Evaluation of the U.S. Marshals Service's Pharmaceutical Drug Costs and Procurement Process

★ ★ ★

EVALUATION AND INSPECTIONS DIVISION

23-014

DECEMBER 2022

REDACTED FOR PUBLIC RELEASE
Redactions were made to the full version of this report for proprietary reasons. The redactions are of certain pricing information.

EXECUTIVE SUMMARY

Evaluation of the U.S. Marshals Service's Pharmaceutical Drug Costs and Procurement Process

Introduction

As a part of its mission, the U.S. Marshals Service (USMS) provides for the housing, care, and security of federal detainees remanded into its custody before and during a detainee's criminal trial, a period that typically lasts less than 1 year. The USMS does not own or operate detention facilities, rather it enters into intergovernmental agreements (IGA) with state and local governments to house most of its detainees at facilities operated by state or local governments or facilities operated by private vendors under contract with state or local governments.

To facilitate the delivery of healthcare to USMS detainees at IGA facilities across the country, in 2007 the USMS awarded a National Managed Care Contract (NMCC) to Heritage Health Solutions, Inc. (Heritage). In 2017 the USMS re-awarded the NMCC to Heritage. Through the NMCC, Heritage provides to the USMS a variety of healthcare related services, including the management of a Pharmacy Program. In managing the Pharmacy Program, Heritage acquires drugs for USMS detainees and performs a variety of clinical and administrative management services. The USMS is ultimately responsible for the cost of drugs purchased through the Pharmacy Program.

While the majority of IGA facilities that routinely house USMS detainees purchase drugs through the Pharmacy Program, some IGA facilities purchase drugs independently. Depending on the nature of the agreements between the USMS and those IGA facilities, either the USMS or the IGA facilities are directly responsible for the cost of drugs. If IGA facilities are directly responsible for the cost of drugs, they will have received from the USMS a comprehensive per-diem rate that covers all of the expenses, including drug expenses, associated with housing USMS detainees.

Between fiscal year (FY) 2012 and FY 2020, the cost of drugs purchased through the Pharmacy Program or for which the USMS is directly responsible increased 84 percent, from $15.1 million to $27.8 million. (These figures do not include the costs of drugs that IGA facilities pay for after receiving a comprehensive per-diem rate.) USMS officials attributed increases in drug costs to a variety of factors including general inflationary increases in drug costs in the broader economy, increases in the USMS detainee population (37,400 to 42,400 detainees between FY 2012 and FY 2020), increases in the proportion of detainees receiving medical care, and increases in the number of inmates requiring high-cost drug treatments to address serious illnesses such as cancer and hepatitis C.

Given that many of the factors driving increases in USMS drug prices are outside of its control, it is vitally important that the USMS effectively limit drug costs through the processes it does control. Therefore, the U.S. Department of Justice (DOJ) Office of the Inspector General (OIG) conducted this evaluation of the USMS's process for drug procurement, the prices it pays for drugs, and the efforts it makes to control associated costs.

Results in Brief

In both 2007 and 2017 the USMS awarded the NMCC following a full and open competition by which multiple vendors submitted bids. This is one method recognized by the Federal Acquisition Regulation (FAR) as sufficient to ensure a contract's price reasonableness. However, we found that in both instances, particularly in 2017, few vendors submitted technically acceptable bids. Additionally, we found that there is another strategy that the USMS could consider in future NMCC contracting actions that might better promote competition and thereby help ensure that the USMS is receiving the best possible mix of prices and services for this important program.

We also found that, because of the manner in which the NMCC bundles drug costs with other services within the Pharmacy Program, the USMS cannot determine

how much it spends on drugs under the NMCC. Further, we found that, although the USMS employed a pricing structure for the contract that is intended to insulate the government from the risk of future cost increases, neither the 2007 nor the 2017 NMCC accomplished that purpose and instead left the USMS exposed to the risk of increased drug costs.

Regarding drug purchases made by IGA facilities that do not participate in the Pharmacy Program, we found that the USMS has no control in place to limit the cost of such purchases.

The USMS Should Consider Ways to Increase Competition for Pharmacy Program Goods and Services to Better Assess Pharmacy Program Drug Prices

In both 2007 and 2017 the USMS met FAR requirements to award the NMCC following a full and open competition in which multiple vendors submitted bids. However, we also found that in both instances, particularly in 2017, few vendors submitted technically acceptable bids, which potentially limited the efficacy of the full and open competition that the USMS relied on to determine whether Pharmacy Program prices, including the prices of component goods like drugs, were reasonable.

Specifically, for the 2007 NMCC four vendors submitted bids, only three of which the USMS deemed technically acceptable, and in 2017 two vendors submitted bids, only one of which (Heritage's bid) the USMS deemed technically acceptable. We believe that one of the reasons few vendors bid on the NMCC is that the USMS decided to combine the Pharmacy Program and non-Pharmacy Program tasks into one contract. This excluded from competition those vendors that might specialize in providing Pharmacy Program goods and services but not other goods and services required by the NMCC, such as developing a nationwide network of medical care providers or processing medical claims.

We also found that before deciding to combine all NMCC tasks into one contract the USMS never fully considered the costs and benefits of doing so, including how this decision might affect Pharmacy Program vendor competition and the USMS's ability to ensure price reasonableness.

The USMS Cannot Determine How Much It Spends on Drugs through the NMCC

Further compounding our concerns regarding the USMS's ability to assess Pharmacy Program prices, we found that the USMS cannot differentiate drug costs from overall Pharmacy Program costs and therefore cannot determine how much it spends on drugs. In awarding the NMCC to Heritage, the USMS agreed to Heritage's pricing schedule, which bases drug prices not on the costs of individual drugs but on the costs associated with managing the entire Pharmacy Program, including administrative and other costs that are unrelated to underlying drug costs. Additionally, under the terms of the NMCC, Heritage is not required to report to the USMS information about its own and its subcontractor's drug acquisition costs. We also found that, although the USMS employed a pricing structure for the contract that is intended to insulate the government from the risk of future cost increases, neither the 2007 nor the 2017 NMCC accomplished that purpose and instead left the USMS exposed to the risk of increased drug costs.

As a result of these issues, the USMS is unable to determine whether the price it pays for drugs through the NMCC is comparable to what other federal agencies pay for drugs—most notably the discounted Federal Supply Schedule price—and therefore cannot use that information to negotiate lower drug prices and assess whether alternative contract types and pricing schedules might reduce overall drug and drug delivery costs.

Non-Pharmacy Program Drug Procurement Lacks an Important Internal Control

We also identified concerns with the USMS's drug acquisition processes for IGA facilities that do not participate in the Pharmacy Program. Specifically, there is no cost control, such as prior authorization, for drugs purchased by non-Pharmacy Program IGA facilities for which the USMS is separately invoiced and, consequently, the USMS is at risk of paying unnecessarily high prices for drugs purchased by those IGA facilities. This is especially concerning because the USMS does not know the procurement methods by which these non-Pharmacy Program IGA facilities obtain drugs or whether those methods are cost-effective.

Recommendations

In this report, we make three recommendations to improve the USMS's oversight of its drug costs and procurement process.

Table of Contents

Introduction **1**

Background 1

Prior Work Related to Federal Drug Spending 8

Scope of the OIG Evaluation 9

The USMS Should Consider Ways to Increase Competition for Pharmacy Program Goods and Services to Better Assess Pharmacy Program Drug Prices 11

The USMS Cannot Determine How Much It Spends on Drugs through the NMCC 13

Non-Pharmacy Program Drug Procurement Lacks an Important Internal Control 18

Conclusions and Recommendations **20**

Conclusion 20

Recommendations 20

Appendix 1: Purpose, Scope, and Methodology **22**

Standards 22

Purpose and Scope 22

Methodology 22

Appendix 2: Status of the USMS's Use of Private Detention Facilities **25**

Appendix 3: National Managed Care Contract Pricing Schedules **28**

Appendix 4: Average Daily Population Data for All Intergovernmental Agreement Facilities **30**

Appendix 5: The USMS's Response to the Draft Report **32**

Appendix 6: OIG Analysis of the USMS's Response **34**

Introduction

Background

As a part of its mission, the U.S. Marshals Service (USMS) provides for the housing, care, and security of federal detainees remanded into its custody before and during a detainee's criminal trial, a period that typically lasts less than 1 year.[1] The USMS does not own or operate detention facilities; rather, it enters into intergovernmental agreements (IGA) with state and local governments to house the majority of its detainees at facilities operated by state or local governments or facilities operated by private vendors under contract with state or local governments (we hereinafter refer to these detention facilities as IGA facilities). During fiscal year (FY) 2020, the USMS average daily population (ADP) for detainees housed at IGA facilities was approximately 42,400.[2] Although the USMS does not physically house these detainees, it is responsible for the costs associated with the provision of their medical care, including the costs of their pharmaceutical drugs (drugs). From FY 2012 through FY 2020, USMS costs associated with procuring drugs for its detainees housed at IGA facilities increased 84 percent—from $15.1 million to $27.8 million.

According to the USMS, increases in costs are attributable to a variety of factors including inflationary increases in drug costs in the broader economy, increases in the USMS detainee population (37,400 to 42,400 detainees between FY 2012 and FY 2020), increases in the proportion of detainees receiving medical care, and increases in the number of inmates requiring high-cost drug treatments to address serious illnesses such as cancer and hepatitis C. Given that many of the factors driving increases in USMS drug prices are outside of its control, it is vitally important that the USMS effectively limits drug costs through the processes it does control. Therefore, the U.S. Department of Justice (Department, DOJ) Office of the

---

[1] The duties of the USMS include protecting the federal judiciary, apprehending federal fugitives, managing seized assets acquired by criminals through illegal activities, housing and transporting federal detainees, and operating the Witness Security Program.

[2] According to the USMS, the ADP is the number of detainees in its custodial jurisdiction, calculated on a per-capita, per-day basis. Individuals in the custody of the USMS are commonly referred to as detainees or prisoners. For the purposes of this report, we collectively refer to all individuals in the custody of the USMS as detainees.

The USMS also houses detainees in Federal Bureau of Prisons (BOP) facilities and in private detention facilities that are under direct contract with the USMS or U.S. Immigration and Customs Enforcement (ICE). Pursuant to a memorandum of understanding between the BOP and the USMS, the BOP is responsible for all costs associated with housing USMS detainees in BOP facilities. During FY 2020, the ADP of USMS detainees at BOP facilities was approximately 9,200.

Pursuant to contracts between the USMS and private detention facilities, the USMS pays private detention facilities a pre-negotiated rate that covers all of the estimated costs, including drug costs, of housing one detainee for 1 day. Private detention facilities are then independently responsible for procuring drugs for USMS detainees without requesting reimbursement from the USMS. As a result, the USMS does not have data on the actual costs these facilities incur in procuring drugs for USMS detainees. During FY 2020, the ADP of USMS detainees at private detention centers under direct contract with the USMS or ICE was approximately 9,800.

On January 26, 2021, President Joseph R. Biden issued Executive Order 14006 on Reforming Our Incarceration System to Eliminate the Use of Privately Operated Criminal Detention Facilities, which stated that the Attorney General "shall not renew Department of Justice contracts with privately operated criminal detention facilities." Appendix 2 of this report describes in greater detail the status as of July 31, 2022, of USMS detainees housed at private detention facilities either under contract with a state or local government or under direct contract with the USMS or ICE.

Inspector General (OIG) conducted this evaluation of the USMS's process for drug procurement, the prices it pays for drugs, and its efforts to control associated costs.[3]

Methods of IGA Facility Drug Procurement

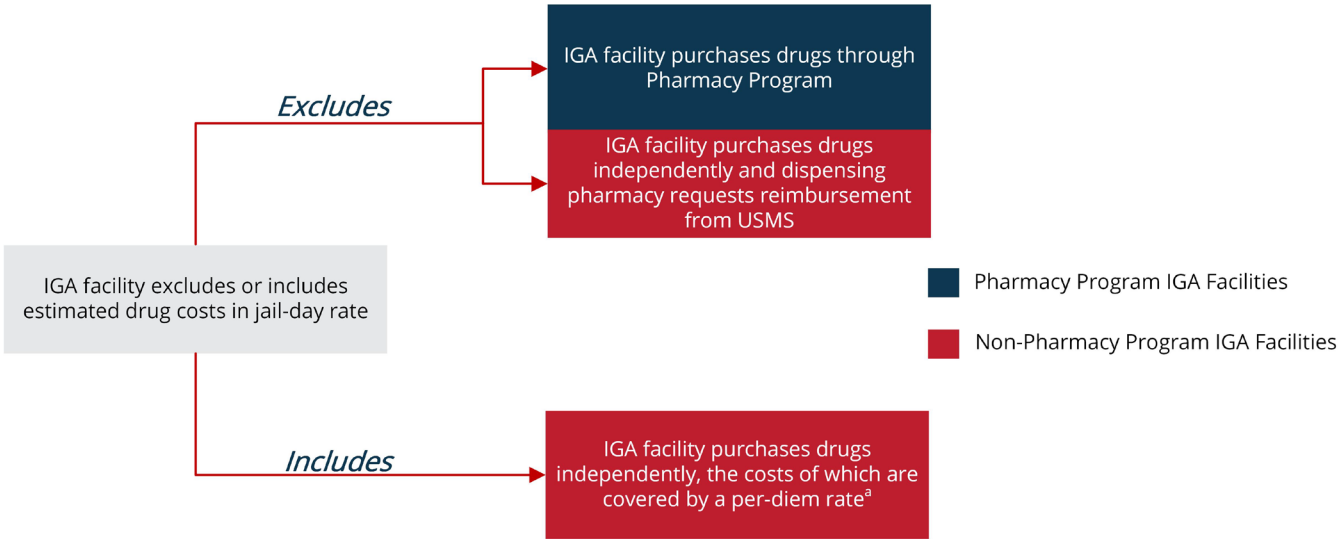
The manner in which IGA facilities procure drugs for USMS detainees depends in part on the nature of the agreement between the USMS and the operator of the IGA facility. When negotiating an IGA, the USMS and the state or local government negotiate a price the USMS pays to hold one detainee for 1 day (herein referred to as a per-diem rate).[4] The state or local government can choose to exclude or include the estimated costs of providing drugs to USMS detainees in its per-diem rate. If the state or local government chooses to exclude the costs of USMS detainee drugs from its per-diem rate, the IGA facility can either purchase drugs for USMS detainees through the USMS Pharmacy Program, the payment of which is handled by the USMS, or it can purchase drugs independently. If the IGA facility purchases drugs independently, the dispensing pharmacy then separately invoices and seeks reimbursement from the USMS. If the state or local government chooses to include estimated USMS detainee drug costs in its per-diem rate, the IGA facility independently procures drugs for USMS detainees and, except in certain instances when the IGA facility purchases a drug not typically prescribed, the USMS does not separately reimburse drug costs. For the purposes of this report, we refer to IGA facilities that purchase drugs through the Pharmacy Program as Pharmacy Program IGA facilities and IGA facilities that purchase drugs independently of the USMS as non-Pharmacy Program IGA facilities. In Figure 1 below, we visualize the different methods IGA facilities use to procure drugs for USMS detainees and their Pharmacy Program participation.

[3] As a point of comparison, between FY 2012 and FY 2020 the costs of medical claims (i.e., the amount the USMS paid outside medical providers) for detainees at IGA facilities increased from $38.3 million to $54.7 million—an increase of 43 percent. We note that the costs associated with medical claims are not inclusive of all USMS costs associated with healthcare administration.

[4] For more information on how the USMS negotiates IGAs with state and local detention facilities, please see DOJ OIG, *Audit of the Intergovernmental Detention Space Negotiation Process (Redacted Version)*, Audit Report 11-21 (March 2011), oig.justice.gov/reports/audit-intergovernmental-agreement-detention-space-negotiation-process-redacted-version.

Figure 1

Methods and Pharmacy Program Participation of IGA Facilities to Procure Drugs for USMS Detainees



[a] Dispensing pharmacies seek reimbursement from the USMS in certain instances when IGA facilities purchase a drug not typically prescribed.

Source: OIG Analysis of USMS information

The USMS's National Managed Care Contract and Pharmacy Program

In a 2004 report assessing USMS medical care, the OIG found that the USMS was not properly managing detainee medical care and was not effectively repricing medical claims to ensure that it paid the lowest possible price for medical services.[5] At that time, individual IGA facilities would acquire drugs according to their own procurement processes and would then seek reimbursement from the USMS. Due to this decentralized procurement model, the USMS had limited insight into overall drug purchasing and could not determine whether the costs it was reimbursing IGA facilities for drugs were reasonable. To help address the issues identified in its 2004 report, the OIG recommended that the USMS complete an ongoing effort to develop a National Managed Care Contract (NMCC) for detainee medical care.

In FY 2007, the DOJ Office of the Federal Detention Trustee (OFDT), on behalf of the USMS, awarded the NMCC to Heritage Health Solutions, Inc. (Heritage).[6] Through the NMCC, Heritage provides the USMS and IGA facilities housing USMS detainees (1) a healthcare delivery system with a network of medical facilities and healthcare providers, (2) a Pharmacy Program that centralizes the acquisition of drugs for USMS

[5] DOJ OIG, *United States Marshals Service's Prisoner Medical Care*, Audit Report 04-14 (February 2004), oig.justice.gov/reports/united-states-marshals-services-prisoner-medical-care.

[6] Congress established the OFDT in September 2001 to provide administrative oversight of DOJ detention functions. As a result, the OFDT awarded the 2007 NMCC to Heritage on the USMS's behalf and administered the contract collaboratively with the USMS through October 2012. In October 2012 the OFDT merged with the USMS. For the purposes of this report, when we describe USMS NMCC administration efforts prior to October 2012 we are also describing OFDT NMCC administration efforts.

detainees and centralizes USMS pharmacy management services, and (3) medical and drug claim processing and payment services. Heritage started providing the USMS with a healthcare delivery system and claim processing and payment services in FY 2007. According to the USMS, due to the challenge of getting IGA facilities to change the manner in which they procured drugs, it was not until FY 2009 that Heritage began operating the Pharmacy Program on the USMS's behalf. The original contract expired in 2017. After the USMS re-competed the contract, the USMS re-awarded the NMCC to Heritage in 2017 and it took effect at the beginning of FY 2018. The USMS awarded the NMCC for 2 base years, with 8 option years. To date, Heritage remains the USMS's NMCC provider.

In managing the Pharmacy Program, Heritage provides a range of services to the USMS and IGA facilities that have chosen to participate in the program. First, Heritage facilitates the provision and delivery of prepackaged drugs to USMS detainees housed in IGA facilities. To do so, Heritage partners with a Pharmacy Benefit Manager (PBM) subcontractor that negotiates contracts and drug prices with a network of pharmacies that agree to dispense drugs to IGA facilities housing USMS detainees.[7] According to Heritage in its 2017 NMCC contract proposal, over 80 percent of all USMS detainee drugs are delivered by mail the day after the order.

Additionally, in collaboration with the USMS and the PBM subcontractor, Heritage manages the USMS's drug formulary.[8] In its 2017 NMCC proposal, Heritage asserted that the USMS's formulary ensures detainee safety at the lowest cost by prioritizing the use of generally cheaper generic drugs over generally more expensive brand name drugs. Heritage clinical staff is also responsible for the prior authorization of drugs that are not on the USMS formulary.[9] Through prior authorization, Heritage seeks to limit the use of high-priced or non-formulary drugs when similar drugs that provide a comparable therapeutic benefit to the patient are available at a lower price. Among other services, Heritage also analyzes USMS detainee drug use trends and processes and pays drug claims.

Pharmacy Program Pricing

In awarding the NMCC to Heritage, the USMS agreed to Heritage's pricing schedule, which makes drugs available at a discount, defined as a percentage off the average wholesale price (AWP) of the drugs. The AWP is an industry benchmark, which is "based on data obtained from drug manufacturers, distributors,

---

[7] PBMs, on behalf of medical insurance companies, employer-sponsored health plans, and other entities (such as the USMS), negotiate drug prices with pharmacies and manufacturers and provide other administrative support for drug purchasing.

[8] According to the Academy of Managed Care Pharmacy, a drug formulary is a continually updated list of drugs and related products supported by current evidence-based medicine and the judgment of physicians, pharmacists, and other experts in the diagnosis and treatment of disease and preservation of health. Academy of Managed Care Pharmacy, "Formulary Management," November 2009, www.amcp.org/sites/default/files/2019-03/Formulary%20Management.pdf (accessed December 15, 2022).

[9] Prior authorization is a cost-saving tool that allows the USMS to explore cheaper, therapeutically similar alternatives for any drug that costs at least $1,800 ($500 for a multi-compound drug). If a medical provider prescribes a drug whose cost exceeds those limits, Heritage will evaluate a request for prior authorization for the prescribed drug, as well as clinical documentation for appropriate usage. It will also evaluate whether there is a lower-cost treatment available and whether the detainee remains in USMS custody. According to Heritage, the decision of approval or denial of the requested prior authorization is based on a predetermined set of clinical criteria. A USMS official told us that the $1,800 threshold helps control the costs of high-cost drugs, especially those that treat HIV/AIDS, hepatitis C, and cancer.

and other suppliers."[10] Under Heritage's pricing schedule, the discount off the AWP that the USMS receives depends on the category of drug being purchased: generic, brand name, specialty, or multi-compound. Heritage also charges the USMS a [redacted] dispense fee per transaction.

The price the USMS pays for each drug includes Heritage's acquisition and delivery cost of the drug, as well as other costs, including a portion of the overall costs Heritage incurs in managing the Pharmacy Program. Accordingly, Heritage told the OIG that Heritage is not able to specify, on an individual claim or on a global basis, how much of the contracted rate is attributable to actual drug cost and how much is attributable to Heritage's services.[11] Rather, the USMS ultimately pays the contracted discounted rate off the AWP and the dispense fee for a drug regardless of the actual costs that the contractor and its subcontractor incur when procuring and delivering the drug to Pharmacy Program detention facilities.

In Table 1 below, we present Heritage's pricing schedule for the USMS Pharmacy Program for the current contract performance period (FYs 2018–2027), as well as a description of the four drug categories outlined in the NMCC. The USMS receives [redacted] Heritage's pricing schedule for the current period of performance provides the USMS [redacted] Heritage's earlier pricing schedules for the 2007 NMCC (FYs 2009–2017). (In Appendix 3 we provide additional information about Heritage's earlier pricing schedules.)

Table 1

Heritage's Pricing Schedule for the USMS Pharmacy Program, FYs 2018–2027

Drug Type	Percentage off the AWP	Dispense Fee	Description of Drug Type
Generic	[redacted]	[redacted]	A drug that has the same active-ingredient formula as a brand name drug: generic drugs are generally cheaper than brand name drugs.
Brand Name	[redacted]	[redacted]	A drug sold under a specific name or trademark and that is protected by a patent
Specialty	[redacted]	[redacted]	High-cost drugs used to treat patients with serious and life-threatening conditions including, but not limited to, HIV/AIDS, hepatitis C, and cancer
Multi-Compound	[redacted]	[redacted]	A combination of ingredients that are mixed to meet the requirements of a patient

Sources: USMS, U.S. Department of Health and Human Services, U.S. Food and Drug Administration

[10] Medical Economics Company, Inc., *Red Book: Drug Topics,* 106th ed. (Montvale, N.J.: Thomson Medical Economics, 2002), 169.

[11] Heritage provided an example of differing levels of effort for prescription fulfillment by explaining that "a prescription for a brand medication that is on the approved formulary may require limited Heritage involvement" but that "a prescription for an expensive specialty medication that requires specific packaging necessitates significant involvement" from Heritage.

As is customary in the pharmaceutical industry, after a PBM purchases certain drugs from a pharmacy the PBM may receive a rebate from the manufacturer. [redacted][12]

Costs of Providing Drugs to USMS Detainees at IGA Facilities

Of the 691 IGA facilities that routinely housed USMS detainees in FY 2020, 427 (or 62 percent) were Pharmacy Program IGA facilities while 264 (or 38 percent) were not.[13] Cumulatively, those 427 Pharmacy Program IGA facilities housed an ADP of 30,545 detainees in FY 2020, which accounted for 72 percent of the USMS detainees housed in IGA facilities during the same period. In FY 2020, USMS Pharmacy Program costs (i.e., the costs of providing drugs to Pharmacy Program IGA facilities) totaled $25.6 million. The USMS also reimbursed pharmacies from which non-Pharmacy Program IGA facilities independently purchased drugs $2.2 million during that year. We summarize these totals below in Table 2.

[12] [redacted]

[13] We define "IGA facilities that routinely housed USMS detainees" as those facilities with an ADP of greater than or equal to 1 during a fiscal year. According to the USMS, an IGA facility ADP is calculated as the number of detainee bed days divided by days in a fiscal year. For example, an IGA facility would have an ADP of 1 if it housed 1 USMS detainee every day of a fiscal year or if on just 1 day during a 365-day fiscal year it housed 365 USMS detainees but housed no other USMS detainees during that fiscal year. An IGA facility would have an ADP of greater than 1 if it housed any other combination of detainees that exceeded the number of days in the year.

We believe that presenting IGA facility and ADP totals for IGA facilities with an ADP greater than or equal to 1 most accurately represents the scope of IGA facilities that procured drugs on behalf of USMS detainees during FY 2020. This is because, according to USMS data, IGA facilities with an ADP of greater than 0 but less than 1 neither purchased drugs through the Pharmacy Program nor invoiced the USMS for detainee drugs during that year. In Appendix 4, we provide additional data on the 335 IGA facilities with an ADP greater than 0 but less than 1 during FY 2020 (i.e., IGA facilities the USMS used, but less frequently than those it used "routinely," by our definition). See Table 2 below.

Table 2

Costs of Providing Drugs to USMS Detainees at IGA Facilities, IGA Facility Pharmacy Program Participation, and the ADP at IGA Facilities by Pharmacy Program Participation, FY 2020

	Pharmacy Program IGA Facilities	Non-Pharmacy Program IGA Facilities	Totals
Cost of Providing Drugs[a]	**$25,600,000**	**$2,200,000**	**$27,800,000**
Percent of Total	*92%*	*8%*	*100%*
Number of IGA Facilities[b]	**427**	**264**	**691**
Percent of Total	*62%*	*38%*	*100%*
ADP	**30,545**	**11,764**	**42,309**
Percent of Total	*72%*	*28%*	*100%*

[a] The cost of providing drugs to Pharmacy Program IGA facilities is inclusive of the acquisition and delivery price of drugs and the costs associated with managing the entire Pharmacy Program. The cost of providing drugs to non-Pharmacy Program IGA facilities is inclusive of the total amount invoiced to the USMS after these facilities independently procured detainee drugs. It does not include any costs for USMS detainee drugs that were paid by non-Pharmacy Program IGA facilities that would be covered under the per-diem rate the facility received to house a detainee.

Costs are rounded to the nearest hundred thousand.

[b] Totals are calculated for IGA facilities that routinely housed USMS detainees during FY 2020 (i.e., IGA facilities with an ADP greater than or equal to 1). Totals do not include the ADP of 62 for the 335 IGA facilities with an ADP greater than 0 but less than 1. The total ADP for all 1,026 IGA facilities that housed at least 1 detainee during FY 2020 was 42,371. For more data on IGA facilities with an ADP greater than 0 but less than 1, see Appendix 4.

Source: USMS

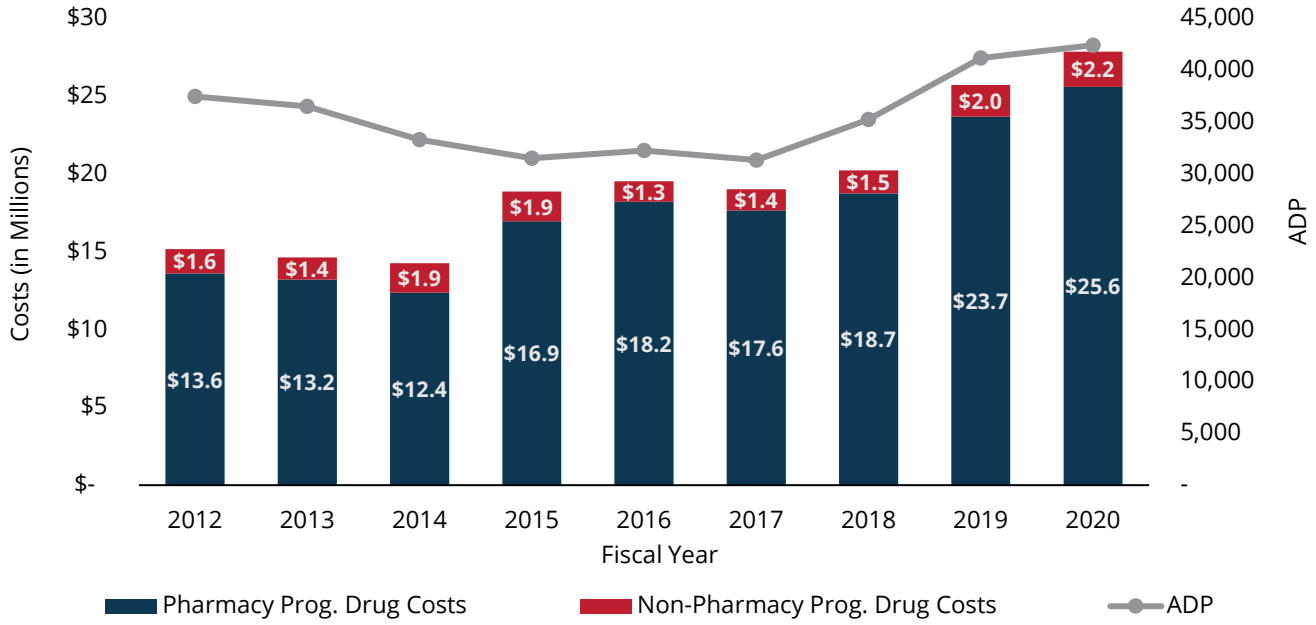
As explained above, between FY 2012 and FY 2020 the USMS's costs associated with procuring drugs for detainees housed in IGA facilities increased 84 percent, from $15.1 million to $27.8 million. According to the USMS, increases in costs are attributable to a variety of factors including inflationary increases in drug costs in the broader economy, increases in the USMS detainee population (37,400 to 42,400 detainees between FY 2012 and FY 2020), increases in the proportion of detainees receiving medical care, and increases in the number of inmates requiring high-cost drug treatments to address serious illnesses such as cancer and hepatitis C.[14] We illustrate the historical increases in USMS costs associated with procuring drugs for detainees at IGA facilities and ADPs for USMS detainees housed at those facilities below in Figure 2.

[14] USMS officials added that, despite the overall increase in the drug prices, the increased availability of certain generic drugs has helped control pharmaceutical expenses.

Heritage's proposal for the 2017 NMCC indicated that hemophilia, hepatitis C, and HIV were among the diseases that most disproportionately contributed to the increase in USMS drug costs. The OIG's 2020 report on BOP drug costs also

Figure 2

Costs of Providing Drugs to USMS Detainees at IGA Facilities, by Pharmacy Program Participation and ADP, FYs 2012–2020



Note: Totals are calculated for all IGA facilities.

Source: USMS

Prior Work Related to Federal Drug Spending

The OIG has issued multiple reports related to medical and drug spending by the USMS and the Federal Bureau of Prisons (BOP). As mentioned above, in a 2004 report on USMS medical care, the OIG found that the USMS was not properly managing detainee medical care and recommended that the USMS pursue the NMCC. The USMS subsequently decided to include the Pharmacy Program in the broader NMCC.[15] In 2020, the OIG issued a report on the way in which the other DOJ component with detention responsibilities, the BOP, managed its drug costs and procurement process and found that, among other issues, the BOP was not ensuring that its institutions procured drugs in the most cost-efficient way.[16] While this report found that the BOP is able to purchase drugs at a discounted price for federal government customers, it also found that the BOP does not have access to the "Big 4" price, which is a further discounted government

found that the cost of hepatitis C drugs for inmates has been a major cause of rising BOP drug costs. DOJ OIG, *Review of the Federal Bureau of Prisons' Pharmaceutical Drug Costs and Procurement*, Evaluation and Inspections Report 20-027 (February 2020), oig.justice.gov/reports/review-federal-bureau-prisons-pharmaceutical-drug-costs-and-procurement.

[15] DOJ OIG, *USMS's Prisoner Medical Care*.

[16] DOJ OIG, *BOP's Pharmaceutical Drug Costs and Procurement*.

price that by law is available to only four government agencies: (1) the U.S. Department of Defense; (2) the U.S. Department of Veterans Affairs; (3) the U.S. Public Health Service, specifically the Indian Health Service; and (4) the U.S. Coast Guard. The BOP has estimated that if it had had access to Big 4 pricing in FY 2017 it could have reduced its total drug spending by approximately $13.1 million.

Other oversight organizations, including the Congressional Budget Office (CBO) and the U.S. Government Accountability Office (GAO), have also examined the prices that federal agencies paid for drugs, trends in federal drug spending, and methods that federal agencies use to control drug costs. In 2005, the CBO issued a report that found that drug prices differ considerably across government programs because they are determined by a variety of statutory rebates or discounts, supplemented by negotiations with drug manufacturers.[17] In 2007, a GAO report explained that "approaches for negotiating drug prices vary among federal programs in the United States. In part, these approaches depend on whether the programs purchase and distribute drugs directly or reimburse retail pharmacies or other providers for dispensing or delivering drugs."[18] This finding is relevant to our evaluation of USMS drug costs and procurement because, absent its own pharmacists, the USMS relies on Heritage to facilitate drug prescription delivery and fulfillment and manage its Pharmacy Program. Finally, a 2009 GAO report found that federal programs can control drug costs using, among other strategies, drug formularies, statutorily established prices such as the Federal Supply Schedule price, and pharmacy networks.[19]

Scope of the OIG Evaluation

The OIG initiated this evaluation to examine the USMS's drug prices and spending from FY 2012 through FY 2016, as well as its drug procurement process. As the evaluation progressed, we extended its scope through FY 2020. We focused our analysis on the various ways IGA facilities obtain drugs for USMS detainees, with a focus on Pharmacy Program IGA facilities. We examined USMS drug procurement procedures, the NMCC, and federal laws and regulations. Our fieldwork, conducted from June 2017 through September 2021, included data collection and analysis, document reviews, and interviews.[20]

We interviewed officials from USMS headquarters, state and local detention facilities, Heritage and its subcontractor staff, and other federal agencies that pay for drugs. We excluded from our evaluation the way the BOP and private detention facilities under direct contract with the USMS or U.S. Immigration and Customs Enforcement procure drugs for USMS detainees. This is because the BOP and nearly all of these

---

[17] CBO, *Prices for Brand-Name Drugs Under Selected Federal Programs* (June 2005), www.cbo.gov/sites/default/files/109th-congress-2005-2006/reports/06-16-prescriptdrug.pdf (accessed December 15, 2022).

[18] John E. Dickens, Director, Health Care, GAO, before the Committee on Finance, U.S. Senate, concerning "Prescription Drugs: An Overview of Approaches to Negotiate Drug Prices Used by Other Countries and U.S. Private Payers and Federal Programs" (January 11, 2007), www.gao.gov/assets/120/115135.pdf (accessed December 15, 2022).

[19] John E. Dickens, Director, Health Care, GAO, before the Subcommittee on Federal Workforce, Postal Service, and the District of Columbia, Committee on Oversight and Government Reform, House of Representatives, concerning "Prescription Drugs: Overview of Approaches to Control Prescription Drug Spending in Federal Programs" (June 24, 2009), www.gao.gov/assets/130/122832.pdf (accessed December 15, 2022).

[20] At the outset of the coronavirus disease 2019 pandemic in March 2020, the OIG shifted resources to extensive pandemic-related oversight, which delayed our completion and issuance of this report.

private detention facilities procure drugs for USMS detainees independent of the USMS.[21] Further, we did not evaluate non-Pharmacy Program tasks required by the NMCC. A more detailed description of our methodology is in Appendix 1.

[21] In January 2021, after the scope of our review, one private detention facility began participating in the USMS Pharmacy Program.

Results of the Evaluation

The USMS Should Consider Ways to Increase Competition for Pharmacy Program Goods and Services to Better Assess Pharmacy Program Drug Prices

In both 2007 and 2017, the USMS met Federal Acquisition Regulation (FAR) requirements to award the National Managed Care Contract (NMCC) following a full and open competition in which multiple vendors submitted bids, a procedure the FAR deems as adequate to determine whether vendor-proposed contract pricing is reasonable.[22] However, we also found that in both instances, particularly in 2017, few vendors submitted technically acceptable bids, which potentially limited the efficacy of the full and open competition that the USMS relied on to determine whether Pharmacy Program prices, including the prices of component goods like drugs, were reasonable.

Specifically, four vendors submitted bids for the 2007 NMCC, only three of which the USMS deemed technically acceptable, and in 2017 two vendors submitted bids, only one of which the USMS deemed technically acceptable (Heritage Health Solutions, Inc.'s bid). Notably, in designing the initial NMCC, the USMS decided to combine Pharmacy Program and non-Pharmacy Program tasks into one contract. As we described in the Introduction, the NMCC includes, among other tasks, developing a nationwide healthcare delivery system, managing the Pharmacy Program, and processing and paying medical claims. USMS officials responsible for monitoring the NMCC could not explain fully why the USMS decided to combine Pharmacy Program and non-Pharmacy Program tasks into the initial NMCC.[23] During our review of procurement planning documents for the initial NMCC, we found that the USMS issued to industry experts a request for information to help develop NMCC requirements. In that request, the USMS indicated that it had an open question about whether it should include a pharmacy program in the NMCC. However, the USMS was unable to provide the OIG any evidence that industry offered the USMS advice in response to this specific question. Other than this question, USMS NMCC market research documentation provided to the

[22] FAR Subparts 15.404-1(b)(2)(i) and 15.403-1(c)(1).

Although not required if multiple vendors submit bids in a fair and open competition, FAR Subpart 15.404-1(b)(2)(ii) explains that the government can also compare proposed prices to historical prices to assess price reasonableness. Prior to awarding the 2007 NMCC, the USMS had no internal drug pricing or Pharmacy Program management pricing data, as intergovernmental agreement (IGA) facilities had previously been responsible for all USMS detainee drug procurement. Further, none of the 2007 NMCC market research data the USMS provided to the OIG indicates that the USMS was able to assess what other federal agencies that operated retail pharmacy programs paid for goods and services like those required by the USMS. When awarding the 2017 NMCC, the USMS did have access to existing historical Pharmacy Program prices from the 2007 NMCC; but those prices were set by Heritage.

[23] The OIG has previously identified issues with DOJ components maintaining contract documentation to support historical procurement decisions. DOJ OIG, *Management Advisory Memorandum Concerning the Department of Justice's Administration and Oversight of Contracts*, Audit Report 20-082 (July 2020), oig.justice.gov/reports/management-advisory-memorandum-concerning-department-justices-administration-and-oversight.

OIG, from both 2007 and 2017 procurements, focused on evaluating the market for an NMCC that combines Pharmacy Program and non-Pharmacy Program tasks, as opposed to considering those tasks separately.[24]

Absent contemporaneous documentation or a complete historical explanation as to why the USMS decided to combine the tasks into one contract, we asked multiple USMS officials responsible for administering the NMCC, including the NMCC Contracting Officer and Contracting Officer's Representative, whether they believe that the tasks should be combined in the current NMCC. All explained that they believe that Pharmacy Program and non-Pharmacy Program tasks should be combined into one contract to ensure the effective delivery of healthcare to USMS detainees. Further, the Contracting Officer's Representative stated that, in general, the costs of managing multiple contracts are greater than the costs of managing one contract. A USMS procurement executive, who had not worked on the NMCC, also suggested that, because the USMS has a need for a comprehensive medical solution, it may in theory make more sense to hire a vendor that performs all NMCC tasks, even if that vendor charges slightly more for performing the Pharmacy Program task than would other vendors that can perform only the Pharmacy Program task because the higher Pharmacy Program task costs could be offset by greater overall savings achieved through the non-Pharmacy Program tasks.

We asked Heritage officials a similar question, and they told us that, by managing both the Pharmacy Program and non-Pharmacy Program tasks of the NMCC, Heritage can provide greater continuity of care to USMS detainees. For example, Heritage can review medical claims information that it has received under the medical program that might validate the use of certain prescription medications under the Pharmacy Program.

We acknowledge that the benefits of combining the Pharmacy Program and non-Pharmacy Program tasks into one contract could be greater than separating these tasks into two contracts. However, we believe that there also could be potential costs to such a combination, including that few vendors have demonstrated the technical competence and willingness to bid on the NMCC, which potentially reduces competition. Additionally, we note that, with so many highly technical tasks combined into the NMCC, the component prices of one task, such as drug prices or related Pharmacy Program management services, carried less weight in vendor selection than the vendor evincing that it had a reasonable technical approach and technical experience to achieve all tasks of the contract. In fact, USMS vendor evaluation guidance for the 2017 NMCC explicitly stated that the "total of all non-price evaluation factors combined is considered significantly more important than cost or price."

Conclusion

Given the importance of ensuring that USMS detainees receive proper medical care, we do not believe that the lowest NMCC prices available would necessarily be the most reasonable prices or that price should be the most important factor for the USMS to consider when awarding a future medical services contract. This is especially true if a vendor submitted a low bid that did not demonstrate the technical competence necessary to perform contract tasks. However, in light of rising drug costs and the fact that the USMS

[24] Additionally, a USMS official told us that he did not believe there was documentation indicating that the USMS had performed a cost-benefit analysis about whether to combine or split Pharmacy Program and non-Pharmacy Program tasks in the NMCC.

appears not to have fully assessed the costs and benefits of separating the Pharmacy Program task from the NMCC, we believe that the USMS should reexamine its assumption that all current NMCC tasks are best combined into one contract.

Recommendation

Therefore, to improve oversight of the Pharmacy Program, we recommend that the USMS:

1. Conduct additional market research to test the existing assumption that combining Pharmacy Program and non-Pharmacy Program tasks into one contract is the most cost-effective method to provide quality healthcare to USMS detainees.

The USMS Cannot Determine How Much It Spends on Drugs through the NMCC

Further compounding our concerns regarding the USMS's ability to assess Pharmacy Program prices, we found that the USMS cannot differentiate drug costs from overall Pharmacy Program costs and therefore cannot determine how much it spends on drugs through the NMCC. This is because, in awarding the NMCC to Heritage, the USMS agreed to Heritage's pricing structure, which bases drug prices not on the costs of individual drugs but on the costs associated with managing the entire Pharmacy Program. Nor does the existing NMCC obligate Heritage to provide the USMS data that would allow the USMS to determine how much of what it pays Heritage under the Pharmacy Program is assigned to either drug costs or related services specifically.[25] Additionally, we found that the Pharmacy Program pricing structure for both the 2007 and the 2017 NMCCs could, contrary to the purpose of the pricing structure, shift the risk of increased drug costs onto the USMS. As a result of these issues, which are described in detail below, the USMS is unable to determine whether the prices it pays for drugs through the NMCC are comparable to the prices other federal agencies pay for drugs. Nor can the USMS use that information to negotiate lower drug prices and assess whether alternative contract types and pricing schedules might reduce overall drug and drug delivery costs.

We reviewed other federal agency drug procurement processes to help us better understand the issues the USMS is facing in containing drug costs. As a result of this review, we found that the Defense Health Agency (DHA), the U.S. Department of Defense (DOD) agency responsible for administering TRICARE, experienced challenges that are similar to the challenges the USMS currently experiences in assessing its retail pharmacy benefit program's drug costs.[26] We describe how DHA addressed its similar challenges, and offer the USMS a recommendation to address its challenges, at the end of this section.

---

[25] Heritage regularly provides the USMS with data that indicates, among other things, each drug claim; the quantity of drugs ordered for each claim; and the associated drug claim's cost elements, which include an ingredient cost and dispense fee. While this data allows the USMS to understand enterprise-wide drug ordering trends, it does not allow the USMS to determine how much of what it pays to Heritage under the Pharmacy Program is assigned to either drug costs or related services, respectively. This is because Heritage bundles the costs of managing the entire Pharmacy Program, including the costs of drugs, in each drug claim's cost elements.

[26] TRICARE is the healthcare program for uniformed service members, retirees, and their families.

The Pharmacy Program's Pricing Schedule Is Not Transparent

As we described in the Introduction to this report, Heritage's Pharmacy Program pricing schedule makes drugs and related Pharmacy Program management services available at a discount, or percentage off the average wholesale price (AWP) of drugs. The USMS ultimately pays the contract-discounted rate off the AWP plus a dispense fee for a drug regardless of the actual costs Heritage and its subcontractor incur and the level of effort they expend in procuring and delivering drugs to USMS detainees. According to Heritage, because the level of Heritage's involvement can vary significantly from one claim to the next, Heritage cannot specify—on an individual claim or global basis—how much of the contracted rate is attributable to the drug cost and how much is attributable to Heritage's services. Further, pursuant to existing contract terms, Heritage is under no obligation to provide to the USMS data that would allow the USMS to determine how much of what it pays Heritage under the Pharmacy Program is assigned to drug costs and related services. As a result, the USMS lacks information to assess how the prices it pays for drugs compare to prices available to other federal agencies and it cannot use that information to negotiate lower drug prices.

We believe that an important benchmark the USMS should consider when evaluating drug prices is the Federal Supply Schedule (FSS) price other federal agencies pay for drugs. The FSS is a price negotiated for federal government customers that is equal to or lower than the lowest price that drug manufacturers report that their most-favored commercial customers have paid for a drug.[27] The Congressional Budget Office (CBO) estimated in 2005 that FSS prices for brand name drugs were approximately 47 percent lower than the AWP and, as of February 2022, the U.S. Department of Veterans Affairs' Health Economics Research Center (VA HERC) recommended using this metric, among others, when conducting cost-effectiveness analyses of brand name drugs in the U.S. healthcare system.[28]

The vast majority (approximately 95 percent) of the drugs the USMS purchased through the Pharmacy Program in FYs 2019 and 2020 were generic, and the purchase of generic over brand name drugs is an important cost-saving measure for the USMS. However, in FY 2019 only 52 percent of Pharmacy Program expenditures (non-inclusive of aggregate per-drug order dispense fees) was attributed to the purchase of generic drugs while 48 percent of Pharmacy Program expenditures was attributed to the purchase of brand name drugs (or approximately $12.3 million versus $11.2 million, respectively). This proportion was similar in FY 2020, when approximately 53 percent of expenditures was attributed to the purchase of generic drugs and 47 percent to the purchase of brand name drugs (or approximately $13.4 million versus $12 million,

---

[27] During our evaluation, we sought to compare the prices the USMS paid for drugs to the FSS prices for the same drugs. Because Heritage does not differentiate drug prices from Pharmacy Program prices when billing the USMS, we sought to compare the prices Heritage paid to acquire drugs through its Pharmacy Benefit Manager (PBM) subcontractor to FSS prices for the same drugs. After analyzing the data we gathered and FSS data from FY 2017, the OIG determined that it could not reliably match a sufficient number of transactions to meaningfully compare the prices Heritage paid to its PBM subcontractor to FSS prices.

[28] CBO, *Prices for Brand-Name Drugs Under Selected Federal Programs* (June 2005), www.cbo.gov/sites/default/files/109th-congress-2005-2006/reports/06-16-prescriptdrug.pdf, and VA HERC, "Determining the Cost of Pharmaceuticals for a Cost-Effectiveness Analysis," last updated February 2022, www.herc.research.va.gov/include/page.asp?id=pharmaceutical-costs#top (both accessed December 15, 2022). The VA HERC acknowledges that the AWP is a benchmark used to estimate drug acquisition costs but cautions that the "AWP may not be an objective statement of the relative costs of pharmaceuticals."

respectively).[29] In light of the significant cost of transactions attributable to the acquisition of brand name drugs, we believe that the USMS would particularly benefit from being able to use the FSS as a benchmark for assessing drug prices.

In a written response to a draft of this report, the USMS emphasized that the USMS lacks the infrastructure and administrative controls necessary to acquire drugs directly through the FSS and ultimately distribute those drugs to its detainees. As a result, the USMS contracts with Heritage to provide a pharmacy delivery system (i.e., the Pharmacy Program) through which Heritage manages the drug procurement and delivery process on behalf of the USMS. The OIG acknowledges this point and does not intend to suggest that the USMS can or should immediately pursue the direct purchase of drugs from the FSS. Rather, we believe that the FSS is an important benchmark for the USMS to consider when evaluating and negotiating, regardless of the method it uses to procure drugs.

Contrary to Its Purpose, the Pharmacy Program's Pricing Structure Places the Risk of Increased Drug Costs on the USMS

The Pharmacy Program's pricing structure is firm-fixed price, a structure that is appealing to the government because, according to the FAR, it places "upon the contractor maximum risk and full responsibility for all costs and resulting profit or loss."[30] For example, if a government agency agreed to purchase a finished product from a manufacturer under a firm-fixed price contract, the manufacturer would bear the risk for an increase in the cost of the finished product's component materials. In the case of the USMS's NMCC, however, Heritage's pricing structure can shift the risk of increased costs of component materials back to the USMS. This is because the price is "fixed" to the AWP, a variable benchmark with no ceiling. Therefore, an increase in the AWP would result in a cost increase for the USMS—which is exactly the type of risk a firm-fixed price contract is designed to help the government avoid.

The USMS justified its use of the AWP as a benchmark for Pharmacy Program pricing by telling the OIG that it "used AWP, a well-known benchmark for the pricing and reimbursement of prescription drugs, to establish a standard that prospective offerors could reference when proposing their pharmacy prices." However, several other federal stakeholders have expressed concerns about the government's use of the AWP, even outside of the context of a firm-fixed price contract. For example, the U.S. Department of Health and Human Services (HHS) Office of Inspector General has stated that the AWP is a "flawed benchmark" that has "little relation to provider drug acquisition costs" and can be substantially greater than the average sales price for certain drugs because it fails to consider the effects of discounts available to various payers.[31]

---

[29] To generate generic and brand name drug usage and cost estimates, the OIG used data provided by Heritage to the USMS in an FY 2020 annual report. Pharmacy Program expenditures attributed to generic and brand name drugs do not include the aggregate amount of per-transaction dispense fees ([redacted] per transaction). As a result, cumulative estimates of Pharmacy Program costs attributed to generic and brand name drug purchases are slightly less than total Pharmacy Program expenditures.

[30] FAR Subpart 16.202-1.

[31] HHS OIG, *Report in Brief: CMS Should Address Medicare's Flawed Payment System for DME Infusion Drugs*, OEI-12-16-00340 (September 2016), oig.hhs.gov/oei/reports/oei-12-16-00340.pdf, and *Medicaid Drug Price Comparison: Average Sales Price to Average Wholesale Price*, OEI-03-05-00200 (June 2005), oig.hhs.gov/oei/reports/oei-03-05-00200.pdf (both accessed December 15, 2022).

Citing similar concerns about the government's use of the AWP as a benchmark for drug reimbursement under Medicare Part B, in 2005 Congress required HHS to stop using the AWP as the Medicare Part B reimbursement basis for many drug types.[32] Further, in 2016 HHS established a regulation that guides states away from using a benchmark informed by the AWP in setting upper limits for Medicaid reimbursement rates for certain brand name drugs.[33] The AWP and its relation to actual drug prices has also been at issue in lawsuits. Of note, in August 2009 the U.S. District Court for the District of Massachusetts approved a $350 million settlement to resolve a civil lawsuit in which a class of plaintiffs asserted that a drug pricing publisher and a drug wholesaler fraudulently increased the published AWP of over 400 branded drugs by 5 percent from late 2001 through 2005.[34]

A Different Federal Retail Pharmacy Program Offers Potential Lessons for the USMS

During our evaluation, we spoke with officials from the DHA, the agency responsible for administering TRICARE.[35] We found that, in administering its retail pharmacy benefit program, TRICARE historically experienced challenges like those currently experienced by the USMS. Prior to 1998, TRICARE maintained agreements with regional managed care vendors to provide beneficiaries access to medical as well as mail order and retail pharmacy services when beneficiaries could not easily access those services at DOD medical treatment facilities.[36] DHA officials found that under those managed care contracts they were unable to differentiate retail pharmacy drug costs from other managed care contract costs and, as a result, they could not determine whether the drug costs TRICARE was being charged by the managed care vendors were reasonable compared to other federal direct-purchasing options available to DOD.[37] Ultimately, DHA cited these challenges as part of its rationale when it carved out the mail order portion of its pharmacy benefit from the regional managed care contracts in 1998 and carved out the rest of the retail pharmacy benefit in 2001, placing them both under one centrally managed benefit.

---

[32] Regarding the use of the AWP as a benchmark for drug reimbursement under Medicare Part B, see Medicare Prescription Drug, Improvement, and Modernization Act (MPDIMA) of 2003, Pub. L. No. 108-173, and accompanying H.R. REP. NO. 108-391, 108th Cong., at 582 (2003). The section of the MPDIMA related to changes in drug pricing methodology is codified at 42 U.S.C. § 1395w-3a. The MPDIMA also allowed for Medicare Part B reimbursement rates for drugs infused through durable medical equipment to remain benchmarked to the AWP (see 42 U.S.C. § 1395u(o)(D)(i)).

[33] Regarding the use of the AWP in setting upper limits for Medicaid reimbursement rates for certain brand name drugs, see 42 C.F.R. § 447.512(b).

[34] *New England Carpenters Health Benefits Fund* v. *First Databank, Inc.*, No. 05-11148, 2009 WL 2408560 (D. Mass. Aug. 3, 2009).

[35] According to DOD, in FY 2021 TRICARE had 9.6 million beneficiaries.

[36] TRICARE contracts were created and phased in beginning in 1993. These contracts divided the continental United States into seven regions, each with its own managed care support contractor. According to DHA documentation provided to the OIG, TRICARE managed care contracts were established in response to the closure of military installations, including military medical facilities. According to DHA documentation, "although military pharmacies continue to play an important role in military medicine, the majority of prescription workload and costs has shifted to retail network pharmacies and a mail order program."

[37] In addition to FSS prices, DOD can also purchase drugs at "Big 4 prices." See the Introduction of this report for more information about Big 4 pricing.

Since carving out TRICARE pharmacy services from other medical services in its managed care contracts, DHA has implemented an alternative contract model through which the PBM administers and manages a retail pharmacy network and reimburses retail pharmacies based on rates the PBM has negotiated with those retail pharmacies. Under this contract model, the PBM acts as a fiscal intermediary for DHA and reimburses the retail pharmacies the cost of a claim (i.e., drug cost and dispensing fee); the government will also pay the PBM a separate fee for each transaction it processes. The costs the PBM reimburses to the retail pharmacies are known to the government, and, if the total actual reimbursement costs in a reported year exceeds the total expected government costs for reimbursement, which are negotiated prior to the start of services, the difference between the actual costs and the total expected government costs for reimbursement will be recouped by the government from the PBM for that reported year.

Conclusion

We acknowledge that DHA spends much more on drugs than does the USMS. For example, in FY 2020 TRICARE's outpatient mail order and retail network pharmacy spending was approximately $5.67 billion.[38] This is far greater than the approximately $25.6 million the USMS paid Heritage through the Pharmacy Program for both detainee drugs and Pharmacy Program management services during the same fiscal year. As a result, DHA has much greater leverage over pharmaceutical industry vendors to obtain lower prices than does the USMS. Notwithstanding this difference in purchasing power, we believe that the prices other federal agencies pay for drugs and the way they procure those drugs can serve as an important baseline for the USMS in its future efforts to determine whether its Pharmacy Program prices are reasonable, whether its pricing benchmarks are appropriate, and whether its contract model is the most cost-effective model to provide quality healthcare to USMS detainees. However, the USMS will not be able to make such an assessment until it has data that would allow it to understand its own Pharmacy Program costs.[39]

Recommendation

Therefore, to improve oversight of the Pharmacy Program, we recommend that the USMS:

2. Seek to incorporate into the National Managed Care Contract Pharmacy Program cost-reporting requirements that would allow the USMS to determine whether the prices it pays for drugs are comparable to the Federal Supply Schedule, to negotiate lower drug prices, and to assess whether alternative contract types and pricing schedules might reduce overall drug and drug delivery costs.

---

[38] DOD Military Health System, "Annual Evaluation of the TRICARE Program," www.health.mil/Military-Health-Topics/Access-Cost-Quality-and-Safety/Health-Care-Program-Evaluation/Annual-Evaluation-of-the-TRICARE-Program (accessed December 15, 2022).

[39] We acknowledge that firm-fixed price contracts are designed to limit the administrative burden, such as that for vendor cost reporting, associated with contract administration. Further, we acknowledge that, pursuant to existing contract terms of the NMCC, Heritage is under no obligation to provide to the USMS data that would allow the USMS to determine how much of what it pays Heritage under the Pharmacy Program is applicable to drug costs. While cost reporting could be an administrative burden that increases contract costs, the USMS lacks sufficient data about drug costs under the NMCC to determine whether the costs associated with that burden outweigh the cost savings that could be achieved by leveraging information to negotiate lower drug prices or consider alternative contract types and pricing schedules that might reduce overall drug costs.

Non-Pharmacy Program Drug Procurement Lacks an Important Internal Control

We found in the USMS's non-Pharmacy Program drug procurement process a lack of an important internal control. Specifically, there is no drug cost control for drugs purchased by non-Pharmacy Program intergovernmental agreement (IGA) facilities for which the USMS is separately invoiced. Consequently, the USMS is at risk of paying unnecessarily high prices for drugs purchased by those IGA facilities.

As described in the Introduction, the USMS reimbursed pharmacies from which non-Pharmacy Program IGA facilities independently purchased drugs $2.2 million during FY 2020. While this is a relatively small amount compared to the $25.6 million the USMS paid in overall Pharmacy Program expenses that year, we found that the USMS is at risk of paying unnecessarily high prices for certain drugs because there is no cost control over non-Pharmacy Program invoiced drug purchases.[40] Instead, the USMS simply reimburses pharmacies from which IGA facilities purchased USMS detainee drugs without prior approval. This is especially concerning because the USMS does not know the procurement methods by which these non-Pharmacy Program IGA facilities obtain drugs or whether those methods are cost-effective.

One control that helps limit the price of USMS Pharmacy Program drug purchases, but is not applied to non-Pharmacy Program drug purchases, is prior authorization. As described in the Introduction, Heritage reviews Pharmacy Program high-priced or non-formulary drug orders to determine whether there is a more cost-effective drug available that is as effective as the drug originally prescribed. Depending on the outcome of the prior authorization review, the order is either approved for purchase or alternative, cheaper drug options are considered in consultation with a physician. A USMS official told us that, in some instances, when reimbursing the costs of non-Pharmacy Program drug purchases, USMS district office staff take it upon themselves to inform USMS headquarters when they receive a high-priced drug invoice (district office staff are the first USMS staff to receive detainee drug invoices). During the same interview, another USMS official told us that the USMS encourages non-Pharmacy Program IGA facilities to consider purchasing drugs at cheaper prices through the Pharmacy Program. However, according to the USMS, non-Pharmacy Program IGA facilities are under no obligation to do so.

Further, in a written response to the OIG, the USMS told us that some IGA facilities so infrequently house detainees that those facilities have no incentive to change their procedures for procuring drugs. As we describe in greater detail in Appendix 4, in addition to the 264 non-Pharmacy Program IGA facilities that routinely housed USMS detainees in FY 2020 (those with an ADP equal to or greater than 1), there were an additional 314 non-Pharmacy Program IGA facilities that did not routinely house USMS detainees in FY 2020 (those that had an ADP of greater than 0 but less than 1). None of these 314 IGA facilities sought reimbursement from the USMS for detainee drugs in FY 2020.

---

[40] As we detail in the Introduction, there were 427 Pharmacy Program IGA facilities that routinely housed USMS detainees during FY 2020; these facilities housed an ADP of 30,545 detainees. Comparatively, there were 264 non-Pharmacy Program IGA facilities that routinely housed USMS detainees during FY 2020; these facilities housed an ADP of 11,764 detainees. The USMS was unable to report the percentage of non-Pharmacy Program IGA facilities that invoice the USMS for detainee drugs and the percentage of IGA facilities that receive a per-diem rate for detainee drugs. This is due in part to the fact that IGA facilities that receive a per-diem rate to cover the cost of USMS detainee drugs may in certain circumstances also seek separate reimbursement from the USMS for specific drugs not regularly prescribed.

Conclusion

While the USMS has asserted that there are reasons why it would not require all non-Pharmacy Program IGA facilities to purchase drugs through the Pharmacy Program, we found that, under the current reimbursement model, the non-Pharmacy Program drug procurement process lacks the important internal control of prior authorization to help limit drug costs.

Recommendation

Therefore, to improve oversight of non-Pharmacy Program drug purchases for which it will be invoiced, we recommend that the USMS:

3. Consider implementing a process by which it could proactively advise on the procurement of high-priced drugs before such drugs are purchased by non-Pharmacy Program intergovernmental agreement facilities.

Conclusions and Recommendations

Conclusion

To fulfill its mission to provide care for the detainees in its custody, the USMS must ensure that detainees receive effective healthcare. Doing so brings inherent logistical challenges. On a given day in FY 2020, more than 40,000 USMS detainees could have been housed in more than 1,000 intergovernmental agreement (IGA) facilities across the country. The USMS does not operate any of these facilities and instead relies on a network of state and local governments or private vendors. Since 2007, the USMS has relied on Heritage Health Solutions, Inc., to facilitate the provision of healthcare, including the provision of drugs, to detainees in USMS custody.[41] During our evaluation, we did not identify any evidence to suggest that Heritage has not fulfilled the terms of the Pharmacy Program task under the National Managed Care Contract (NMCC). However, we did identify risks in the process by which the USMS procures drugs that cause the OIG to question whether the USMS has sufficient information to fully assess Pharmacy Program drug prices or whether the USMS's current contract model for procuring Pharmacy Program goods and services is cost-effective.

Specifically, we found that the USMS received few technically acceptable bids for the NMCC in both prior contracting actions, particularly in 2017, and that there is another strategy that the USMS could consider in future NMCC contracting actions that might better promote competition and help ensure that the USMS is receiving the best possible mix of prices and services for this important program. We also found that the USMS cannot determine how much it spends on drugs under the Pharmacy Program and, as a result, cannot determine whether Pharmacy Program drug prices are comparable to the Federal Supply Schedule (FSS) and use this information to negotiate lower drug costs. Further, the USMS awarded the Pharmacy Program task as a firm-fixed price contract, a contract type that is intended to shift the risk of potential cost increases away from the government. However, because the Pharmacy Program pricing structure is pegged to a moving average (the average wholesale price), the price is not in fact fixed, creating a risk that increased drug costs can shift back to the USMS.

Finally, we found that there is no cost control, such as prior authorization, for drugs purchased by non-Pharmacy Program IGA facilities for which the USMS is separately invoiced. As a result, the USMS is at risk of paying unnecessarily high prices for drugs purchased by these facilities.

Recommendations

To improve oversight of the Pharmacy Program, we recommend that the USMS:

1. Conduct additional market research to test the existing assumption that combining Pharmacy Program and non-Pharmacy Program tasks into one contract is the most cost-effective method to provide quality healthcare to USMS detainees.

[41] As described in in the Introduction, it was not until 2009 that Heritage began operating the Pharmacy Program on the USMS's behalf.

2. Seek to incorporate into the National Managed Care Contract Pharmacy Program cost-reporting requirements that would allow the USMS to determine whether the prices it pays for drugs are comparable to the Federal Supply Schedule, to negotiate lower drug prices, and to assess whether alternative contract types and pricing schedules might reduce overall drug and drug delivery costs.

To improve oversight of non-Pharmacy Program drug purchases for which it will be invoiced, we recommend that the USMS:

3. Consider implementing a process by which it could proactively advise on the procurement of high-priced drugs before such drugs are purchased by non-Pharmacy Program intergovernmental agreement facilities.

Appendix 1: Purpose, Scope, and Methodology

Standards

The OIG conducted this evaluation in accordance with the Council of the Inspectors General on Integrity and Efficiency's *Quality Standards for Inspection and Evaluation* (January 2012).

Purpose and Scope

The OIG conducted this evaluation of the USMS's process for drug procurement, the prices it pays for drugs, and the efforts it makes to control associated costs. Our evaluation initially focused on USMS Pharmacy Program drug prices and spending from FY 2012 through FY 2016. As the evaluation progressed, we extended the scope through FY 2020.[42] We also reviewed non-Pharmacy Program drug procurement and pricing. We excluded from our evaluation the way the BOP and private detention facilities under direct contract with the USMS or U.S. Immigration and Customs Enforcement (ICE) procure drugs for USMS detainees given that these facilities procure drugs for USMS detainees independent of the USMS. Further, we did not evaluate non-Pharmacy Program tasks required by the National Managed Care Contract (NMCC).

Methodology

Our fieldwork, conducted from June 2017 through September 2021, included data collection and analysis, interviews, and document review. At the outset of the coronavirus disease 2019 pandemic in March 2020, the OIG shifted resources to conduct extensive pandemic-related oversight, which delayed our completion and issuance of this report.

Data Collection and Analysis

We focused our data collection and analysis on drug procurement for USMS detainees housed at Pharmacy Program intergovernmental agreement facilities. We analyzed overall USMS Pharmacy Program expenditure data from FY 2012 through FY 2020. Additionally, we reviewed data, provided by Heritage Solutions, Inc., to the USMS in annual reports, to generate generic and brand name drug usage and cost estimates. Heritage presents this data exclusive of the aggregate amount of per-transaction dispense fees ([redacted] per transaction under the 2017 NMCC). As a result, cumulative estimates of Pharmacy Program costs attributed to generic and brand name drug purchases are slightly less than total Pharmacy Program expenditures. Further, we reviewed USMS medical spending under the NMCC to provide context for the scale of USMS Pharmacy Program spending under the NMCC.

During the evaluation, we also sought to compare the prices the USMS paid for drugs to the Federal Supply Schedule (FSS) prices for the same drugs. Because Heritage does not differentiate drug prices from Pharmacy Program prices when billing the USMS, we considered the prices Heritage paid to acquire drugs through its Pharmacy Benefit Manager (PBM) subcontractor to be a proxy for the prices the USMS paid for drugs. We then sought to compare the prices Heritage paid to acquire drugs through its PBM subcontractor

[42] While this evaluation focused on USMS Pharmacy Program drug prices and spending from FY 2012 through FY 2020, in Appendix 2, we provide information about the USMS's use of private detention facilities as of July 31, 2022.

to FSS prices for the same drugs. After analyzing this data and FSS data from FY 2017, the OIG determined that it could not reliably match a sufficient number of transactions to draw a conclusion that would allow the OIG to compare, in aggregate, the prices Heritage paid to its PBM subcontractor for drugs to the costs of the same drugs at FSS prices.

Interviews

We interviewed officials from USMS headquarters; local detention facilities; the DOJ Office of the Deputy Attorney General; Heritage; and federal agencies, other than the USMS, that pay for drugs (including some of their respective Offices of Inspector General).

At USMS headquarters, in the Prisoner Operations Division, we interviewed the Chief of the Prisoner Medical Branch, the NMCC Contracting Officer's Representative/Nurse Consultant, a Supervisory Accountant who helped oversee the NMCC, the Contracting Specialist who awarded the 2017 NMCC, the Chief U.S. Public Health Service Officer who was assigned to the USMS, a Supervisory Contract Officer, and a Medical Officer. At USMS headquarters, we also interviewed the Procurement Executive and the Chief of Procurement Services. Additionally, we interviewed officials from five local detention facilities, including two county jails and three detention centers.

At the DOJ Office of the Deputy Attorney General, we interviewed an Associate Deputy Attorney General responsible for USMS matters.

From Heritage, we interviewed the Senior Director of Clinical Services, the Vice President of Federal Programs, the Program Manager for the USMS NMCC Account, the Vice President of Finance/Accounting and Comptroller, the Financial Reporting Manager/Assistant Comptroller, the Clinical Pharmacist, and the General Counsel.

To gain a greater understanding of how other federal agencies procure drugs, we interviewed officials from several of them. From the Defense Health Agency, we interviewed the Branch Chief of the Purchased Care Branch in the Pharmacy Operations Division, responsible for administering the TRICARE retail pharmacy program. From ICE, we interviewed a Regional Pharmacy Consultant (detailed from the U.S. Public Health Service) with knowledge of the process by which ICE acquires drugs for its detainees. From the U.S. Department of Veterans Affairs Office of Acquisition and Logistics, we interviewed a Contracting Officer and Contract Specialist who work on the Pharmaceutical Prime Vendor Program. From the U.S. Department of Veterans Affairs Office of Inspector General, we interviewed an Audit Manager with subject matter knowledge of federally discounted drug prices. Finally, from the U.S. Department of Health and Human Services (HHS) Office of Inspector General, we interviewed an Assistant Inspector General with subject matter knowledge of Medicare and Medicaid managed care organization cost allocation reporting requirements.

Document Review

For the 2007 and 2017 NMCCs, we reviewed procurement planning (including market research and government cost estimates), vendor bids, performance work statements, and awarded-contract documentation. Additionally, we reviewed USMS reports evaluating Heritage's performance under the NMCC. We also reviewed Heritage documentation, including a Pharmacy Program annual report to the

USMS and other documentation. Further, we reviewed federal laws and regulations related to drug pricing and consulted the Federal Acquisition Regulation. Finally, we reviewed reports about federal drug spending authored by the Congressional Budget Office, U.S. Government Accountability Office, the HHS Office of Inspector General, and the U.S. Department of Defense.

Appendix 2: Status of the USMS's Use of Private Detention Facilities

On January 26, 2021, President Joseph R. Biden issued Executive Order 14006 on Reforming Our Incarceration System to Eliminate the Use of Privately Operated Criminal Detention Facilities, which directed the Attorney General not to renew DOJ contracts with privately operated criminal detention facilities. As of July 31, 2022, the USMS maintained intergovernmental agreements (IGA) with state and local governments to house USMS detainees at 28 private detention facilities under contract with state or local government. Further, as of July 31, 2022, the USMS maintained direct contracts with private detention facility operators to house USMS detainees at eight private detention facilities. Finally, as of July 31, 2022, the USMS utilized contracts negotiated by U.S. Immigration and Customs Enforcement (ICE), a U.S. Department of Homeland Security agency, to house USMS detainees at two private detention facilities. In total, as of July 31, 2022, 22,400 USMS detainees were housed at 38 private detention facilities.

In Tables 3 and 4 below, we detail the private detention facilities the USMS used to house its detainees as of July 31, 2022, as well as the nature of the agreement governing the USMS's relationship with those facilities and the USMS detainee population at those facilities as of that date.

Table 3

Private Detention Facilities Housing USMS Detainees, by State, as of July 31, 2022

Detention Facility Name	Location	Nature of Agreement	USMS Population
CCA Central Arizona Detention Center	Florence, AZ	Contract with the USMS	3,701
San Luis Regional Detention and Support Center	San Luis, AZ	Contract with state or local government	580
Central Valley Annex	McFarland, CA	Contract with ICE	203
El Centro Detention Facility	El Centro, CA	Contract with the USMS	307
Otay Mesa Detention Center	San Diego, CA	Contract with ICE	539
Western Region Detention Facility	San Diego, CA	Contract with the USMS	443
Aurora Processing Center	Aurora, CO	Contract with the USMS	35
Citrus County Detention Facility	Lecanto, FL	Contract with state or local government	58
Robert A. Deyton Detention Facility	Lovejoy, GA	Contract with the USMS	548
Irwin County Detention Facility	Ocilla, GA	Contract with state or local government	412
Tallahatchie County Correctional Facility	Tutwiler, MS	Contract with state or local government	451
Cibola County Correctional Center	Milan, NM	Contract with state or local government	763
Otero County Prison Facility	Chaparral, NM	Contract with state or local government	580

Table 3 (Continued)

Torrance County Detention Facility	Estancia, NM	Contract with state or local government	51
Nevada Southern Detention Center	Pahrump, NV	Contract with the USMS	585
Northeast Ohio Correctional Center[a]	Youngstown, OH	Contract with state or local government	804
Cimarron Correctional Facility	Cushing, OK	Contract with state or local government	1,177
Columbia Regional Care Center	Columbia, SC	Contract with the USMS	10
Jefferson County Downtown Jail	Beaumont, TX	Contract with state or local government	271
Fannin County Detention Center	Bonham, TX	Contract with state or local government	362
Kinney County Detention Center	Brackettville, TX	Contract with state or local government	398
Johnson County Detention Center	Cleburne, TX	Contract with state or local government	270
Joe Corley Detention Facility	Conroe, TX	Contract with state or local government	806
Val Verde Correctional Facility	Del Rio, TX	Contract with state or local government	1,257
Eagle Pass Correctional Center	Eagle Pass, TX	Contract with state or local government	691
Eden Detention Center	Eden, TX	Contract with state or local government	831
Brooks County Detention Center	Falfurrias, TX	Contract with state or local government	424
Limestone County Detention Center	Groesbeck, TX	Contract with state or local government	591
Rolling Plains Regional Jail and Detention Center	Haskell, TX	Contract with state or local government	250
Karnes County Correctional Center	Karnes City, TX	Contract with state or local government	490
East Hidalgo Detention Center	La Villa, TX	Contract with state or local government	1,363
Rio Grande Detention Center	Laredo, TX	Contract with the USMS	729
Webb County Detention Center	Laredo, TX	Contract with state or local government	24
IAH Polk Adult Detention Facility	Livingston, TX	Contract with state or local government	49
Coastal Bend Detention Center	Robstown, TX	Contract with state or local government	910

Table 3 (Continued)			
West Texas Regional Detention Facility	Sierra Blanca, TX	Contract with state or local government	1,069
Jack Harwell Detention Center	Waco, TX	Contract with state or local government	341
Parker County Jail	Weatherford, TX	Contract with state or local government	27
Total			**22,400**

[a] The USMS terminated its contract with the operator of the Northeast Ohio Correctional Center on May 31, 2021. The USMS continues to house detainees at this facility pursuant to an IGA with Mahoning County, Ohio. Mahoning County maintains a separate agreement with the operator of the facility to house USMS detainees.

Source: USMS

Table 4

Nature of Agreement of Private Detention Facilities Housing USMS Detainees, as of July 31, 2022

Nature of Agreement	Number of Facilities	USMS Population
Contract with state or local government	28	15,300
Contract with the USMS	8	6,358
Contract with ICE	2	742
Total	**38**	**22,400**

Source: USMS

Appendix 3: National Managed Care Contract Pricing Schedules

During the period of the first National Managed Care Contract (NMCC), the USMS and Heritage Health Solutions, Inc., agreed to two different Pharmacy Program pricing schedules. The first pricing schedule was in effect between FY 2009 and January 2013.[43] Following a contract modification in February 2013, the second pricing schedule was in effect until the end of FY 2017. For the first pricing schedule, [redacted] Additionally, between FY 2009 and January 2013, [redacted] See details for Heritage's first pricing schedule for the 2007 NMCC in Table 5.

Table 5

Heritage Pricing Schedule for the USMS Pharmacy Program Under the 2007 NMCC, FY 2009–January 2013

Drug Type	Percentage off the AWP	Dispense Fee
Generic–Retail	[redacted]	[redacted]
Generic–Mail Order	[redacted]	[redacted]
Brand Name–Retail	[redacted]	[redacted]
Brand Name–Mail Order	[redacted]	[redacted]

Source: USMS

Since February 2013, [redacted] See details for Heritage's second pricing schedule for the 2007 NMCC in Table 6.

Table 6

Heritage Pricing Schedule for the USMS Pharmacy Program Under the 2007 NMCC, February 2013–FY 2017

Drug Type	Percentage off the AWP	Dispense Fee
Generic	[redacted]	[redacted]
Brand Name	[redacted]	[redacted]

Source: USMS

[43] As described in in the Introduction, it was not until 2009 that Heritage began operating the Pharmacy Program on the USMS's behalf.

For the 2017 NMCC, Heritage's pricing schedule provides the USMS [redacted] the pricing schedules of the 2007 NMCC; the 2017 NMCC pricing schedule [redacted] See details for Heritage's pricing schedule for the 2017 NMCC in Table 7.

Table 7

Heritage Pricing Schedule for the USMS Pharmacy Program Under the 2017 NMCC, FYs 2018–2027

Drug Type	Percentage off the AWP	Dispense Fee
Generic	[redacted]	[redacted]
Brand Name	[redacted]	[redacted]
Specialty	[redacted]	[redacted]
Multi-Compound	[redacted]	[redacted]

Source: USMS

Appendix 4: Average Daily Population Data for All Intergovernmental Agreement Facilities

In the Introduction to this report, we provided USMS population data for detainees housed at intergovernmental agreement (IGA) detention facilities that routinely housed USMS detainees during FY 2020. We defined IGA facilities that "routinely housed USMS detainees" as those IGA facilities with an average daily population (ADP) of greater than or equal to 1. According to the USMS, IGA facility ADP is calculated as the number of detainee bed days divided by days in a fiscal year. Therefore, IGA facilities that routinely housed USMS detainees provided the USMS with at least 365 bed days per fiscal year. An IGA facility could provide the USMS at least 365 bed days a year in several ways. For example, an IGA facility could have an ADP of 1 if the IGA facility housed just 1 USMS detainee every day of a fiscal year or if it housed 365 USMS detainees on just 1 day of a fiscal year (even if it housed no other USMS detainees during the rest of the fiscal year). In Table 8, we present the total number of IGA facilities with an ADP greater than or equal to 1 during FY 2020, as well as the total number of USMS detainees housed in those IGA facilities during the same year.

Table 8

Number of IGA Facilities and ADP at Facilities with an ADP Greater Than or Equal to 1 (Routinely Used Facilities), FY 2020

	Pharmacy Program	Non-Pharmacy Program	Totals
Number of IGA Facilities	427	264	691
Average Daily Population	30,545	11,764	42,309

Source: USMS

The USMS also houses detainees at other IGA facilities it uses less frequently than those it routinely uses. We define IGA facilities the USMS "uses less frequently than those it routinely uses" as those that have an ADP greater than 0 but less than 1. Such IGA facilities would provide the USMS with at least 1 bed day per fiscal year but fewer than 365 bed days in the same fiscal year. IGA facilities that the USMS uses less frequently than it routinely uses may be in rural locations or other locations where the USMS's need for detainee bed space varies. We note that, according to USMS data, IGA facilities with an ADP greater than 0 but less than 1 neither purchased drugs for USMS detainees through the Pharmacy Program nor invoiced the USMS for USMS detainee drugs during FY 2020. In Table 9 below we present the total number of IGA facilities with an ADP of greater than 0 but less than 1 during FY 2020, as well as the ADP of USMS detainees housed in those IGA facilities during the same fiscal year.

Table 9

Number of IGA Facilities and ADP at IGA Facilities with an ADP Greater Than 0 but Less Than 1 (Less Routinely Used Facilities), FY 2020

	Pharmacy Program	Non-Pharmacy Program	Totals
Number of IGA Facilities	21	314	335
Average Daily Population	6	56	62

Source: USMS

Appendix 5: The USMS's Response to the Draft Report

U.S. Department of Justice

United States Marshals Service

Office of Professional Responsibility

Washington, DC 20530-0001

December 13, 2022

MEMORANDUM TO: Rene L. Roque
Assistant Inspector General
Office of the Inspector General

FROM: Geoffrey S. Deas
Assistant Director

GEOFFREY DEAS
Digitally signed by GEOFFREY DEAS
Date: 2022.12.13 15:33:59 -05'00'

SUBJECT: Response to Draft Audit Report: Evaluation of the United States Marshals Service's Pharmaceutical Drug Costs and Procurement Process

This is in response to correspondence from the Office of the Inspector General (OIG), requesting comment on the recommendations associated with the subject draft audit report. The United States Marshals Service (USMS) appreciates the opportunity to review the Report and concurs with the recommendations therein. Actions planned by the USMS with respect to OIG's recommendations are outlined in the attached response.

Should you have any questions or concerns regarding this response, please contact Krista Eck, External Audit Liaison, at 202-819-4371.

Attachments

cc: Allison Russo
Deputy Assistant Inspector General
Office of the Inspector General

Bradley Weinsheimer
Associate Deputy Attorney General
Department of Justice

Louise Duhamel
Acting Assistant Director, Audit Liaison Group
Internal Review and Evaluation Office
Justice Management Division

Silas V. Darden
Chief of Staff
United States Marshals Service

United States Marshals Service Response to the
Office of Inspector General Draft Report
Evaluation of the U.S. Marshals Service's Pharmaceutical Drug Costs and Procurement Process

Recommendation 1: Conduct additional market research to test the existing assumption that combining Pharmacy Program and non-Pharmacy Program tasks into one contract is the most cost-effective method to provide quality healthcare to USMS detainees.

USMS Response (Concur): The United States Marshals Service (USMS) concurs with Recommendation #1. Prior to issuing a solicitation for a follow-on contract for the National Medical Care contract, the USMS will conduct additional market research to evaluate the merits, practicality, and cost-effectiveness of issuing separate solicitations for the healthcare and pharmaceutical portions of the program.

Recommendation 2: Seek to incorporate into the National Managed Care Contract Pharmacy Program cost-reporting requirements that would allow the USMS to determine whether the prices it pays for drugs are comparable to the Federal Supply Schedule, to negotiate lower drug prices, and to assess whether alternative contract types and pricing schedules might reduce overall drug and drug delivery costs.

USMS Response (Concur): The USMS concurs with Recommendation #2. As part of the follow-on contract that addresses USMS prisoner pharmaceutical requirements, the USMS will require that the offeror, as part of the cost proposal, provide the USMS with current pricing schedule for routinely prescribed pharmaceuticals. Additionally, the selected service provider will be required to provide routine reports describing the unit cost of pharmaceuticals prescribed separate from any service fees charged to dispense the pharmaceuticals.

Recommendation 3: Consider implementing a process by which it could proactively advise on the procurement of high-priced drugs before such drugs are purchased by non-Pharmacy Program intergovernmental agreement facilities.

USMS Response (Concur): The USMS conditionally concurs with Recommendation #3. It is the USMS' understanding that in the limited instances where a particular facility does not participate in the USMS contract pharmacy program, these facilities are contractually precluded by their healthcare service providers from obtaining pharmaceuticals from third-party sources. Accordingly, while the USMS could attempt to exercise more control over how detention facilities procure pharmaceuticals for USMS prisoners remanded to their custody, the USMS might have limited capabilities to compel the use of third-party sources, such as the USMS contract pharmacy program.

Appendix 6: OIG Analysis of the USMS's Response

The OIG provided a draft of this report to the USMS for its comment. The USMS's response is included in Appendix 5 to this report. The OIG's analysis of the USMS's response and the actions necessary to close the recommendations are discussed below.

Recommendation 1

Conduct additional market research to test the existing assumption that combining Pharmacy Program and non-Pharmacy Program tasks into one contract is the most cost-effective method to provide quality healthcare to USMS detainees.

Status: Resolved.

USMS Response: The USMS concurs with Recommendation 1. Prior to issuing a solicitation for a follow-on contract for the National Medical Care contract, the USMS will conduct additional market research to evaluate the merits, practicality, and cost-effectiveness of issuing separate solicitations for the healthcare and pharmaceutical portions of the program.

OIG Analysis: The USMS's planned actions are responsive to the recommendation. The OIG notes that market research need not be limited to the period immediately before the award of a contract. The USMS can conduct ongoing market research to test the assumption that combining Pharmacy Program and non-Pharmacy Program tasks into one contract is the most cost-effective method to provide quality healthcare to USMS detainees. Such research can include both gaining an increased understanding of its current drug purchasing trends and comparing the prices it pays through the Pharmacy Program—for routinely prescribed, as well as other high-cost, drugs—to other drug prices including Federal Supply Schedule drug prices. The OIG will consider market research activity undertaken by the USMS in preparation for future healthcare and pharmaceutical contracts in determining when this recommendation can be closed. By April 1, 2023, please describe the USMS's efforts consistent with the foregoing analysis.

Recommendation 2

Seek to incorporate into the National Managed Care Contract Pharmacy Program cost-reporting requirements that would allow the USMS to determine whether the prices it pays for drugs are comparable to the Federal Supply Schedule, to negotiate lower drug prices, and to assess whether alternative contract types and pricing schedules might reduce overall drug and drug delivery costs.

Status: Resolved.

USMS Response: The USMS concurs with Recommendation 2. As part of the follow-on contract that addresses USMS prisoner pharmaceutical requirements, the USMS will require that the offeror, as part of the cost proposal, provide the USMS with current pricing schedule for routinely prescribed pharmaceuticals. Additionally, the selected service provider will be required to provide routine reports describing the unit cost of pharmaceuticals prescribed separate from any service fees charged to dispense the pharmaceuticals.

OIG Analysis: The USMS's planned actions are responsive to the recommendation. For the USMS to best be able to compare the prices it pays for drugs to those available on the Federal Supply Schedule, it should require pricing schedules in future cost proposals to indicate if drug prices are inclusive of program management or other service fees. If the USMS pursues that action, the USMS can take steps to address this recommendation before the current National Managed Care Contract expires in 2027. Specifically, as suggested above, the USMS can both gain an increased understanding of its current drug purchasing trends and compare the prices it pays through the Pharmacy Program—for routinely prescribed, as well as other high-cost, drugs—to other drug prices including Federal Supply Schedule drug prices. The OIG will consider such activity undertaken by the USMS in preparation for future healthcare and pharmaceutical contracts in determining when this recommendation can be closed. By April 1, 2023, please describe the USMS's efforts consistent with the foregoing analysis.

Recommendation 3

Consider implementing a process by which it could proactively advise on the procurement of high-priced drugs before such drugs are purchased by non-Pharmacy Program intergovernmental agreement facilities.

Status: Resolved.

USMS Response: The USMS conditionally concurs with Recommendation 3. It is the USMS's understanding that in the limited instances where a particular facility does not participate in the USMS contract pharmacy program, these facilities are contractually precluded by their healthcare service providers from obtaining pharmaceuticals from third-party sources. Accordingly, while the USMS could attempt to exercise more control over how detention facilities procure pharmaceuticals for USMS prisoners remanded to their custody, the USMS might have limited capabilities to compel the use of third-party sources, such as the USMS contract pharmacy program.

OIG Analysis: The USMS's planned actions are responsive to the recommendation. By April 1, 2023, please describe any progress the USMS has made in implementing a process to proactively advise on the procurement of high priced drugs purchased by non-Pharmacy Program intergovernmental agreement facilities or explain specific limitations the USMS has encountered in considering such a process.