



AN EXAMINATION OF INMATE HEALTH CARE COSTS

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Executive Summary

In response to the increased need for funding to provide medical care to offenders housed in state correctional centers and state responsible offenders housed in local/regional jails, the 2011 Acts of Assembly requires the following:

“The Department of Corrections, with the support of the Department of Planning and Budget, shall conduct a thorough examination of, inmate medical expenses, with the goal of substantially reducing the increase in costs. Among the areas to be examined are the appropriate level of the use of part-time contracted physicians, the rate schedules of hospitals and other private medical providers utilized by the department, and enhanced treatment of offenders with chronic medical conditions with department personnel. The department shall examine those correctional facilities for which it has contracted with a private company to provide medical services to determine if the department could provide comparable medical services to inmates in those facilities at a lower cost, as well as the benefit of issuing a new request for proposals to take effect in FY 2012 when the current contracts are subject to renewal. In addition to these areas and steps, the department shall examine any other areas or issues if feels may result in cost decreases. The department shall submit a report, outlining its findings, the steps it has taken, and any recommendations for policy changes it feels are needed to reduce increases in inmate medical costs, to the Secretary of Public Safety and the Chairmen of the House Appropriations and Senate Finance Committees by September 30, 2011”. (Item 379.M)

The delivery of medical and mental health treatment to offenders is articulated in §53.1-32, Code of Virginia. Grounded in the Eighth Amendment prohibiting cruel and unusual punishment, offenders have a Constitutional right to healthcare. The legal system has further defined that healthcare is adequate and necessary if it meets the community standard of care. Therefore, the Department of Corrections (Department) is charged, by the Commonwealth of Virginia, to provide healthcare to the offender that is equivalent to community healthcare and one that is cost effective. Correctional facilities provide varying levels of healthcare to offenders as their medical needs indicate. The Department of Corrections' Health Services encompasses a comprehensive group of dedicated administrators, physicians, nurses, dental staff, and mental health staff who provide adequate, medically necessary, and cost-effective health care services to offenders.

The following report focuses on actions taken by the Department to curb the growth in expenditures in the area of salaries, off-site health care services and pharmaceuticals. It also provides a comparison of the offsite healthcare costs for offenders compared to a large employer group as well as data which reflect the impact of catastrophic claims on increased medical costs. The report also includes an example of how the state of Texas provides medical services to its offenders and proposes recommended policy changes that could reduce medical service costs within the Commonwealth.

The majority of the Department of Corrections' health care costs are in three areas (1) staffing, (2) off-site healthcare services and (3) pharmaceuticals.

Staffing

Staffing is the key component of any correctional health care operation. With the advent of National Health Care Reform (30,000,000 more Americans with medical insurance) and the medical demand of aging baby boomers, we can expect a continued shortage of primary care physicians and nurses nationwide including in corrections. Scholarships and loan repayment benefits are plentiful to encourage medical or nursing education, yet over the last 65 years the supply has not met demand and this trend will continue.

The typical staffing for a 1,000 bed correctional institution with 24/7 care generally requires:

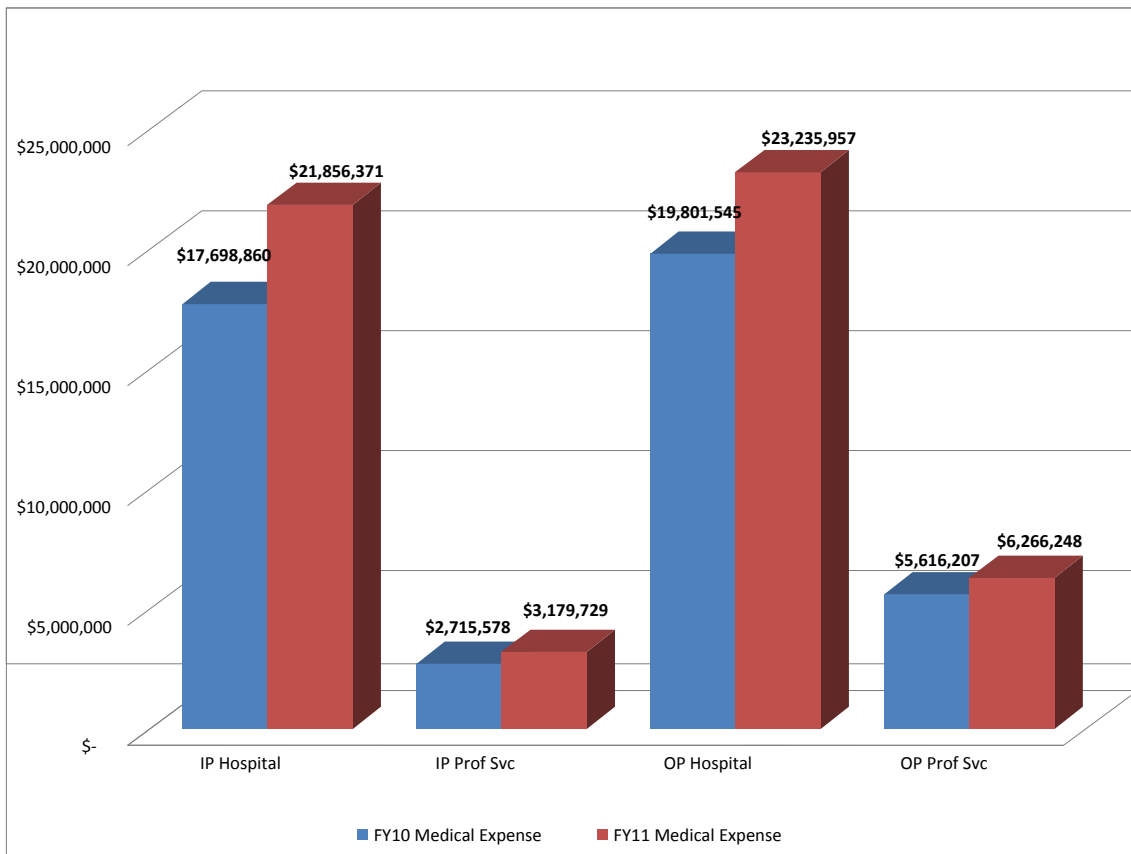
- One Health Authority
- Thirteen Nurses
- One Physician (25-40 hours/week)
- One Dentist
- Two Dental Assistants
- Two Office Assistants
- Four Mental Health Professionals
- One Part-time Optometrist
- One Part-time X-Ray Technologist
- One Part-time Psychiatrist

The Department employs state classified staff as well as contractual services to address its staffing needs. The amount of physician hours at an institution depends on a number of factors: mission, population, security level, number of inmates sent by security to medical, and the capability of an individual medical department's nurses. State compensation (salary, benefits) for physician employees has historically been below the market. However, within the last few years, the Commonwealth's compensation procedures have allowed greater flexibility for salaries. This salary flexibility coupled with a poor economy has enabled the Department to recruit more state physicians. Until recently, the Department employed only three classified institutional physicians: one at Deep Meadow (covering Central Virginia Correctional Unit as well), Buckingham, and at the Virginia Correctional Center for Women. In the past year, the Department has replaced several contractual agreements with state classified physicians, thereby reducing staffing costs. The Department continues to advertise and actively recruit qualified, interested candidates to fill similar positions at Haynesville, Nottoway, Dillwyn, Mecklenburg and Augusta Correctional Centers. For those facilities which require only part-time physician services, the Department employs contract physicians. The cost of these services has been controlled by limiting the total part-time physician contract compensation to no more than a state full-time employed physician's compensation.

Off-Site Costs

According to the Department of Justice, today's offenders are older, sicker and stay longer behind bars than ever before. As health care sparks debate across the nation, the prison community faces its own battle against rising medical costs. The elderly constitute the fastest-growing sector of the inmate population and is a group that needs more frequent and costlier treatment. Also, offenders are entering the system with more acute medical needs. Since enactment of Virginia's truth-in-sentencing legislation in 1995, state responsible geriatric offenders (age 50 and above) account for 15.1% of the confined population in FY 2010 compared with 5% in FY 1995.

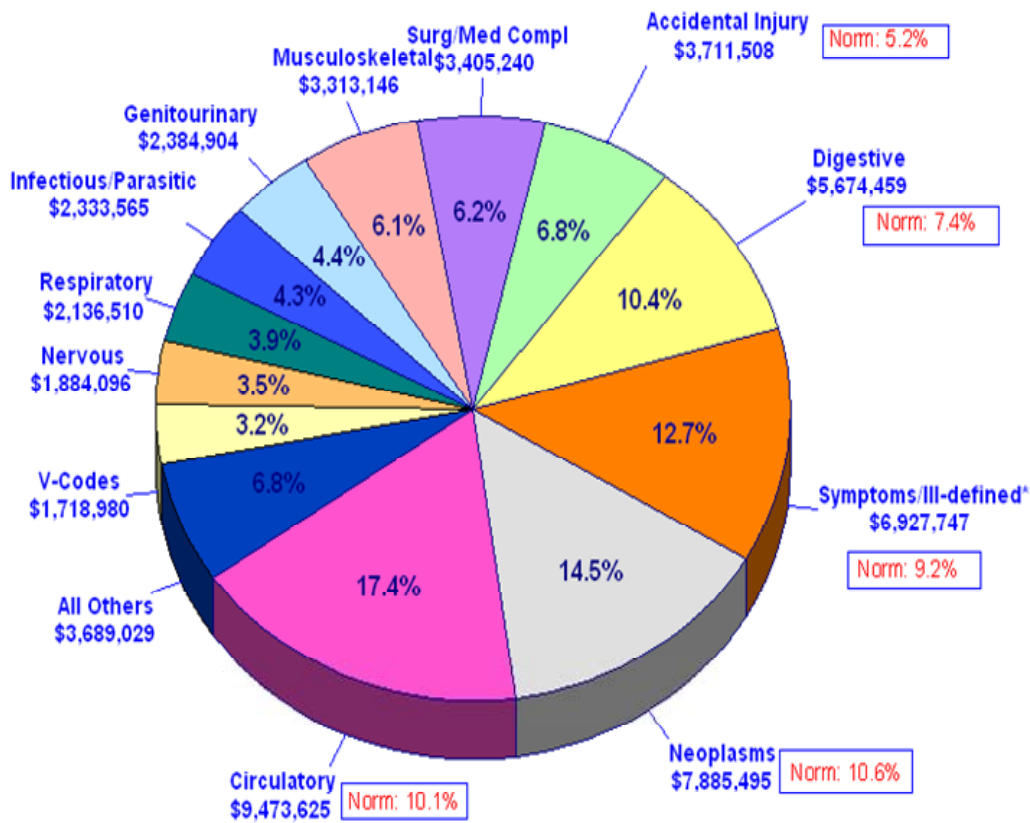
The Department continues to experience an increase in the cost of off-site healthcare. Off-site services include inpatient and outpatient hospital services and specialty physician care. The cost for these services, as reported by Anthem (third party administrator), increased by 19% from FY 2010 to FY 2011 (an increase of \$8.7 million), excluding pharmacy costs.



	% Change	\$ Change
Inpatient Hospital	23.5%	\$ 4,157,511
Inpatient Professional Services	17.1%	\$ 464,151
Outpatient Services	17.3%	\$ 3,434,412
Outpatient Professional Services	11.6%	\$ 650,041

During the current review period with Anthem, the largest amount of expense categorically was incurred within those diseases related to circulatory conditions. Claims with this diagnosis category created medical expenses totaling \$9.5 million or 17.4% of the annual medical expense in the current period. Nineteen percent of the catastrophic claimant expense incurred was in relation to heart disease. Heart disease accounted for 70% of the circulatory expense in the current period. Comparatively, the Anthem large employer group (which encompasses Commonwealth of Virginia government employees) average for circulatory expense currently runs at 10.1% of total medical expense.

Total Medical Expense by Diagnostic Category



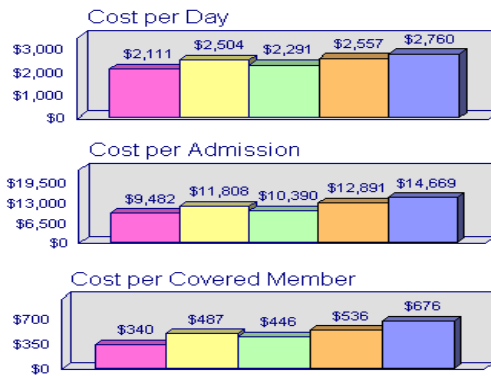
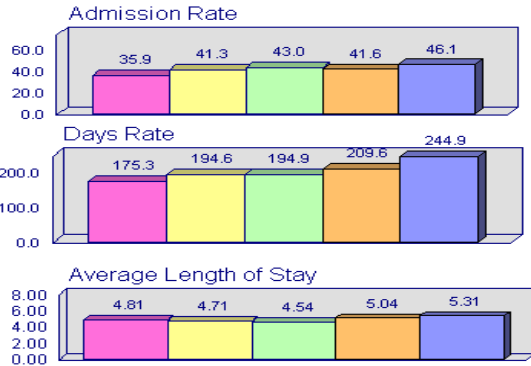
Norm = the Anthem large employer group percent.

The following data depicts the growth of medical costs over the last five years for various aspects of providing outpatient and inpatient services. These increases are attributable to the rising cost of medical services, as well as the impact of providing medical care to an increasingly aging offender population and a population entering the system with more acute medical needs.

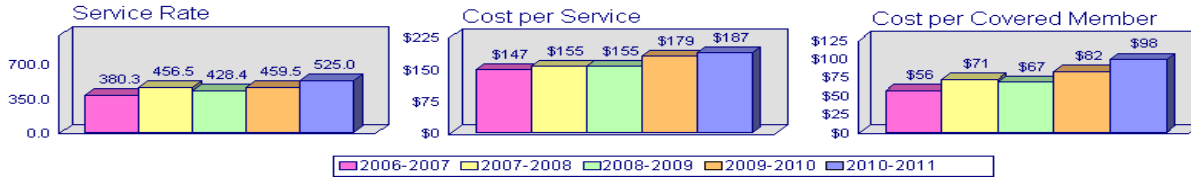
Inpatient Indicators

Facility data:

Five Year Compare



Professional:

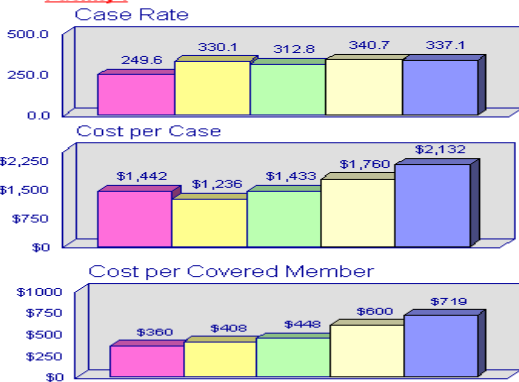


■ 2006-2007
 ■ 2007-2008
 ■ 2008-2009
 ■ 2009-2010
 ■ 2010-2011

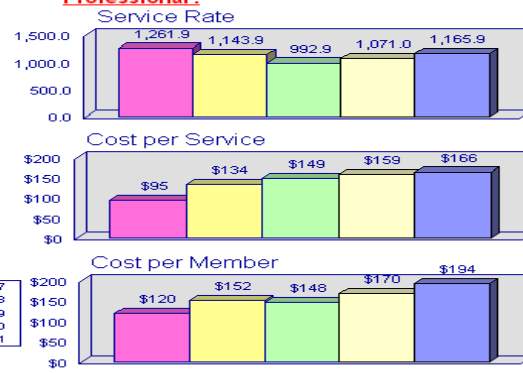
Outpatient Indicators

Facility:

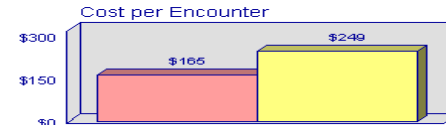
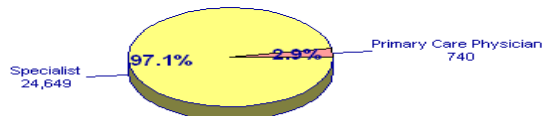
Five Year Compare



Professional:



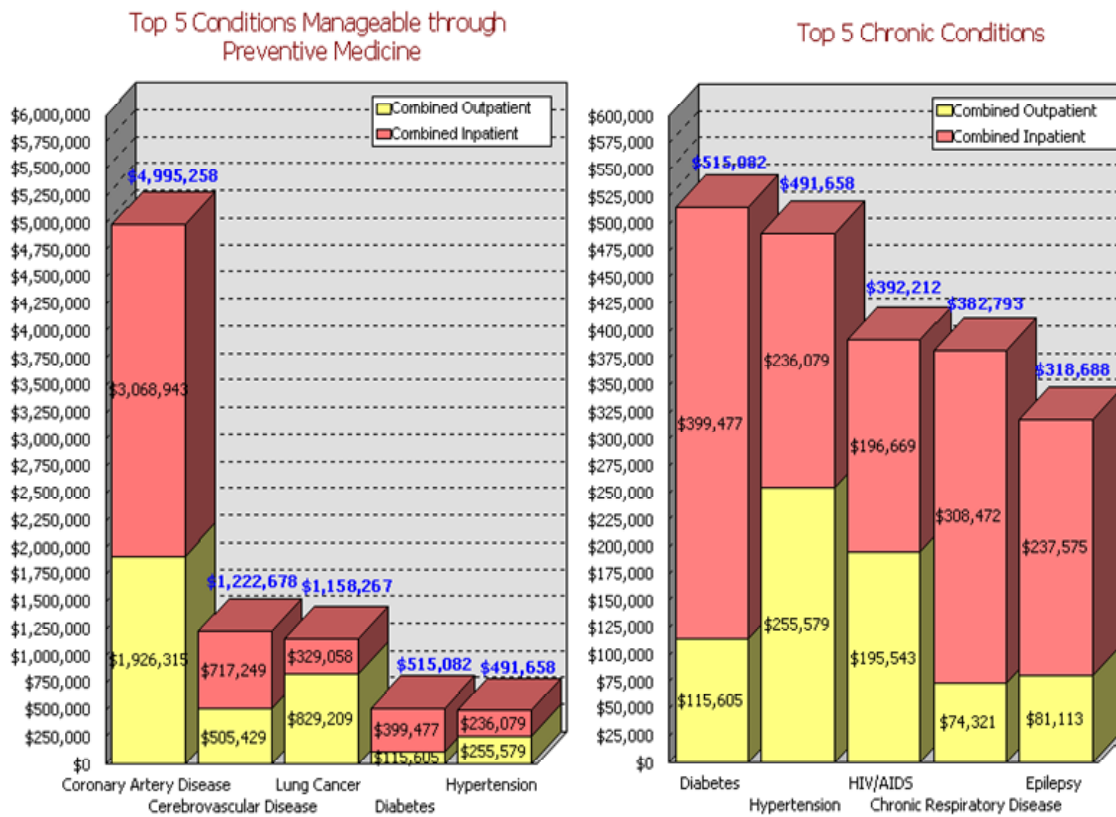
Encounters - Current Year:



Chronic Care Clinics and Prevention

One of the ways the Department is attempting to curb the rise of outpatient and inpatient costs is to manage chronic conditions. Many illnesses that are chronic or preventable in nature can be identified in the early stages through routine screening services. Until the implementation of the Electronic Health Record, it is not possible to effectively measure results, but we believe that improving chronic illness care within the correctional facility can lead to better long term health and will reduce the escalation of off-site specialist and hospital costs.

Medical Condition Detail



About 1/3 of the inmates have a chronic care condition (asthma, diabetes, hypertension, HIV) with some having multiple chronic diseases. Inmate self-responsibility and discipline (diet, exercise, rest, and medication) are keys to health although genes account for approximately 30% of wellness. Currently, all chronic care inmates are scheduled to be seen in chronic care clinic at least twice per year or more often if necessary.

Except for HIV treatment, which is conducted by VCU Health System specialists via telemedicine, the institutional primary care physician conducts the clinic inside the prison. Our plan with telemedicine is to use more specialists to provide preventive care, diagnostic and chronic care at the institutions as well as at Southampton Memorial Hospital which costs less for outpatients than VCU Medical Center.

For quality assurance, we are beginning clinical outcomes management which will focus on improving our most unstable chronic patients, and measuring the results. Clinic outcome management measures the change in a patient's health status which is attributable to intervention. As an example, the hemoglobin A1C test is used to determine the blood sugar of a diabetic patient. The normal range is below 7. If through individual responsibility and chronic care intervention, the patient's hemoglobin A1C drops from 9 to 6 over an eighteen month period, then outcomes have improved.

While early diagnosis can save the Department future expense before more acute care is required, the impact of catastrophic cases continues to rise not only in terms of the numbers of occurrences, but the average cost per occurrence as well.

Catastrophic Claims Experience

For the purposes of this report, a catastrophic claimant is a patient who incurred combined medical and pharmacy expense in excess of \$50,000. Catastrophic claimant expense represented 43% of the Department's costs processed through Anthem for medical and pharmacy expense during this reporting period. Two hundred and sixty-six catastrophic claimants were responsible for \$26 million in expense.

	Prior Year (May 2009- April 2010)	Current Year (May 2010 – April 2011)	Percent of Change
Number of Claimants	171	266	56%
Total Expense	\$15,175,899	\$26,023,836	71.4%
Claimants per 1000	5.2	8.0	53.8%
Avg Cost per Claimant	\$88,748	\$97,834	10.2%

Five Highest % Catastrophic Illnesses	CY Catastrophic Expense	% of CY Catastrophic \$
Malignant Neoplasms	\$6,544,404	25%
Heart Disease	\$4,866,591	19%
Med/Surg	\$3,544,312	14%
Digestive	\$2,049,405	8%
Infectious/Parasitic	\$1,495,557	6%

These type cases are expected to continue to have an impact of the cost of medical care. No matter how catastrophic the case, the security of our citizens is the Commonwealth's priority.

The Benefit of Hospital and Other Medical Provider Rate Schedules

Wellpoint/Anthem Blue Cross Blue Shield serves 33 million members nationwide. In Virginia, they have approximately 2.9 million members. There are 83 hospitals, 9,025 specialists, and 6,673 personal care practitioners in our Preferred Provider Organization (PPO) network. The Department has contracted with Anthem to provide third party administration and managed health care. The agreement with Anthem provides claims processing, negotiation and maintenance of a broad provider network, and the mechanism to control medical costs through utilization management.

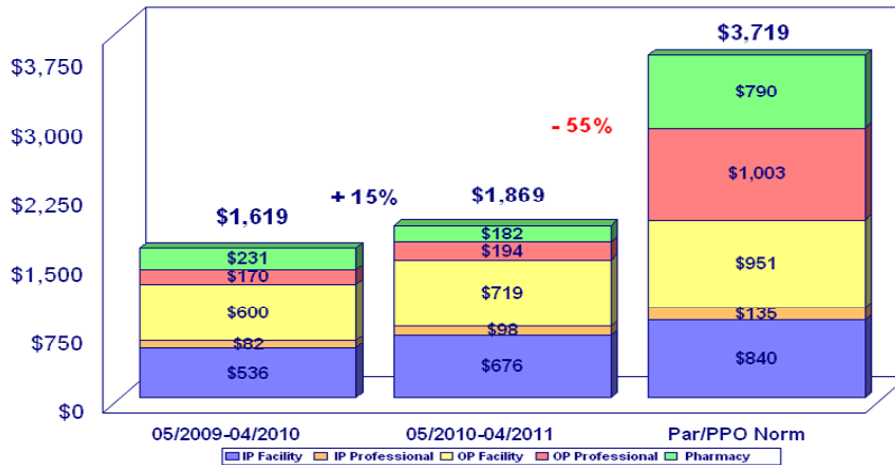
Anthem's hospital contracts generally contain more than one inpatient payment mechanism and are typically paid on a per diem and or a per confinement basis. This is generally a less expensive pricing structure than fee for service pricing, which has no cost limitations. For some of their larger hospitals, reimbursement is based on a Diagnosis Related Group weight multiplied by a base rate. Most of their hospital contracts are written for a period of two to five years; however, there are some which run longer. For Ambulatory Surgery Centers and hospital outpatient procedures, reimbursement is predominately based on a fixed fee basis. Anthem fee schedules are primarily based on the Resource Based Relative Value Scale (RBRVS). This scale is used by the Centers for Medicare and Medicaid Services to determine allowances for Medicare. Anthem may depart from the RBRVS methodology for a limited number of codes. The RBRVS system is used by Anthem for all their insured groups, including the Department of Corrections.

RBRVS is a relative scale developed by a Harvard research team that assigns values to physician services based on the resource cost of providing those services. Each service is assigned relative value units for physician work, practice expenses, and malpractice risk. The three added together are the relative value of the service. For example, using the 2009 National Physician Fee Schedule Relative Value File, a diagnostic colonoscopy performed in a facility is assigned 5.77 relative value units while quadruple coronary bypass surgery is assigned 67.27 relative value units. The RBRVS has undergone constant revision since 1992 to keep up with changes in technology and medical practices. Anthem's fee schedule for most services is determined by multiplying the relative value units for each service by a dollar conversion factor, which is established at a rate to reflect market and economic factors and is reviewed annually.

Over the last 12 month review period (5/1/10-4/30/11) Anthem saved the Department of Corrections \$55,532,793 in facility discounts, and \$10,245,869 in professional discounts. Approximately 55% in savings from charges was achieved. The Department would only save more money if providers accepted either Medicare or Medicaid rates for inmate health care. However, physicians are reluctant to take Medicaid patients because of the low reimbursement rate.

Despite the growth in costs for outpatient and inpatient services for our offender population, data provided by Anthem reveals that the average cost per offender still represents a 55% lower rate when compared to the Par/PPO Norm, which is the Anthem large employer group to whom state employees belong.

Medical Cost per Member



¹ Par/PPO Norm is the Anthem large employer group.

Utilization Comparison in Total and Norm

	2006-2007	2007-2008	2008-2009	2009-2010	2010-2011	Par/PPO Norm
IP Fac Admit Rate	36.5	41.3	43.0	41.6	46.1	60.5
IP Fac Days Rate	15.3	194.6	194.9	209.6	244.9	264.5
Average Length of Stay	4.81	4.71	4.54	5.04	5.31	4.37
Expense per Day	\$2,160	\$2,504	\$2,291	\$2,557	\$2,760	\$3,174
Expense per Admission	\$10,379	\$11,808	\$10,390	\$12,891	\$14,669	\$13,874
Cost per Member	\$379	\$487	\$446	\$536	\$676	\$840
IP Prof Service Rate	383.8	456.5	428.4	459.5	525.0	619.8
Expense per IP Service	\$152	\$155	\$155	\$179	\$187	\$217
Cost per Member	\$59	\$71	\$67	\$82	\$98	\$135
OP Fac Case Rate	263.6	330.1	312.8	340.7	337.1	1,035.0
Expense per Case	\$1581	\$1236	\$1,433	\$1760	\$2,132	\$918
Cost per Member	\$417	\$408	\$448	\$600	\$719	\$951
OP Prof Service Rate	1,112.1	1,143.9	992.9	1,071.0	1,165.9 ¹	17,476.0
Expense per Service	\$123	\$134	\$149	\$159	\$166	\$57
Cost per Member	\$136	\$152	\$148	\$170	\$194	\$1003
# of Scripts/Member	2.60	2.77	3.29	3.67	2.95	13.67
Expense per Script	\$82.94	\$79.05	\$72.29	\$63.15	\$61.62	\$57.78
Cost per Member	\$215	\$220	\$238	\$232	\$182	\$790
Number of Inmates	32,725	34,326	35,032	33,029	32,333	
Total Expense	\$39,449,156	\$45,948,462	\$47,170,207	\$53,478,265	\$60,417,688	
Avg Cost per Inmate	\$1,205	\$1,339	\$1,343	\$1,620	\$1,869	

Pharmaceuticals

The Virginia Department of Corrections constantly reviews pharmacy expenditures and evaluates cost avoidance strategies and opportunities. Examples of recent actions include:

- Issued Request for Proposals for pharmacy services in 2010 resulting in a new contract effective January 1, 2011, reflecting a revised reimbursement model (cost plus fee vs. capitated rate plus third party administrator reimbursement) and an expanded credit process. The medication acquisition cost plus dispensing fee is anticipated to be less costly than wholesale market pricing.
- Developed a new formulary (*formulary is a preferred list of lower cost, effective medications developed by the Pharmacy and Therapeutics Committee composed of clinicians, and management*) and non-formulary approval process to provide practitioners a broad range of cost efficient medication options for the treatment of the offender population. The full financial impact of this change will require several months to evaluate, however, since the June 1, 2011 start date, the Department has seen a drop in non-formulary usage from 16-17% to 3.5%. In the coming months, several high use, high cost brand medications will become available as generics. The DOC Pharmacy and Therapeutics Committee will evaluate appropriate potential formulary additions.
- Renewed the Memorandum of Agreement with Virginia Commonwealth University Health System Out-Patient Pharmacy for antiretroviral (HIV+ medications) at 340B federal pricing. 340B pharmaceutical pricing is a federal program for hospitals that serve a significantly disproportionate number of low-income patients. This MOA with VCUHS allows the Department to receive antiretroviral medications at a discounted cost which has historically provided the DOC with approximately \$1,000,000 in annual cost avoidance for this segment of our population. The Health Services Unit will continue to evaluate the potential to expand this program. It should be noted that a “willing partner” is required to access the 340B federal prices.
- Began implementation of electronic medication order entry as Phase One for electronic health records. National reports suggest decreased waste will be a by-product of this technology.

The Department has participated in various studies and vendor presentations over the past two years:

- In 2009, the DOC, in addition to other State agencies, was included in the Virginia Rx Initiative conducted by the University of Massachusetts. The study failed to provide significant and/or practical cost savings recommendations for the Department.
- Mental Health Management, Inc. presented a program to lower the cost of psychotropic medications in July 2010, however, their data proved inaccurate as it related to the Virginia Department of Corrections.
- In April 2011, the National Institute of Corrections conducted a webinar on medication cost savings. Although it was noted that most State DOCs faced many of the same issues as Virginia, effective “new” strategies have proven difficult to find.
- The Department met with RxQuest in May 2011. RxQuest offers pharmacy benefit management review services to organizations. RxQuest could not improve upon the cost containment measures currently implemented by DOC.

Hepatitis C

During 2011, two new medications, incivek and victrelis, were introduced as more successful treatment for those who do not respond to current Hepatitis C treatment. These new medications have a significantly higher cost. At this time, the financial impact to the Department is unknown, but could cost millions of dollars more. We will continue current treatment strategy, and the following:

- Monitor success rates, adverse reactions, discontinuation percentages for several months based on “community” usage reports rather than manufacturer pre-release studies (package inserts);
- Review guidelines established by other entities as noted below and including other states’ department of corrections, Department of Medical Assistance, and Anthem plans;
- Discuss Memorandum of Agreement with VCU Hepatology/Out-Patient Pharmacy similar to HIV+ and estimate potential total cost (hepatology clinic, labs, pharmacy, anemia therapy) or contract a community hepatologist for consults. The latter eliminates the 340B model; however, total expense may be less;
- Incorporate new medication into protocol if appropriate;
- Data:
 - 14 active offenders on therapy (increasing number treated leads to increasing costs for medications, labs, hepatology visits if we incorporate VCUHS)
 - 43 offenders received at least one order for peginterferon/ribavirin
 - Approximately \$20,000 per offender current regimen (peginterferon/ribavirin)
 - Approximately \$50,000 - \$70,000/offender new regimen (peginterferon/ribavirin + new medication)

The American Association for the Study of Liver Disease is the foremost expert on liver disease, and will publish new guidelines in the future. In the past, the Federal Bureau of Prisons has followed them in writing their guidelines. The Department will wait for the updating of guidelines by these groups before assessing changes to the current Department guidelines.

Privatization of Offender Health Care

The Department's main reason for having private companies do comprehensive health care management at select locations has been our inability to recruit staff, especially in geographic areas where the supply of health care professionals are unable to meet demand, not for the reason of cost savings.

Some of the prisons are in rural areas, and the work environment is not attractive to many health care workers. Furthermore, the Department's pay until recent years has lagged behind the private sector despite better benefits. The amount of the paycheck has been most important, and the private companies have had more latitude in this regard; i.e. They offer shift differentials, sign-on bonuses and additional compensation for supervisory responsibilities.

A cost comparison between private company annual health care cost per inmate and the Department was done by the Budget Unit and by the Department's Internal Audit Unit. Both studies concluded the private company health care cost per inmate was similar or higher than the Department, but not lower.

The ultimate cost savings from privatization can be a full-risk capitation agreement in which the company is responsible for all costs including the off-site health care expenses. The Department and Correctional Medical Services had this arrangement in the 1990s, but the national companies lost money and stopped the practice of full-risk capitation. In the last couple of months, some of the national companies including Armor Correctional Health Services are willing to take full financial responsibility for their contract which is the best possible arrangement for the Commonwealth as long as the company's charges are reasonable. Over the past 10 years, there has been shared financial risk between the Department and the contractor i.e. if the labor or off-site health care costs exceed an agreed amount, they are shared. Likewise, if the costs are below an agreed upon amount, the savings are shared.

A directive of this report was to consider alternatives. We considered deprivatization of the eight institutions at a net annual savings of \$4 million. The Department has contracted with a private company to provide full medical services at designated prisons since 1990, beginning with Greenville Correctional Center and Work Center. Beginning in May 1, 2006 and effective until October 31, 2011, the contracts were split between two private vendors, Corizon (formerly known as PHS) and Armor Correctional Health Services, Inc (Armor). In 2011, the following facilities are covered under the contracts: Greenville Correctional Center (and work center), Powhatan Correctional Center, Powhatan Reception and Classification Center, Sussex I State Prison, Sussex II State Prison, Coffeewood Correctional Center, Indian Creek Correctional Center, Lunenburg Correctional Center and Fluvanna Correctional Center for Women. We had both private companies compete for the other's business within the context of the existing contract for a \$3.4 million annual cost avoidance from Armor, and a \$300,000 annual cost avoidance from Corizon. Finally, we asked both companies for full capitated proposals with Armor offering a \$500,000 net monthly savings (\$9,000,000 from 11/01/2011-04/30/2013), and Corizon's proposal fell short in comparison to Armor. We have proceeded with Armor for all eight institutions effective 11/01/2011 through 04/30/2013. We will issue a new Request for Proposal for the eight facilities in 2012 using the full-capitated reimbursement model again. Other institutions will be added to privatization only if staffing becomes an issue, and if the private cost is similar to the Department's cost.

Cost Decreases ¹

The Virginia Department of Corrections health services are cost effective. According to the American Correctional Association, in 2009 Virginia was the 18th lowest cost per inmate in the country, and in 2010, the 19th lowest cost. The following actions by Department management helps control total health care expenses. However, increased funding requirements will still require the Department to submit a 2012 – 2014 biennium budget request.

- 1) The Department saved \$66,000,000 this last 12 month review period (5/1/10-4/30/11) in facility and professional discounts. These savings represent the difference between provider charges and their allowable reimbursement through Anthem.
- 2) The Department will avoid \$9,000,000 in costs with its capitated Armor contract from 11/1/11 to 4/30/13.
- 3) The Department avoided \$1,000,000 this past year from its 340-B pharmaceutical HIV program with VCU Health Systems.
- 4) The Department deprivatized 5 dental contract managed institutions for an annual cost avoidance of about \$900,000.
- 5) The Department's new pharmacy contract and formulary should generate annual cost avoidance of about \$1,000,000.
- 6) In 2009, generic risperdone (risperdal) became available for use resulting in an annual cost avoidance of about \$300,000.
- 7) In 2009 and 2010, the Department negotiated no Consumer Price Index (CPI) increases for Anthem for an annual cost avoidance of about \$100,000.
- 8) The Department negotiated no CPI increase in 2009 from our dialysis contractor for an annual cost avoidance of about \$60,000.
- 9) The Department converted contract physician to state physician coverage for an annual cost avoidance of \$50,000.
- 10) In the area of utilization of off-site services, cost savings continues to be sought through scrutinizing each individual request for off-site services to make sure the requested service is the appropriate service and/or cannot be provided on-site. Guidelines continue to help standardize care.

¹Cost decreases slow down the net increases, not eliminate them.

National Health Care Reform and Medicaid

As this law is written today, effective January 1, 2014, most inmates will financially qualify for Medicaid. State legislation needs to be introduced in 2013 requiring all Virginia health providers to accept Medicaid payment for all inmate medical care. The annual cost avoidance approximates \$12,000,000.

Past legislation has been introduced in the Virginia General Assembly to require the Department to pay Medicaid rates to the providers. The providers must be mandated by the General Assembly to accept Medicaid for inmate health care as Medicaid pays them below their cost. As an example, in late 1995 and early 1996, VCU Health System balked at being paid the lower PPO-1 rate of Anthem, and the higher PAR rate was accepted by them. Putting into state law that all health care providers servicing inmates be reimbursed only at Medicaid rates will greatly reduce cost for the Commonwealth of Virginia.

Health Care Delivery in the Texas Prison System and VCU Health System

After 17 years of experience in a managed care model, the Texas prison system demonstrates that putting the state academic medical centers at full financial risk/reward for all inmate health care can be cost effective.

Organizational Structure and Funding

One of the lowest health care cost per inmate systems in America is the Texas Correctional Managed Health care system which is structured on a series of contractual relationships between Texas Department of Criminal Justice (TDCJ), Correctional Managed Health Care Committee and 2 state medical schools. Texas Department of Criminal Justice contracts with Correctional Managed Health Care Committee to provide statewide oversight and coordination of health services. The Correctional Managed Health Care Committee (CMHCC) in turn contracts with University Texas Medical Branch (UTMB) and Texas Tech University Health Sciences Center (TTUHSC) to provide medical, dental, and psychiatric care to the prison population. Both universities subcontract with local clinicians on an as needed basis. The program is funded by an annual capitated appropriation from the State Legislature to TDCJ. Acting as an independent third party, CMHCC allocates funds to UTMB and TTUHSC based on a specified capitation rate. Capitation rates for the 2 universities differ because of variations in the type and extent of services they provide and the health characteristics of the population under their care. A university health care system could be directly funded for all Virginia Department of Corrections inmate health care using capitation. The TDCJ Health Services Division monitors the quality of care delivered by the contracted clinicians via its Health Services Quality Improvement Program. Biennial operational reviews of prison health facilities are conducted to ensure compliance with national and state standards and laws. Additionally, the division investigates all medical-related grievances, reviews all prisoner deaths, and monitors the incidence of communicable diseases.

The CMHCC is composed of 9 appointed members, including 3 public members and 2 representatives from TDCJ, UTMB, and TTUHSC. Five members are physicians. In addition to coordinating the contractual provision of health services, the committee monitors the general quality of health care, resolves disputes related to medical care, and implements the use of case management, utilization review, and other managed care tools. The committee has the power to enforce compliance with contract provisions. A similar arrangement can be developed with the university health care system, owned by Virginia Commonwealth University.

Recommendations

- 1) The Department should issue a new Request for Proposals in 2012 for the eight current privatized institutions, and any others having recruiting issues.
- 2) The Department should continue its efforts in health prevention and chronic care.
- 3) The General Assembly should require all Virginia health care providers to accept Medicaid payment for inmate health care beginning 01/01/2014.
- 4) The General Assembly should require a university health system to manage all Department of Corrections health services on a capitated rate per inmate which would put them at total financial risk, and save millions of dollars for the Commonwealth. According to the 2010 American Correctional Association (ACA) Survey of Health Care Costs, Texas per inmate healthcare cost is 35% lower than Virginia's. Without a mandate from the legislature, Texas university health systems were unwilling to administer offender healthcare.

Should this management model not develop, then we recommend the General Assembly proceed with the 2007 proposed "Master Plan for Healthcare Services" design/development of the \$170,000,000 freestanding Statewide Correctional Medical Center. This project eliminates the Powhatan and Greensville infirmaries; it reduces provider facility charges, and has a ten year payback. Design/Development should be accomplished so that the project may continue when construction funds are available.