159,921	$ 159,921
Dental Director South	Senior Dentist	1.0	$ 111,646	$ 159,921	$ 159,921
Regional Director of Nursing	Executive Nursing Director	4.0	$ 67,502	$ 96,691	$ 386,762
Electronic Health Record Project Manager	Program Administrator	1.0	$ 79,624	$ 114,053	$ 114,053
Electronic Health Record Liaison	Health Information Specialist	2.0	$ 37,000	$ 52,998	$ 105,997
Electronic Health Record Information Technology/Offender Based Information System Specialist	Health Information Specialist	4.0	$ 37,000	$ 52,998	$ 211,993
Information Technology Support Specialists	Government Operations Consultant	4.0	$ 59,119	$ 84,683	$ 338,730
Information Technology Support Lead	Government Operations Consultant	1.0	$ 64,687	$ 92,658	$ 92,658

Contract Title	State Title	FTEs	State Salary	Salary + Benefits	State Cost
Regional Director of Nursing – Mental Health	Executive Nursing Director	1.0	$ 67,502	$ 96,691	$ 96,691
Mental Health Nurse Educator	Registered Nurse Specialist	1.0	$ 56,185	$ 80,479	$ 80,479
Mental Health Educator	Reg. Mental Health Consultant	1.0	$ 80,584	$ 115,429	$ 115,429
Nurse Educator	Registered Nurse Specialist	1.0	$ 67,502	$ 96,691	$ 96,691
Administration subtotal		31.0			$ 2,744,531
TOTAL		2,609.0			$ 171,997,243

Professional Contract Positions Required Under Insourcing

State Title	FTE	Contract Salary	Cost
Optometrist	9.0	$ 165,605	$ 1,490,445
Physician	16.2	$ 253,625	$ 4,108,725
Orthopedic Surgeon	1.0	$ 299,048	$ 299,048
Psychiatric Director	1.0	$ 317,408	$ 317,408
Psychiatrist	23.1	$ 317,408	$ 7,332,125
Psychologist	46.6	$ 165,605	$ 7,717,193
Psychology Intern	4.0	$ 76,616	$ 306,464
Residents	4.0	$ 110,325	$ 441,300
Regional Psychiatrist	1.0	$ 431,453	$ 431,453
Regional Psychologists	4.0	$ 165,605	$ 662,420
Regional Psychologists - Sp. Projects	1.0	$ 165,605	$ 165,605
Total Contracts	110.9	$ 440,840	$ 23,272,186

State Employee & Contract Position Costs	$195,269,429
Total State Insourcing Cost for Personnel	$3,905,388
Total State Insourcing Cost for Personnel	$199,174,817

Pharmacy. Insourcing would entail no change in pharmacy services as the Department already manages this function. Based on past attempts to privatize, insourcing is the most cost-effective means to provide the service.

Off-site care management. Coordination and management of off-site care was a substantial challenge for the Department when the system was insourced. A 2005 performance review of the Department found the following and recommended that the Department contract out management of all off-site care to a professional managed care firm[39]:

- Office of Health Services (OHS) staff managed over 170 major contracts
- Most contracts were with providers with long-term relationships with the Department, were exempt from bidding, and were renewed annually
- Staff were primarily oriented toward maintaining service levels, not necessarily toward holding contractors accountable
- Contract terms did not provide adequate monitoring terms or performance measures
- Monitoring of contractor performance by regional staff was perfunctory
- Contractor invoices were generally processed by clerical staff without meaningful review

OHS managers acknowledged the system of contracting and coordinating off-site care used by the Department was cumbersome to administer and did not achieve effective performance. Insourcing management of off-site care using this same system would defeat the purpose of increasing operational efficiency.

A 2017 study of this issue by the consulting group North Highland projected that in the event of insourcing, a restoration of the Department's former status quo method of managing contracts for off-site care would likely increase costs by 20 percent. In order to maintain costs at the more efficient level achieved under the outsourced health services contract, North Highland recommended that the Department contract with a managed care organization such as a Preferred Provider Organization (PPO) or Third Party Administrator (TPA).

Health care network administration and these related functions are not a core competency of correctional systems. These are complex functions that require a high degree of technical expertise in a very specific field to perform well. This is a classic example of specialized work that can be performed more efficiently by private organizations with appropriate skillsets and experience. Serious consideration of any insourcing scenario should incorporate outsourcing of off-site health care services to achieve maximum efficiency.

[39] MGT of America, Performance Review of the Florida Department of Corrections, 2005.

In this approach, the correctional system contracts with outside health care or insurance company to manage its offsite care network for a flat, fixed fee per inmate on top of actual utilization. The PPO or TPA would then administer the Department's hospital and specialty provider network, provide claims adjudication and processing, conduct utilization management reviews, and develop data analytics on network performance.[40] Network efficiencies and negotiated discounts could more than offset the cost of the contract. This approach has been used successfully in the Virginia Department of Corrections.[41] Based on the North Highland analysis, this approach should enable the Department to maintain offsite care costs at approximately the same level as now experienced under Centurion management.

Administration. Given the history of OHS with insourced system management and the experience of the current senior management, the reconfiguration of its responsibilities from a policy direction/contract monitoring role, to insourced system manager can be accommodated with existing resources, augmented by select retained vendor administrative positions and contracting out for offsite care management. This approach will require ongoing investment in development of internal management resources.

Custody Support. Whether the medical program is insourced or outsourced, effective provision of correctional health care services requires support from across FDC operations. While correctional officer staffing levels present many serious issues across the entirety of FDC operations, shortfalls in staffing can have a serious impact on access to care. As of November 4, 2019, the FDC had 2,305 correctional officer vacancies, placing severe stress on operations in nearly all its facilities. The project team's limited review of FDC facility operations indicated that the availability of correctional officer staff to escort inmates to treatment is a significant issue. The demand on staffing for outside transportation can also be substantial. For example, movement and supervision of severely mentally ill offenders in need of hospitalization requires the assignment of three officers, 24 hours per day, seven days per week. Facility administrators and staff appear to appropriately prioritize custody support for health care but are handicapped by chronic shortages in correctional officer staffing.

Technology. Telemedicine has huge potential application in the FDC, particularly in the delivery of psychiatric services. However, while telepsychiatry is available, there are limitations in availability. Many facilities have network bandwidth problems that severely limit telemedicine capacity. For example, at Lowell Correctional Institution, the technology to allow for the provision of telepsychiatry was available for outpatient treatment only. Staff at the facility were unable to utilize telepsychiatry on the inpatient units due to technology infrastructure issues.

The FDC should augment its cable and wiring infrastructure to accommodate a robust telemedicine program. This type of upgrade will be needed to support the electronic medical record (EMR) system as well. Some of the advantages of an EMR going forward will be expedited electronic submission of

[40] North Highland, Health Services Study of the Florida Department of Corrections, FY 2017-18, 2017.
[41] Stephen Weiss, "Medical Care Provided in State Prisons – Study of the Costs," Joint Commission on Health Care, October 5, 2016, at http://jchc.virginia.gov/4. Medical Care Provided in State Prisons CLR.pdf

medical orders, improved accuracy and access to patient records, and monitoring of the delivery of health care services statewide. There will also be potential operational efficiencies as clinicians and nurses directly enter data into the system instead of handing off encounter forms to a data entry operator/medical records clerk. Again, this is an issue that should be addressed irrespective of the future service delivery model adopted by the Department.

Implementation. The timeline for actual implementation of a transition to insourcing needs to address the short-term transition of current vendor staff to state employment as well as development of a long-term strategy to address the long-term challenge of recruiting and retaining health care staff in a competitive labor marker.

Assuming that most vendor staff would transition to state employment if offered, FDC Human Resource staff indicate that the hiring and onboarding of these employees would take approximately 60 days. This process would entail establishing standardized selection criteria and guidelines for each position title, verifying staff credentials and conducting background checks. The Department would bring on six temporary Personnel Technicians to facilitate the transition at a one-time projected cost of $238,794.

The next phase in the implementation process would be filling remaining vacant positions, which will require an aggressive recruitment campaign using Jobs.myflorida.com, colleges and universities job placement programs, social media advertising/ Indeed.com, and regional/local job fairs. The final step would be development of a long-term strategy to address future recruitment and retention issues.

Planning an effective approach to address recruitment and retention is the biggest challenge facing the FDC in the implementation of insourcing. In the past, the Department has experienced issues in keeping health care positions filled and attracting a stable pool of applicants. Vendors have experienced the same issues. A transition to insourced health services will require an intensive review of possible strategies to address this issue over an extended time period. While the FDC has successfully managed transitions from insourced to outsourced services and multiple transitions to different vendors without serious operational disruptions, a change to an insourced service delivery model will require more intensive preparation to assure successful implementation.

Cost-Effectiveness. This analysis has examined the impact of insourcing on the primary components of the inmate health care delivery system. To summarize, insourcing appears to reduce staffing costs by $3.3 million through eliminating vendor administrative positions and $10.4 million by converting contract positions to state employees. With the use of a contracted provider to manage off-site care, costs for these services should be equivalent to the level experienced under Centurion. Pharmacy costs would remain unchanged. The Department already pays the actual costs of ancillary items such as laboratory expenses, supplies, and equipment, under the current cost-plus contract and these expenses would remain unchanged. The administrative burden of hiring and retaining over 2,000 new staff would create additional ongoing human resource expenses for the Department, totaling $774.3 thousand along with a one-time cost of $238.8 thousand to manage the initial hiring/transition process.

The final and most significant savings element associated with in-sourcing is elimination of the administration/profit fee paid annually to the vendor. The rate for this fee under the contract is set at 11.5 percent of reimbursable expenses, which are essentially the direct expenditures for service on behalf of the FDC. The FDC is reimbursed for direct expenditures for service and pays a fee in the amount of 11.5 percent of these expenses to the vendor to cover overhead and profit. The administrative/profit fee paid against Centurion's contract for Fiscal Year 2018-19 totals $37.3 million. Insourcing eliminates this expense.

In summary a transition to an insourced model of inmate health care delivery could reduce FDC annual spending by $46.2 million.

Exhibit 25: Projected Savings Impact of Insourcing

	$ millions
Elimination of Vendor Administrative positions	$ 3.2
Convert Vendor positions to state employees	$ 6.5
Eliminate vendor administration/profit fee	$ 37.3
Additional HR costs	$ (0.8)
Total Savings	**$ 46.2**

Source: CGL analysis

The FDC has the internal capability and expertise to manage inmate health care delivery. Insourcing the delivery of on-site facility health care serviced throughout the correctional system is feasible, although the FDC would face substantial challenges in recruiting and retaining staff. The Department, however, would require substantial improvement in management of off-site care. This could be accommodated by contracting with an insurance company or health care organization to manage all off-site care, utilization review, and claims management for the FDC. The resulting approach would move the FDC closer to a hybrid insourcing/outsourcing model.

Outsourcing

As described earlier, the FDC has experimented with a variety of different approaches to outsourcing over the last eighteen years. Early efforts to use outsourcing to drive health care costs lower appear to have had some success, but also produced substantial problems in service delivery, including reduced staffing levels, dramatic decreases in episodes of outside care; increases in health care grievances; and a proliferation of litigation.

These performance issues have been addressed in more recent contracts. However, growth in program spending has accelerated. The overall utility of outsourcing as a future service delivery model for the Department depends upon achieving a balance between efficiencies in cost management and adequate program quality.

FDC Internal Capacity to Support Outsourcing

Effective management of an outsourced health care system requires that a correctional system take a pro-active stance toward accountability and oversight of the vendor. The FDC over the course of its experience with privatization has developed a sound management infrastructure for outsourcing. Components of this infrastructure include:

- Policies – the Office of Health Services has a comprehensive set of policies, bulletins, and procedures to provide clear direction to a vendor on the expectations and parameters for health care delivery.

- Contract – the outcome-based format of the contract establishes clear standards and metrics that directly relate to policies and service quality objectives.

- Monitoring – FDC monitoring teams and protocols provide a ready means to assess vendor performance and enforce contract terms. Its QM program provides clinical reviews of service delivery systems and outcomes. Department monitoring is also supplemented by external reviews of service delivery by the Correctional Medical Authority.

The FDC, both through the Office of Health Services and its administrative bureaus, supports effective use of outsourcing. The one notable area of need is timely access to data documenting program activity and performance. The lack of an electronic medical record (EMR) system hampers management access to quality reviews, statistics, and audit data and requires a labor-intensive process to gather data for review. The plans for EMR development under the current contract with Centurion will ultimately address this need.

Outsourcing Impact on Cost and Performance

The impact of outsourcing on health care service cost and quality depends upon the outsourcing model employed, The FDC has used both risk-based and cost-plus models in its history with privatization. This analysis first examines the impact of the current outsourcing model.

Cost. The FDC's current contract with Centurion follows a cost-plus model. The Department reimburses Centurion for direct health care costs up to a designated cap, including staffing, and pays the vendor a fee to cover its overhead and profit. The contract has recently been amended to provide a three-year extension at an annual funding cap of $421 million for each of the contract years. As described earlier, the increase in funding for FY 2019-20 covers over 460 additional staff required to comply with the terms of recent litigation, maintenance of current staffing and service levels, an 11.5 percent administrative fee, and development of an EMR system.

After several years of significant increases in health care spending, the FDC is now assured of annual contract spending that will remain stable at no more than $421 million for each of the next three years. The contract will not entail any additional administrative workload or cost on the Department. Other than additional potential costs associated with litigation and increased costs for

pharmaceuticals, the Department should experience relatively constant overall health care costs under this contract through FY 2021-22.

Exhibit 26: Actual and Projected Cost-Plus Health Care Annual Contract Caps, FY 2017-2022
($ millions)

	FY 2017-18	FY 2018-19	FY 2019-20	FY 2020-21	FY 2021-22	Average Annual Increase
Centurion Contract Cap	$321	$375	$421	$421	$421	6.2%

Source: Florida Department of Corrections

Performance. Service quality levels attained under this contract approach should be comparable to the Department's experience with Centurion over the last two years. This experience has been relatively positive, particularly when contrasted with the FDC's experience with prior contractors. Central office and facility administrators indicated improvements in service have been achieved under the cost-plus model. This is a feature of the cost-plus approach, in that the vendor has no incentive to reduce services to lower costs and manage risk. Any additional costs that may be incurred to achieve required service levels are simply passed on to the client. However, there are two areas where modifications in the model could facilitate improved service quality, staffing and performance measurement.

Maintaining adequate facility staffing levels is a critical component of health care service quality. Most cost-plus contracts make detailed facility staffing plans part of the contract and monitor vacancy levels. The FDC contract with Centurion is somewhat unique in that it does not specify or require monitoring of facility staffing levels. As an outcome-based contract, in the current model vendor performance is assessed solely based on program results. This assumes that these performance measures completely convey the quality of vendor services provided.

The impact of staffing levels on services however is so significant that it arguably should be tracked, and the vendor held accountable for providing agreed levels. This can be seen in recent consent decrees entered by the Department where the plaintiffs have required that the Department add specific numbers and types of staff to facilities, rather than only require attainment of specific outcome measures.

A reliable facility health care program that consistently produces good results requires a stable cadre of full-time professional staff. Vacancies need to be filled in a timely manner. However, under the Department's current cost-plus approach, the vendor may choose to use registry, temporary contract, or locum tenens staff to fill vacancies for extended periods of time rather than recruit and hire permanent replacements. This has an impact on service quality, as temporary staff do not generally provide the same level of performance. Additionally, under this approach costs are typically higher than hiring replacement staff. Tracking and holding the vendor accountable for compliance with an agreed staffing plan would provide the department with an additional, valuable tool for managing vendor performance.

Another approach to improving vendor performance under the cost-plus model would be to shift the focus of the current contract measures away from process or compliance measures, to more qualitative metrics. Internal monitoring should be linked to the quality management program. FDC monitoring teams are now attempting to evaluate identified problems and to train staff so that there can be improvement. Many health care organizations are utilizing lean manufacturing and six sigma techniques in their quality improvement programs. The California prison system has a robust six sigma and quality improvement program utilizing these techniques.

The following compliance monitoring items should be considered in addition to current compliance questions.

- Percent of all types of scheduled appointments (nurse sick call, physician on-site appointments, off-site consultations and diagnostic testing, dental appointments, mental health appointments, mental health programming) kept with reasons for no show
- Time to triage health service requests
- Time to nursing assessment appointments for health service requests
- Percent of patients who require nurse sick call for a health request and who are evaluated with 72 hours
- Percent of ordered doses of medication that patients receive in a timely manner
- Percent of patients who failed to receive their first dose of ordered medication within 24 hours of the order
- Percent of patients who failed to have intake screening done within 24 hours
- Percent of patients who failed to have intake physical examination within a week
- Number and percent of patients who missed intake screening
- Percent of patients in need of screening who obtained tuberculosis screening
- Percent of patient admitted to infirmaries who have an nurse intake note within two hours of admission
- Percent of patients admitted to infirmaries who have a provider admission note within 24 hours and have a discharge summary completed the day of discharge
- Percent of off-site diagnostic test results and consultation reports that are scanned to the record within 3 business days
- The number and percent of patients who failed to meet time tables for specialty care appointments as determined by clinical necessity

- The number and percent of urgent appointments occurring within 14 days and routine appointments occurring within 45 days
- Percent of patients who receive immunizations as indicated by the Advisory Committee on Immunization Practices (ACIP)
- Percent of patients with diabetes who have hemoglobin A1c at 7 or below (considered good control)
- Percent of patients with diabetes who have hemoglobin A1c above 9 (considered poor control)
- Percent of patients with hypertension who have blood pressure controlled below 140/90
- Percent of diabetics who have an annual eye examination
- Percent of diabetics who are annually screened for nephropathy (with micro-albumin)

Compliance measures can be displayed on a shared intranet as a dashboard as is done in California.[42] Dashboards are a concise display of compliance type process measures that are a component of the quality program. Integrated into the electronic record system, this approach will free up quality improvement and monitoring time for other purposes.

One additional quality monitoring function should include safety/sanitation/administrative checklist tours that verify that every institution has adequate clinical space, supplies, equipment, and sanitation. These rounds can result in scoring and corrective action plans.

A second additional function of the quality management program is to institute clinical quality review. Almost all physician care at the institutions is primary care. Board certified primary care physicians[43] (or at a minimum, physicians who completed residency training in primary care) should perform clinical quality record reviews. These should include mortality reviews, sentinel event reviews, and potentially preventable hospitalizations. Health organizations nationwide, including the Mayo Clinic, have robust mortality review processes that assist in improvement of clinical care and process improvement.

Nursing reviews should also be performed for potentially serious complaints on health requests; for emergency evaluations; and for care on the infirmary unit.

These clinical quality reviews should have an aim of identifying opportunities for improvement and detection of systemic errors. These reviews can also provide professional performance evaluations (peer review). The clinical quality reviews and compliance monitoring should be incorporated into

[42] The California prison dashboard can be found at https://cchcs.ca.gov/reports/#dashboard
[43] A primary care physician is a physician who completed residency in internal medicine or family practice. In some cases physicians who completed residency in emergency medicine is adequate.

the quality improvement program. The program should track the number of clinical quality reviews that result in identification of opportunities for improvement.

A process improvement strategy like the lean manufacturing or six sigma model would provide the data needed by the quality management team to reduce cost and improve quality.

Alternative Approaches to Outsourcing. The primary alternative to the cost-plus outsourcing model is the capitated approach in which the vendor is paid at a per diem rate per inmate to manage all health care services. This approach shifts all financial risk to the vendor and has the greatest potential for achieving cost savings as it incentivizes the vendor to maximize efficiency in order to achieve profits. In fact, the primary basis for the Department's initial adoption of an outsourcing model was potential cost savings. The capitated contract approach used by the Department in its initial approach to outsourcing was entirely consistent with this goal.

Impact of Capitation on Cost. A change to a capitated model could reduce costs if potential vendors in the market perceive an opportunity to leverage their expertise to achieve efficiencies in service delivery. The two primary areas to achieve potential efficiencies with a significant impact on cost are staffing and off-site services. Due to the transparency of the Department's current cost-plus contract, current levels of expenditures in these areas is readily available.

Fiscal Year 2018-19 expenditures for staff salary and benefits under the Centurion contract totaled $209 million. This amount will increase with the additional staff provided in the FY 2019-20 budget to address litigation requirements. Comparisons with national data on health care staffing suggests that current facility health care staffing levels are below levels maintained in other states.[44] Our high-level review on facility staffing plans and onsite operational reviews provided no indications of excess or inefficient use of staff in the system.

Under a capitated approach, the vendor can reduce staffing costs by eliminating positions, leaving vacancies open, or reducing compensation and benefits levels. Eliminating positions and keeping vacancies open directly reduces services, while lowering compensation levels would exacerbate issues in maintaining adequate staffing. None of these measures is advisable and all would likely have a very negative impact on service quality. In fact, any shift to a capitated outsourcing model would likely need to be accompanied by strong contract monitoring provisions that provide a means to hold the vendor accountable for maintaining required staffing levels. Accordingly, significant cost savings from current contract levels in the area of facility staffing levels are unlikely in a change to a capitated approach.

Off-site health care services under the Centurion contract totaled $109 million in FY 2018-19. Approximately 52 percent of this amount was for inpatient hospitalization, 23 percent for outpatient services, 14.6 percent for specialist care, and 4.9 percent for emergency room treatment. While

[44] Pew Charitable Trusts

Centurion does provide utilization and invoice review, the fact that these costs are simply passed through to the FDC indicates at least a potential for an incentivized vendor to identify savings.

There are no studies of the relative impact on health care costs in correctional systems of a cost-plus versus capitated approach to off-site care management. However, there has been substantial research on the impact of managed care programs compared to fee-for-service plans under Medicaid, which is in many respects analogous to the capitated health care program management versus the cost-plus model. One meta-review of the research on this topic found that managed care plans in 24 studies showed savings ranging from 1 percent to 20 percent from fee-for service plans.[45]

The median of the savings identified in these studies is 10.5 percent. Applying this rate of savings to all the off-site care paid for under the Centurion contract in FY 2018-19 results in potential savings under a capitated model of $11 million. How much of the savings achieved under the contract are passed back to the client versus retained as profit is an open question. Assuming the vendor passed 50 percent of the savings achieved back to the client, this model could achieve a potential cost reduction of $5.5 million.

Impact of Capitation on Service. The risk assumed by the vendor in the capitated model places added stress on service quality. Adverse utilization experience or cost exposure incentivizes reduction in services to mitigate the negative financial consequences for the vendor. This describes much of the FDC's experience with capitated health care outsourcing from 2001-2017.While privatization provided costs savings in the short-term under the capitated model, vendors were unable to provide consistent service that met contract performance standards at the funding levels they had bid. This led to a turbulent period of vendor appeals for additional funding, contract terminations, and multiple vendor transitions. For its part, the FDC experienced reduced facility staffing levels, reduced access to off-site care, increased inmate grievances regarding health care services, and ultimately significant costly litigation.

To avoid this scenario, any change in outsourcing approaches needs to be accompanied by a very robust system of contract monitoring, thorough vendor understanding of program service requirements, and a realistic sense of program funding needs. The capitated Wexford and Corizon contracts which the FDC entered in 2013 produced substantial cost savings, but also had a pronounced negative impact on service quality. Future outsourcing initiatives need to balance these objectives.

Impact of Modified Contract Terms. An alternative to cost-plus or capitated models is to incorporate cost containment mechanisms into the current framework. The Department's current cost-plus contract does include an overall cost containment measure in the annual cap that it places on total compensation to the vendor. This provides the Department with certainty regarding overall contract expenditures. Additional cost containment measures commonly found in correctional health care contracts are variations on approaches to lower vendor risk. If the vendor is responsible for managing

[45] The Lewin Group, Medicaid Managed Care Cost Savings: A Synthesis of 24 Studies. Prepared for America's Health Insurance Plans, (March 2009).

all health care costs, as under the capitated model, they typically must include a substantial risk premium as insurance against adverse experience. By sharing or reducing this risk, states can reasonably expect lower per diem cost proposals. Vendors can effectively price the more routine care and will not build in the additional cost to cover the major cases that might occur. Common approaches to mitigating vendor risk include:

- Stop Loss – Require the vendor to cover off-site care costs subject to a stop-loss cap, either on a per case basis or in aggregate. This eliminates the risk premium that vendors must build in to cover catastrophic losses and shifts risk to the state. In effect the state self-insures the vendor.

- Shared Risk – The vendor and the Department establish a framework for sharing off-site care costs above a certain threshold, typically on a per case basis. For example, the vendor may be 100 percent responsible for care up to $50,000 per case, share 50 percent of the cost up to $100,000, and the state assumes responsibility for costs above $100,000. This approach diminishes vendor risk on an escalating scale, while preserving some incentive for their management of costs up to a catastrophic level.

- Condition Exemptions – Many states will exclude the cost of care for certain treatments or conditions to reduce vendor risk. Common exemptions include the cost of treatment of HIV/AIDS, Hepatitis C, hemophilia, or organ transplants.

These approaches all entail a trade-off in the price reduction to the state realized through reducing vendor risk and the increased cost to the state in assuming some level of responsibility for catastrophic or high treatment cost cases. The projected impact of any of these measures on cost relies upon how vendors use these provisions in pricing their services in a competitive bid process. Any cost savings again would accrue only to the off-site care expenses covered under the contract. A further 5 percent reduction in the contract price covering off-site care would lower up-front contract costs to the Department by an additional $5.5 million. These savings would be offset at least to a partial degree, depending upon the level of shared financial risk assumed by the Department.

Implementation. The Department has signed a contract extension with Centurion that covers the next three years, through FY 2021-22. Adopting a new outsourcing model would require development of an ITN or RFP, evaluation of responses, and negotiation of a contract. Based upon the Department's experience with the ITN process, the entire process to select a vendor under a new outsourcing model could take approximately 12 months, allowing time for ITN development, solicitation, evaluation, negotiation, and rebidding if necessary. At the same time, the Department would provide Centurion with notice of intent to terminate the contract, a minimum of 60 days.

Outsourcing Competitive Environment. Outsourcing works best in a procurement environment where there is ample competitive pressure on potential bidders to produce better quality proposals at lower prices. Competition is unfortunately limited in Florida. The high degree of financial risk makes attracting enough bidders to facilitate a competitive environment extremely difficult. This degree of risk also makes the use of capitated contracts a strong disincentive for potential vendors.

In its ITN process, the Department made multiple attempts to attract additional vendors in order to create competition on price and service level for a capitated outsourcing model. The process culminated in only one vendor proposing to contract with the Department to provide its required services. Further, that vendor required the Department to adopt a cost-plus model to minimize its risk exposure.

There are few vendors who can provide services on the scale required by FDC, which also diminishes competition. Nationally, there are only three vendors that have managed entire state correctional health care systems: Centurion, Wexford, and Corizon. The FDC has substantial negative experience with both Corizon and Wexford. Centurion was the only responsive bidder to the FDC's most outsourcing procurement. This level of vendor interest makes obtaining competitive proposals unlikely.

Based on this experience, any discussion of alternative approaches to outsourcing appear to be hypothetical. The size of the system, the level of risk inherent in assuming responsibility for cost and service management, and the very limited number of vendors capable of delivering this service diminishes competition to a level where the benefits produced by outsourcing are substantially reduced.

The current cost-plus approach appears to be the only means available to the FDC to privatize on a system-wide scale. Efforts to achieve savings by instituting shared risk provisions or stop losses in a future contract will likely result in higher vendor cost proposals as they factor increased risk into their budgets. Because there is no competition for this contract, the FDC has little choice but to accept the current contract approach if it wants to continue to use outsourcing. By most reports, the current vendor is performing reasonably well, and quality of care has improved under the current cost-plus contract. However, this approach to privatization does not incentivize efficiency and requires the FDC pay a significant administration/profit to the vendor in addition to paying all direct costs.

Hybrid Systems

Because there are several different forms of hybrid systems, it is important to define the form to be reviewed here. As described earlier, the FDC in effect has always operated a hybrid system. During that time where the Department provided on-site services with a largely state employee workforce, it still maintained an extensive network of contracts for off-site care. In this report, we have defined this approach as a form of insourcing. Similarly, the current service model is a hybrid in that the Department manages its substantial pharmacy program with state employees while contracting for all other services. In this report, we have defined this approach as outsourcing.

As used here, a hybrid system refers to an approach where the Department manages some facilities with state employees and their own network of off-site contracts, while also outsourcing other facilities in the correctional system to vendors that provide comprehensive health care services. The Department in effect used this approach during that time in which Region 4 health care services were outsourced while all other facilities provided services with FDC employees.

Cost. The primary factor in favor of a hybrid approach is the fact that smaller contracts, centered on a region or facility, should be more manageable for smaller firms than a large statewide contract, and therefore may attract more competition, which should have a favorable impact on price and service quality. The counter-argument is that the smaller contractors that bid on these contracts may lack the economies of scale to achieve efficient procurement of services such as pharmaceuticals. Moreover, the smaller population bases of these contracts provide less margin against risk of catastrophic cases. The cost of high cost cases may be better managed against a larger population base in order to spread the risk across a broader revenue base.

There is very little research on the cost performance of this hybrid model versus more conventional insourcing and outsourcing approaches. The one study that has been conducted examined the cost performance of privately contracted health care for correctional facilities relative to state-provided healthcare in the Virginia correctional system. Approximately 50 percent of the state's prison population is housed in facilities that receive outsourced health care services from two vendors, Armor Correctional Health Services and Mediko Correctional Healthcare. Outsourcing was used for these facilities primarily because of their specialized mission, providing intensive, specialized health care services such as dialysis, advanced infirmary care, and specialized behavioral health services.[46] Because of these services, these facilities require larger numbers of more specialized health care professionals. The Virginia Department of Corrections used a capitated outsourcing model in contracting for all health care services in these facilities.

The Virginia Joint Legislative Audit and Review Commission conducted a sophisticated statistical analysis of correctional health care spending over three fiscal years in outsourced and insourced Virginia Department of Corrections facilities, controlling for inmate demographics including age and race, as well as health characteristics such as mental health status and chronic disease diagnoses. The analysis found no evidence that outsourced facilities had lower costs for inmate health care than facilities that provided services with Virginia Department of Corrections staff. Insourced facilities in a hybrid system experienced the same levels of health care cost as the outsourced facilities.[47]

Applying the results of this study to Florida, a hybrid system which relies both on insourced and outsourced capitated health care can be expected to have a cost profile in which contracted facilities have the same level of cost as insourced facilities. With no difference in cost between outsourced and insourced facilities, the system would in effect have the same overall cost as an entirely insourced model. Our previous analysis showed that insourcing would provide approximately $46.2 million in savings from the current cost-plus model used by the FDC. The Virginia study of health care costs in that state's correctional system suggests that a hybrid system would have a similar cost profile and consequently, would provide the same level of savings. This assumes that private companies would be willing to bid on smaller capitated contracts for regions or groups of facilities.

[46] Virginia Joint Legislative Audit and Review Commission.
[47] Ibid

Performance. The primary issue with hybrid systems is establishing a fair allocation of healthy and sick inmates for the different insourced and outsourced facilities. In Florida's experience with a hybrid model, the vendor responsible for outsourced health care in Region 4 charged that the FDC was sending them the sickest inmates, allocating healthier inmates to insourced health care programs in state-managed health care programs. This seems unlikely, particularly given that the Reception and Medical Center, operated by the FDC, housed the sickest inmates in the system. However, the issue of cost shifting between facilities and regions becomes significant considering the extreme difficulty in achieving an even distribution of inmate health care needs among facilities managed by different vendors. Perceived inequities in health care requirements can create contract disputes, or efforts by vendors to reduce service levels to compensate for these perceived inequities.

The administrative complexity of managing multiple vendors can also make partial outsourcing on a facility basis a less effective approach. The transfer of inmates between facilities managed by different companies and state employees necessarily requires a higher level of coordination to assure continuity of care.

The Virginia Department of Corrections addressed this issue by explicitly assigning outsourced health care contracts to facilities with specific health care missions. These vendors had an expectation that they would serve populations with more intensive health care needs and structured their proposals accordingly. This suggests that transparency and access to population and utilization data are effective means to address this issue. As with other models, a robust system of quality assurance monitoring, focused on qualitative performance metrics provides the best approach to assuring adequate service quality under a hybrid model.

Implementation. Transitioning to a hybrid system is a more complex process than implementation of other models. The multiple approaches to health care delivery require that the Department develop a plan to both insource programs at facilities or regions to be determined, and at the same time conduct a procurement process for capitated contracts at other facilities or regions. The resulting transition to different management models in different parts of the state would also be challenging.

A phased approach would require a longer implementation period but would facilitate management of these issues. In the first phase, the Department would develop a plan that identifies which facilities or regions would be insourced or outsourced. The next step could be procurement and implementation of capitated outsourcing in the facilities or regions designated. If successful, the Department could then proceed with implementation of insourcing in remaining facilities or regions. Alternatively, if the outsourcing initiative fails to attract bidders at anticipated prices, the Department could proceed with insourcing of the entire system. The entire process could take up to 12- 16 months.

University Model

In this model, the FDC would develop partnerships with one or more of the state's medical schools such as the University of Florida, Florida State University, or the University of Miami. The structure of

such a partnership could be similar to the Department's current cost-plus contract but could be initiated as a pilot program covering a smaller number of facilities. The university health system would be responsible for management and staffing for onsite care in the facility and assume responsibility for offsite care and prescription drugs. This can be done as a contract with each agency as is done in Texas or by development of an independent entity that then contracts with the prison system as is done in Georgia.

Among other state correctional systems using this approach, Texas has the most comprehensive system, with two universities, the University of Texas Medical Branch and Texas Tech University, managing the delivery of all inmate health care. The Texas correctional health care system is widely recognized as one of the most effective in the United States and provides services with a lower cost per inmate than Florida. New Jersey also contracts with the state university medical program for comprehensive health care delivery. Several other states including Ohio and Illinois have partial contracting agreements. The University of Ohio contracts with the Ohio prison system for specialty care and telemedicine care for HIV. The University of Illinois at Chicago medical school contracts with the Illinois Department of Corrections for HIV and hepatitis C care via telemedicine.

Cost. The cost structure of a university-operated model using the same approach as Texas, combines elements of the outsourced cost-plus and insourced models. Facility health care staff would be employees of the university medical system, with a compensation cost comparable to that of an insourced model. For off-site care, the University would provide managed care services to coordinate contracted services in addition to providing services at university-operated inpatient and outpatient facilities. Costs should be comparable to levels achieved through outsourced models. As a public sector organization, a university model would still charge an administrative fee to cover indirect and overhead costs, but this would not include the profit built into the administrative fee paid under the FDC's current cost-plus contract. The University of Texas Medical Branch charges the Texas Department of Criminal Justice a 2.75 percent fee to cover administrative costs. This compares with an 11.5 percent administrative fee charged by Centurion under the FDC's current outsourcing model. Substituting this rate for the administration/profit fee of paid by the FDC would reduce this fee from $37.3 million to $8.1 million.

Because a University operates the entire medical program, it is also possible to obtain 340b pricing for all pharmaceuticals. Significant savings can accrue when the entire pharmacy budget is subject to 340b pricing. Department pharmacy expenditures in 2018-19 were $85 million of which approximately 60% were for "infectious disease drugs". Part of the infectious disease component would be for Hepatitis C drugs which are not part of the 340b pricing discount currently received by the FDC through the Department of Health. This discount allows from 23 – 40 percent discounts on outpatient medications. Due to the consent agreement on Hepatitis C, many more additional inmates can be expected to require treatment, increasing demand for the medications. The projected cost of Hepatitis C drugs in the FY 2019-20 budget is $49.2 million. Applying a 23 percent discount factor to these drugs alone would reduce costs by $11.3 million.

Potential savings provided by University Management model total $40.5 million, as shown below.

Exhibit 28: Projected Savings Impact of a University Management Model

	$ millions
340b discount for Hepatitis C drugs	$ 11.3
Reduce vendor administration/profit fee	$ 29.2
Total Savings	**$ 40.5**

Source: CGL analysis

Performance. As discussed earlier, the quality of care under the University model appears to be high. University medical school programs also have more professional prestige than state prison systems and can be expected to have more success in recruiting and retaining professional staff. The other significant benefit to a University program is that medical schools credential physicians appropriately, requiring physicians to work only in areas for which they have residency training. A University program can also effectively coordinate the use of telemedicine including primary care.

Implementation. FDC managers indicated they have approached several of the state's medical schools but have been unable to generate any interest in the concept of university-managed correctional health care. Absent cooperation from one of the state's university medical programs, the potential application of this model in Florida is moot.

In order to further this concept in Virginia, the state legislature has considered legislation creating a pilot project in which Virginia Commonwealth University (VCU) would build on its current relationship of providing inpatient hospital services to the state correctional system, to assume authority for comprehensive management of health care delivery at one prison. The Department of Corrections and VCU are currently in discussions for further development of the concept. A similar approach in Florida could pilot an interim model in which a university agrees to take on one aspect of the correctional health care program, such as management of off-site care for a region or group of facilities.

The implementation of such an approach is realistically a long-term alternative at best. However, as more states experience problems with conventional outsourcing with private vendors, interest in this concept will likely grow.