COMMONWEALTH of VIRGINIA

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September 30, 2015

TO: The Honorable Brian Moran
Secretary of Public Safety and Homeland Security

The Honorable Walter A. Stosch
The Honorable Charles J. Colgan, Sr.
Co-Chairmen, Senate Finance Committee

The Honorable S. Chris Jones
Chairman, House Appropriations Committee

FROM: Harold W. Clarke, Director
Virginia Department of Corrections

RE: Budget Bill HB 1400 Item 384

Pursuant to Budget Bill HB 1400 Item 384 passed by the Virginia General Assembly in the 2015 General Assembly Session, the Virginia Department of Corrections submits this reporting of responses from a Request for Information focusing on "identifying health care management models that use the best practices and cost containment methods…"

Summary Report

Summary of Health Care Models As Directed by 2015 Budget Bill HB 1400 Item 384

September 30, 2015

PREFACE

Current Health Care Model in regards to VA HB 1400 Item 384

The Virginia Department of Corrections (DOC) has responded to HB 1400 Item 384 by enlisting the services of the Department of Health Administration at Virginia Commonwealth University (VCU) who produced a summary report regarding offender health care models based on the nine responses from the Request for Information (RFI #DOC-15-077). The report is a third party account of responses. An evaluation of current DOC practices that have either been implemented or explored in the past was not part of the RFI. Time spent at the DOC by the nine responding companies would shed light on the many suggestions that are already in place and have been for years as the Department strives to better serve the Commonwealth. The purpose of this preface is to provide information and clarification of current strategies used by the Department of Corrections.

Leveraging Existing State-Funded Managed Care Networks

The term ***managed care*** or ***managed health care*** is used in the United States to describe a variety of techniques intended to reduce the cost of providing health benefits and improve the quality of care for organizations that use those techniques or provide them as services to other organizations ("managed care organization" or "MCO"), or to describe systems of financing and delivering health care to enrollees organized around managed care techniques and concepts ("managed care delivery systems"). The Virginia Department of Corrections has been using managed care for over two decades. The contract with our current third party administrator, Anthem Blue Cross Blue Shield, was converted from a Preferred Provider Organization (PPO) to a Health Maintenance Organization (HMO), Anthem HealthKeepers, on 7/1/2015. This change reduced reimbursement for outpatient services to 29.5% of the charge. This move to Anthem HealthKeepers will produce an estimated annual statewide cost avoidance of approximately $9.0 million. Under the Affordable Care Act if Medicaid expands in Virginia, the DOC could expand its Medicaid participation. The DOC currently has a healthcare reimbursement team which enrolls all Medicaid eligible offenders for covered inpatient visits.

Federal Health Care Funding Opportunities

There are two opportunities for federal funding identified: Medicaid and 340b drug purchasing. Both of these programs are being accessed by the DOC.

The 340b HIV Disease Telemedicine Clinic with Virginia Commonwealth University Health System (VCUHS) has been in operation since 2003 and in fiscal year 2015 saved the Commonwealth an estimated $4.5 million. Additionally, the DOC is in contract with VCUHS to operate clinics for Hepatitis C. This contract allows VCUHS to dispense both the HIV and Hepatitis C medications from their pharmacy. With the recent addition of the Hepatitis C treatment an estimated cost avoidance $6.8 million is forecasted for fiscal year 2016. To access this pricing the care must be under the supervision of a provider employed by the covered 340b entity. States that have academic medical centers running correctional health systems realize a much greater savings. This model will be discussed further in the final section, "Innovative Correctional Health Care Management Systems from Other States".

Since July, 2013, the DOC & Department of Medical Assistance Services have worked together to provide Medicaid reimbursement to providers for eligible offender inpatient hospitalizations. In fiscal year 2014 this joint effort reduced funding for the DOC by $2.7 million in General Funds. The 2013 Act transferred $1.3 million to DMAS to fund the impact and appropriated a like amount of federal matching funds. This joint effort, therefore, saved the Commonwealth a minimum of $1.3 million in General Funds for fiscal year 2014.

State of the Art Practices in Care Coordination and Utilization Review

Care coordination

Of the five topics discussed to further care coordination the Department already has four topics fully operational and has sought funding for the fifth topic for many years. The DOC has on site chronic care clinics at all correctional facilities to slow progression of disease whenever medically possible and decrease the number of hospital admissions. The DOC has been using telemedicine for specialty visits since 1995 to increase offender access and decrease security costs. Our current pharmacy services contractor provides all of the innovative services listed in the report. Offenders who are released are provided at least a month's supply of medications and provided a second month's prescription for mental health medications to promote continuity of care. Additionally, the health services unit helps re-entry specialists find placement for offenders with acute care needs and connects HIV positive patients with the AIDS Drug Assistance Program (ADAP) clinics in their areas. Furthermore, for care coordination, the DOC has sought funding for an electronic health record, completed an RFP and chose a vendor, but the Virginia General Assembly has not appropriated the funding.

Utilization Review and Management

The DOC currently uses a VADOC specific electronic system to authorize and monitor offsite health care. This prospective review allows the Chief Physician to proactively collaborate with facility physicians to treat onsite or approve necessary offsite care when appropriate. According to Anthem Blue Cross Blue Shield, DOC practice was found to be in line with current community practice.

Anthem Blue Cross Blue Shield also reviews offsite care both concurrently and retrospectively. They have the ability to dispute days and charges related to visits.

The DOC also has a full time clinical care coordinator who works with VCUHS to discharge offenders when medically appropriate to decrease inpatient days and costs.

Innovative Correctional Health Care Management Systems from Other States

Two suggestions were made regarding innovations to the health care system. In the first, utilizing a fully contracted medical system was suggested. The immediate benefits are realized when a "vendor not to exceed rate" is utilized and staffing concerns are passed onto the vendor. Virginia has utilized this method for its hard to staff sites, sites that have infirmaries, and for its more acute medical need offender populations. The concern is that the driving force for selecting a totally contracted medical model will be based mainly on price. This may lead to decreased offender medical care as contractors are the recipients of and will benefit from any cost avoidance. The Commonwealth in this model is still responsible for offender care and is legally liable. This has been proven in a recent health care lawsuit from a contracted medical site.

The second suggestion is that an academic medical center would manage the DOC health system. Historically, the Department has explored an offender health system managed by an academic medical center. In the opinion of the Department this change would have to be mandated by the legislature as has been done in other states. This option would allow all medications to be purchased at 340b pricing and would reduce medication costs statewide by about 50%. This model will provide high quality care and reduce expenses by bypassing the need for most contractors.

Conclusion

The Virginia Department of Corrections has and will continue to stay abreast of emerging correctional and community healthcare trends to ensure adequate and cost effective care. This type of review provides an opportunity for self-reflection and health services looks forward to the coming months to identify areas for improvement. With concrete data gathering, review of current operation and looking for the best evidenced based practices, the Department is certain that it can find ways to continue to improve the operations to better serve the Commonwealth.

SUMMARY REPORT

Prepared for

The Virginia Department of Corrections

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Introduction

Virginia's 2015 Budget Bill HB 1400 Item 384 states:

> *"P.1. The Department of Corrections shall develop and issue a Request for Information for the comprehensive management and provision of health care services for (i) all inmates confined at facilities not covered by the August 4, 2014, solicitation for health care management services, and (ii) all inmates confined at Department facilities statewide. This request for information shall focus on identifying health care management models that use the best practices and cost containment methods employed by Medicaid managed care organizations in delivering provider-managed and outcome-based comprehensive health care services. These services shall include consolidated management and operational responsibility for delivering all primary and specialty care, nursing, x-ray, dialysis, dental, medical supplies, laboratory services, and pharmaceuticals, as well as all off-site care, case management, and related services. Specific information shall be sought on 1) how existing state-funded managed care networks can be leveraged; 2) federal health care funding opportunities; 3) identifying state-of-the-art practices in care coordination and utilization review; and 4) identifying innovative correctional health care management systems being used or developed in other states. A report summarizing the responses to the Request for Information and estimating the potential long-term savings from the approaches identified in the responses shall be provided to the Chairmen of the House Appropriations and Senate Finance Committees, the Secretary of Public Safety and Homeland Security, and the Department of Planning and Budget no later than October 1, 2015.*
>
> *2. The Department shall provide to the Secretary of Public Safety and Homeland Security, the Directors of the Departments of Planning and Budget and Human Resources Management, and the Chairmen of the House Appropriations and Senate Finance Committees by July 1, 2016, a report assessing:*
>
> *a. The costs, benefits, and administrative actions required to eliminate the Department's reliance on a private contractor for the delivery of inmate health care at multiple facilities, and to provide the same services internally using either state employees or individual contract medical personnel.*
>
> *b. The costs, benefits, and administrative actions required to transition to a statewide health care management model that uses best practices and cost containment methods employed by prison health care management and Medicaid managed care organizations to deliver provider-managed and outcome-based comprehensive health care services through a single statewide contract for all of the Department's adult correctional centers.*
>
> *c. A review of the Department's actual cost experience comparing the previous arrangement in which the contractor assumed full financial risk for the payment of off-site inpatient and outpatient services, and the current and proposed arrangement in which the Department assumes that risk and also receives any Medicaid reimbursement*

for such off-site expenses. For purposes of analyzing the first arrangement, it is assumed that the benefit of any Medicaid or other third-party reimbursement for hospital or other services would accrue to the contractor. This review shall also compare cost trends experienced by other states which have adopted these two arrangements.

d. A comparison of the costs and benefits of the Department's current management of inmate health care, including the model envisioned in its August 2014 Request for Proposals, to the alternative models the Department is directed to assess in subsections a, b, and c above.

e. The Department of Human Resources Management, the Department of Planning and Budget and other executive branch agencies shall provide technical assistance to the Department as needed."

As directed, DOC sought specific information on:

1) How existing state-funded managed care networks can be leveraged;
2) Federal health care funding opportunities;
3) State of the art practices in care coordination and utilization review; and
4) Innovative correctional health care management systems being used or developed in other states.

On May 7, 2015, DOC received nine responses to its Request for Information from the following organizations (in alphabetical order):

Anthem Blue Cross Blue Shield
Richmond, VA

Armor Correctional Health Services, Inc.
Miami, FL

Centurion of Virginia, LLC
Vienna, VA

Corizon Health
Brentwood, TN

Correct Care Solutions, LLC
Nashville, TN

Diamond Pharmacy Services
Indiana, PA

Health Management Associates
Lansing, MI

PTX Dialysis LLC/Old Dominion Dialysis Services, Inc.
Hopewell, VA

Wexford Health Sources Incorporated
Pittsburgh, PA

In what follows, these companies will each be referred to by a letter selected at random.

Of the nine responses, one was a proposal for consulting services to assist the writing of the next RFP to solicit an outside contractor to provide offender services. Another was a brief letter emphasizing the importance of prevention and patient education in the area of kidney disease. Company F's submission was largely a description of its services. Company W's submission again described its services and was not directly responsive to the four topics. Company M's submission addressed the four topics of the RFI, but only from the standpoint of pharmacy services.

The report is organized around the four topics of the RFI noted above. Each section combines and summarizes the content of the four submissions that addressed these topics directly, with the addition of content from others where appropriate. The report concludes with some overall thoughts and an appendix that provides case studies of several states that have developed or are developing what are thought to be innovative models for managing offender health care services.

1. Leveraging Existing State-Funded Managed Care Networks

Virginia has extensive experience with state-funded managed care. Virginia is among the 38 states plus the District of Columbia that use managed care plans to provide services to many Medicaid enrollees.[1] Managed care Medicaid in Virginia began in 1993 as Medallion Primary Care Case Management.[2] As of May 2014, 69% of all Medicaid recipients in Virginia were enrolled in one of seven managed care companies (note: MajestaCare dropped its Virginia Medicaid contract in December 2014).[3,4] Since 2014, Virginia has been engaged in a 3-year demonstration project to enroll individuals who are eligible for both Medicare and Medicaid in managed care. The program covered about 27,300 dually eligible enrollees statewide in January 2015.[5]

Only three respondents addressed the use of existing managed care networks. Company K noted that leveraging existing networks maximizes the state's buying power for health care services. A 2013 study published by the California Healthcare Foundation examined efforts by 17 states to

coordinate purchasing across agencies, mostly Medicaid and public employees.[6] While there were some successes in such things as using common contracting language and sometimes forms, common performance schedules, common preferred drug schedules, and common fee schedules or payment methodologies, the efforts often waned when the proposing governor left office or when there were leadership changes in the legislature. Other barriers to successful coordination included agency staffing limitations and differences (real and perceived) in the vision for and needs of the different populations for which the different agencies were responsible. None of the states included services for offenders in these inter-agency efforts.

Company K also stated that DOC should at a minimum be comparing its negotiated pricing structures within its current network of contracted providers to those used by DMAS, to identify discrepancies and opportunities to lower prices and expenditures. While the respondent noted that some states have legislated the ability of corrections officials to use Medicaid rates as benchmarks for off-site claims payment, we were unable to corroborate this assertion. However, absent legislation prohibiting this approach, there would be no need for specific legislative authority to do so. Certainly as benchmarks for comparison, Medicaid rates might provide a useful starting point for negotiation. However, as the recent DOC negotiation with VCUHS demonstrates, negotiated prices are as much a function of what the provider is willing to accept as what the agency would like to pay.[7] In an environment in which DOC's provider choices are constrained, offering Medicaid rates may not allow DOC to meet its constitutional requirement of providing adequate access to health care services to all offenders for which it is responsible.

Company R noted that three of the six Medicaid managed care organizations serving Medicaid enrollees are provider-affiliated (Virginia Premier with VCUHS, Optima with Sentara, and InTotal with Inova Health System). In its view, DOC has an opportunity (through Company R) to negotiate better rates by contracting directly with the health care providers rather than the managed care companies. There is no direct evidence to support or refute this assertion. However, it should be noted that the benefit of managed care – at least in principle – is not simply lower prices per service but rather lower expenditures through care coordination across the spectrum of care. To the extent this care coordination is facilitated at the plan level rather than through the providers, this benefit might not be fully realized through contracts exclusively with providers.

Finally, Company B stated that DOC would not gain anything by leveraging existing state-funded managed care networks because in its view the former contract with VCU Medical Center, which paid 80% of billed outpatient charges, was not cost-effective. In our view, this respondent has interpreted the question narrowly to focus on the existing managed care contract with DOC, not the managed care networks of the six managed care companies that serve Medicaid recipients throughout the Commonwealth. Thus, it is not clear that this observation adds anything to the points made by the other respondents.

2. Federal Health Care Funding Opportunities

There are two primary avenues for federal financial support of offender health services: Medicaid and the 340B Drug Pricing Program.

Medicaid

Healthcare services that are eligible for Medicaid coverage reduce Commonwealth expenditures by 50% because that is the share of Medicaid expenditures that is paid from federal Medicaid funds. While federal Medicaid funding is expressly prohibited for most health care services provided to incarcerated individuals, there is a narrow exception for offenders when they are receiving inpatient services in off-site hospitals.[8]

As noted by several respondents, however, the process of seeking Medicaid reimbursement could be made more efficient by improving the coordination between DOC and DMAS. In some states, Medicaid eligibility of all offenders is monitored on a regular basis so that eligibility has already been established for offenders *before* a covered hospitalization rather than *after,* per the current DMAS guidelines. This not only reduces the time lag for reimbursement from Medicaid, it also reduces the transactions costs. Under the present system, inpatient charges are generally billed and paid by Anthem. If the offender is determined to be Medicaid eligible and the inpatient charges are approved by Medicaid, Medicaid pays the charges (at Medicaid rates) to the inpatient provider. Any payment that DOC has made to Anthem for these services is then retracted. Each transaction takes time and resources, and increases the opportunity for errors.

A recent change to the process provides an exception for offenders who enter a DOC facility with current Medicaid eligibility. For these offenders in all 40 facilities, providers can direct bill Medicaid rather than going through Anthem. This simplifies the process for these offenders.

Another advantage of continuous Medicaid eligibility is that the eligibility status of offenders would be current when they are released to the community. When offenders, particularly those with active or chronic illnesses or mental health/substance abuse issues, leave the prison system without employment or insurance, they are at high risk for medical events. These events may either result in preventable emergency room visits and hospitalizations or recidivism, both of which have consequences for state budgets as well as the health and safety of residents of the Commonwealth. The submission from Company K outlines this point succinctly:

> In addition to impacting costs for the Department while inmates are in custody, the accessing of federal funds through entitlement programs has a strong impact on recidivism. This issue ties in with the Department's reentry initiatives. Reentry from a healthcare standpoint means enrolling inmates in subsidized coverage or community-based programs so that funding and support services are available after release so that inmates, particularly those with chronic medical and/or mental health conditions, can

continue care and treatment after release. The fragmented nature in which the Department currently procures healthcare services makes it difficult to manage a consistent healthcare reentry program for inmates with chronic conditions.

Finally, most submissions mentioned the issue of Medicaid expansion. If Virginia were to expand its Medicaid program to the full extent allowed by the Affordable Care Act, there would be a significant increase in the number of offenders eligible for coverage of inpatient services. According to a 2013 publication of the DOC, 92% of the prison population is male, none are below the age of 20, and only 5% are over the age of 60.[9] Under the current Virginia Medicaid program, none of these offenders are eligible for Medicaid coverage– regardless of their income – unless they are disabled or over 65.[10] Under an expanded Medicaid program, all of these offenders with incomes up to 133% of the federal poverty level (FPL) would be eligible and the costs of their inpatient hospitalizations would be covered by Medicaid.[11] This would yield a savings to the Commonwealth of at least 90% for these services (somewhat more before 2017). In addition to increased offender eligibility during incarceration, an expanded Medicaid program could better address the issue of continuity of care after release raised by Company K. Childless women with incomes up to 133% of FPL would also be newly eligible under an expanded Medicaid program. Estimates of the percent of the Virginia prison population that would be affected by an expanded Medicaid program vary from 2% in the Company R submission to 15% in the Company Y submission. These figures cannot be verified with existing data.

340B Drug Pricing

Section 340B of the Public Service Act "requires drug manufacturers to provide outpatient drugs to eligible health care organizations/covered entities at significantly reduced prices."[12] Only certain types of entities are eligible to participate in the 340B program including nonprofit health care organizations with certain federal designations (mostly safety net facilities and Ryan White HIV/AIDS program grantees). In general, patients who receive 340B-purchased drugs must also receive other services from the eligible provider.

The following drugs are eligible for 340B coverage:

- FDA-approved prescription drugs;
- Over-the-counter (OTC) drugs written on a prescription;
- Biological products that can be dispensed only by a prescription (other than vaccines); and
- FDA-approved insulin.

Since 1996, DOC offenders have received HIV, Hepatitis C, and Factor VIII (for hemophilia) drugs through the 340B program. These drugs are purchased through the DOC contract with Virginia Commonwealth University Health System (VCUHS), but they are available to all offenders in all facilities. While these three drugs probably represent the largest opportunities for

savings, there may be more outpatient drugs that could be purchased through the 340B program and perhaps more entities through which the drugs could be purchased if that either made logistical sense or if 340B drug prices differed across entities (which they do not at present). According to Commonwealth of Virginia accounting records, DOC spent $13.6M on all prescription drugs in FY 2015, $4.6M of which was for HIV medication purchased at reduced prices through the 340B program.[13]

Many observers have commented on the potential for new Hepatitis C drugs to have a major impact on the cost (and effectiveness) of treatment for that disease.[14] Given the high prevalence of Hepatitis C in the prison population generally, it certainly makes sense to maximize 340B drug purchasing in this area.[15] DOC estimates that savings from using the 340B program to purchase Harvoni, Gilead's new Hep C drug, for 50 offenders requiring treatment a year could save a total of more than $2M annually.[16]

3. State of the Art Practices in Care Coordination and Utilization Review

Four respondents provided the majority of the feedback on the state of the art practices in care coordination and utilization review. One company provided state of the art practices in pharmacy services and one company's response mainly focused on how DOC should alter the contracts with Anthem and VCU as they pertain to utilization review.

Care Coordination

As noted by several respondents, care coordination allows for the shifting of services from expensive options to controlled, less expensive options. While DOC does provide care coordination, the respondents identified a few practices that could be introduced or expanded, including on-site care, telemedicine, electronic health records, pharmacy services, and community outreach.

On-site Care

As addressed by several of the respondents, on-site care has substantial cost savings potential for DOC. The prison population has a high prevalence of chronic diseases, substantially higher than the general population, leading to higher costs to DOC.[17] Use of on-site clinics allows for a more preventive approach as well as the management of chronic diseases. Respondents argued it costs less to provide minor treatment and medication for chronic diseases on-site than to wait for a major incident that requires costly inpatient care. Additionally, on-site care can reduce the costs associated with transportation and security.

Company B advocated for on-site clinics to be conducted at least every 90 days, or sooner if the patient's condition warrants. During on-site clinics, the patient would see a physician, be prescribed necessary medications, undergo necessary testing, and receive health education.

Company W provided a list of potential clinics to be offered by DOC: cardiology, gastroenterology, HIV/infectious disease, nephrology, OB/GYN, endocrinology, urology, dermatology, ENT, general surgery, oral surgery, physical therapy, neurology, optometry/ophthalmology, and rheumatology.

Telemedicine

Since 1995, DOC has been using telemedicine to increase offender access to physicians, medication management, interdisciplinary care, and chronic care clinics and to reduce off-site costs. Company W identified telepsychiatry, HIV and infectious disease, cardiology, orthopedic services, nephrology, rheumatology, and dermatology as potential specialty telemedicine clinics.

Through the reduction of off-site care, telemedicine has the ability to lower security and transportation costs. Company Y claimed that utilization of telemedicine in Maryland has saved the state $680,000 in transportation and security costs since its "recent" (no date given) implementation.

Electronic Health Records

At the present time, DOC utilizes paper records that are digitally stored after offender release with a third party vendor. According to DOC, it would cost roughly $12 million dollars to implement an electronic health record (EHR). Each respondent except Company B proposed the use of electronic health records. Company Y advocated contracting with a third party of DOC's choosing to implement an EHR system rather than trying to develop one internally, as some organizations have done.

The implementation of an EHR allows for better patient management through immediate access to patient records. Several respondents addressed the number of reports that could be generated from an EHR, allowing for better prediction of trends, areas where services can be added, and resource monitoring. Additionally, there is the opportunity to make the EHR system compatible with community providers to assist with the transition of released offenders.

Pharmacy Services

Each year DOC spends $13.6M on pharmaceuticals for the offender population.[18] While the utilization of the 340B program helps to reduce drug costs substantially, there are other opportunities for care coordination and cost savings. Company M and Company K provided the majority of feedback on state of the art pharmacy services. Company K recommended contracting with a third party pharmacy management company to manage the pharmaceutical needs of offenders in all facilities.

Company M argued that for any managed care prison health model to be successful, the pharmacy provider must provide formulary development and enforcement, medication therapy management, prescription drug monitoring, drug utilization review and utilization management, and step therapy. Step therapy is the practice of beginning medication therapy with the most cost

effective and safest medication then progressing to other more costly or risky therapy only if necessary.

Formularies allow for the selection of cost-effective generic drugs in place of high cost alternatives. Company M advocated the use of formulary management to identify usage trends and areas of potential cost savings.

Company M recognized telemedicine, specifically pharmacist consultation, as a major source of cost savings and enhancement of care quality. Pharmaceutical telemedicine allows offenders access to clinical pharmacy care without leaving the facility. Company M also listed medication management for diabetes, anticoagulation, HIV, Hepatitis C, and asthma as areas where pharmaceutical telemedicine has been demonstrated to be useful. Telemedicine allows the pharmacist to ensure that patients are receiving the right drugs and on the right drug management regimen. The more involved the pharmacist is with the offender, the greater the likelihood that the offender maintains his/her regimen. The offender is also more likely to maintain the drug regimen once released if he/she is actively involved and informed in the management of his/her care.

Community Outreach

Two respondents identified community outreach as part of care coordination. Community outreach provides offenders with increased access to care upon release and a better chance for successful reentry into society. Virginia's reentry rate of 22.8% in 2012 was well below the national average of 43.3%.[19, 20] However, as noted by several of the respondents, there is opportunity for improvement. According to researchers, the effective management of care while in prison and the continuity of care upon release directly affect the recidivism rate.[21] Recently released offenders often face a number of challenges including reestablishing housing, employment, and relationships, leaving health care a low priority. Collaboration among agencies that provide support in the community for people released from prison help them deal with these challenges, and reduce the probability of re-offending.[22]

Company K identified Virginia's Adult Reentry Initiative as a platform for continued offender care upon release. Company K also proposed the use of a national long term services and support provider as one method to connect medically frail offenders with appropriate services and assistance in the community. Company K offers an online network directory for offenders to identify local services and resources in their communities.

Company W also emphasized the importance of reentry planning for offenders who are to be released. With this approach, offenders are provided with information prior to their release regarding appropriate resources and services available to them. Studies of reentry in Michigan,

Texas, and California have found that offenders who chose to go through the program have lower recidivism rates than those who do not participate.[23] Company W also actively works with

state and community organizations, such as the Virginia Department of Social Services and Virginia CARES, to create discharge plans and coordinate continuity of care.

Utilization Review and Management

There are two approaches to monitoring and managing the use of health care services: utilization review (UR) and utilization management (UM). The primary difference between them is timing, and therefore, perhaps, outcome. Utilization review is performed retrospectively while utilization management occurs both prospectively and concurrently.

Utilization Review

The notion behind UR is that "unnecessary" or "inappropriate" services can be identified and brought to the attention of both provider and payer. If there are negative consequences of having provided services deemed unnecessary or inappropriate (such as non-payment), providers have incentives to change their practice patterns in the future. Further, a retrospective review allows the identification of trends and errors so that resource use (including transportation, security, and litigation costs) can be reduced in the future. At present, Anthem provides all UR for inpatient services for all 40 DOC facilities. DOC or the outside contractor who manages the facility performs UR for outpatient services. Two companies provided responses to the effectiveness of the current system. Company B claimed Anthem performs little meaningful UR, leading to lengthy hospital stays and unnecessary costs. Company B also noted that the average length of hospital stay at VCUHS is more than 30% higher than that for Company B's offender population in other states. Company K similarly claimed there are cost saving opportunities available by modifying current DOC practice of relying solely on Anthem for UR.

Company B also stated that under the current emergency contract, there is a disincentive for Anthem to reduce inpatient utilization because its fees increase as expenditures increase. VCUHS also operates under a volume-based contract, failing to create an incentive for the provider to shorten length of stay. The result for DOC is higher inpatient costs. Company B's statement is incorrect about Anthem. Anthem fees do not increase due to utilization at any hospital. VCUHS does not currently get reimbursed based upon hospital length of stay.

Utilization Management

Utilization management occurs prior to and concurrent with the care of patients to ensure that appropriate care is being given in a timely manner. The notion behind UM is that prior approval of non-emergency care can reduce unnecessary or inappropriate care before it occurs, saving resources in the present (including for transportation and security) as opposed to in a future time period. Continuing concurrent review not only reduces the probability that the patient will receive (and DOC will pay for) low value care, it may increase the probability that the patient

will receive all the care that is appropriate. Careful UM that is consistent with prevailing standards of care not only protects the offender, it also reduces the probability of successful litigation resulting from allegations of inadequate care.

A point of emphasis for UM is the approval of non-emergency off-site care. Several respondents noted that effective UM only allows off-site care when absolutely necessary. One respondent opined that UM must address both overutilization and underutilization. While the majority of the focus is on reducing unnecessary care and costs, it is equally important to ensure that offenders are receiving the level of care needed.

UM includes several review phases from the initiation of care until patient discharge, most notably prospective review and concurrent review. Prospective review refers to the prior approval of non-urgent care. Concurrent review refers to review of inpatient services as they are delivered once the offender has been admitted. UM has been demonstrated to reduce costs by denying medically unnecessary services, by approving a more cost-efficient alternative, and by preventing hospitalization that is not necessary.[24]

4. Innovative Correctional Health Care Management Systems from Other States

In 1976, the Supreme Court decided that quality and adequate care of offenders is a constitutional right, supported by the eighth amendment that addresses cruel and unusual punishment.[25] Prison health care represents a growing concern for states. The ever increasing offender population and the rising cost of health care are forcing states to seek alternatives to state-run health care solutions. The delivery of health care is complex, especially when operating under strict budgetary constraints, and it is often outside the expertise of correctional facilities. Correctional facilities house some of the nation's most vulnerable populations with serious health complications like STDs, addiction, mental illness, and chronic illness. Many states are shifting toward a privatized model of offender care, while others are partnering with academic medical centers.

Third Party Contracting for Health Care
There are currently 36 states that outsource part of their prison health care, with 24 of the 36 utilizing a completely outsourced model.[26] Texas, Connecticut, and New Jersey's correctional health care services are completely managed by their state academic medical centers. States assume that contracting with third parties gives them a way to implement fixed cost contracts that are seemingly predictable, and provide greater control over their budgets. Conversely, those that favor partnering with academic medical centers cite better health outcomes and greater risk mitigation as the primary benefits.

A 2013 Pew Charitable Trusts study implies that there is an opportunity for states to outsource their prison health care and realize cost savings while improving the quality of care provided to inmates.[27] Private companies have an advantage over government-run facilities because of greater flexibility. Private companies typically can pay higher salaries and offer more added incentives than can government operated facilities.[28] Contracting also motivates the provider to streamline care because any surplus dollars earned through reducing cost is retained by the contractor as profit.[29] A study performed by the National Institute of Corrections found that privatized correctional health care saved prisons over $2 per inmate per day.[30] States are able to control costs by building a fixed payment or a "vendor not to exceed rate" into their contracts. Florida, for example, executed two 5-year agreements in 2012, one with Wexford Health Sources and the other with Corizon, Inc. to provide health care services to offenders in all of its prison facilities.[31] Both companies use a managed care model to deliver services, including mental health care, chronic illness clinics, preventive screenings, infirmary care, and health education. Ancillary services such as radiology, labs, and dialysis are subcontracted to other local vendors. The Florida Department of Corrections set rates at just over $8 per inmate per day for both vendors, which is a significant reduction compared to previous years.[32] In 2008, Florida provided health care services in-house and spent $12.93 per inmate per day.[33] As a result of contracting with a private company for health care delivery, Florida is saving over $5 per inmate per day, which translates to approximately $50 million in savings each year. By establishing a fixed rate contract, states can deflect a bulk of the financial burden to the contractor, which may force the contractor to provide care in a more cost effective manner.

While many states are embracing public-private partnerships to deliver health care to inmates, there are several critics of the practice. A major component of winning prison health care contracts is demonstrating the ability to reduce expenditures, which can jeopardize quality of care and expose both parties to lawsuits. Although states are typically shielded from litigation, the burden to provide quality care still resides with the state and exposes it to risk. Between 2008 and 2012, Wexford Health Source had 1,092 malpractice claims filed against it for inadequate care; Corizon has been taken to court over 600 times in the last five years.[34] The claims brought against them allege inadequate care that violates prisoners' constitutional rights. In February of this year, Corizon and Alameda County Jail in California settled a lawsuit for $8.3 million because an RN failed to refer an alcoholic who was going through withdrawal for treatment.[35] Other states are also having problems with Corizon, which has caused this company to lose major contracts in Maine, Maryland, Minnesota and Pennsylvania over the past three years.[36] States cite quality issues as the primary driver for dropping Corizon's contract, including misdiagnosis and abnormal wait times. Wexford lost its contract with Arizona in 2013 after only seven months because an inmate suffering from Hepatitis C was denied medication and treatment in a Wexford-managed facility.[37] The outcome of this case is expected to cost Arizona millions of dollars.

Partnering with an Academic Medical Center

Another form of outsourcing that is growing in popularity is partnering with state sponsored academic medical centers. Two states that are at the forefront of this model are Texas and New Jersey. New Jersey is the most recent state to contract with an academic medical center, forming a partnership with Rutgers University in 2005. Several lawsuits prompted the state to seek this partnership, including one in which an inmate was not made aware that he had Hepatitis C until 10 years after his incarceration.[38] With an annual budget of $150 million, Rutgers provides dental, mental health care, and physical health care to roughly 23,000 inmates at all 13 of New Jersey's state-operated correctional facilities.[39] Since partnering with Rutgers, the New Jersey Department of Corrections (NJDOC) has yet to exceed its annual health care budget, and has steadily decreased health care costs to the state. Some of the primary cost saving measures include: controlling pharmaceutical drug costs by taking advantage of 340B pricing, comparing prescription drug costs with other state agencies and negotiating new pricing when applicable, and substituting generic drugs when possible. Controlling drug costs translates to about a 12% savings monthly. Rutgers also utilizes telemedicine for 25% of specialist appointments, which has cut transportation costs by $100 per telemedicine consult.[40,41] Since partnering with Rutgers, NJDOC prison health care costs are lower than health care costs for the general population in New Jersey. The partnership has also decreased mental health care spending by 39% from 2009 to 2014, while spending on physical health care decreased by 7% from 2008 to 2011.[42,43]

The Texas Department of Criminal Justice (TDCJ) employed a fee for service model before partnering with two local academic medical centers for correctional health care. The fee for service model proved ineffective, as Texas prisons experienced an 8.5% increase in health care expenditures from 1989 to 1992.[44] To combat rising costs, TDCJ developed the Texas Correctional Managed Health Care program. The program is a partnership between TDCJ and two academic medical centers, University of Texas Medical Branch (UTMB) and Texas Tech University Health Sciences Center (TTUHSC). The Correctional Managed Health Care Committee (CMHCC) was developed to administer the program.[45] CMHCC comprises nine members from each stakeholder organization who work together to provide oversight on the program. UTMB and TTUHSC provide all inpatient services at their respective hospitals, while most other services are provided onsite within TDCJ prisons. One key feature of the delivery model is an in-house, centralized pharmacy that works in tandem with the 340B drug program.[46] This program is owned and operated by UTMB and has helped TDCJ recoup $60 million in medication expenses. Another key feature is the telemedicine program. Since its inception, TDCJ has saved over $780 million by cutting transport costs and the fees associated with a hospital visit.[47] Additional detail on the experiences of Texas and New Jersey is provided in Appendix A.

Conclusion

The DOC, directed by the Virginia General Assembly, sought input on four areas of relevance to offender health care:

1. How existing state-funded managed care networks can be leveraged
2. Federal health care funding opportunities
3. State of the art practices in care coordination and utilization review
4. Innovative correctional health care management systems being used or developed in other states

This report has summarized relevant information provided by the nine respondents to DOC's RFI in May, 2015. We have supplemented this information with observations from the literature to more completely address the questions posed by DOC in that request.

In general, we can conclude that respondents believe that DOC has a number of opportunities to improve offender health care and/or reduce expenditures for health care services. These opportunities, in the opinions of respondents, come primarily from increased third party contracting for health care, and increased utilization management (including pharmaceutical management) and care coordination facilitated by the implementation of electronic health records. Increased inter-agency collaboration to streamline the process of Medicaid eligibility determination and maximized participation in the 340B drug program were also noted as opportunities for cost savings. Finally, several respondents commented on the importance of including planning for health care services post-discharge in reentry programs. Other states have implemented a number of these strategies with some success, while others have experienced important barriers that warrant additional exploration.

Because only a few of the respondents provided sufficiently detailed and verifiable information in their submissions, we are not able in this first report to provide recommendations for changes to DOC's current procedures, nor estimates of cost savings that might result from such changes. In the report that we will provide in July, 2016, we will present information from a variety of other sources, including the research, policy, and trade literature; interviews with experts in correctional health care around the country; and DOC reports and records. This later report will propose options for DOC to consider and will attempt to provide estimates of cost savings and other benefits that might result from pursuing these options.

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APPENDIX

State Innovations in Prison Health Care

New Jersey

New Jersey is one of the most recent states to contract with an academic medical center to meet its prison health care needs. In 2005, New Jersey entered into an agreement with Rutgers University to provide health care services to offenders in all 13 of its state-operated correctional facilities. Several lawsuits prompted this change, including one filed by Jose Lopez against the New Jersey Department of Corrections (NJDOC) and the prison health care contractor, Correctional Medical Services Inc. (CMS). The suit alleged that Mr. Lopez had tested positive for Hepatitis C while incarcerated in 1992, but was not informed of his condition until almost ten years later when the disease worsened.[1]

The partnership between the NJDOC and Rutgers led to the formation of University Correctional HealthCare (UCHC), which is the correctional health care services provider within the university.[2] With an annual budget of $150 million, UCHC provides dental, mental health care, and physical health care services to roughly 23,000 inmates.[3] The contract is structured as a cost-based model that accounts for indirect overhead costs, and has an annual cap on spending.[3] There is mutual responsibility to monitor against overspending, and the NJDOC and UCHC meet monthly to discuss any expenses that may exceed the annual budget.[2] Since entering into the agreement, the NJDOC has yet to exceed its annual health care budget and it has steadily decreased health care costs to the state. This is achieved through several cost containment measures developed collaboratively between NJDOC and UCHC.

One of the largest line items on prison health care budgets is staffing. A national shortage of RNs and physicians is driving staffing budgets up by forcing hospitals to pay more in salaries to compete in the marketplace. UCHC addressed the shortage by adjusting its staffing model and replacing a number of its physicians with nurse practitioners and physician assistants.[2] UCHC also supplements its RN staff with LPNs and nursing assistants, all of whom receive advanced training in medication administration, wound care, and medical terminology from RN leadership.[2] Reducing overtime payouts is also addressed in the current contract. By monitoring schedules and ensuring that any additional hours go to part-time employees who are not positioned to collect overtime, UCHC was able to decrease overtime by 10%.[2] This small change enabled it to hire additional staff, both full-time and part-time, to maintain adequate staffing levels. Monitoring site utilization and closing sites that are underused has also significantly impacted the staffing budget. UCHC identified three specialty care units that could be combined or closed, resulting in $2 million in savings.[2]

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The NJDOC realizes about a 12% savings in monthly drug costs for inmates through strict cost controls and by leveraging 340B pricing.[2] Every effort is made to use generic drugs that offer cost savings of 80-85% when compared to their name brand equivalents.[4] UCHC also reviews its prescription pricing agreements with other local health care providers to ensure competitive pricing from vendors.[2] This practice allows several providers to leverage each other in order to negotiate the lowest price from their vendors. UCHC minimizes waste and unneeded inventory by utilizing modified dosage schedules and formulary controls. Through these practices, the NJDOC pharmaceutical costs are operating at the FY 2008 level.[3]

The NJDOC and UCHC are embracing telemedicine, mainly due to the success experienced by the correctional program at the University of Texas Medical Branch. The program in New Jersey is fairly new, but offered cost savings almost immediately. UCHC is currently providing 25% of specialist appointments via teleconference, which has cut transportation cost by $100 per telemedicine consult.[2,3]

Changes in prison health care delivery within the NJDOC have resulted in significant financial savings. Available cost figures represent inpatient and outpatient services, and are not inclusive of transportation and security costs. Between 2011 and 2012, NJDOC realized a reduction in mental health care spending of 12%; between 2009 and 2014, spending decreased by 39%.

Physical health spending decreased by 7% from 2008 to 2011, which translated to $6.6 million.[2] Overall, prison health care costs are lower than the cost of health care for the general population of New Jersey. In 2009, the per capita cost for the general population was $7,583, significantly more than the $5,667 per inmate cost documented in 2012.

Texas

Before the current model was developed in 1993, Texas prison health care was state-operated, and care was delivered using a fee for service model with local hospitals. This delivery model proved ineffective as Texas prisons experienced a 6% average annual increase in prison healthcare expenditures which translated to 10-14% of the Texas prison system's overall operating costs. This is a significant number given that Texas has over 150,000 offenders in its prison system, and each offender cost the state around $9.54 per inmate per day. The surge in cost prompted the Texas Department of Criminal Justice Health Services Division (TDCJ Health Services) to implement the Texas Correctional Managed Healthcare program to contend with its increasing inmate population and growing budgetary constraints. It has proven to be an efficient model of health care delivery for the Texas prison system. Two important components of the program are its contractual agreement between the Texas Department of Criminal Justice (TDCJ) and its two partner facilities, the University of Texas Medical Branch (UTMB) and Texas Tech University Health Sciences Center (TTUHSC). The program is administered by a cooperative committee called the Correctional Managed Healthcare Committee (CMHCC) that comprises nine members representing the public, TDCJ, UTMB, and TTUHSC. Together, members of this committee work to control prison health care spending while providing oversight on the development of policies that impact correctional health care delivery. The program is funded by an appropriation from the Texas Legislature. Funds are distributed to each medical center by CMHCC according to its respective capitation rate. The board members' high degree of communication and collaboration is essential to the operational success of the model.

Health care delivery is divided among TDCJ, UTMB, and TTUHSC. TDCJ Health Services has non-medical responsibilities that include preventive medicine, operational reviews, quality monitoring, and medical transfer. Medical delivery is coordinated between the two academic medical centers, and is largely based on geography. Both medical centers provide primary and specialty care, pharmaceutical services, inpatient care, mental health care, dental care, and other ancillary services. While inpatient care is provided at one of the two medical facilities, most other services can be provided at one of the 83 ambulatory clinics or 13 infirmaries housed within TDCJ prisons. For certain services, the medical centers may contract with one of their community partners when deemed necessary. UTMB is unique in that there is a hospital, Hospital Galveston, specifically dedicated to inmate care. Medical care at this facility is provided and administered by UTMB.

Cost containment is achieved through the use of several established initiatives. UTMB has been involved in the federal 340B pharmacy program since 2002, and has realized a reduction in medication costs of almost a third. The 340B drug program works in tandem with the centralized pharmacy facility. Physicians can order medication quickly, track its use, and return unused portions through this system. The facility is owned and operated by UTMB and has been instrumental in controlling the costs of medications. The program also uses strict clinical management protocols that include chronic care clinics, case management, and utilization review. Telemedicine utilization has also had a profound effect on providing timely access to

care and decreasing transportation costs. Video conferencing capabilities are the responsibility of UTMB and TTUHSC. Having this capability has decreased the number of inmate transports, which has decreased cost and provided greater security. Partnering with UTMB and TTUHSC has addressed one of the most difficult and costly challenges faced by hospitals across the country: physician and nurse staffing. Each medical facility is responsible for staffing levels, which allows the state freedom from worry about salary and pension requirements. The medical centers also have fewer staff vacancy rates because of their access to medical personnel through their graduate and physician networks.

According to the Pew Charitable Trusts, between 2001 and 2008, correctional health care increased 28%.[4] Despite this national increase, Texas was one of two states to see a decrease in prison health care costs of around 12% during the same period. Through the partnership with the two academic medical centers, CMHCC saved over $215 million between 1994 and 2000 for the state of Texas. Purchasing medications through 340B provided even more benefits, as Texas was able to save over $60 million dollars on outpatient prescription drugs. Video conferencing capabilities have helped TDCJ save over $780 million dollars since its inception in 1994 and will likely continue to provide significant cost savings.[5]

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