

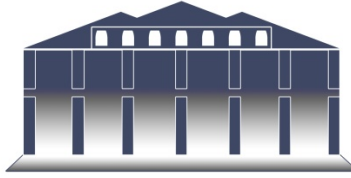
# **Modifications to Inmate Pharmacy Purchasing and Monitoring Could Save \$13.4 Million Annually**



**Final Report to the Joint Legislative  
Program Evaluation Oversight Committee**

**Report Number 2018-09**

**September 17, 2018**



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**NORTH CAROLINA GENERAL ASSEMBLY**  
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*John W. Turcotte*  
Director

September 17, 2018

Senator Brent Jackson, Co-Chair, Joint Legislative Program Evaluation Oversight Committee  
Representative Craig Horn, Co-Chair, Joint Legislative Program Evaluation Oversight Committee

North Carolina General Assembly  
Legislative Building  
16 West Jones Street  
Raleigh, NC 27601

Honorable Co-Chairs:

The 2015–17 Work Plan of the Joint Legislative Program Evaluation Oversight Committee directed the Program Evaluation Division to examine the efficiency and economy of medical and dental services provided for North Carolina state prison inmates. This report is the second in a four-part series and focuses on inmate pharmacy services.

I am pleased to report that the Department of Public Safety cooperated with us fully and was at all times courteous to our evaluators during the evaluation.

Sincerely,

A handwritten signature in black ink, appearing to read "J. W. Turcotte".

John W. Turcotte  
Director



# PROGRAM EVALUATION DIVISION

## NORTH CAROLINA GENERAL ASSEMBLY

September 2018

Report No. 2018-09

# Modifications to Inmate Pharmacy Purchasing and Monitoring Could Save \$13.4 Million Annually

## Summary

The Joint Legislative Program Evaluation Oversight Committee directed the Program Evaluation Division to examine the efficiency and economy of inmate healthcare. This report is the second in a four-part series and focuses on pharmaceutical-related expenditures for inmates, which totaled \$72.7 million in Fiscal Year 2016–17, an 88% (\$33.9 million) increase from five years ago.

**North Carolina's failure to participate in a federal discount program caused the State to pay more for inmate prescription medications than necessary.** The Department of Public Safety (DPS) incorrectly asserts it cannot participate in a federal 340B program, which offers certain governmental units significantly discounted medications. Corrections departments in 16 other states have established such arrangements, which could save North Carolina approximately \$13.3 million annually.

**DPS cannot ensure the effectiveness of the State's expenditures on certain high-cost medications because it allows inmates to keep these medications on their person.** DPS allows inmates to keep supplies of certain medications worth more than \$7,000 each on their person and therefore cannot ensure that inmates are actually self-administering these high-cost prescriptions.

**DPS does not collect sufficient data to take disciplinary action when medications are lost during inmate transfer.** When inmates transfer from one prison to another, their medications travel with them; in Fiscal Year 2016–17, medications worth a combined \$115,000 were lost during this process. Insufficient data collection, internal controls, and monitoring activities have restricted DPS's ability to limit losses.

**Inadequate data collection and oversight of prescriptions filled at local pharmacies prevents DPS from limiting these expenditures and enforcing its short-supply policy.** DPS does not collect and analyze data on medications purchased locally and cannot ensure providers are only writing 10-day-supply prescriptions to be filled at local pharmacies.

**North Carolina does not charge inmates copayments for prescriptions; establishing such charges could generate up to \$1.5 million annually.** Thirteen states charge inmates a copayment for prescriptions.

Based on these findings, the General Assembly should (1) direct DPS and UNC to establish a 340B discount program, (2) direct DPS to require certain high-cost medications not be kept on an inmate's person, (3) direct DPS to establish controls and collect and analyze data on medications lost during inmate transfer, and (4) direct DPS to develop statewide contracts with retail pharmacies for local medication purchases and develop an oversight mechanism for providers ordering such purchases.

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## Purpose and Scope

The 2015–17 Work Plan of the Joint Legislative Program Evaluation Oversight Committee directed the Program Evaluation Division to examine the efficiency and economy of medical and dental services provided for North Carolina state prison inmates. This evaluation only includes healthcare services provided in adult prison facilities and does not include services provided to youth offenders residing in youth detention centers or individuals serving temporary sentences in county jails through the State’s Misdemeanant Confinement Program.

This report is the second in a four-part series on the efficiency and economy of inmate healthcare. This report focuses on inmate pharmacy services that are administratively housed within DPS Health Services’s Operations section.

This evaluation addressed four research questions:

1. How does the State deliver pharmacy services to inmates?
2. How efficient is the provision of pharmacy services to inmates?
3. What measures has the State taken to contain inmate pharmacy costs?
4. How could the provision of inmate pharmacy services be made more efficient?

The Program Evaluation Division collected and analyzed data from several sources, including

- queries and interviews of DPS staff;
- demographic data on the prison population;
- expenditure and revenue data on health services between Fiscal Years 2006–07 and 2016–17;
- contract and corresponding usage data for supplies and services for inmate health services;
- outside health services claims data from DPS’s claims management vendor;
- site inspections of state prison healthcare facilities and interviews with healthcare staff;
- purchasing and contracting data from the Department of Administration (DOA);
- interviews and queries of stakeholders, staff from other states’ corrections departments, and national organizations;
- personnel data for prison and central health services staff from the Office of the State Controller (OSC); and
- a review of data and reports from other states and national organizations on efforts to contain healthcare costs for inmates.

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## Background

**To support the medication needs of inmates, the Department of Public Safety's Health Services division (DPS Health Services) operates three pharmacies.** Central Pharmacy in Apex is DPS Health Services's main pharmacy; here, staff process medication orders for 55 of the State's 57 prisons.<sup>1,2</sup> When medications arrive, pharmacists dispense and label them for inmates per provider instructions. Apex Central Pharmacy staff then package together all medications for a prison's inmates for distribution through a private shipping vendor, the State's courier system, or via pick-up by prison staff.

DPS Health Services operates two additional pharmacies (at Central Prison and the North Carolina Correctional Institute for Women) that primarily process medication orders for inmates in these prisons or in health centers within these prisons.<sup>3</sup>

Exhibit 1 depicts the general process by which DPS obtains and dispenses inmate medications. As the exhibit shows, determination of which pharmacy will process an inmate's prescription is largely based upon the inmate's prison. Each pharmacy is responsible for a number of services, including

- filling and refilling prescriptions from DPS Health Services providers,
- filling prescriptions from outside providers for inmates receiving outside services,
- replenishing lost medications,
- filling medications for starter packs, and
- filling prescriptions for inmates soon to be released.<sup>4</sup>

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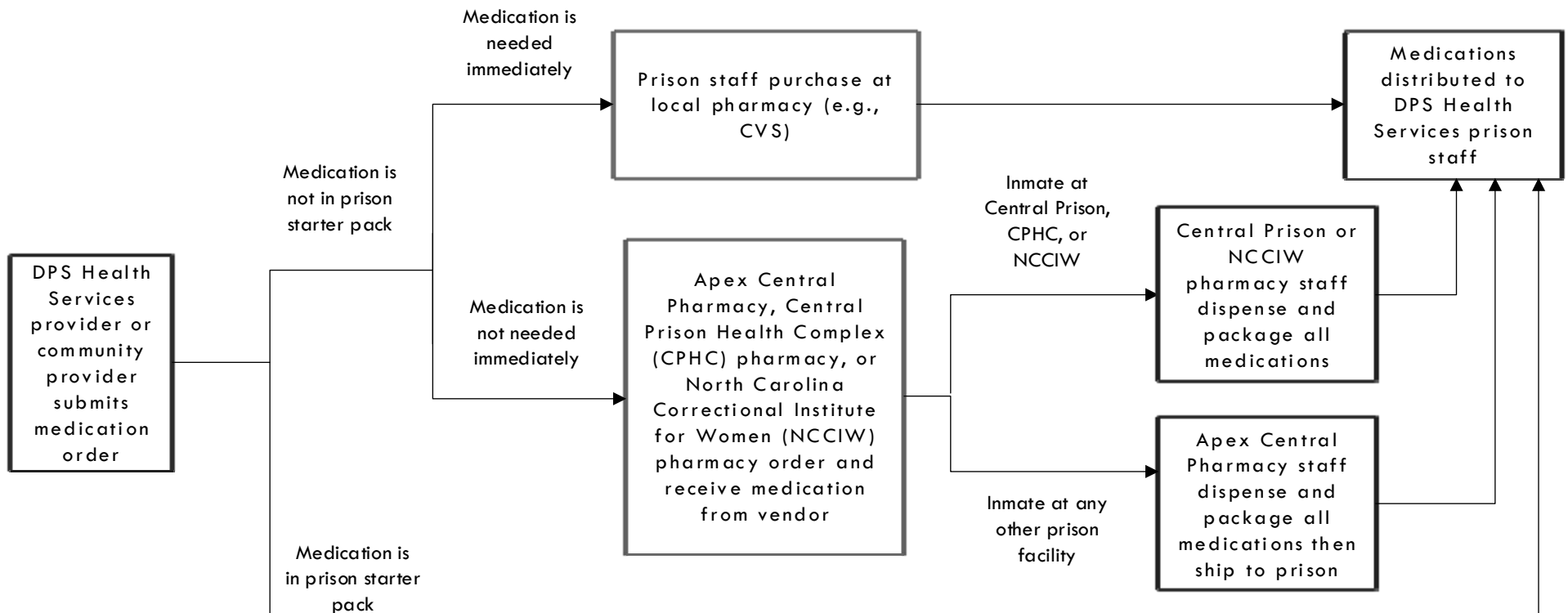
<sup>1</sup> Although the Central Pharmacy in Apex primarily provides pharmaceutical products to these 55 prisons, it does provide some products to Central Prison and the North Carolina Correctional Institution for Women.

<sup>2</sup> Two of these prison facilities are specialized units referred to as Confinement in Response to Violation units.

<sup>3</sup> DPS Health Services contends that operating these two pharmacies allows it to more immediately serve inmates receiving health services at the adjoining higher-level centralized health service facilities of those prisons, which often includes inmates who are there only for health services purposes.

<sup>4</sup> Starter packs are supplies of commonly used medications kept within each prison, the contents of which are determined through discussions between staff at Central Pharmacy in Apex and health services staff at each prison. Central Prison's pharmacy and the North Carolina Correctional Institute for Women's pharmacy are also responsible for filling medications for starter packs when their starter packs or pharmacies do not hold a supply of a necessary medication and they need to order it from the vendor.

## Exhibit 1: Three Pharmacies Acquire and Distribute Inmate Medications



Notes: This exhibit does not account for intravenous medications that are processed by the Central Prison pharmacy or North Carolina Correctional Institute for Women pharmacy, unless the intravenous medications are obtained from a local pharmacy. Keep on Person medications that come out of starter packs are provided directly to the inmate as opposed to being administered under observation.

Source: Program Evaluation Division based on interviews with DPS Health Services staff and review of DPS policies and procedures.

**DPS Health Services purchases most of its medications through a multi-state purchasing consortium that limits the State's expenditures on inmate medications.** Each of DPS Health Services's three pharmacies orders the majority of its medications through the Minnesota Multistate Contracting Alliance for Pharmacy (MMCAP). MMCAP is a free, voluntary group-purchasing organization for government entities that provide healthcare services. An additional 45 state departments of corrections and other government entities ranging from health departments to state psychiatric facilities also participate in the program. MMCAP is one of a limited number of purchasing programs offering savings for medications that are available to government entities, and it is a primary way state departments of corrections achieve savings on retail medication prices.

MMCAP's bulk purchasing power enables it to negotiate discounts with vendors and pass savings on to members. Members also receive volume discounts based on their percentage of total purchases statewide. MMCAP reports its members achieve savings of approximately 24% off the average wholesale price for brand-name drugs and 65% off the average wholesale price for generic drugs.

When a medication is not available through MMCAP, a state's distributor can either provide the medication through an alternative contract or purchase off-contract. Many newer medications are off-contract and, as a result, MMCAP members pay higher prices; thus, although an entity like DPS Health Services pays more for these medications, they are still counted as having been distributed through its MMCAP vendor. DPS Health Services staff report working with vendors to lower the price of Hepatitis C medications even below MMCAP vendor prices.

**Instances arise in which DPS Health Services prison staff cannot wait for delivery of medications from a distributor or from Central Pharmacy in Apex and must purchase them from a local vendor.**

Although most medications are purchased through MMCAP, DPS Health Services prison staff sometimes need to purchase medications from a private vendor within the community. As shown in Exhibit 1, a prison's starter pack might not contain a medication prescribed by a provider to an inmate that the inmate needs to begin taking immediately upon entering the facility. In these instances, DPS Health Services prison staff cannot wait approximately two to three days for a medication shipment from the Apex Central Pharmacy and instead must purchase these medications at a local pharmacy such as CVS.

**The first report in this series showed that state expenditures for inmate health have increased by approximately \$89 million in the last 10 years.<sup>5</sup>** North Carolina spent \$6,923 per inmate on healthcare in Fiscal Year 2014–15, which was higher than 31 other states and \$1,023 (21%) more than the national median of \$5,720. Two years later, DPS Health Services paid \$322 million, or approximately \$8,591 per inmate, for these services in Fiscal Year 2016–17. As that report discusses, several factors led to increasing state expenditures for inmate healthcare,

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<sup>5</sup> Program Evaluation Division. (2018, August). Improvements to Inmate Healthcare Reimbursement and Internal Processes Could Save \$4.3 Million Annually. Report to the Joint Legislative Program Evaluation Oversight Committee. Raleigh, NC: General Assembly.



including a growing number of inmates having certain expensive-to-treat conditions and an increasing portion of the prison population being age 50 or older.

**As Exhibit 2 shows, pharmacy expenditures represented the highest rate of growth among DPS Health Services budgeting areas in the last five years.** Pharmacy expenditures for inmate healthcare have increased 88% (\$33.9 million) in the last five years, the highest percentage change of any programmatic health services area.<sup>6</sup>

**Exhibit 2: Inmate Pharmacy Expenditures Have Increased by 88% in the Last Five Years**

DPS Health Services Budgeting Area	Fiscal Year 2012–13 Expenditures	Fiscal Year 2016–17 Expenditures	Five Year Difference in Expenditures	Five Year Percentage Difference in Expenditures
Pharmacy	\$ 38,725,308	\$ 72,662,715	\$ 33,937,407	88%
Mental Health	22,341,362	30,858,472	8,517,110	38
General Health	165,184,397	206,879,130	41,694,733	25
Dental	9,838,424	11,647,615	1,809,191	18
<b>Total</b>	<b>\$ 236,089,490</b>	<b>\$ 322,047,931</b>	<b>\$ 85,958,441</b>	<b>36%</b>

Notes: Expenditures only include those reported by the respective budget fund code and do not account for expenditures in other budget fund codes as discussed in the first Program Evaluation Division report in this series. For example, the Program Evaluation Division found the salaries of several central office DPS Health Services staff are reflected in budget fund codes not included within this exhibit. Values for categories shown may not add up to total due to rounding.

Source: Program Evaluation Division based on interviews with DPS staff and data from the North Carolina Accounting System.

Within total pharmacy expenditures, prescription medication expenses have grown at a faster rate than expenses overall and accounted for 85.2% of all pharmacy expenditures in Fiscal Year 2016–17. During that year, DPS Health Services spent \$61.9 million on prescription medications, a 71% increase from Fiscal Year 2014–15 when the department spent \$36.3 million on prescription medications. A primary contributor to this increase was the development and distribution of new, higher-cost medications that can now cure Hepatitis C rather than simply treat it. In Fiscal Year 2016–17, DPS spent more than \$19 million on these medications, which did not exist in 2014.

Both the General Assembly and the Office of the State Auditor (OSA) have demonstrated recent interest in inmate pharmacy services. In 2009, OSA issued a report on the Apex Central Pharmacy’s practices regarding supply inventory and disposition of expired medications. In 2014, the General Assembly required DPS to report on an alternative method (340B) to contain prescription drug costs (discussed in Finding 1).<sup>7</sup>

<sup>6</sup> Although spending on General Health services increased more in actual dollars spent (\$41.7 million) over the five-year period, its percentage increase (25%) was substantially less than the percentage increase in pharmacy expenditures (88%).

<sup>7</sup> N.C. Sess. Law 2014-100, Section 16C.13.

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## Findings

### **Finding 1. Failure to participate in the 340B program causes North Carolina to pay more for inmate prescription medications than necessary.**

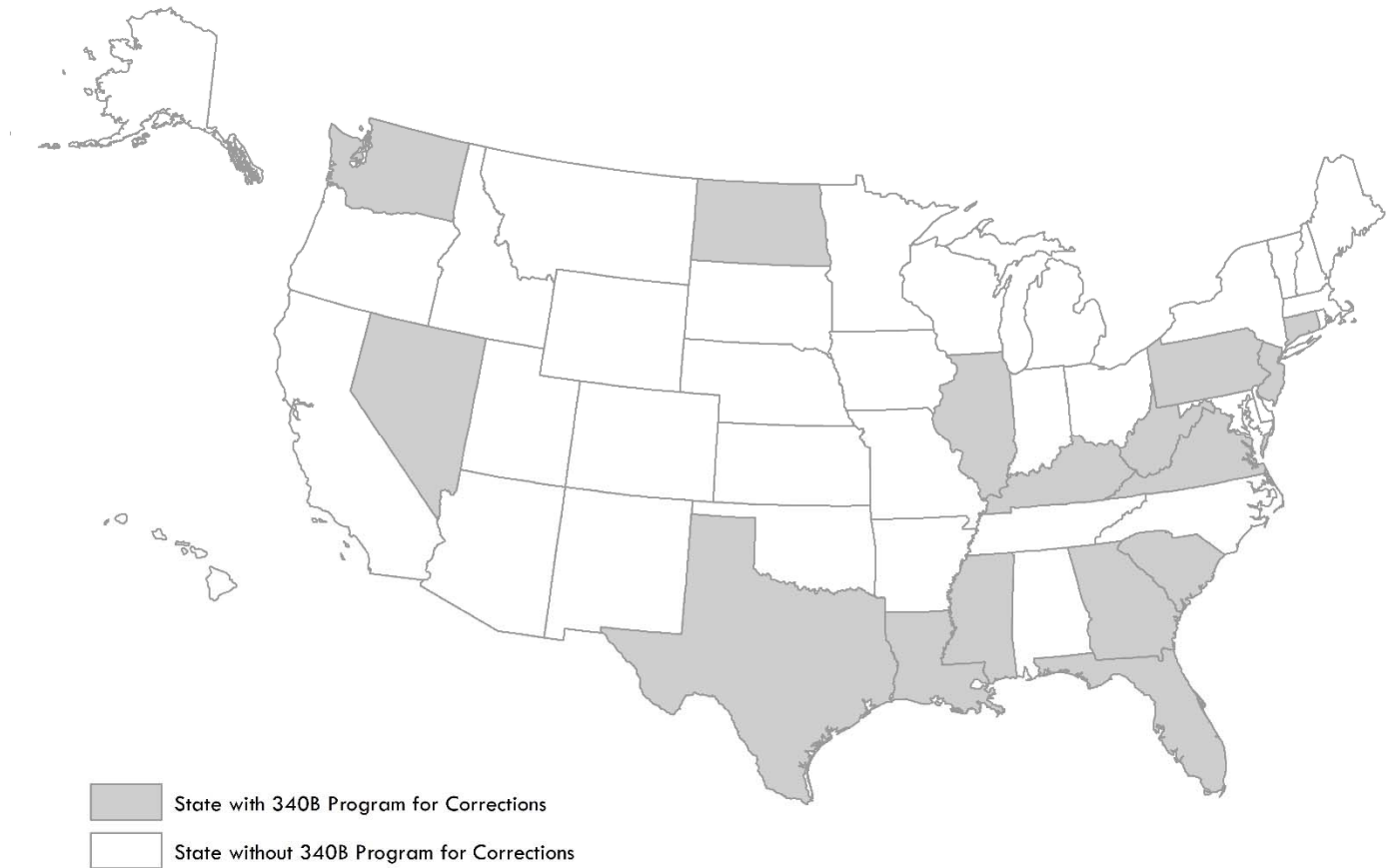
To summarize the finding below, DPS Health Services purchases medications at discounted rates through participation in a multi-state purchasing consortium. An additional purchasing arrangement, the 340B program, exists at the federal level and also gives participating entities significant savings on medication purchases. In a 2015 memorandum to select General Assembly oversight committees, DPS failed to identify all opportunities available to the State for purchasing inmate medications through the 340B program. Program Evaluation Division interviews with other states and experts reveal that at least 16 state departments of corrections use a 340B arrangement. Should DPS be required to pursue 340B participation for two high-cost groups of medications, the Program Evaluation Division estimates DPS Health Services would realize initial annual savings of approximately \$13.3 million and could save even more in future years with the addition of other types of medications. Implementing such a program would require the willing collaboration of both DPS Health Services and a covered entity such as UNC Hospitals.

As discussed in the Background, many state departments of corrections—including North Carolina’s DPS—purchase medications at discount prices through participation in the Minnesota Multistate Contracting Alliance for Pharmacy (MMCAP). Another method government entities use to control inmate prescription medication costs is to obtain high-cost medications through the federal 340B Drug Discount Program, codified in 1992 under Section 340B of the Public Health Service Act. Congress created the 340B program to assist certain community-based providers that treat a large number of low-income or uninsured patients in purchasing drugs at advantageous prices. Eligible providers include

- federally qualified health centers,
- Ryan White HIV/AIDS grantees,
- hospitals that serve a large number of Medicaid enrollees and uninsured individuals, and
- other safety net providers.

**Although departments of corrections themselves cannot qualify as 340B entities, 16 states have established partnerships allowing them to obtain inmate medications at significantly discounted prices through this program.** Per federal guidelines, departments of corrections are not able to directly qualify as eligible providers for the 340B program. However, the Program Evaluation Division identified at least 16 state departments of corrections that have entered into such agreements with entities that are covered such as public university-affiliated hospitals and health departments. Exhibit 3 shows a map of the 16 states with 340B programs as of 2017.

### Exhibit 3: Sixteen State Corrections Departments Use the 340B Program to Purchase Prescriptions



Source: Program Evaluation Division based on information from the Pew Charitable Trusts.

During interviews, several departments of corrections stated that they use the 340B program exclusively for high-cost medications such as those for treating conditions like Hepatitis C, HIV/AIDS, or hemophilia because program participation requires compliance auditing with complex rules. Conversely, Texas uses its 340B program to purchase up to 80% of all medications used by its inmates.

**DPS asserted in 2015 that it is unable to participate in the 340B program because its hospital cannot be certified as a covered entity, failing to acknowledge the potential for participation through a partnership with a covered entity.** In 2014, the General Assembly directed DPS to evaluate the potential of using a 340B program to reduce medication costs.<sup>8</sup> Specifically, the General Assembly required:

The Department of Public Safety, Division of Adult Correction, shall study opportunities for the State to obtain savings under the 340B Drug Pricing Program on drugs provided to prisoners in State correctional facilities. The Division shall conduct this study in

<sup>8</sup> N.C. Sess. Law 2014-100, Section 16C.13.

conjunction with the University of North Carolina Health Care System.<sup>9</sup>

DPS submitted its required report as a June 22, 2015 memorandum to various legislative committees overseeing justice and public safety matters. The report asserted the following:

NCDPS Health Services facilities and patients do not meet the stringent eligibility criteria established by Section 340B of the Public Health Service Act. Based upon the current definition of patient, Central Prison Healthcare Complex Hospital cannot qualify as a Disproportionate Share Hospital and therefore is not eligible for the 340B Program.<sup>10</sup>

**DPS's report to the General Assembly failed to identify opportunities to purchase inmate medications through the 340B program aside from designation of the Central Prison Healthcare Complex (CPHC) as a covered entity.** Although it is accurate that the CPHC is legally prohibited from being designated as a covered entity, the Program Evaluation Division found that this barrier does not mean DPS cannot take advantage of the 340B program. As discussed earlier, the General Assembly's directive was to study opportunities for obtaining medications through the 340B program. The study was not limited to whether the CPHC could be designated as a covered entity, and the study was explicitly required to be conducted in conjunction with the University of North Carolina Health Care System. The DPS memorandum containing the study's findings only explored one opportunity for purchasing inmate medications through the 340B program, and in doing so failed to acknowledge other potential opportunities, such as a partnership with the University of North Carolina Health Care System. Thus, the General Assembly was not presented with full information on all potential opportunities for purchasing inmate medications through the 340B program.

**The Program Evaluation Division found that DPS can participate in the 340B program as long as DPS formally partners with a covered entity to treat patients.** In fact, DPS Health Services already has a contract with one such covered entity, University of North Carolina Hospitals (UNC Hospitals).<sup>11</sup> DPS contracts with UNC Hospitals to provide specialty health care clinics, including one for infectious diseases such as HIV/AIDS. Although these entities are contractually affiliated, DPS does not receive access to the UNC Hospitals's 340B program. Interviews with corrections staff in other states revealed that several departments of corrections partner with a hospital within a state-operated university. The University of North Carolina Health Care System's formal response (which is appended to this report), states that accessing inmate medications through UNC Hospitals's 340B program may be possible using a telemedicine model. According to interviews with legal experts who have implemented

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<sup>9</sup> N.C. Sess. Law 2014-100, Section 16C.13.

<sup>10</sup> Disproportionate Share Hospitals serve a significantly disproportionate number of low-income patients and receive payments from the Centers for Medicare and Medicaid Services to cover the costs of providing care to uninsured patients.

<sup>11</sup> UNC Hospitals is a sub-entity of the University of North Carolina Health Care System.

such programs in other states, developing such a relationship should take only a few months and should include:

- the hiring of an outside legal consultant with expertise in obtaining 340B program participation for inmate medications;
- discussions between DPS and UNC Hospitals to establish shared goals and performance measures and to resolve issues concerning ownership of the medical record and implementation of the partnership, including how medications would be transported to corrections environments; and
- negotiations between DPS and UNC Hospitals to determine the medications for which the 340B program would be used and a cost-effective fee structure for both DPS and UNC Hospitals.

**North Carolina could initially save approximately \$13.3 million per year through the creation of a 340B program.** The savings achieved through participation in a 340B program can be substantial. Texas, which has the highest level of 340B use, estimates it has generated a 60% cost savings during the last five years. Lower-population states interviewed by the Program Evaluation Division reported savings between \$1.2 million and \$3 million annually from using 340B just for HIV/AIDS patients.

As Exhibit 4 shows, the Program Evaluation Division estimates the State could save approximately \$13.3 million annually if it participated in a 340B program just to obtain medications to treat inmates with HIV/AIDS and Hepatitis C. Potential cost savings would be expected to decrease over time as medication prices for these high-cost drugs decline; however, savings also could be increased if the State included additional drugs in its 340B program, such as those used to treat cancer.

**Exhibit 4: North Carolina Could Save Approximately \$13.3 Million Annually by Using a 340B Program to Purchase HIV/AIDS and Hepatitis C Medications**

Use	DPS Cost Range	340B Cost Range	Actual DPS Health Services Spending in 2016-17	Estimated Spending with 340B Program in 2016-17	Potential Annual Savings
Hepatitis C	\$15,647	\$12,619	\$ 18,143,789	\$ 14,418,699	\$ 3,725,089
	to \$24,272	to \$17,733			
HIV	\$1,378	\$355	\$ 13,536,524	\$ 3,941,457	\$ 9,595,067
	to \$2,592	to \$817			
<b>Total</b>			<b>\$ 31,680,312</b>	<b>\$ 18,360,156</b>	<b>\$ 13,320,157</b>

Notes: Unit prices do not include discounts or reductions that may be offered by medication manufacturers and distributors. Hepatitis C medications include Harvoni and Epclusa. HIV medications include Atripla, Descovy, Genvoya, Odefsey, Prezcobix, Prezista, Tivicay, Triumeq, and Truvada. Costs paid by DPS for medications are for Fiscal Year 2016–17. Values for categories shown may not add up to total due to rounding.

Source: Program Evaluation Division based on information from DPS, DOA, and the University of North Carolina at Chapel Hill.

**Finding 2. The Department of Public Safety cannot ensure the effectiveness of state expenditures for high-cost medications because current DPS policies allow inmates to keep some high-cost medications on their person.**

To summarize the finding below, DPS Health Services does, to some degree, consider the cost of a medication in determining whether it allows inmates to keep the medication on their person or requires the medication to be administered by a DPS Health Services staff member. However, DPS Health Services allows certain expensive medications to be kept on an inmate's person. Because DPS Health Services cannot ensure these medications are taken as intended, it cannot ensure the State's expenditures on these high-cost medications are effective.

**Medications for inmates are either kept in the inmate's possession or are kept and administered by DPS Health Services staff.** In Fiscal Year 2016–17, DPS Health Services pharmacies filled approximately 1.6 million prescriptions for inmates. DPS Health Services policy stipulates two primary methods of administering medications.<sup>12</sup>

- **Keep on Person (KOP).** This method involves providing an inmate with a supply of medication that is kept on the inmate's person and self-administered as the inmate deems necessary.
- **Direct Observation Therapy (DOT).** This method involves DPS staff administering a single dose of medication at a pre-defined time and location. At this "pill line" location, staff either hand an inmate a medication or crush the medication into water and observe its consumption. This method of administration ensures inmates take their medications and do not hold onto pills, therefore foregoing treatment, for potential sale or bargaining with other inmates, thereby reducing the risk of abuse.

As Exhibit 5 shows, DPS Health Services policies stipulate which of these two medication administration protocols staff are to follow for different medications. DPS Health Services staff state that they consider a number of factors in determining the protocol for a medication's administration, such as ensuring the administration of medications for certain conditions (i.e., tuberculosis) in an effort to limit outbreaks to other inmates or ensuring a return on investment for high-cost medications (e.g., drugs used to treat Hepatitis C, which cost approximately \$60,000 for a four-month supply).

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<sup>12</sup> DPS Health Services policies stipulate a third method of medication administration called daily self-administration. The Program Evaluation Division grouped this method under the broader category of Keep on Person because the method relies on an inmate picking up a supply of a medication for self-administration throughout the day.

**Exhibit 5: DPS Policies Specify Medication Administration for Inmates as either KOP or DOT**

Medication Administration Protocol and Description	Method(s) and Time of Administration	DPS Health Services Staff Involvement	Example Medications
KOP—Keep on Person (unsecure location accessible by inmate [i.e. cell])	<ul style="list-style-type: none"> <li>• When and where an inmate determines (cafeteria, cell, etc.)</li> <li>• By mouth</li> </ul>	<ul style="list-style-type: none"> <li>• Prescribe and dispense a supply of medication (i.e., 30 days)</li> </ul>	<ul style="list-style-type: none"> <li>• Over the Counter products</li> </ul>
DOT—Direct Observation Therapy (secure location only accessible by staff)	<ul style="list-style-type: none"> <li>• Four pre-defined statewide times (and otherwise as necessary) at a window/door for medication administration (“pill line”)</li> <li>• By mouth or other method as necessary</li> </ul>	<ul style="list-style-type: none"> <li>• Prescribe, dispense, and observe consumption of specific unit of medication (i.e., one pill)</li> </ul>	<ul style="list-style-type: none"> <li>• Controlled substances</li> <li>• Insulin</li> <li>• Psychotropics (mental illness drugs)</li> </ul>

Source: Program Evaluation Division based on interviews, site inspections, and DPS Health Services policies and procedures.

**The cost-effectiveness of the State’s expenditures for high-volume and high-cost medications may be limited because some of these medications are designated as Keep on Person (KOP).** Although DPS Health Services staff stated the price of a medication is a factor in determining its administration protocol, current policy and practice does not reflect this consideration, as several of the costliest prescriptions are designated as KOP. Program Evaluation Division analyses of all medications for which DPS Health Services spent more than \$1 million in Fiscal Year 2016–17 shows that 8 of these 10 drugs are designated KOP.<sup>13</sup> A standard (often 30-day) supply of these eight high-cost KOP medications, most of which are for the treatment of HIV, costs an average of \$1,699 and ranges from \$879 to \$3,081 for a supply.

Research shows medication compliance is not affected when prisoners are issued HIV medications as KOP, and therefore the Program Evaluation Division examined non-HIV KOP medications for which an average monthly supply costs \$1,000 or more. Exhibit 6 shows each of these KOP medications and its respective costs.

<sup>13</sup> Program Evaluation Division analyses show the two medications with the highest expenditures in Fiscal Year 2016–17 were designated DOT, and DPS Health Services staff state this designation is primarily because of their high costs.

**Exhibit 6: The State Spent Nearly \$300,000 in Fiscal Year 2016–17 on 11 Medications Worth More than \$1,000 Per Supply That DPS Allows Inmates to Keep on Their Person**

Keep on Person Medication	Purpose of Medication	Average Cost Per Supply	Total Expenditures in State Fiscal Year 2016–17
Sensipar (90Mg Tab)	Hyperparathyroidism	\$7,376	\$83,088
Sensipar (60Mg Tab)	Hyperparathyroidism	4,919	58,004
Creon (2400 Cap)	Cystic Fibrosis	4,054	52,061
Creon (3600 Cap)	Cystic Fibrosis	2,272	34,185
Gilenya	Multiple Sclerosis	2,002	25,196
Gabitril	Partial Seizures	1,930	12,395
Zenpep (20000 Cap)	Cystic Fibrosis	1,683	9,195
Uceris	Crohn's Disease / Ulcerative Colitis	1,682	7,909
Prograf	Prophylaxis of Organ Rejection	1,515	713
Cresemba	Invasive Aspergillosis or Mucormycosis	1,489	0
Zenpep (40000 Cap)	Cystic Fibrosis	1,138	0
<b>Total</b>			<b>\$282,747</b>

Note: Total expenditures reflect all spending on these Keep On Person (KOP) medications because it is their official designation; data limitations prevented the identification of doses that may have been administered by Direct Observation Therapy (DOT). The Per Supply value corresponds to the pre-defined quantity listed on the medication's packaging. Values for categories shown may not add up to total due to rounding.

Source: Program Evaluation Division based on data from DPS.

**As the exhibit shows, the State spent \$282,747 in Fiscal Year 2016–17 for these 11 KOP medications and therefore has no guarantee of the effectiveness of these expenditures.** Although the medications listed in Exhibit 6 present a low risk for resale or abuse, the State pays between \$1,138 and \$7,376 per supply with no assurances that inmates are taking them. Not taking medications as prescribed makes it less likely that DPS Health Services will be able to manage an inmate's condition and may result in further costs to the State for reasons such as uncontrolled symptoms or relapse. Because DPS Health Services policies allow these high-cost medications to be kept on an inmate's person, the effectiveness of the State's expenditures cannot be guaranteed.

**Finding 3. DPS does not collect sufficient data to take corrective action when medications are lost during inmate transfer.**

To summarize the finding below, DPS Health Services pharmacies replace medications lost or damaged for a variety of reasons. DPS Health Services reports that medication lost while transferring an inmate from one prison to another represents a primary cause of medication loss expenditures. In Fiscal Year 2016–17, approximately \$115,665 in prescription losses occurred during inmate transfer. Medication loss



management reports fail to provide information sufficient to facilitate corrective actions by DPS staff. The lack of oversight of this process likely contributes to unnecessary expenditures to resupply these prescriptions.

At times, inmate medications are lost and must be replaced by one of DPS Health Services's three pharmacies. Appendix A shows the 15 reasons for which DPS Health Services may replace medications. The process of transferring an inmate between prisons is among the most common reasons that medication loss occurs.

**The Program Evaluation Division's review of lost medications reveals that \$115,665 worth of medications and health supplies were lost during the inmate transfer process in Fiscal Year 2016–17.** The Program Evaluation Division only reviewed losses that occurred during inmate transfer. This analysis shows 1,754 instances of items lost during inmate transfer with a total value of \$115,665 in Fiscal Year 2016–17. The most expensive lost item (per supply) was a medication that cost \$23,405, which policy indicated was a DOT medication that was supposed to be in custody staff possession during the inmate's transfer. In Fiscal Year 2016–17, 29 items worth more than \$1,000 each (per supply) were lost during the transfer process. Together, these high-cost items totaled \$53,030, which represents 46% of the total cost of medications lost during inmate transfer in Fiscal Year 2016–17.

Medication loss can affect the health of inmates if not discovered; once discovered, it often contributes to immediate unnecessary expenditures.

- **Local purchases.** If the medication lost in transport is not held within the receiving prison's stock inventory (starter pack), the prison's staff must obtain a partial supply of the medication from a local pharmacy. Local pharmacies, as discussed in Finding 4, are typically not under contract with DPS Health Services and therefore medications purchased from them cost the State more than products purchased and shipped through Central Pharmacy in Apex. DPS Health Services staff do not collect detailed and centralized information on these purchases, and therefore the Program Evaluation Division could not estimate which local pharmacy purchases had resulted from medications lost in transport.
- **Repurchasing by the Apex Central Pharmacy.** Replacing lost items through Central Pharmacy in Apex incurs unnecessary expenditures because the pharmacy not only must replace the item but also pay for shipment to the inmate's current prison.

**DPS Health Services's monitoring of medications lost when inmates are being transferred does not adequately limit such losses and does not facilitate corrective action.** During a transfer, DPS Health Services policy stipulates that medications travel with the inmate.<sup>14</sup> This practice attempts to ensure inmates have access to their medications upon arrival at their new prison facilities and to ensure the use of already-purchased

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<sup>14</sup> During interviews with the Program Evaluation Division, DPS Health Services staff stated that the transport of narcotics follows a different procedure whereby each DPS staff member handling such medications signs off upon the medication's receipt from and transfer to another staff member.

medications.<sup>15</sup> This policy also specifies separate methods of medication handling for both Keep on Person (KOP) and Direct Observation Therapy (DOT) medications that travel with an inmate.

- **KOP medications.** The inmate keeps the medication during the transfer process.
- **DOT medications.** A nurse at the inmate's current facility secures the medication in an envelope with information about the inmate and provides the envelope to the bus driver transporting the inmate. The driver is responsible for ensuring the delivery of the medication envelope to the receiving prison.

**DPS Health Services management reports do not collect adequate information to facilitate implementing corrective action to minimize medication losses.** DPS custody staff are primarily responsible for the transfer of an inmate including any medications for that inmate once they have been packaged by the sending prison's health services staff. Management reports on medications lost in the transfer process only include the prison requesting the replacement medication, not the inmate's prior prison facility that might have failed to send the medication. Central DPS Health Services staff are therefore limited in the actions they—or DPS custody management staff—can take to ensure prisons send medications because they are unable to identify trends such as particular prisons that consistently fail to send medications to an inmate's new prison.

Further, these reports do not distinguish whether the medication lost during transfer was a KOP medication, which would have been lost by the inmate, or a DOT medication, which would have been DPS staff's responsibility. It does not appear that DPS Health Services staff investigate these incidents on a per-case basis. In addition, information on custody staff who lose an inmate's DOT medication is not systematically collected. DPS policies do not provide a mechanism to hold staff accountable for these losses, such as through internal controls consisting of potential disciplinary actions. This lack of accountability and oversight pertaining to medication losses contributes to further unnecessary expenditures.

**Finding 4. Inadequate data collection and oversight of prescriptions filled at local pharmacies prevents DPS from limiting these expenditures and enforcing its short-supply policy.**

To summarize the finding below, instances arise in which DPS Health Services prison staff must obtain medications immediately from a local private pharmacy as they await shipments from Central Pharmacy in Apex. DPS Health Services does not collect systematic information on these local purchases, which often cost more than the price paid through the State's medication wholesale distributor. This lack of data collection prevents staff from ensuring providers adhere to the policy of prescribing

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<sup>15</sup> A 2005 Department of Justice Inspector General's audit found that an estimated \$1.1 million in medication waste in Federal Fiscal Year 2003–04, or 37% of all medication waste, occurred during the transferring of inmates.

a limited quantity of medications for local pharmacies to fill, which could contribute to unnecessary higher-cost expenditures.

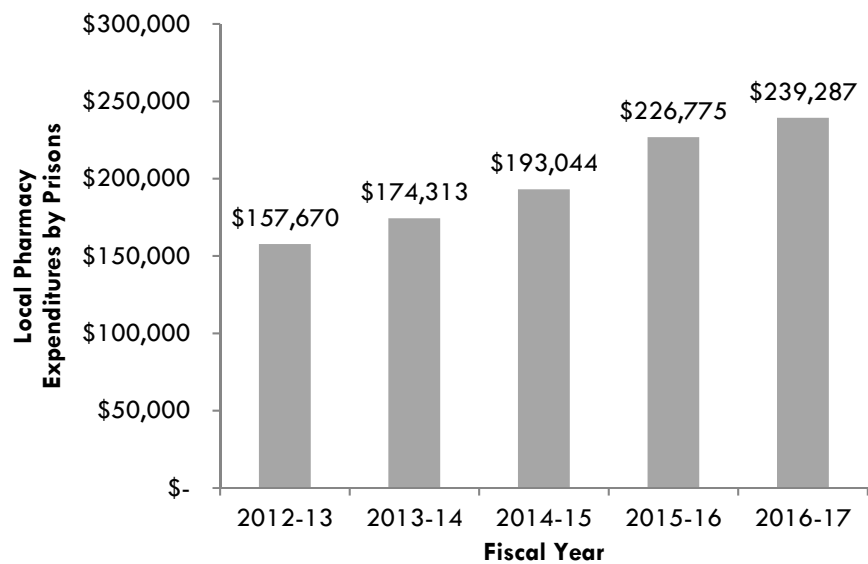
As discussed in the Background, inmates sometimes need particular medications that are not within a prison's starter pack, such as during emergencies, prior to an upcoming release, or upon returning from the hospital. In such instances, prison health services staff must obtain at least a portion of the medication supply from a local private pharmacy (e.g., CVS) while awaiting the arrival of the full supply of the medication from Central Pharmacy in Apex.

**DPS Health Services staff do not collect data on these local medication purchases.** The Program Evaluation Division conducted a review of local purchasing records and interviewed prison health services staff and discovered local pharmaceutical purchases are recorded on paper and receipts are not scanned to a central location. Locally purchased medications are billed to a specific accounting code, but the types of prescriptions, prescribing providers, and amounts paid are not collected by central DPS Health Services staff.

**Local pharmacy expenditures have increased by approximately 52% (\$81,617) during the last five fiscal years.** Absent any centralized method of collecting data on local medication purchases, the Program Evaluation Division relied on expenditures by prisons that are billed to the Pharmacy budget fund code. This approach might not include all medication purchases because prison accounting staff may be entering some of these expenditures under other budget fund codes. As Exhibit 7 shows, the Program Evaluation Division estimates prisons spent approximately \$239,287 in Fiscal Year 2016–17 on local pharmacy purchases, or \$81,617 (52%) more than they spent five years ago. Due to a lack of data collection for these purchases, it is unclear if the increasing costs are due to an increasing number of prescriptions written to be filled at local pharmacies, providers incorrectly writing prescriptions for more days than allowed by DPS Health Services policy, a general increase in the cost of medications, or some other reason.

### Exhibit 7

Local Pharmacy Purchases Have Increased 52% in the Last Five Fiscal Years



Source: Program Evaluation Division based on financial data from the North Carolina Accounting System.

**Lack of data collection and oversight prevents central DPS Health Services staff from identifying providers who violate the short-supply policy for medications.** DPS Health Services policy states that providers are not to prescribe more than a 10-day supply of a medication when it is being filled at a local pharmacy. This policy seeks to provide the inmate with necessary medication in a timely manner while limiting the costs associated with using private pharmacy vendors to whom the State likely must pay the full price unless there is a previously established contractual relationship.<sup>16</sup>

Because DPS Health Services does not centrally collect this information, the Program Evaluation Division could not determine the extent to which the short-supply policy is being violated. However, through a review of accounting records and discussions with DPS Health Services prison staff, the Program Evaluation Division did discover one instance of a provider writing a 28-day supply of a medication to be filled by a local pharmacy, violating DPS Health Services policy against prescribing more than a 10-day supply in such a situation. This violation likely contributed to higher than necessary local pharmacy expenditures. During interviews, DPS Health Services staff identified the provider as a contract staff member. As the Program Evaluation Division’s first report in this series discusses, some prison staff who are state employees believe contract staff are less knowledgeable about DPS Health Services policies. Because of a lack of systematic data collection on local pharmaceutical purchases, the Program Evaluation Division was unable to identify similar instances. Nonetheless, the fact remains that DPS Health Services central office staff cannot ensure adherence to this policy that is intended to contain costs.

<sup>16</sup> DPS Health Services staff do not maintain centralized records of prison contracts with local pharmacies. During site inspections, the Program Evaluation Division was informed that at least one prison has a contractual relationship with a local pharmacy, but there are no statewide purchasing agreements with private pharmacies. DPS Health Services states that it issued a Request for Proposal in December 2017 for a statewide vendor for local pharmacy purchases, which included predetermined medication restrictions and limits on quantities and dollar amounts that can be purchased.

**Finding 5. Relatively few states assess pharmaceutical copayments for inmates, which is likely attributable to a lack of research on the costs and benefits of such copayments as well as national corrections health guidelines regarding adequacy of care.**

To summarize the finding below, the National Commission on Correctional Health Care recognizes several arguments both in favor of and in opposition to establishing copayments. North Carolina is in the majority of states that charge some form of copayment to inmates, but the state does not charge copayments for prescription drugs. Thirteen states do charge inmates a copayment for prescription drugs. If North Carolina implemented a \$2 pharmacy copayment for inmate prescription medications and supplies, the Program Evaluation Division estimates the State could generate up to \$2.5 million each year, which would be reduced if DPS Health Services follows through on its plan to begin selling over-the-counter medications in prison canteens. However, because of a lack of sufficient research and because of concerns raised by national corrections healthcare experts, the Program Evaluation Division is not recommending that North Carolina require prescription copayments for inmates at this time.

Departments of corrections often charge copayments to inmates for health services. According to the Pew Charitable Trusts, state departments of corrections assess copayments for a number of services, including

- individual-initiated primary or specialist visits;
- care needed due to an altercation;
- purchasing of pharmaceutical medications; and
- purchasing of equipment for inmates, such as eyeglasses.

**Research on the efficacy of copayments for inmate health services is limited, but there are several reasons states assess them.** The National Commission on Correctional Health Care recognizes several arguments in favor of charging copayments to inmates.<sup>17</sup>

- The high costs of medical care are an increasing burden on governments and need to be controlled without affecting quality of care.
- The abuse of sick call by some inmates places a strain on resources and makes it more difficult to provide adequate care for inmates who legitimately need attention.<sup>18</sup>
- By reducing utilization, copayments cut down on security problems experienced in transporting inmates to and from sick call.
- Copayments instill a sense of fiscal responsibility and force inmates to make choices on how to spend money.
- Inmates who can afford discretionary items (e.g., candy bars) should be able to pay for medical care.

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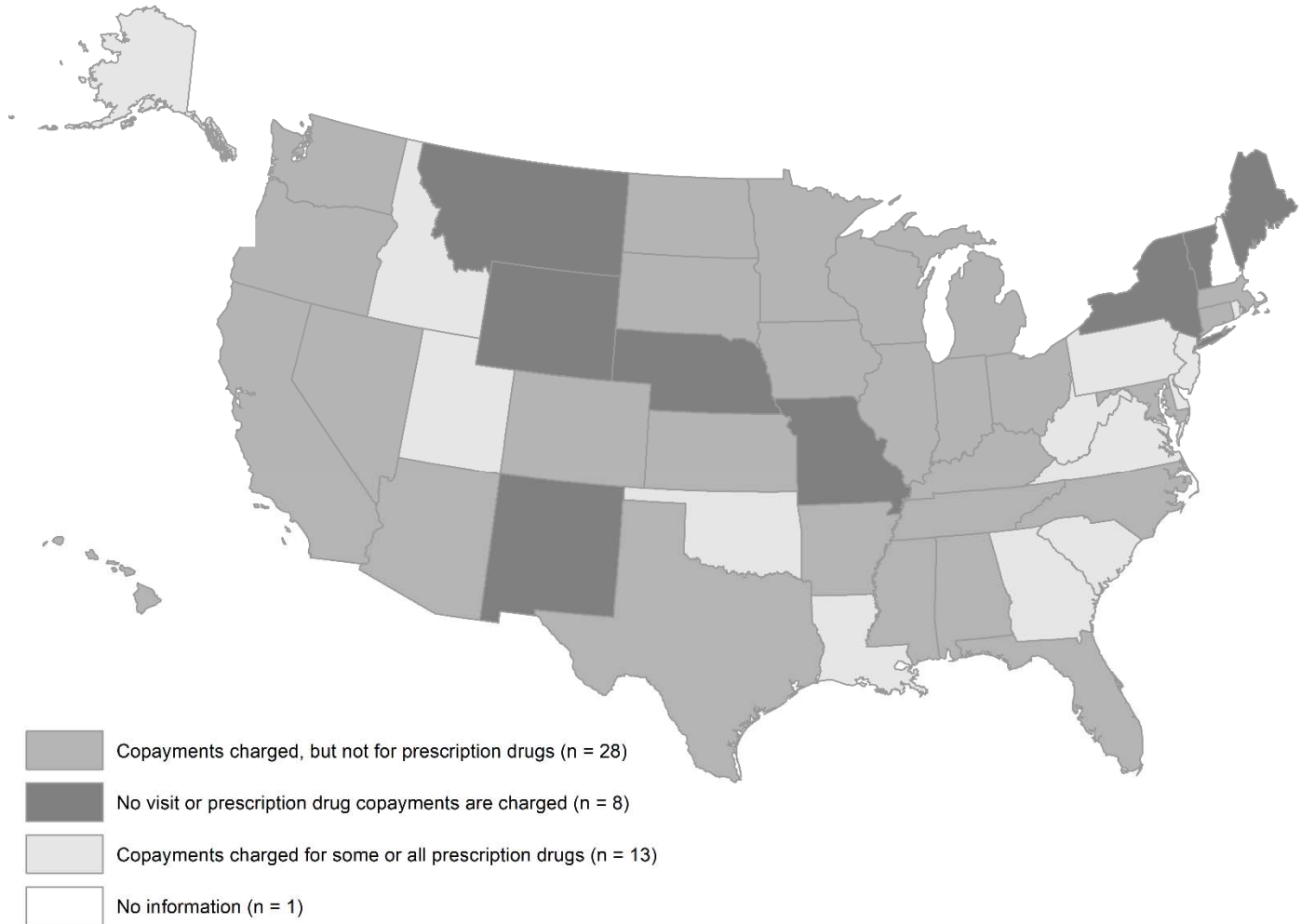
<sup>17</sup> National Commission on Correctional Health Care. *Charging Inmates a Fee for Health Care Services*, 2017.

<sup>18</sup> During interviews, DPS Health Services staff stated that copayments have not been an effective deterrent to unnecessary sick call encounters.

The commission has guidelines for corrections departments in establishing and monitoring copayments (See Appendix B).

States choosing to assess inmate copayments differ in the manner and services for which they assess such charges, with some states charging a per-encounter copayment and at least one state charging a flat annual services fee covering all services for a year. As shown in Exhibit 8, North Carolina is one of 41 states that charges some form of copayment for inmate health services.

### Exhibit 8: North Carolina is One of 41 States That Assess Some Type of Copayment for Inmate Healthcare



Source: Program Evaluation Division based on information from the Pew Charitable Trusts.

**North Carolina is in the majority of states that charge copayments to inmates for some health services but not for prescription drugs.** Twenty-eight states charge inmates copayments for health care purposes other than prescription drugs. Following a 1994 report by the Office of the State Auditor, North Carolina began assessing copayments for inmate health services. As shown in Exhibit 9, North Carolina’s inmates are assessed copayments on a per-service basis depending on the type of service requested.

## Exhibit 9

### North Carolina's Inmates Do Not Pay Copayments for Pharmaceutical Medications or Related Supplies

	Offender Initiated Sick Call	Offender Initiated Emergency Care Request	Pharmaceuticals and Related Supplies
<b>Copayment Charged to Inmates</b>	✓	✓	✗
<b>Copayment Description and Exclusions</b>	Encounters with a medical provider or dentist  Not applied for follow-up medical visits occurring within 14 days	Encounters with a medical provider or dentist  Only applied when incident was determined to be a nonemergency	Not applicable
<b>Copayment Amount</b>	\$5	\$7	\$0

Notes: Copayments are only assessed to the general inmate population and include consideration of the inmate's available funds. Certain populations of inmates (Safekeepers and Confinement in Response to Violation participants) are not subject to copayments.

Source: Program Evaluation Division based on data provided by DPS Health Services.

- Non-emergency sick call requests.** Inmates seeking non-emergency medical attention initiate a sick call request that DPS Health Services staff then process and schedule for an encounter with a provider. For these non-emergent encounters, DPS Health Services staff assess the inmate's trust fund account a \$5 copayment; revenues from these copayments are subsequently directed to the department's general fund.<sup>19</sup> Although the \$5 copayment applies to almost every medical or dental service area, there are certain exceptions. DPS Health Services does not assess copayments for follow-up services (i.e., subsequent visits to a physician or nurse for the same issue and a necessary course of treatment for that issue as determined by DPS Health Services staff).
- Emergent sick call requests.** Inmates seeking emergency medical attention initiate an emergency sick call request and are immediately seen by a DPS Health Services provider. For these emergent encounters, DPS Health Services staff do not assess copayments to inmates if staff determine the encounter was a medical emergency. However, if staff determine the visit was not an emergency and the inmate could have waited for a traditional sick call encounter, the inmate is assessed a \$7 copayment. Copayments for emergent sick call requests are slightly higher than the traditional sick call encounter copayment because DPS

<sup>19</sup> Inmates determined to be indigent (defined as those with a balance of \$2 or less in their accounts) are not denied access to healthcare services and are not assessed copayments for sick call requests.

Health Services staff try to disincentivize inmates from claiming a false emergency that requires an unnecessary redirection of staff resources.

**Thirteen states additionally assess copayments to inmates for prescription medications.** As shown in Exhibit 8, 13 states charge copayments to inmates for prescriptions in addition to other health services. These states vary in terms of what pharmaceutical products are subject to an inmate copayment as well as specific copayment amounts. Some of these states exempt certain types of medications from a copayment charge, such as those for mental illness or for conditions presenting a public health concern, such as tuberculosis.

The pharmaceutical copayments assessed in these 13 states range from \$1 (New Jersey) to \$5 (Alaska, Georgia, Pennsylvania, and South Carolina) for each initial and refill prescription, which are similar to copayments some state Medicaid agencies charge their enrollees. Virginia's Department of Corrections assesses a \$2 copayment for each new and refilled inmate prescription but excludes select medications from its policy, including psychotropic drugs, those used as antiretroviral medications, and nonprescription medications.<sup>20</sup>

**The Program Evaluation Division estimates the State could save up to \$1.5 million annually by assessing prescription copayments to inmates at \$2 per prescription.** As a state that does not assess prescription copayments, North Carolina's inmates are entitled to receive both over-the-counter products and prescription medications free of charge as long as a provider has written a prescription for the product. When an inmate refuses medication administration, the medication must be discarded and destroyed. Requiring inmates to make copayments for medications may reduce medication waste due to avoiding the disposal and destruction of refused medications.

DPS Health Services plans to begin selling high-volume over-the-counter products (OTCs) prescribed by providers in prison canteens in 2018, which is intended to eliminate the practice of DPS pharmacies providing OTCs to non-indigent inmates without collecting any payment; DPS Health Services estimates this practice will save the State approximately \$1 million annually.

In 1994, the Office of the State Auditor recommended the State initiate a \$1 copayment for inmate medications. At present time, several states charge a \$2 copayment for inmate medications. Assuming DPS Health Services's OTC plan achieves its estimated annual savings of \$1 million, the Program Evaluation Division estimates the implementation of a \$2 copayment for all initial and refilled non-OTC pharmaceutical products could save the State up to \$1.5 million annually.<sup>21</sup> Implementing a

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<sup>20</sup> The Virginia Department of Corrections urges offenders to purchase these nonprescription over-the-counter products from canteens.

<sup>21</sup> This estimate assumes that only prescription medications filled by the Central Pharmacy in Apex would be subject to a \$2 copay and that every inmate would pay for each initial product and refill. Thus, it does not account for potential instances in which an indigent inmate might not be subject to such a copayment, as is the current procedure for assessed sick call copayments. Data limitations prevented the Program Evaluation Division from determining if prescription transactions were original prescriptions or refilled prescriptions.



copayment charge for pharmaceuticals for inmates in North Carolina could generate state receipts that would offset a portion of DPS Health Services expenditures.

**Because of a lack of sufficient research and because of concerns raised by national corrections healthcare experts, the Program Evaluation Division is not recommending that North Carolina require prescription copayments for inmates at this time.** The Program Evaluation Division could not find any empirical research that assesses the specific impact of charging prescription copayments on inmate health outcomes. For the non-incarcerated population, copayments have been shown to reduce essential prescription drug use among community-dwelling Medicaid enrollees and other low-income individuals.<sup>22</sup>

Just as the National Commission on Correctional Health Care recognizes arguments in favor of inmate copayments, the organization also acknowledges the following arguments against the practice of charging copayments for health services in general, not just for prescriptions.<sup>23</sup>

- Copayments impede access to care and ignore the significance of full and unimpeded access to sick call and the importance of preventative care.<sup>24</sup>
- Inmates are almost always indigent and seldom have sources of income while incarcerated, making them rely on non-incarcerated individuals to provide funds for toiletries, paper and pens, and other “extras” which become important to inmates and may lead to inmates forgoing treatment of a medical problem to purchase such items.

As seen in Appendix B, the commission recommends against charging inmates for prescriptions to maintain their health.

In addition, the potential for delayed care due to inmates prioritizing other spending over paying a copayment could lead to significant health concerns beyond the individual inmate. The Centers for Disease Control and Prevention identified copayments required for acute care visits, not necessarily those for medications, as one of four factors contributing to significant outbreaks of methicillin-resistant *Staphylococcus aureus* in a prison in Texas and three prisons in Georgia.<sup>25</sup> Such concerns could explain why most states do not assess prescription copayments, and why others exempt certain medications from prescription copayments.

Although charging inmates prescription copayments would save North Carolina money, the Program Evaluation Division is not recommending to do so at this time because of the concerns discussed above.

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<sup>22</sup> Smith, V. et. al. *Managing Medicaid Pharmacy Benefits: Current issues and options*. Washington, District of Columbia: Kaiser Commission on Medicaid and the Uninsured, 2011.

<sup>23</sup> National Commission on Correctional Health Care. *Charging Inmates a Fee for Health Care Services*, 2017.

<sup>24</sup> As a result, the commission advises states to assess copayments only after ensuring they would not impede access to care.

<sup>25</sup> Huh, K., et. al. *Pharmaceuticals in State Prisons: How departments of corrections purchase, use, and monitor prescription drugs*. Philadelphia, Pennsylvania: Pew Charitable Trusts, 2017. Centers for Disease Control and Prevention. *Methicillin-Resistant Staphylococcus aureus Infections in Correctional Facilities—Georgia, California, and Texas, 2001–2003*. Morbidity and Mortality Weekly Report, 52(41), 992-996, 2003.

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## Recommendations

**Recommendation 1. The General Assembly should direct the University of North Carolina Health Care System to modify and expand its 340B program to provide for the purchasing of certain inmate medications in cooperation with the Department of Public Safety.**

As shown in Finding 1, 16 states have agreements between their departments of corrections and health departments or hospitals to provide 340B medication pricing. Having access to less-costly medications for HIV/AIDS, Hepatitis C, and other infectious diseases will not only save the State approximately \$13.3 million annually, it also may lead to a greater number of inmates being properly treated and will reduce the risk to the general public once these individuals are released from prison.

The General Assembly should direct the University of North Carolina Health Care System (UNCHCS) to modify its 340B program regarding its qualification as a Disproportionate Share Hospital. In collaboration with DPS Health Services, UNCHCS should be required to acquire the necessary approval, if any, from the U.S. Health Resources and Services Administration (HRSA) to provide inmate medications to inmates with HIV/AIDS and Hepatitis C. Further, UNCHCS and DPS Health Services should enter into a Memorandum of Understanding, modifying and creating policies and procedures as needed to guide the processes by which these medications will be obtained. Ideally, this partnership would use telemedicine and the existing infectious disease clinics already housed at Central Prison Healthcare Complex to treat offenders.

To facilitate this partnership between DPS and UNCHCS, the General Assembly should require the Department of Public Safety to transfer \$25,000 to UNCHCS to fund a legal consultant to assist with program design and spend \$7,000 annually for program auditing as required by HRSA. This recurring expenditure would be offset by the savings achieved from 340B participation. In addition, UNCHCS and DPS Health Services should develop a plan for obtaining additional medications through the 340B program in the future, including but not limited to drugs for treating cancer, neurological conditions, rheumatic diseases, and other costly medical conditions.

Beginning October 1, 2019 and quarterly thereafter until a 340B program is in operation for purchasing HIV/AIDS and Hepatitis C medications, UNCHCS and DPS Health Services should report to the Joint Legislative Oversight Committee on Justice and Public Safety and the Fiscal Research Division on related activities conducted to date and activities planned. In addition, by July 1, 2020 and annually thereafter, UNCHCS and DPS Health Services should report to the Joint Legislative Oversight Committee on Justice and Public Safety on annual savings achieved from purchasing inmate medications through the established 340B program as well as any activities conducted or planned to maintain and expand the number of medications purchased through the program.

**Recommendation 2. The General Assembly should direct DPS Health Services to revise its medication administration protocol to require each supply of certain medications worth more than \$1,000 be designated as Direct Observation Therapy.**

As Finding 2 discusses, the two highest-cost prescriptions dispensed to inmates are designated as Direct Observation Therapy (DOT), thereby requiring inmates to be observed taking these medications. However, the Program Evaluation Division identified 11 additional prescriptions for conditions other than HIV valued between \$1,138 and \$7,376 each (per supply) that DPS Health Services allows to be kept on an inmate's person. As a result of this protocol, the effectiveness of nearly \$300,000 in annual state expenditures for these high-cost medications may be limited because there are no assurances inmates are taking them.

The General Assembly should direct DPS Health Services to revise its policies and procedures to reflect that any supply of a prescription for the treatment of conditions other than HIV with a per-supply value of \$1,000 or more be designated as DOT. The General Assembly should direct DPS Health Services to report to the Joint Legislative Oversight Committee on Justice and Public Safety by October 1, 2019 on this change in policy.

**Recommendation 3. The General Assembly should direct DPS to collect additional data on medications lost during the inmate transfer process, establish internal oversight, controls, and audit activities to limit such losses, and report annually on such losses to the General Assembly.**

Finding 3 discusses two primary challenges with DPS Health Services's method of data collection as it pertains to medications lost during inmate transfers.

- First, current management reports do not designate whether medications lost are designated as Keep on Person (KOP) or Direct Observation Therapy (DOT); systematically collecting such data would indicate if a custody staff member or an inmate was responsible for the loss.
- Second, current management reports do not indicate the prison from which an inmate was transferred, which may not have sent the medication, nor do these reports indicate which custody staff member was responsible for DOT medications.

It does not appear that DPS takes corrective or disciplinary action when medications are lost, likely due to a lack of data available on such losses. As Finding 3 shows, medication losses during inmate transfer resulted in additional state expenditures of \$115,665 in Fiscal Year 2016–17.

The General Assembly should direct DPS Health Services to revise its methods of collecting data on medication losses. First, DPS Health Services should be required to develop a mechanism to easily summarize medication losses across the 15 reasons identified in policy. Second, DPS should be required to collect data on the prison from which an inmate was transferred in any cases of medication loss. In addition, the General

Assembly should require DPS to track information on custody officials involved in the transfer process.

The General Assembly should also require DPS to develop internal controls related to the oversight of medications lost during inmate transfers, including establishing disciplinary actions for staff responsible for such losses, based on the data to be collected as part of this recommendation. In addition, the General Assembly should require DPS to initiate an internal audit of its processes for transporting medications during inmate transfer. This report should examine all medication losses incurred during Fiscal Year 2018–19 and should include recommendations to improve controls and promote accountability for medication losses. This report should be submitted to the Joint Legislative Oversight Committee on Justice and Public Safety by December 1, 2019.

Once these additional data collection efforts are in place, the General Assembly should also require the Internal Audit unit of DPS to establish an internal oversight function to investigate any medication losses with a value greater than \$200. Central DPS Health Services staff would be responsible for identifying and implementing corrective action for trends in medication losses. Further, central DPS Health Services staff would be responsible for issuing any disciplinary actions for DPS Health Services prison staff or referring any custody staff to the appropriate DPS unit for such action.

Beginning December 1, 2019 and annually thereafter, the General Assembly should require DPS to report to the Joint Legislative Oversight Committee on Justice and Public Safety on medication losses for the preceding fiscal year with the information obtained from these additional data collection efforts. This report should summarize medications lost and include the name and quantity of each medication lost, its purchase price and total value, the reason(s) for loss, and the entities responsible for losses. The first report should summarize actions DPS plans to take to identify, investigate, and develop corrective actions to limit medication losses during inmate transfers.

**Recommendation 4. The General Assembly should direct DPS Health Services to contract with statewide retail pharmacies for local purchasing of limited quantities of medications and develop a data collection and oversight mechanism to ensure adherence to the short-supply policy for local medication purchases.**

As Finding 4 discusses, when DPS Health Services prison staff need an immediate supply of a medication, they often purchase limited quantities from a local private pharmacy while awaiting the full order from one of the DPS Health Services pharmacies. In Fiscal Year 2016–17, DPS Health Services spent \$239,287 on such purchases, a 52% increase from five years ago. Information on these purchases is not collected and aggregated either at the individual prison level or across the State's 57 prisons. Likely due to this lack of data collection, DPS Health Services central office staff lack oversight of local purchases and cannot ensure

adherence to the Division's policy of requesting limited quantities from local pharmacies.

The General Assembly should require DPS Health Services to award a statewide contract to a private pharmacy for such local purchases and require prison health services staff to use this pharmacy except under extenuating circumstances and with the written approval of the Director of Central Pharmacy in Apex.

Upon awarding this contract, DPS Health Services should be directed to obtain monthly electronic invoices of prescriptions filled by each prison from the chosen vendor and should develop a mechanism to collect information on purchases made outside the contract. At a minimum, the following information should be collected for each prescription:

- the inmate's prison,
- the requesting provider,
- the medication,
- the quantity, and
- the total value.

Such information would be helpful in identifying prisons that rely heavily on outside private pharmacies. Further, collecting this information would provide a mechanism to ensure adherence to DPS Health Services policy that providers not write prescriptions for more than a 10-day supply when a medication is being filled at a local pharmacy.

In addition, the General Assembly should require DPS to establish a formal oversight mechanism to ensure prescriptions written by providers to be filled at local pharmacies do not exceed the quantities specified in DPS Health Services policy. This oversight mechanism should be headed by the DPS Health Services central office and should use the data discussed above and include corrective actions and disciplinary actions as necessary.

The General Assembly should direct DPS to award a contract for this service by October 31, 2019. The General Assembly should require DPS to report to the Joint Legislative Oversight Committee on Justice and Public Safety by November 1, 2019 on its efforts to award this contract.

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## Appendices

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Appendix A: DPS Health Services Pharmacies Replace Inmate Medications for 15 Reasons

Appendix B: The National Commission on Correctional Health Care's Recommended Guidelines for Charging Inmates a Fee for Health Care Services

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## Agency Response

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A draft of this report was submitted to the Department of Public Safety for review. Its response to the report is provided following the appendices.

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A draft of Finding 1 and Recommendation 1 related to the federal 340B program was submitted to the University of North Carolina Health Care System for review. Its response to these sections of the report is provided following the appendices.

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## Program Evaluation Division Contact and Acknowledgments

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For more information on this report, please contact the lead evaluator, Brent Lucas, at [brent.lucas@ncleg.net](mailto:brent.lucas@ncleg.net).

Staff members who made key contributions to this report include Sara Nienow and Adora Thayer. John W. Turcotte is the director of the Program Evaluation Division.

## Appendix A: DPS Health Services Pharmacies Replace Inmate Medications for 15 Reasons

Replacement Reason	Definition of Replacement Reason
Confiscated	Confiscated by custody officer, likely when moving to restrictive housing unit
Contaminated	Tablets, capsules dropped by staff; tube of cream damaged by staff; broken glass vial (e.g., insulin, haldol decanoate)
Damaged During Shipping	Broken or damaged in shipping box (e.g., UPS truck fire, broken bottle/vial)
Defective Product	Items worn out before refill due: insoles, abdominal binders, back braces, donut cushions; damaged seal on vials; broken needle or cracked syringe; inhalers do not work upon receipt
Dispensing Error	Pharmacy dispenses wrong item
Facility Evacuation	Facility is evacuated because of natural disaster, fire, etc.
Manufacturer Recall	Inventory Team notifies facility of manufacturer recall
Missing Doses	Facility reports bottle contains less than labeled amount; facility must notify Inventory Team of replacement
Offender Med Loss	KOP issued medication lost, thrown away, damaged, or DOT medication given and dropped
Release Medication	Only to be used by staff responsible for Release Medication
Shipping Error	Item sent to incorrect facility by Central Pharmacy, or common carrier failed to deliver box
Staff Med Loss	KOP medication not issued to offender or medication issued to the wrong offender, or a DOT medication is not issued to offender or is a refrigerated item left at room temperature
Stolen	Offender states item was stolen
Transfer Before Med Arrived	Offender transfers before medication can be received and issued, which is verified by checking packing slip generation date and time compared to offender movement date and time
Transfer Med Loss	DOT medication does not arrive with offender when transferred or KOP medication is not issued at the previous facility before transfer, which is verified using eMAR.

Note: KOP stands for Keep on Person. DOT stands for Direct Observation Therapy. eMAR stands for Electronic Medication Administration Record.

Source: Program Evaluation Division based on DPS Health Services policies and procedures.

## Appendix B: The National Commission on Correctional Health Care's Recommended Guidelines for Charging Inmates a Fee for Health Care Services

1. Before initiating a fee-for-service program, the institution should examine its management of sick call, use of emergency services, system of triage, and other aspects of the health care system for efficiency and efficacy.
2. Facilities should track the incidence of disease and all other health problems before and after the implementation of the fee-for-service program. Statistics should be maintained and reviewed. The data should demonstrate that infection levels and other adverse outcome indicators, as well as incidents of delayed diagnosis and treatment of serious medical problems, are either consistent with or lower than the levels before implementation. Data that show an increase in infection levels or other adverse outcomes may indicate that the program is unintentionally blocking access to needed care.
3. All inmates should be informed of the details of the fee-for-service program on admission, and it should be made clear that the program is not designed to deny access to care. Inmates should have a full working knowledge of the situations in which they will or will not be assessed a fee as well as any administrative procedures necessary to request a visit with a health care provider.
4. Only services initiated by the inmate should be subject to a fee or other charges. No charges should be made for the following: admission health screening (medical, dental, and mental) or any required follow-up to the screening; the health assessments required by facility policy; emergency care and trauma care; hospitalization; infirmary care; perinatal care; in-house lab and diagnostic services; pharmacy medications to maintain health; diagnosis and treatment of contagious disease; chronic care or other staff-initiated care, including follow-up and referral visits; and mental health care, including drug abuse and addiction.
5. The assessment of a charge should be made after the fact. The health care provider should be removed from the operation of collecting the fee.
6. Charges should be small and not compounded when a patient is seen by more than one provider for the same circumstance.
7. No inmate should be denied care because of a record of nonpayment or current inability to pay for same.
8. The system should allow for a minimum balance in the inmate's account, or provide another mechanism permitting the inmate to have access to necessary hygiene items (shampoo, shaving accessories, etc.) and over-the-counter medications.
9. The facility should have a grievance system in place that accurately tracks complaints about the program. Grievances should be reviewed periodically, and a consistently high rate of grievances should draw attention to the need to work with staff to address specific problems that may have accompanied the fee-for-service program.
10. The continuation of any fee-for-service health care program should be contingent on evidence that it does not impede access to care. Such evidence might consist of increased infection rates, delayed diagnosis and treatment of medical problems, or other adverse outcomes.





# North Carolina Department of Public Safety

*Prevent. Protect. Prepare.*

Roy Cooper, Governor

Erik A. Hooks, Secretary

August 8, 2018

Mr. John Turcotte  
Director, Program Evaluation Division  
300 North Salisbury Street, Suite 100 LOB  
Raleigh, NC 27603-5925

**Re: *Modifications to Inmate Pharmacy Purchasing and Monitoring Could Save \$13.4 Million Annually (PED Report 2018-09)***

Dear Mr. Turcotte:

Thank you for providing the North Carolina Department of Public Safety (“DPS”) with the opportunity to respond to the Program Evaluation Division’s Report 2018-09: *Modifications to Inmate Pharmacy Purchasing and Monitoring Could Save \$13.4 Million Annually*.

**Recommendation 1. The General Assembly should direct the University of North Carolina Health Care System to modify and expand its 340B program to provide for the purchasing of certain inmate medications in cooperation with the Department of Public Safety.**

DPS has always been, and continues to be, receptive to participating in the 340B Drug Pricing Program to decrease the cost of medication purchases. However, DPS does not qualify to participate in this program independently because it is not a covered entity. DPS welcomes the opportunity to work with the University of North Carolina Health Care System to explore this recommendation, but would point out that the cost savings (if any) cannot be ascertained until the 340B prices are known and the fiscal cost to DPS to partner with the UNC Health Care System is identified. This is a complicated area, because 340B pricing rules are complex and the requirements for participation are stringent. For example:

1. The covered entity must have an established relationship with the individual patient, such that the covered entity maintains a health care record for the individual;
2. The individual must receive health care services from a provider directly employed or contracted with the covered entity;
3. The individual must receive health care services from the covered entity that are consistent with the range of services for which federal grant funding has been provided; and

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4. The covered entity cannot only dispense drugs to the individual, it must also provide additional health care services.<sup>1</sup>

As the PED report mentions, DPS Pharmacy Services is currently a member of the Minnesota Multistate Contracting Alliance for Pharmacy (MMCAP), which is a group purchasing organization for government agencies to which 45 other states also belong. DPS continues to work closely with MMCAP to obtain the lowest drug costs available and, since PED's data collection, has secured significant price reductions in two of the most expensive drugs used to treat Hepatitis C.<sup>2</sup>

**Recommendation 2. The General Assembly should direct DPS Health Services to revise its medication administration protocol to require any prescribed supply of medication worth more than \$1,000 to be designated as Direct Observation Therapy (DOT).**

Upon review of the medications exceeding \$1,000 per month for an individual inmate's supply, DPS has identified eleven medications, other than those for HIV, which meet this criterion. From a pharmaceutical management standpoint, DPS does not object to adding these identified medications to the DOT ("Direct Observation Therapy") list. However, it should be noted that additional nursing staff will be necessary to manage the DOT component of this change. Also, DPS notes that 196 full-time nursing positions were eliminated by the General Assembly in the FY 2018-19 budget. While the General Assembly redirected the funds for the nursing positions to contractual dollars to cover temporary nurse costs, the Department maintains use of temporary nursing staff is not as efficient from a clinical or budget perspective, and transitioning more medications to DOT would further strain already overburdened clinicians.

**Recommendation 3. The General Assembly should direct DPS to collect additional data on medications lost during the inmate transfer process, establish an internal oversight function to limit such losses, conduct an internal audit of lost medication processes, and report annually on such losses to the Joint Legislative Oversight Committee on Justice and Public Safety.**

DPS Pharmacy Services replaces medications delayed during the facility inmate transfer process to avoid an interruption in medication administration to the inmate. Efforts by nursing and custody staff to recover the medications continue, and when recovered the medications are routed to the inmate's current location for administration if an active order exists. DPS Health Services will seek data system programming changes that support nursing and pharmacy data entry for enhanced tracking of medications. DPS continually strives to improve the medication transfer process through education and email reporting and tracking. It is important to note that the reported \$115,655 represents costs of replacement medications delayed during the facility inmate transfer process. For fiscal year 2016-17, this cost represents 0.19% of the total annual

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<sup>1</sup> *Pharmaceuticals in State Prisons: How Departments of Corrections Purchase, Use, and Monitor Prescription Drugs*, Pew Charitable Trusts, Dec. 2017 at 8.

<sup>2</sup> DPS has worked with MMCAP to lower the purchase price of both Harvoni and Eplusa. Previous Harvoni cost was \$15,647 which has been reduced to \$10,645 and previous Eplusa cost was \$24,272 which has been reduced to \$8,188. DPS now uses Eplusa as its drug of choice for the treatment of Hepatitis C.

pharmacy expenditures. For these reasons, DPS does not believe the PED-recommended level of legislative oversight is necessary.

**Recommendation 4. The General Assembly should direct DPS Health Services to contract with statewide retail pharmacies for local purchasing of limited quantities of medications and develop a data collection and oversight mechanism to ensure adherence to the short-supply policy for local medication purchases.**

DPS agrees with PED's conclusion that local pharmacy services are needed, and DPS has been exploring options for such services for several years. Currently, DPS is seeking a vendor that will provide secondary-coverage pharmacy services for Prisons; primary and secondary-coverage pharmacy services for Alcoholism and Chemical Dependency Programs; and primary and secondary-coverage pharmacy services for Juvenile Justice. However, these pharmacy services must be provided through local pharmacies near each facility. Additional requirements include: the capability to set predetermined medication restrictions and limits on quantities and dollar amounts that can be purchased; the provision of detailed and accurate electronic dispensing records which can be sorted by medication, provider, or facility; online services for invoices, reconciliation, billing, and consolidated payment; and the offering of initial and on-going training programs at multiple locations across the state. DPS recently issued a Request for Information regarding this issue and has received several vendor presentations. The Department intends to issue a Request for Proposal and, depending on bids received, execute a contract for this service.

Thanks again to the Division staff for their work in evaluating this issue and for affording the Department an opportunity to respond to the report.

Sincerely,



Erik A. Hooks  
Secretary  
North Carolina Department of Public Safety

June 12, 2018

**Via email to [brent.lucas@ncleg.net](mailto:brent.lucas@ncleg.net)**

Brent Lucas, Ph.D.  
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**Re: Draft Report on Inmate Pharmacy Services**

Dear Dr. Lucas:

The University of North Carolina Health Care System (“UNCHCS”) appreciates the opportunity to respond to the Program Evaluation Division (“PED”) of the North Carolina General Assembly (“General Assembly”) regarding the PED’s preliminary draft report on Inmate Pharmacy Services (“Draft Report”). UNCHCS previously submitted its Technical Response to the Draft Report and writes this supplemental letter to provide further comments on the Draft Report’s proposal that the North Carolina Department of Public Safety (“DPS”) partner with University of North Carolina Hospitals (“UNC Hospitals”), a subsidiary of UNCHCS, to dispense drugs purchased at discounted pricing under the federal 340B Drug Discount Program (“340B Program” or “340B”).

#### Discussion of Draft Report

Consistent with our role as the state’s leading safety net institution and our vision to nurture collaborative partnerships with the state of North Carolina,<sup>1</sup> UNCHCS appreciates the opportunity to cooperate with efforts by the General Assembly to partner with an eligible covered entity under the 340B Program that would allow DPS to access discounted 340B drug pricing for inmates and potentially other patients, including at the DPS Central Healthcare Complex Hospital in Raleigh. UNCHCS is supportive of an arrangement like that contemplated by the PED to the extent viable from a legal, operational, and financial perspective.

As the Draft Report notes, correctional facilities are not eligible 340B covered entities under the Public Health Service Act. However, these facilities’ patients may be eligible for the 340B Program if they meet all criteria for eligibility and are seen at a covered entity. A covered entity must be registered with HRSA and comply with all regulations and requirements to access 340B pricing. UNC Hospitals, which participates in the 340B Program as a disproportionate share hospital (340B ID: DSH340061), meets the criteria for a covered entity and can therefore access 340B pricing on drugs that are utilized for patients

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<sup>1</sup> See UNC Health Care, Vision and Values, <https://www.unchealthcare.org/about-us/vision-and-values/>.

meeting all requirements of eligibility. In this regard, any patients who would receive 340B drugs must also become a “patient” of UNC Hospitals, which the Health Resources and Services Administration (“HRSA”) generally interprets to mean that the patient’s prescription must be written by a provider employed by the covered entity, pursuant to a visit at an eligible outpatient location of UNC Hospitals.<sup>2</sup>

In this regard, it may be possible using a telemedicine model for incarcerated patients in a correctional health care facility to otherwise be seen via a telemedicine link in a qualifying location of UNC Hospitals, and thus become patients of the hospital for purposes of the 340B Program. However, any telemedicine services provided by UNC Hospitals must also comply with state and federal law more broadly.<sup>3</sup> By contrast, an arrangement in which an incarcerated patient is seen at a prison clinic – even if by a UNC Hospitals employed provider – would likely not be sufficient to establish such prescriptions as 340B-eligible, absent additional facts or clarification from HRSA. As a result, we anticipate that significant additional discussions will be necessary to arrive at a detailed structure that would allow UNC Hospitals to ensure that the arrangement is consistent with 340B Program requirements. In addition, to ensure 340B Program compliance, UNCHCS would seek review and approval from HRSA before finalizing such an arrangement. As the PED notes in the Draft Report, although states have developed and implemented programs to provide 340B Program drugs to incarcerated individuals, HRSA has not officially endorsed such arrangements, nor has it issued parameters for covered entities and other organizations to follow as they implement such arrangements.

Additionally, UNCHCS has several questions relating to the PED and the General Assembly’s expectations relating to the proposal, including but not limited to the following:

- What contractual model is anticipated for the arrangement? As noted above, the parties would need to enter into an enhanced clinical arrangement for UNC Hospitals to provide both the clinical care

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<sup>2</sup> Guidance from HRSA, which administers the 340B Program, provides that an individual is a patient of a 340B-participating covered entity only if: (1) the covered entity has established a relationship with the individual, such that the covered entity maintains records of the individual’s health care; and (2) the individual receives health care services from a health care professional who is either employed by the covered entity or provides health care under contractual or other arrangements (e.g., referral for consultation) such that responsibility for the care provided remains with the covered entity. Further, an individual will not be considered a patient of the entity for purposes of the 340B Program if the only health care service received by the individual from the covered entity is the dispensing of a drug or drugs for subsequent self-administration or administration in the home setting. HRSA, Notice Regarding Section 602 of the Veterans Health Care Act of 1992 Patient and Entity Eligibility, 61 Fed. Reg. 55,156, 55,157-58 (Oct. 24, 1996), <https://www.hrsa.gov/sites/default/files/opa/programrequirements/federalregisternotices/patientandentityeligibility102496.pdf>.

<sup>3</sup> HRSA suggested that compliant telemedicine arrangements should meet this requirement in guidance that was issued but ultimately not finalized. *See* HRSA, 340B Drug Pricing Program Omnibus Guidance, 80 Fed. Reg. 52,300, 52,306 (Aug. 28, 2015), (“An individual will be considered a patient of a covered entity if the health care service received results in a drug order or prescription. The use of telemedicine, telepharmacy, remote, and other health care service arrangements (e.g., medication therapy management) involving the issuance of a prescription by a covered entity is permitted, as long as the practice is authorized under State or Federal law and otherwise complies with the 340B Program.”). In this regard, at a minimum any arrangement must meet applicable standards set forth by the North Carolina Medical Board. *See* N.C. MED. BD., POSITION STATEMENTS: CONTACT WITH PATIENTS BEFORE PRESCRIBING, [https://www.ncmedboard.org/resources-information/professional-resources/laws-rules-position-statements/position-statements/contact\\_with\\_patients\\_before\\_prescribing](https://www.ncmedboard.org/resources-information/professional-resources/laws-rules-position-statements/position-statements/contact_with_patients_before_prescribing) (last amended June 2015); N.C. MED. BD., POSITION STATEMENTS: TELEMEDICINE, <https://www.ncmedboard.org/resources-information/professional-resources/laws-rules-position-statements/position-statements/telemedicine> (last amended Nov. 2014).

and pharmacy services to these patients – also potentially including the creation of a telemedicine arrangement.

- What reimbursement model is anticipated for the arrangement?
- Would the implementation of the arrangement impact other arrangements that DPS has with third party providers of services, including pharmacy services?
- Would implementation of the arrangement be subject to a public bidding process?
- How did PED arrive at the cost estimates contained in the Draft Report relating to program design and HRSA audits?
- Given that federal policymakers are actively exploring statutory and regulatory changes to the 340B Program, how would the model account for potential changes relating to the 340B Program that may occur in the future?

We would request that a full examination of these questions (and others) occur before the parties begin implementation of a model similar to the one discussed in the Draft Report. Such comprehensive due diligence and discussions around these legal, operational, and financial issues will help ensure that any potential partnership will serve its intended purposes and not result in undue risk to DPS or UNC Hospitals.

Thank you for your consideration of these comments regarding the Draft Report and the possibility of UNC Hospitals entering into an arrangement with DPS. UNCHCS looks forward to exploring the issues discussed in this letter and others that may arise as the PED and the General Assembly consider how to improve the delivery of health care services to inmates in North Carolina.

Sincerely,

Rowell Daniels, PharmD, MS, FASHP  
System Vice President Pharmacy Services, UNC Health Care System

Janet Hadar, MSN, MBA  
Senior Vice President of Operations UNC Hospitals and Clinics