REPORT OF THE
JOINT COMMISSION ON HEALTH CARE

Medical Care Provided in State Prisons – Study of the Costs

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

REPORT DOCUMENT NO. 172
COMMONWEALTH OF VIRGINIA RICHMOND
June 21, 2017

Code of Virginia § 30-168.

The Joint Commission on Health Care (the Commission) is established in the legislative branch of state government. The purpose of the Commission is to study, report and make recommendations on all areas of health care provision, regulation, insurance, liability, licensing, and delivery of services. In so doing, the Commission shall endeavor to ensure that the Commonwealth as provider, financier, and regulator adopts the most cost-effective and efficacious means of delivery of health care services so that the greatest number of Virginians receive quality health care. Further, the Commission shall encourage the development of uniform policies and services to ensure the availability of quality, affordable and accessible health services and provide a forum for continuing the review and study of programs and services.

The Commission may make recommendations and coordinate the proposals and recommendations of all commissions and agencies as to legislation affecting the provision and delivery of health care. For the purposes of this chapter, "health care" shall include behavioral health care.

Preface

By letter to the JCHC Chair, Delegate Kaye Kory requested that the JCHC "study or evaluate the costs to the state for prisoner medical care provided by the Commonwealth while offenders are incarcerated, especially costs for pharmaceutical products." [1]

Action by the Joint Commission on Health Care. After considering the study findings and public comments, Joint Commission members voted to request by letter that the Virginia Department of Corrections (VADOC) review the policy options presented to the JCHC, evaluate and analyze whether they are feasible for the department to do, and provide the JCHC with a report detailing their evaluation and analysis by the October 2017 JCHC meeting.

Joint Commission members and staff would like to thank the individuals who assisted in this study, including:

From the Virginia Department of Corrections: Harold W. Clarke, Director; Steve Herrick, Director of Health Services; Linda L. Capen, Agency Management Lead Analyst, Financial Management and Planning Unit; Trey Fuller, Chief Pharmacist; Tama S. Celi, Chief of Research, Policy and Planning; and Warren B. McGehee, Manager Statistical Analysis & Forecast Unit.

Dick Hickman, Deputy Staff Director, Virginia Senate Finance Committee; David Reynolds, Legislative Fiscal Analyst, House Appropriations Committee; Dick-Hall Sizemore, Budget and Policy Analyst, Virginia Department of Planning and Budget; Mike Tweedy, Legislative Analyst, Virginia Senate Finance Committee; Karah L. Gunther, Executive Director of Government Relations and Health Policy, Virginia Commonwealth University and VCU Health System; Carolyn (Cindy) A. Watts, Richard M. Bracken Chair and Chairman, Department of Health Administration-School of Allied Health Professions, Virginia Commonwealth University; Michele Thomas, Pharmacy Services Manager, Office of Pharmacy Services, Department of Behavioral Health & Developmental Services; Linda K. Pace, Account Manager for State and Local Government Programs, Anthem, Inc.; Jeff Pinsky, Health Information Manager Virginia State and Local Government Large Groups, Anthem, Inc.; Jeff Schimbeno, Senior Account Executive, Eastern Region Minnesota Multistate Contracting Alliance for Pharmacy, State of Minnesota, Department of Administration; David Jesse Huertas, VCO Statewide Contract Officer, Department of General Services.

[1] Kory, Delegate Kaye. "Study or Evaluate the Costs to the Commonwealth of Medical Care for Prisoners, Especially the Costs of Pharmaceutical Products." Letter to Delegate John O'Bannon. May 16, 2016. Richmond, Virginia.

Contents

Background - Legal Obligation to Provide Health Care to Offenders

By law VADOC is required to provide adequate health care to incarcerated offenders (U.S. Const. Amend. VIII; §53.1-40.1, et. seq., Code of Virginia). Adequate health care was defined by the United States Supreme Court beginning in 1976 (*Estelle v. Gamble*, 429 U.S. 97, 97 S.Ct. 285). The definition encompasses the idea of providing incarcerated offenders with a "community standard" of care that includes a full range of services. The courts identified the following three rights to health care for incarcerated offenders:

- Right to have access to care
- Right to have care that is ordered by a health care professional
- Right to professional medical judgment [2]

On July 12, 2012 a class action lawsuit was filed in federal court against VADOC over medical care at Fluvanna Correctional Center for Women. The lawsuit was settled through a Memorandum of Understanding on November 25, 2014. The settlement agreement was approved by the court in February 2016. The agreement includes the hiring of a compliance monitor and continued court supervision of the agreement. [3]

The agreement reached between VADOC and the plaintiffs at Fluvanna is comprehensive and involves all aspects of the health care system, including mental health. Some of the agreement issues addressed include: timely access to care and treatment, the following of national clinical guidelines for treatments and medical testing, admission and discharge planning, quality improvement compliance, security and treatment of pregnant women, accommodations for prisoners with special needs and compliance with the Americans with Disability Act (ADA).[4]

Brief Description of the VADOC Health Care System

VADOC is responsible for over 30,000 incarcerated offenders on any given day in 46 prison facilities. Each prison provides health care services to incarcerated offenders. The level of health care depends on the facility. Because offenders are transferred around the system comparing one facility to another is difficult. In addition, several of the facilities include health care services for specific chronic diseases and conditions. For example:

[2] Conway,J.D. LLM; Craig A. A Right of Access to Medical and Mental Health Care for the Incarcerated. 2009. Health Law Perspectives (June)

[3] Scott, et. al. v. Clarke, et al. Civil Action No. 3:12-CV-00036. Order Granting the Plaintiffs' Consent Motion for Preliminary Approval of Class Settlement. https://www.clearinghouse.net/chDocs/public/PC-VA-0017-0020.pdf . All documents can be found at: Legal Aid Justice Center. Preliminary Approval of FCCW Settlement https://www.justice4all.org/get-informed/news/preliminary-approval-of-fccw-settlement-granted/ and the Civil Rights Litigation Clearinghouse, University of Michigan, https://www.clearinghouse.net/detailDocument.php?id=81601

[4] Ibid (Scott v. Clarke)

- Deerfield Correctional Facility has an infirmary, an assisted living facility and beds reserved for offenders with diabetes;
- Fluvanna Correctional Center for Women has an infirmary and an inpatient psychiatric unit;
- Greensville Correctional Center has an infirmary, a mental health unit and a residential treatment unit, and
- Powhatan Correctional Facility has an infirmary.

DOC Managed Facilities

Facility	ADP (8/2016)	Facility	ADP (8/2016)
Appalachian Detention Center	107	James River Work Center	292
Baskerville	386	Keen Mountain	708
Bland	647	Marion Correctional and Treatment Center	298
Buckingham	1,152	Nottoway	1,421
Caroline Unit 2	120	Nottoway Work Center	194
Central Virginia Unit 13	225	Patrick Henry Unit 28	115
Chesterfield Detention and Diversion Center	128	Pocahontas State	1,031
Cold Springs Detention Center & Unit 10	98	Red Onion State Prison	863
Deep Meadow	726	River North	976
Dillwyn	899	Rustburg	135
Green Rock	1,031	Stafford Diversion Center	105
Halifax Unit 23	230	Virginia Correctional Center for Women	444
Harrisonburg Detention Center	94	Wallens Ridge State Prison	1,084
Haynesville Unit 17	94	Wise Unit 18	105
Haynesville	912		
		Total	**14,620**

ADP: Average Daily Offender Population

VADOC's health care system for incarcerated offenders is a combination of state run and privately contracted services.[5]

VADOC contracts with Armor Correctional Health Services, a national for-profit company based in Miami, Florida, to provide health care services to offenders at 14 prison facilities, 4 of which also have infirmaries. VADOC also contracts with Mediko Correctional HealthCare, a Virginia based for-profit company, to provide health care services to offenders at 2 prison facilities. In a separate contract, VADOC contracts with the GEO Group to operate the Lawrenceville Correctional Center. The GEO Group provides all prison services, including health care services, through one capitated payment from VADOC.

Privately Managed Facilities for Health Care

Facility	Vendor	ADP (8/2016)
Brunswick Women's Pre-Release Center	Armor	197
Deerfield – Infirmary & General Population	Armor	1,066
Deerfield Work Center - Men	Armor	202
Deerfield Work Center - Women	Armor	155
Fluvanna Center for Women – Infirmary & General Population	Armor	1,223
Greensville Work Center	Armor	229
Greensville - Infirmary & General Population	Armor	2,972
Indian Creek	Armor	1,013
Lunenburg	Armor	940
Powhatan Reception Center (includes Medical Unit and Infirmary)	Armor	453
St. Brides	Armor	1,184
Sussex I	Armor	1,148
Sussex II	Armor	1,247
Augusta	Mediko	1,329
Coffeewood	Mediko	984
Lawrenceville	The Geo Group	1,567
Total		**15,909**

Armor and Mediko provide health care services to approximately 50% of the VADOC average-daily-population (ADP) or a little over 15,000 offenders in 16 prisons. VADOC operates the other 30 facilities and provides health care services through a combination of direct provider contracts and state employees.[6]

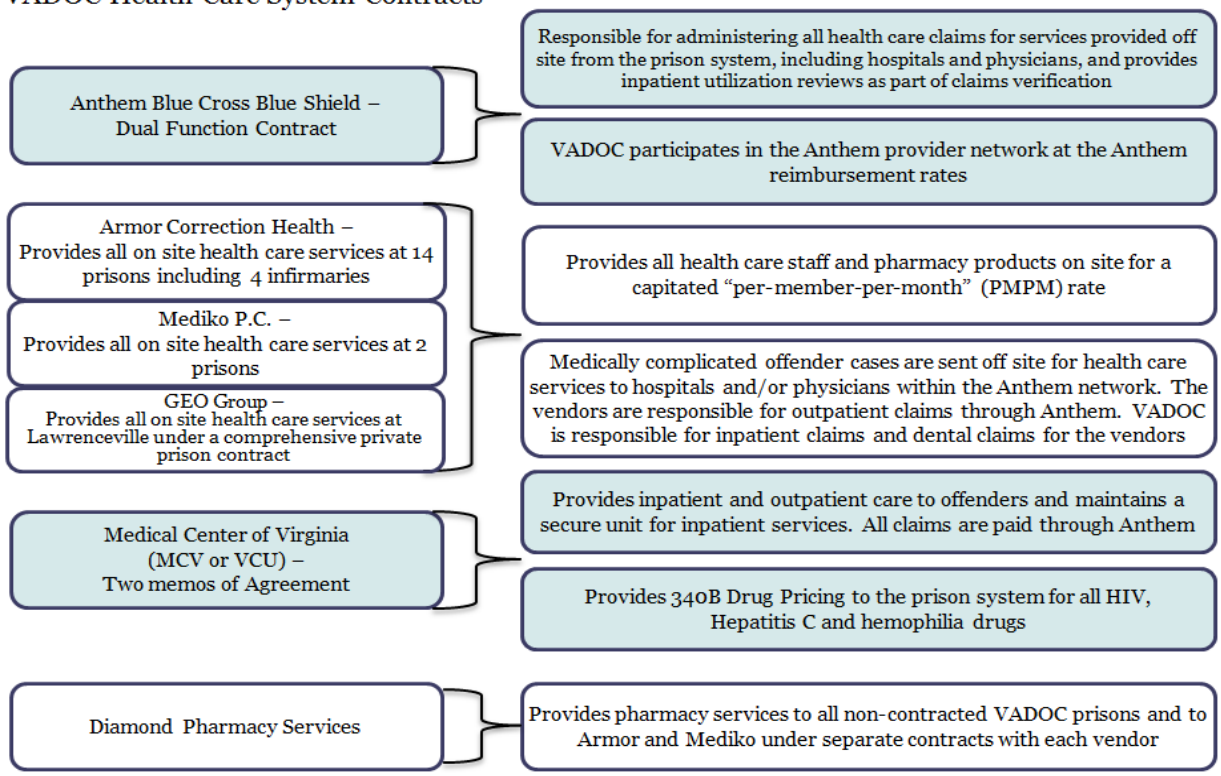
Services Provided by Vendors

The following graphic displays the vendors used by VADOC and the services they provide.

[5] Watts, PhD. Carolyn, et. al. Report To The Virginia Department Of Corrections. Department of Health Administration. Virginia Commonwealth University. June 27, 2016.

[6] Virginia Department of Corrections Monthly Population Summary. Statistical Analysis & Forecast Unit. August 2016. https://vadoc.virginia.gov/about/facts/research/new-popsum/2016/aug16popsummary.pdf

VADOC Health Care System Contracts



Beginning in 2015 all inpatient hospital claims are paid by VADOC through a contract with Anthem Blue Cross Blue Shield. The process was designed in 2015 to accommodate reimbursements for eligible offenders through the Medicaid program. Anthem pays the claims at their negotiated provider-network rates. Anthem then bills the VADOC monthly for all claims paid. VADOC invoices Armor and Mediko for all outpatient claims from the Anthem billing. VADOC is financially responsible for paying the inpatient claims, and all dental claims. [7]

Each facility managed by the vendors has its own per-member-per-month (PMPM) capitated payment. According to VADOC, the department does not have an actuary on contract to provide the state with benchmark pricing for the facilities or for the contract in general. VADOC relies on the bids submitted and an administrative claims analysis to determine the appropriate pricing for each vendor contract. [8] VADOC is legally responsible for all aspects of the offender health care system whether the care is provided by VADOC directly or through a private contract.

Fluvanna Settlement – Potential Implications on Health Care Spending

The Fluvanna Correctional Center for Women settlement agreement may have serious implications on the VADOC budget and expenditures. In an article appearing in Prison Legal News, states that were court ordered to improve prison conditions spent almost 30% more per prisoner than they did prior to the court-

[7] Capen, Linda. "Re: RE: UNTITLED.pptx." Message to Stephen Weiss. September 22, 2016; Watts, Carolyn, et. al. Report To The Virginia Department Of Corrections. Department of Health Administration. Virginia Commonwealth University. June 27, 2016.
[8] Hendrick, Steve, Director of Health Services, Virginia Department of Corrections.. VADOC Central Offices. September 19, 2017.

order. According to the article, the increased spending led to better prison conditions and forced states to "cut incarceration rates to more manageable levels without increasing crime rates." The increased spending on prisons to comply with court orders, however, resulted in unintended consequences to state budgets that have not been thoroughly examined in any state where an order exists. The professor found that most states' balanced budget requirements led to increased state spending on prisons to comply with court orders and a 22% cut in state welfare and social service spending.[9]

California's prison health care system was placed under a federal receiver in 2006 after a federal district court assumed oversight. To comply with the court-order, the receiver "filled hundreds of longtime vacancies, increased salaries, and created new positions at higher pay rates. The number of medical, mental health and dental workers in state prisons increased from 5,100 in 2005 to 12,200 in 2011." [10]

California spent $1.1 billion in fiscal year 2003-04 to provide medical care to the state prison population. While the number of in-state prisoners fell after a 2011 state initiative to realign the prison system, the projected cost of prison healthcare for the state in fiscal year 2013-14 was expected to top $2 billion – "an 82.3% increase compared to a decade ago after adjusting for inflation." [11] Since 2005, the average cost of prison healthcare in California increased from $7,747 per prisoner annually to more than $18,000. [12]

The Fluvanna settlement agreement provides the Commonwealth with a unique opportunity to better coordinate and improve its prisoner health care system, improve data collection and management, and to understand how the VADOC health care system is administered and operated. VADOC will need to be able to prove through the use of quality data and information that it may be able to provide any court mandated programs or services with alternatives that may be more efficient and cost effective. But VADOC will need to have the capacity and capability to access its health care data and information in a timely way. Otherwise, the Commonwealth may be confronted with a similar situation as California where court mandated changes may not be the most beneficial for the system or cost effective.

VADOC Health Care Expenditures Compared to Other States

A review of data (illustrated in the charts and graphs on the next page) from the federal Bureau of Justice Statistics and Pew Charitable Trust indicates that in 2011 VADOC's percentage of spending on offender health care ranked 33rd nationally. In addition, VADOC spent 12.6% of its prison budget on health care in 2011, which ranked the Commonwealth 30th in the nation on prison health care spending. [13]

Finally, according to the survey by Pew, Virginia's prison health care spending increased 15.3% between 2007 and 2011. The rate of increase was 2.3-percentage points higher than the national average of 13.0% and ranked the Commonwealth 24th in the nation in the rate of increase for prison health care spending from 2007 through 2011. [14]

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[9] Gilna, Derek. Professor Urges Study of Unintended Consequences of Court-ordered Prison Reform. 2016. Prison Legal News. March.; page 24.

[10] California Prison Healthcare Costs Soar Under Federal Receiver. 2014. Prison Legal News. October; page 50.

[11] Ibid. (Prison Legal News, 2014)

[12] Ibid. (Prison Legal News, 2014)

[13] For State prison spending: Kyckelhahn, Tracey. 2011. Bureau of Justice Statistics - Justice Expenditure and Employment. Bureau of Justice Statistics. July 1, 2014. (NCJ 247020)
http://www.bjs.gov/index.cfm?ty=pbdetail&iid=5050
For prison health care spending: Pew Charitable Trust State Prison Health Care Spending July 2014, Page 19 and 21 Appendix C.http://www.pewtrusts.org/en/research-and-analysis/reports/2014/07/08/state-prison-health-care-spending

[14] Ibid. (Pew, 2014)

State Prison Health Care Spending as a Percent of Total State Prison Spending – 2011 *

Rank by % of Prison Health Spending	State	State Prison Spending 2011	Prison Health Care Spending 2011	Percent Spent on Health Care
1	California	$8,528,335,000	$2,137,045,000	***25.1%***
2	Missouri	$683,665,000	$142,988,000	***20.9%***
3	New Hampshire	$112,666,000	$23,564,000	***20.9%***
4	Mississippi	$309,694,000	$64,575,000	***20.9%***
5	Michigan	$1,625,653,000	$330,400,000	***20.3%***
6	Ohio	$1,452,841,000	$279,716,000	***19.3%***
7	Alabama	$531,700,000	$97,266,000	***18.3%***
8	North Carolina	$1,420,666,000	$255,125,000	***18.0%***
9	Delaware	$266,666,000	$46,094,000	***17.3%***
10	Nevada	$270,381,000	$46,593,000	***17.2%***
33	**Virginia**	**$1,193,345,000**	**$149,850,000**	***12.6%***
41	Colorado	$871,379,000	$102,355,000	***11.7%***
42	Iowa	$329,694,000	$38,001,000	***11.5%***
43	Maryland	$1,364,884,000	$147,856,000	***10.8%***
44	Rhode Island	$181,796,000	$19,364,000	***10.7%***
45	New Jersey	$1,408,614,000	$141,752,000	***10.1%***
46	Utah	$297,609,000	$29,529,000	***9.9%***
47	Illinois	$1,513,117,000	$144,039,000	***9.5%***
48	Massachusetts	$1,050,827,000	$95,348,000	***9.1%***
49	West Virginia	$269,308,000	$23,150,000	***8.6%***
50	North Dakota	$87,671,000	$6,350,000	***7.2%***
	National Average	**$46,711,103,000**	**$7,679,772,001**	**16.4%**

** For State prison spending: Kyckelhahn, Tracey. 2011. Bureau of Justice Statistics - Justice Expenditure and Employment. Bureau of Justice Statistics. July 1, 2014. (NCJ 247020) http://www.bjs.gov/index.cfm?ty=pbdetail&iid=5050*
For prison health care spending: Pew Charitable Trust State Prison Health Care Spending July 2014, Page 19 and 21 Appendix C. http://www.pewtrusts.org/en/research-and-analysis/reports/2014/07/08/state-prison-health-care-spending

Per Average-Daily-Population (ADP) State Prison Health Care Spending – 2011 *

Rank by % of Prison Health Spending	State	Prison Health Care Spending 2011	ADP 2011	Health Care Per ADP (2011)
1	California	$2,137,045,000	147,438	$14,495
2	Vermont	$18,077,000	1,537	$11,761
3	Wyoming	$20,707,000	1,905	$10,870
4	New Hampshire	$23,564,000	2,312	$10,192
5	Alaska	$38,963,000	3,835	$10,160
6	Montana	$29,284,000	3,464	$8,454
7	Massachusetts	$95,348,000	11,315	$8,427
8	Maine	$17,049,000	2,124	$8,027
9	Michigan	$330,400,000	44,262	$7,465
10	Oregon	$103,836,000	14,116	$7,356
30	***Virginia***	***$149,850,000***	***30,772***	***$4,870***
40	Arkansas	$66,888,000	16,057	$4,166
41	Georgia	$208,103,000	51,794	$4,018
42	Indiana	$103,396,000	26,800	$3,858
43	Texas	$581,555,000	152,841	$3,805
44	Alabama	$97,266,000	25,806	$3,769
45	Nevada	$46,593,000	12,466	$3,738
46	Mississippi	$64,575,000	19,305	$3,345
47	Arizona	$129,627,000	39,764	$3,260
48	Illinois	$144,039,000	47,212	$3,051
49	South Carolina	$68,520,000	23,358	$2,933
50	Oklahoma	$62,692,000	24,511	$2,558
	National Average	**$7,679,772,001**	**1,270,036**	**$6,047**

** For State prison spending: Kyckelhahn, Tracey. 2011. Bureau of Justice Statistics - Justice Expenditure and Employment. Bureau of Justice Statistics. July 1, 2014. (NCJ 247020) http://www.bjs.gov/index.cfm?ty=pbdetail&iid=5050*
For prison health care spending: Pew Charitable Trust State Prison Health Care Spending July 2014, Page 19 and 21 Appendix C. http://www.pewtrusts.org/en/research-and-analysis/reports/2014/07/08/state-prison-health-care-spending

Pew Charitable Trust and Vera Institute of Justice State Survey
Total Correctional Health Care Spending (thousands)

State	2007	2008	2009	2010	2011	Real change in spending 2007-11
United States	**$6,798,873**	**$7,722,955**	**$8,204,873**	**$7,847,256**	**$7,679,772**	**13.0%**
Montana	$19,721	$26,883	$27,315	$28,866	$29,284	48.5%
Wyoming	$15,397	$16,888	$16,243	$19,582	$20,707	34.5%
Delaware	$34,987	$45,213	$46,983	$45,315	$46,094	31.7%
Missouri	$110,545	$127,086	$132,805	$138,756	$142,988	29.3%
Indiana	$80,289	$84,838	$90,561	$93,894	$103,396	28.8%
Oregon	$80,778	$82,648	$100,872	$93,662	$103,836	28.5%
California	$1,688,342	$2,277,690	$2,577,835	$2,218,926	$2,137,045	26.6%
Kentucky	$49,933	$59,279	$61,226	$65,587	$62,972	26.1%
Alaska	$31,108	$32,014	$33,424	$43,050	$38,963	25.3%
Texas	$464,354	$505,633	$555,101	$583,760	$581,555	25.2%
Minnesota	$51,950	$55,350	$59,778	$61,509	$63,880	23.0%
Tennessee	$77,488	$82,744	$88,599	$90,985	$95,090	22.7%
North Dakota	$5,248	$5,555	$6,514	$6,681	$6,350	21.0%
New Hampshire	$19,586	$26,884	$24,913	$24,817	$23,564	20.3%
Pennsylvania	$218,758	$231,421	$241,122	$254,647	$262,024	19.8%
Colorado	$85,725	$93,611	$98,457	$99,331	$102,355	19.4%
New Mexico	$41,036	$52,418	$53,533	$55,391	$48,790	18.9%
Iowa	$32,365	$38,013	$39,681	$37,429	$38,001	17.4%
Idaho	$21,515	$24,034	$25,086	$25,542	$25,232	17.3%
Massachusetts	$81,567	$100,606	$102,357	$96,261	$95,348	16.9%
Nebraska	$27,709	$28,620	$29,453	$31,498	$32,363	16.8%
Maine	$14,676	$14,195	$14,939	$15,798	$17,049	16.2%
Arkansas	$57,741	$58,325	$60,136	$65,268	$66,888	15.8%
Virginia	**$130,003**	**$142,427**	**$143,099**	**$149,298**	**$149,850**	**15.3%**
Utah	$25,968	$28,481	$31,571	$30,094	$29,529	13.7%
Mississippi	$57,775	$66,743	$66,262	$69,299	$64,575	11.8%
Vermont	$16,340	$16,175	$17,279	$18,064	$18,077	10.6%
North Carolina	$233,169	$253,454	$276,005	$274,532	$255,125	9.4%
Alabama	$89,057	$92,465	$94,206	$96,215	$97,266	9.2%
West Virginia	$21,291	$20,669	$25,074	$24,931	$23,150	8.7%
Nevada	$43,016	$44,411	$49,782	$48,539	$46,593	8.3%
Illinois	$133,878	$139,612	$145,458	$145,983	$144,039	7.6%
South Dakota	$16,467	$16,738	$17,536	$18,054	$17,487	6.2%
Louisiana	$69,459	$78,186	$83,605	$78,602	$73,362	5.6%
Maryland	$142,071	$121,166	$130,873	$145,852	$147,856	4.1%
Florida	$409,646	$443,595	$416,244	$427,795	$424,592	3.6%
Wisconsin	$151,546	$148,519	$156,868	$153,093	$156,060	3.0%
Hawaii	$23,573	$24,350	$26,335	$22,569	$23,934	1.5%
Kansas	$46,144	$47,590	$48,618	$48,004	$46,738	1.3%
Washington	$117,865	$140,581	$143,222	$128,503	$119,253	1.2%
Georgia	$206,094	$229,106	$215,069	$207,282	$208,103	1.0%
South Carolina	$68,633	$69,213	$75,944	$71,705	$68,520	-0.2%
New York	$363,460	$377,928	$386,396	$372,454	$360,567	-0.8%
Michigan	$335,525	$340,223	$352,120	$343,538	$330,400	-1.5%
Ohio	$287,087	$281,926	$303,040	$301,032	$279,716	-2.6%
Arizona	$138,223	$158,454	$161,691	$138,273	$129,627	-6.2%
Connecticut	$108,414	$115,581	$111,361	$101,652	$97,774	-9.8%
New Jersey	$158,019	$159,238	$150,122	$151,170	$141,752	-10.3%
Rhode Island	$22,038	$22,633	$22,155	$19,819	$19,364	-12.1%
Oklahoma	$73,293	$73,545	$68,002	$64,353	$62,692	-14.5%
State Prison Health Care Spending An examination						
Table C1. Appendix C: State prison health care spending and population data.						

Source: Pew Charitable Trust State Prison Health Care Spending July 2014, Page 19 and 21 Appendix C.http://www.pewtrusts.org/en/research-and-analysis/reports/2014/07/08/state-prison-health-care-spending

Demographics of the Offender Population and Impact on Health Spending

According to the Pew Charitable Trust State Health Care Spending Project, there are several factors that drive the cost of health care in state prisons. The factors identified include an aging offender population and the prevalance of infectious and chronic diseases, mental illness, and substance use disorders among offenders. [15]

Pew Charitable Trust State Health Care Spending Project

The Pew study reports that the share of older offenders (age 55 and above) in each state rose between 2007 and 2011in all but 2 of the 42 states that submitted data. Pew researchers found that where older offenders represented a relatively large share of the total prisoner population in a state system those states' tended to have higher per-offender health care expenditures. Pew also reported that "per-offender" health care spending rose in 35 of the 44 states, with 32% being median growth.[16] The Pew study also reported that the annual average cost of incarcerating prisoners age 55 and older with chronic and terminal illnesses is two to three times that of the costs for younger offenders. [17]

Federal Prisons

In 2015 the office of the Inspector General for the U.S. Department of Justice issued a report that found that the share of older offenders (age 50 years and above) in the federal prison system was the fastest growing segment of the federal prison system, increasing by 25% between 2009 and 2013 in contrast to the number of offenders under age 50 which decreased by 1% during the same period. Officials and staff of the Bureau of Prisons (BOP) said that the aging offender population was having a "significant impact" on medical costs. After reviewing the overall cost-of-incarceration data the OIG found that, on average, the cost to incarcerate an aging offender over 50 years old was 8% more than the cost of incarcerating a younger offender. The OIG concluded that the higher overall cost of incarceration for offenders over 50 years old was due to their medical needs. [18]

State Prisons

Chronic illnesses among offender populations, including mental illness and substance use disorders, were also identified as drivers of increasing health care costs in state prison systems. A survey and report of states done by the Treatment Advocacy Center and the National Sheriffs Association found that the number of mentally ill persons in state prisons and local jails was 10 times the number remaining in state operated psychiatric hospitals in those states surveyed. The study also found that, on average, between 15% and 20% of the offender population in state prisons and local jails nationally met the medical criteria for a psychotic disorder and were determined to be mentally ill or seriously mentally ill. The study concluded that mentally ill people being housed in prisons and jails would have been in state psychiatric hospitals prior to deinstitutionalization and that state prisons and local jails are not an appropriate setting for people in need of mental health treatment. State prisons and local jails do not have the resources or the expertise necessary to treat the mentally ill. [19]

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[15] State Prison Health Care Spending, An examination. The Pew Charitable Trusts and the John D. and Catherine T. MacArthur Foundation. July 2014, page 8 and 11.

[16] Ibid., page 2. (Pew, 2014)

[17] Ibid, page 11. (Pew, 2014)

[18] The Impact of an Aging Offender Population on the Federal Bureau of Prisons. Office of the Inspector General U.S. Department of Justice. Evaluation and Inspections Division 15-05. May 2015 (Revised February 2016)

[19] Torrey, E. Fuller, M.D. et. al**.** The Treatment of Persons with Mental Illness in Prisons and Jails: A State Survey. April 8, 2014. Page 6 and 24.

In 2010 the National Center on Addiction and Substance Abuse reported that alcohol and substance use disorders among incarcerated individuals ranged from 65% (for those offenders that meet the strict medical criteria for substance use disorder) to 85% (when including those with a history of substance use disorders). The report also stated that 33% of the prison population is considered mentally ill and 24% of the overall prison population has both a mental illness and a substance use disorder problem. [20]

Identifying and quantifying the cost of treatment for the mentally ill and offenders with substance use disorders in prisons is difficult due to a lack of adequate data. However, a national comorbidity survey found that 68% of adults with a mental disorder had at least one general medical disorder. Another medical claims-based-analysis found that general medical costs were 40% higher for people who were also being treated for a bipolar disorder as compared to those being treated without a bi-polar disorder. [21]

Demographics of Virginia Prison System and Impact on Health Care Spending [22]

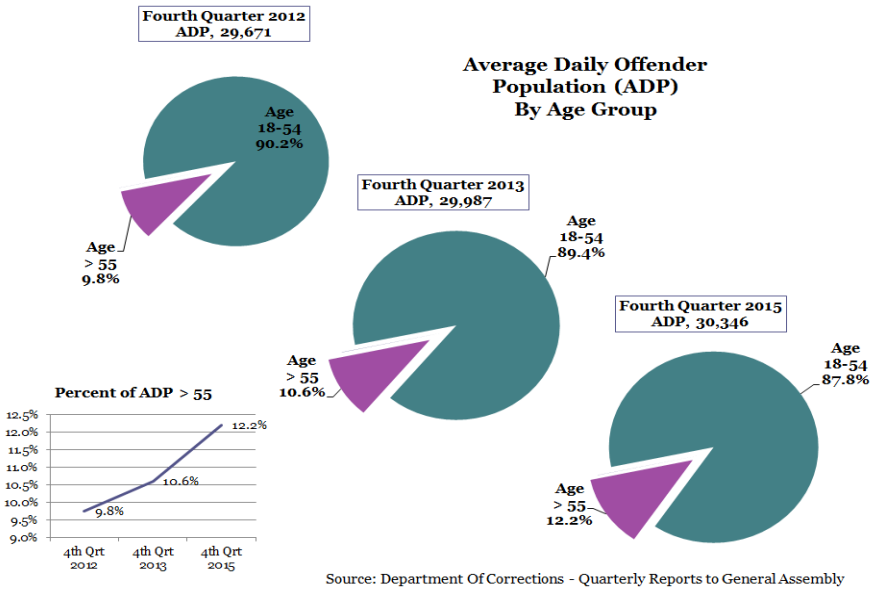
The demographic profile of the VADOC offender population, when viewed through the lens of national studies and reports, indicates that the growing cost of health care in Virginia's prison system is due in part to the growing number of incarcerated individuals over age 55 and the growing number of offenders with mental health and substance use disorders. Quarterly data reports provided to the Virginia General Assembly along with a variety of special data reports provided to the JCHC display similar trends as those found in the national studies.

Offenders

Age 55 years & older

The proportion of the VADOC prison population age 55 and above increased by 2.4 percentage points from 2012 to 2015.

The cause for the change in the age mix of offenders appears to be a combination of annual new commitments versuses annual releases by age group. The data indicate that state incarcerated offenders are "aging in place" within the prison system. [23]



[20] National Center on Addiction and Substance Abuse. Behind Bars II: Substance Abuse and America's Prison Population. Published: February 2010. http://www.centeronaddiction.org/addiction-research/reports/behind-bars-ii-substance-abuse-and-america%E2%80%99s-prison-population

[21] Kim, KiDeuk, et. al. The Processing and Treatment of Mentally Ill Persons in the Criminal Justice System. A scan of practice and background analysis. Urban Institute. March 2015. Pages 4 and 12.

[22] The source of information for the graphs is the Department of Corrections Quarterly Reports to the Virginia General Assembly and can be found on the Virginia Legislative Information System.
The Information describing the processes used by VADOC to determine mental health, alcohol and substance use disorders of offenders was provided to JCHC in an email to Stephen Weiss from Tama Celi on October 13, 2016.

[23] Virginia Department of Corrections Analysis and Forecast Unit, July 2015. (www.vadoc.virginia.gov)

Offenders with Mental Health Conditions

Per VADOC procedure, an offender's mental health classification code reflects the offender's current mental status and service needs as determined by a Qualified Mental Health Professional (QMHP). An offender's mental health information is updated annually for those with a classification code of 1 to 4, or as needed dependent on symptoms and behavioral functioning currently demonstrated by the offender. The mental health classification codes used are:

1. *MH-0 – No impairment* - The offender has no documented history of treatment within the past year and no current symptoms or behaviors that are indicative of mental health issues; no treatment or monitoring currently required.

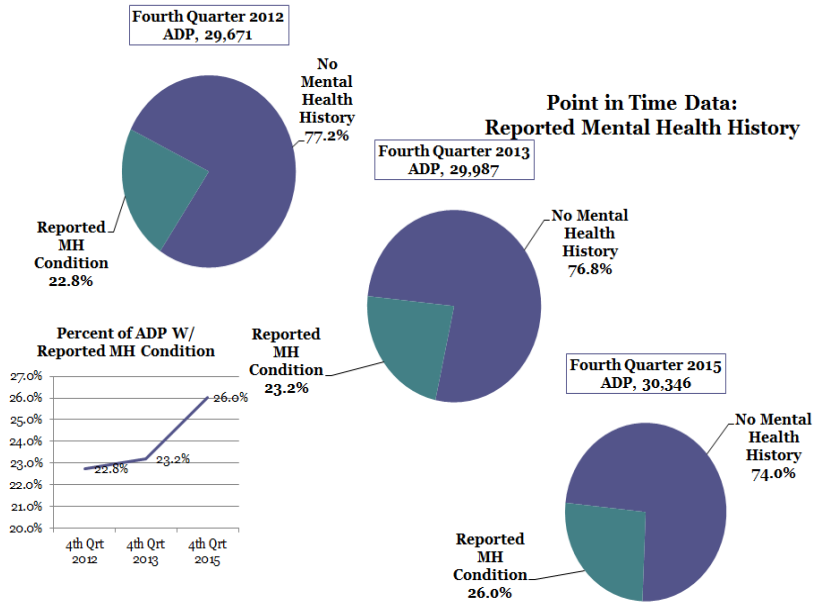
2. *MH-1 – Minimal Impairment* – Treatment is not required but there has been need for it within the past two years; generally functions satisfactorily without additional treatment or support.

3. *MH-2 – Mild to Moderate Impairment* – These offenders have a documented significant impairment and formal diagnosis; mental health symptoms are usually mild to moderate but stable; offender may need treatment (which could include medications) to maintain functioning and manage mental health symptoms especially in the event of increased situational, personal, or interpersonal stressors which could destabilize the offender.

4. *MH-3 – Moderate Impairment* – This offender has a documented serious mental disorder and may be chronically unstable; this offender will likely require ongoing treatment and monitoring (which could include medications) to manage symptoms and maintain behavioral functioning; intermittent assignment to residential or acute mental health treatment is probably a periodic occurrence.

5. *MH-4 – Severe Impairment* – This offender has a formal, serious mental health diagnosis and has demonstrated he/she can be considered a danger to self, others, and/or may be substantially unable to care for self; this offender will require assignment to an acute mental health treatment unit, and is likely to need medications to manage symptoms and maximize adaptive functioning. [24]

The mental health history or condition of an offender is determined through an assessment upon intake by state prison personnel and is considered along with any prior offender records that indicate previous experience with mental health treatment or confinement, as explained in the previous section.



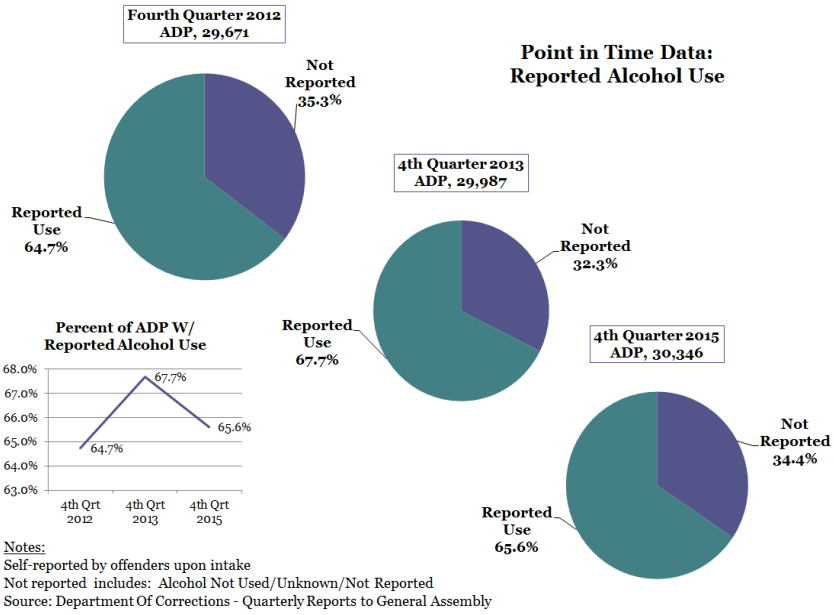
No Mental Health History includes: No Code Assigned and No History or Current Evidence of Impairment.
MH information is not self-reported by the offender.
Source: Department Of Corrections - Quarterly Reports to General Assembly

[24] Celi, Tama S. VADOC Response to Joint Commission on Health Care Question. Message to Stephen Weiss. October 13, 2016.

The proportion of offenders with a mental health history or condition has increased from 22.8% in 2012 to 26.0% in 2015, or 3.2 percentage points, of the overall prison population.

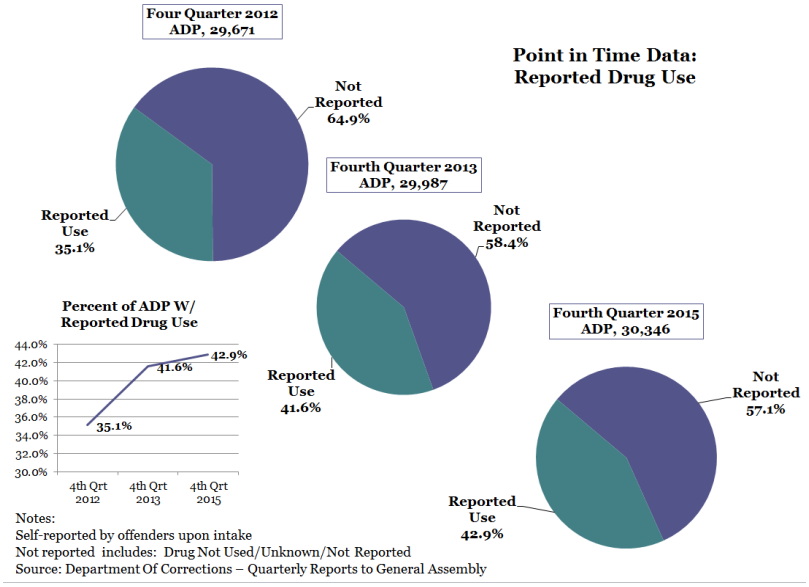
Offenders with Alcohol and Substance Use Disorders

Unlike the mental health condition assessment, VADOC uses offender self-reporting through the Correctional Offender Management Profiling for Alternative Sanctions (COMPAS) risk and needs assessment as a broad screener to identify substance use disorders and/or mental health needs, along with other programming needs, interventions, and appropriate levels of treatment or intervention.[25] If the screener indicates a need, more thorough assessments are conducted.



Notes:
Self-reported by offenders upon intake
Not reported includes: Alcohol Not Used/Unknown/Not Reported
Source: Department Of Corrections - Quarterly Reports to General Assembly

Based upon the COMPAS screening tool, a score of "Probable" for substance use disorders will require an offender to complete evidence based curriculum called MATRIX. If, however, the COMPAS screener notes a score of "Highly Probable", the offender is referred to the most intensive level of drug treatment, the Cognitive Therapeutic Community.



Notes:
Self-reported by offenders upon intake
Not reported includes: Drug Not Used/Unknown/Not Reported
Source: Department Of Corrections – Quarterly Reports to General Assembly

Collateral information is also used to support the information obtained during the COMPAS screening process. For example, screening information from a pre-sentence investigation or previous drug-related conviction is included in the supporting documentation.

The graphs indicate that while offender reported alcohol use has remained steady at roughly 65%, the percent of offenders in Virginia reporting drug use rose from 35.4% in 2012 to 42.9% in 2015, a 7 percentage point increase. [26]

[25] Developed by Northpointe Institute for Public Management, Inc.
[26] The reference period, as noted on the graphs, is the 4th quarter of each year.

Offenders with Multiple Issues- Mental Health & Alcohol and Substance Use Disorders

The mental health information and the substance use disorder information reported in the Quarterly Reports to the General Assembly are mutually exclusive. If an offender has both a mental health diagnosis and a substance use disorder, the offender is counted separately in each category in the report. As previously mentioned, all offenders are screened for both mental health issues and a substance use disorder at the time of the VADOC intake. For example:

- Of the 29,724 offenders incarcerated in VADOC facilities on September 30, 2016:
  - 7,775 (26.2%) had a mental health code of MH-1 through MH-4
  - 20,668 (69.5%) had a history of alcohol "use/abuse"
  - 19,549 (65.8%) had a history of drug "use/abuse"

- Of the 7,775 offenders with a mental health code of MH-1 through MH-4:
  - 1,802 (23.2%) had a mental health diagnosis only
  - 4,410 56.7%) also had a history of alcohol "use/abuse" AND a history of drug "use/abuse"
  - 885 (11.4%) also had a history of alcohol "use/abuse" with no history of drug "use/abuse"
  - 678 (8.7%) also had a history of drug "use/abuse" with no history of alcohol "use/abuse." [27]

VADOC Expenditures on Health Care Services [28]

Between SFY-2012 and SFY-2016 health care expenditures within VADOC increased from $155.2 million to $192.2 million, a $37 million (23.85%) increase. The majority of the increase occurred in vendor contracts with Anthem BC/BS, Diamond Pharmacy for the VADOC operated facility sites, the 340B drug services provided by Virginia Commonwealth University Medical Center (VCU) * and medical equipment.

VADOC Health Care System
Change in Actual Expenditures: 2012 to 2016

Description	FY2012	FY2016	FY 2012 - 2016	% Change
Medical Services Contracts - includes infirmaries	$72,310,858	$80,240,212	$7,929,354	10.97%
Anthem	$30,957,892	$43,649,734	$12,691,842	41.00%
Diamond Pharmacy DOC sites only	$7,154,184	$8,819,740	$1,665,556	23.28%
Dialysis at Greensville and Sussex II	$2,131,759	$1,848,906	-$282,853	-13.27%
VCUHS Stipend	$0	$3,000,000	$3,000,000	-
340B drugs – VCU	$4,502,370	$11,542,053	$7,039,683	156.36%
Personnel Services (salaries, benefits)	$30,191,201	$29,032,714	-$1,158,487	-3.84%
Other medical services (facilities & headquarters)	$7,763,209	$13,528,013	$5,764,804	74.26%
Medical Equipment	$167,466	$524,197	$356,731	213.02%
TOTAL	**$155,178,939**	**$192,185,569**	**$37,006,630**	**23.85%**
Medical Services Contract Average Daily Population	12,291	14,239	$1,948	15.85%
DOC Operated Average Daily Population	17,380	15,967	$(1,413)	-8.13%
Average Daily Population	**29,671**	**30,206**	**$535**	**1.80%**
Cost Per Inmate	*$5,230*	*$6,362*	*$1,133*	*21.65%*
Number of Contracted Facilities	*10*	*16*	*6*	

Source: VADOC report, 9-2016

[27] The source of information for the graphs is the Department of Corrections Quarterly Reports to the Virginia General Assembly and can be found on the Virginia Legislative Information System.
The Information describing the processes used by VADOC to determine mental health, alcohol and substance abuse of offenders was provided to JCHC in an email to Stephen Weiss from Tama Celi on October 13, 2016.

[28] The material used to create this section, and the material used to create the following sections of this report, were created through the use of a variety of existing reports and special request reports from VADOC. VADOC does not combine this material into an annual report and the sources of data available to the public are often disparate and unclear.

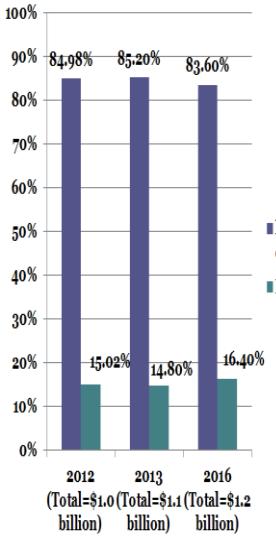
* Virginia Commonwealth University Medical Center (VCU) is also referred to as VCU Health System (VCUHS) and the Medical Center of Virginia (MCV) depending on the source of the reports.

The data provided by VADOC to the JCHC indicates that the percent of expenditures applied to health services within the state prison system went from 15.02% in SFY-2012 of the total VADOC expenditures to 16.4% in SFY-2016. A key cost-driver of the health expenditures involves pharmacy expenditures that can be identified in the VADOC operated prison facilities. Pharmacy expenditures in this limited review increased from 7.5% of health care expenditures in SFY-2012 to 10.59% of health care expenditures in 2016.

A Review of Pharmacy Products and a Claims Analysis by Anthem BC/BS

In this section of the report an analysis of pharmacy products and a claims analysis by Anthem BC/BS will provide an indication of what type of pharmacy provided drugs distributed to offenders, what the volume for them is per drug class, drugs costs, and where offsite health services are provided.

The data in this section will show that, in terms of health care expenditures, the high cost offenders tend to be over age 55, and/or have mental health and/or a substance use disorder.
Prescription drugs can be viewed in terms of volume – the number of prescriptions written – and the cost per prescription. The high cost drugs, regardless of prescription volume, include new brand name prescription drugs that do not have a corresponding generic brand or an alternative.

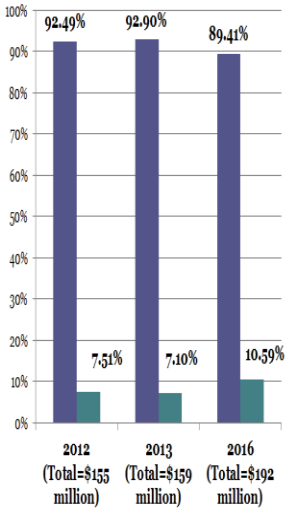


VADOC Percent of Expenditures for Prison Operations Compared to Health Care Services

Non-Health Prison operations
Health Care

SFY	Non-Health Prison Operations	Total Health Services Expenses	Total
2012	$877,776,003	$155,178,939	$1,032,954,942
2013	$915,538,629	$159,204,148	$1,074,742,777
2016	$979,684,590	$192,185,569	$1,171,870,159

Source: VADOC report, 9-2016



VADOC Percent of Expenditures for Health Care Services Compared to Pharmacy
(340B and Diamond Contract does not include Armor, Mediko or Geo facilities)

Health Care
Pharmacy

SFY	Health Care	Pharmacy 340B & Diamond	Total
2012	$143,522,385	$11,656,554	$155,178,939
2013	$147,906,677	$11,297,471	$159,204,148
2016	$171,823,776	$20,361,793	$192,185,569

Source: VADOC report, 9-2016

Pharmacy Carve-outs

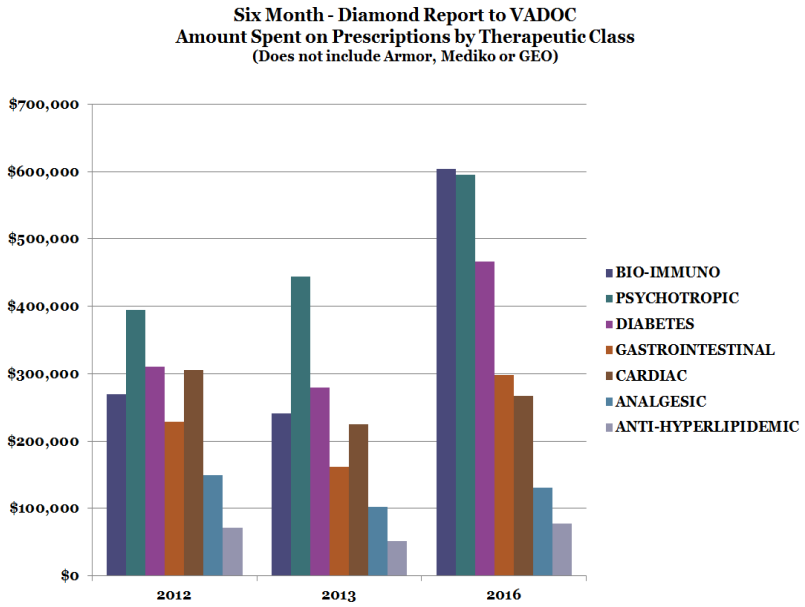
VADOC carves out Hepatitis C (HCV), Human Immunodeficiency Virus (HIV) and hemophilia drugs from the Diamond contract and pays for those drugs through a memorandum of agreement with VCU using the federal 340B Drug Purchasing program.

VADOC Offenders on Prescription Medications

A review of VADOC operated prisons (see page 2) indicates that approximately half of the offenders in those prisons are receiving at least one prescription for a medical condition.

Analysis of Diamond Pharmacy Services Monthly Management Reports

VADOC contracts with Diamond Pharmacy for all prescription and over-the-counter pharmacy products purchased within the 30 prisons that VADOC operates.

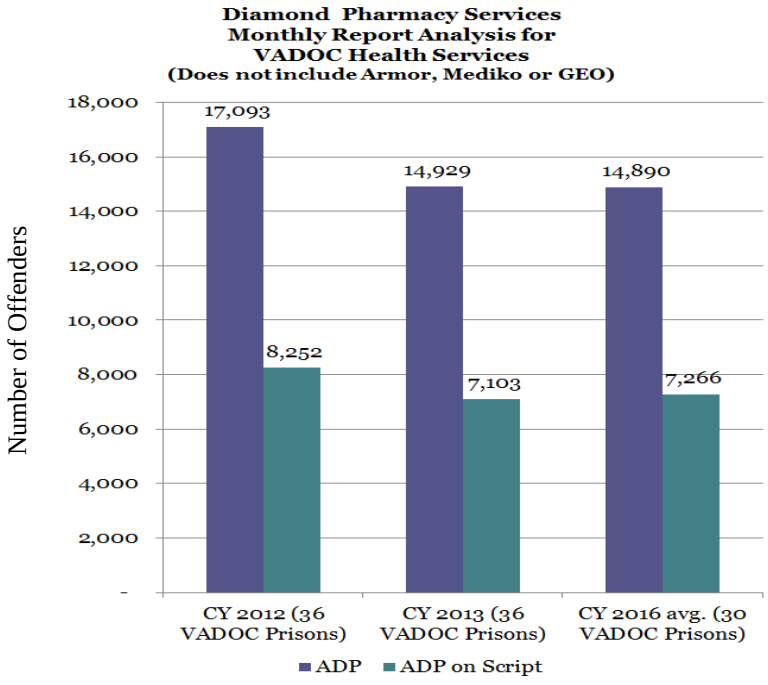


The 16 other prisons that use a health services contract with Armor and Mediko provide pharmacy products to offenders as part of their overall contract. According to VADOC, Armor and Mediko use Diamond. The Lawrenceville prison operated by the GEO, Inc. Group uses Correct Rx for their pharmacy products.

According to VADOC, Armor, Mediko and Geo, Inc. do not share their contractual pricing with the state – claiming the information is proprietary. As a result, under the current system, VADOC does not know if the prisons operated by Armor, Mediko or GEO, Inc. are getting the best prices for the pharmacy products they purchase.

For those facilities where health services are provided by VADOC (see page 2) the chart indicates that approximately 50% of incarcerated offenders receive prescription drugs.

The average number of prescriptions per offender for those that have a prescription is four, and that number has not changed since 2012.

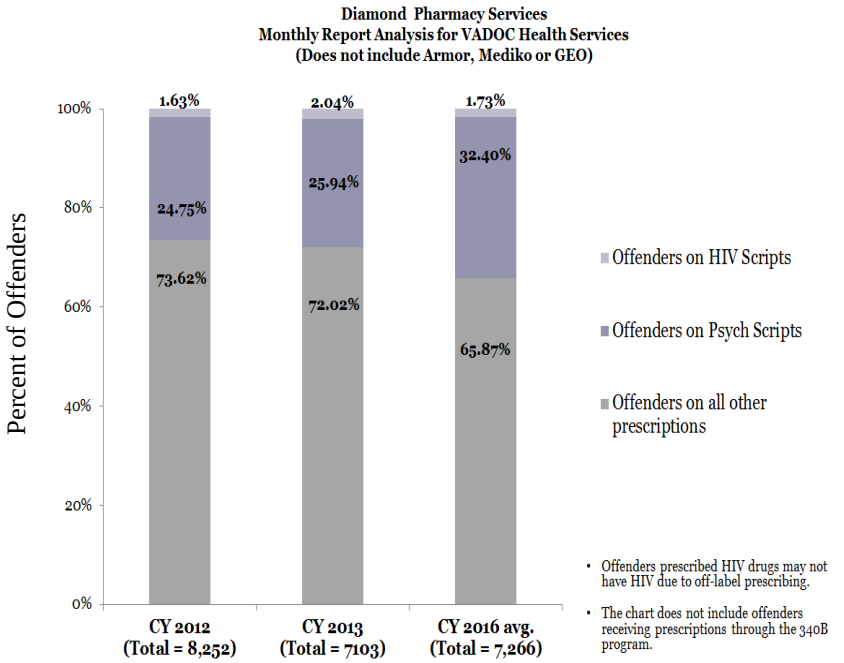


Number of Prescriptions

The next series of graphs show that the number of offenders receiving psychotropic medications increased from 24.75% in 2012 to 32.4% by 2016, or by 7.65 percentage points.

The percentage increase in the prescribing of psychotropic medications is a little over 2 times the increase in the percentage point increase of offenders with mental health conditions (see page 9).

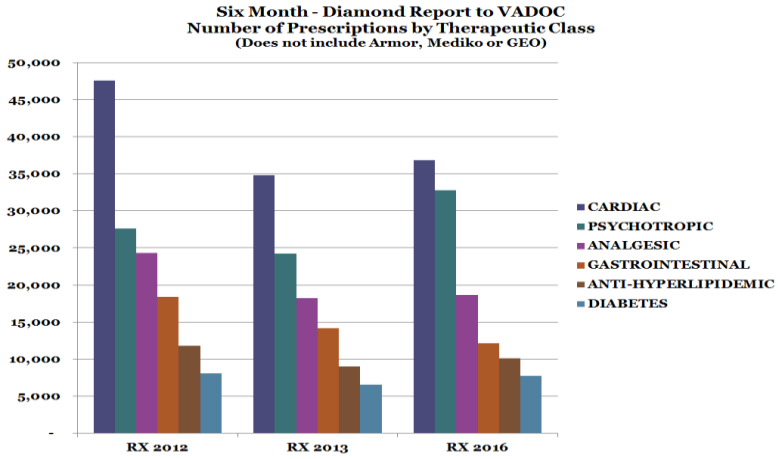
The number of prescriptions, by class, provided to VADOC offenders within the 16 prisons reflects the needs of an aging offender population and a growing percent of offenders with mental health conditions.



The top 2 prescription drug classes are cardiac and psychotropic drugs.
Of the six drug classes listed, the only class that has seen an increase in the number of prescriptions written between 2012 and 2016 is the psychotropic class even as the number of offenders under the non-vendor VADOC health care system declined, from 17,093 to 14,890 (12.8%)

Expenditures on Prescriptions

Expenditures on prescriptions by class also reflect the demographics of the non-vendor health care services provided in the VADOC prison system. Bio-Immuno (biologic) therapy drugs are used for cancer, arthritis, renal failure, Crohn's disease and other ailments often associated with an older population. The drugs are inherently expensive because of how they work within the body and because of the methods used to make them.
Prior to 2010 biologic drugs could not be replicated as generics because there was no process in place to approve a similar but least costly alternative (bio-similar). The bio-similar drugs will also be expensive even though their costs may be 20% to 30% lower than their



Therapeutic Class	RX 2012	RX 2013	RX 2016	Change 2012 to 2016
CARDIAC	47,562	34,840	36,797	(10,765)
PSYCHOTROPIC	27,607	24,273	32,764	5,157
ANALGESIC	24,317	18,211	18,649	(5,668)
GASTROINTESTINAL	18,435	14,191	12,129	(6,306)
ANTI-HYPERLIPIDEMIC	11,788	9,040	10,124	(1,664)
DIABETES	8,085	6,530	7,707	(378)

Source: Virginia Department of Corrections, September 2016.

corresponding biologic drugs.[29, 30] VADOC has to use these treatment methods because offenders have a legal and constitutional right to access adequate and appropriate health care.[31]

Anthem BC/BS Utilization Reports

Anthem BC/BS is the third-party administrator for all outpatient health care claims provided by providers outside of the prison system. Anthem BC/BS does utilization reviews on inpatient claims as part of the claim verification process. Offsite outpatient claims are the financial responsibility of the vendors (Armor and Mediko) based on where the offender comes from for health care. According to VADOC, Anthem pays claims at their negotiated rates to health care providers within their provider network. Anthem then invoices VADOC monthly for all claims.

- Incarcerated offenders that need physician, specialty or hospital care offsite from their prison facility are transported by VADOC to the provider.
- The contract with Anthem allows the state healthcare system to access the Anthem provider network at Anthem's provider negotiated rates.

VADOC pays the invoices for their claims and invoices Armor and Mediko for reimbursement for their claims. VADOC is financially responsible for paying all inpatient claims and all dental claims for all offenders regardless of where they reside.[32]

Offenders Receiving Health Care

The Anthem BC/BS utilization review reports show that 22.36% of the 37,190 offenders passing through or being housed at a VADOC prison received health care services (i.e. physician, hospital, dental, etc.) outside of the state prison system.

Of the 8,317 offenders receiving offsite health care, 35.46% were served by VCU and 25.97% were served through a non-hospital based outpatient care setting.

Expenditures for Offsite Health Care

Anthem BC/BS processed $62.4 million of claims for VADOC and its vendors in a 12 month period that ended March 31, 2016. Of the $62.4 million, $51.3 million, or 82%, were spent on hospital based health care.

All Offenders

	Number of Offenders	Percent of Total
w/o Offsite Care	28,873	77.64%
VCUHS Hospital	2,949	7.93%
Non-Hospital Based Care	2,160	5.81%
Armor/Other Hospital	1,410	3.79%
DOC/Other Hospitals	1,353	3.64%
Mediko/Geo	445	1.20%
Total	37,190	

Offenders Receiving Off Prison Site Health Care

	Number of Offenders	Percent of Total Offenders w/ Off Prison Site Care
VCUHS Hospital	2,949	35.46%
Non-Hospital Based Care	2,160	25.97%
Armor/Other Hospital	1,410	16.95%
DOC/Other Hospitals	1,353	16.27%
Mediko/Geo	445	5.35%
Total	8,317	

[29] Glover, Lacie. Why Are Biologic Drugs So Costly? A look at how biologics are made, how much they cost and why. U.S. News and World Report. February 6, 2015. http://health.usnews.com/health-news/health-wellness/articles/2015/02/06/why-are-biologic-drugs-so-costly

[30] Millman, Jason. The Coming Revolution in much cheaper Life-Saving Drugs. The Washington Post. January 16, 2015.

[31] Conway,J.D. LLM; Craig A. A Right of Access to Medical and Mental Health Care for the Incarcerated. 2009. Health Law Perspectives (June)

[32] Capen, Linda. "Re: RE: UNTITLED.pptx." Message to Stephen Weiss. September 22, 2016.

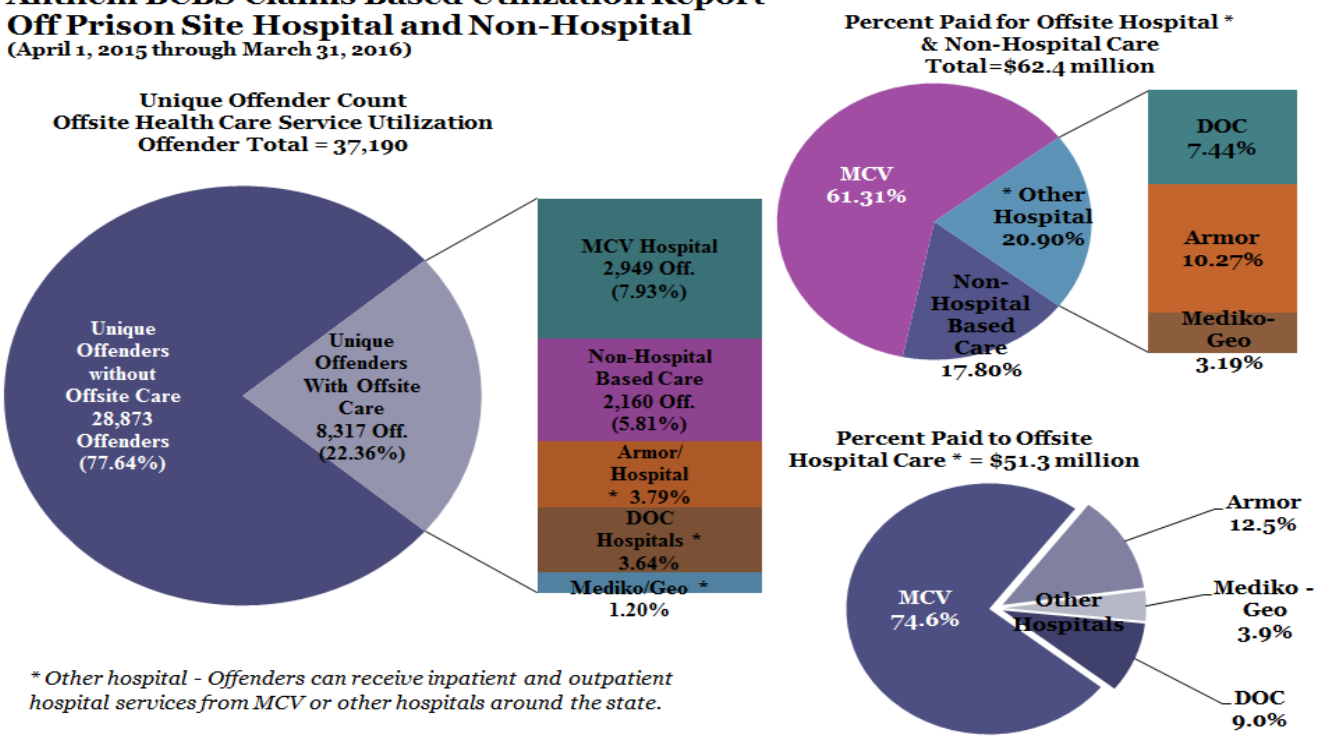
While only 35.5% of the offenders receiving offsite health services were served at VCU, the majority of the expenditures were for health care services provided by VCU (61.31%). VCU also accounted for 74.6% of the hospital based expenditures.[33]

Anthem BC/BS provided the JCHC with a separate utilization report for VCU. The report displays which vendor or VADOC was responsible for paying the claims for the offender health care at VCU. Armor operates 4 prison infirmaries and Mediko operates a reception facility where offenders are received from local jails before they are assigned to their appropriate prison. [34]

Anthem BC/BS Claims Based Utilization Report for VCUHS
(April 1, 2015 through March 31, 2016)

Origination / Vendor or VADOC	Number of Offenders	Number of Visits	Amount Paid	Cost Per Offender	Cost Per Visit
ARMOR	1,386	3,405	$21,430,759	$15,462	$6,294
DOC	1,339	2,794	$13,217,952	$9,872	$4,731
MEDIKO	167	382	$2,552,784	$15,286	$6,683
Geo	57	124	$1,042,536	$18,290	$8,408
Grand Total	2,949	6,705	$38,244,032	$12,968	$5,704

Anthem BCBS Claims Based Utilization Report
Off Prison Site Hospital and Non-Hospital
(April 1, 2015 through March 31, 2016)



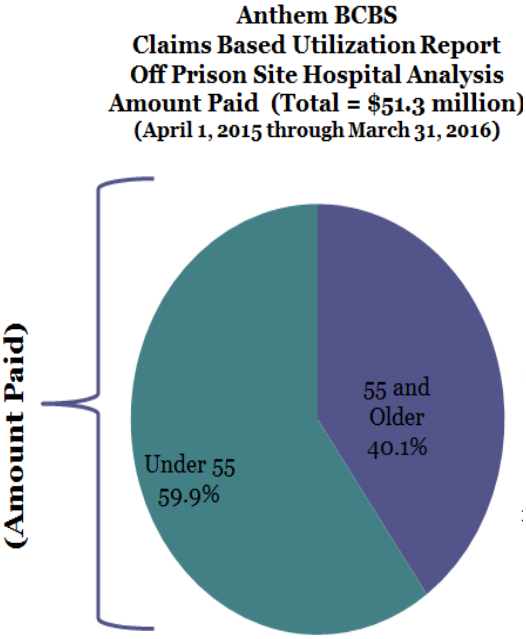
** Other hospital - Offenders can receive inpatient and outpatient hospital services from MCV or other hospitals around the state.*

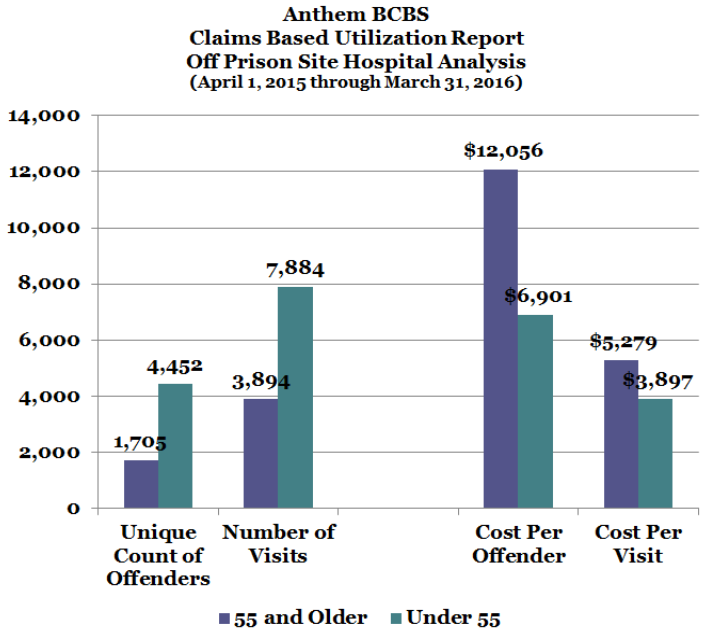
Unique offenders represent an unduplicated count for the 12 month reporting period. Includes Inpatient and Outpatient Care.
Source: Department of Corrections Clinical Analysis for claims paid from 4/2015 – 3/2016; Anthem Report

[33] Pinsky, Jeffrey H. Anthem Blue Cross Blue Shield. "DOC reporting follow up" Message to Stephen Weiss. September 28, 2016.
[34] Ibid. (Pinsky).

Offenders 55 and Older

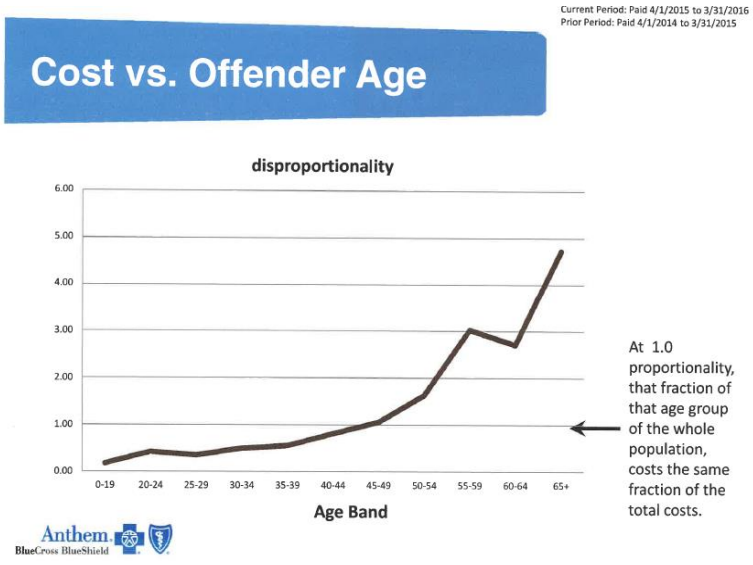
The Anthem utilization report indicates that the unduplicated count of VADOC offenders that received inpatient and/or outpatient hospital care in 2016 was 6,157. Of that amount, 1,705 (28%) were age 55 and over and 4,452 (72%) were under age 55. The utilization report also indicates that the cost to provide health care services to offenders over age 55 is almost twice as much as the cost of care for those under age 55. [35]





Anthem BC/BS Claims Analysis – Cost of Care

Anthem BC/BS provided VADOC with a 12-month paid-claims analysis. One part of the analysis showed that there is a proportional rise in the cost-of-care to offenders as they age within the state prison system relative to the prison population as a whole. According to the analysis, once an offender reaches the age of 55 and older group the cost of medical care to those offenders' increases between 3 and 5 times the cost of medical care for all other offenders. [36]



[35] Ibid. (Pinsky)

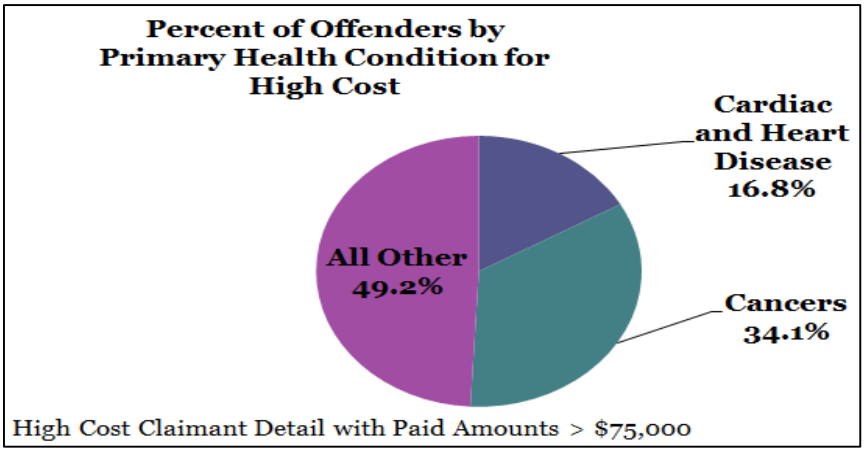
[36] Anthem Blue Cross Blue Shield. Department of Corrections Clinical Analysis for claims paid 4/1/2015 to 3/31/2016. Slide 7.

Anthem Analysis of High Cost Claims > $75,000 [37]

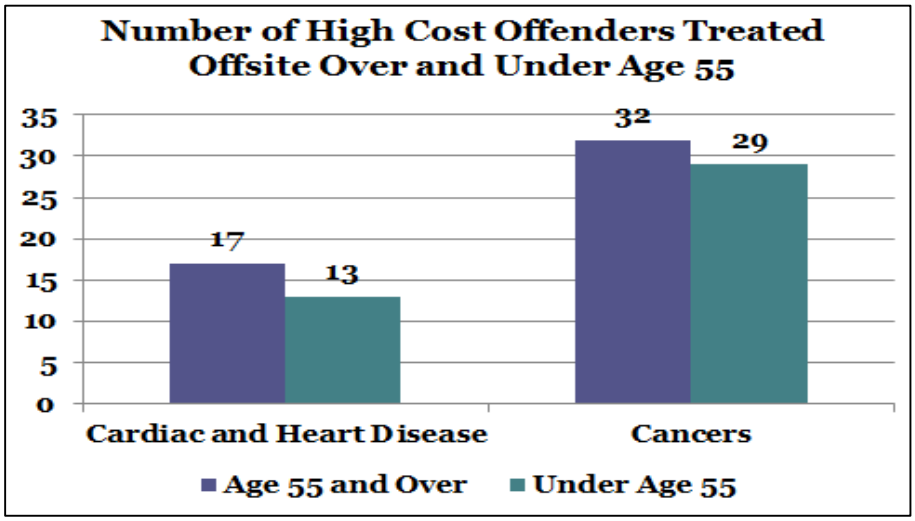
According to the Anthem claims analysis, approximately $29.2 million (46.8%) of the $62.4 million spent on offsite health care claims were spent on 179 offenders.

Primary Health Condition	Number of Offenders	Total Amount Paid	Amount Per Offender
Cardiac and Heart Disease	30	$4,632,663	$154,422
Cancers	61	$9,918,442	$162,597
All Other	88	$14,612,508	$166,051
Total	**179**	**$29,163,613**	**$162,925**

The 179 offenders represent only 2.9% of the offenders cared for offsite within the Anthem analysis.



A profile of the 179 offenders reveals that 91 (51.0%) were treated for cardiac/ heart disease or cancer. Of the 91 offenders, 49 (54%) were over age 55.



[37] Ibid. (Pinsky)

Programs to Consider for Cost Savings

Pharmacy

At the time of the presentation to the JCHC, the Secretary of Health and Human Resources was doing a comprehensive study on drug purchasing within the Commonwealth. Part of the study included how VADOC purchases drugs and whether the state is getting the best prices available. One of the strategies discussed was to form a statewide pharmacy program to take advantage of the Minnesota Multistate Contracting Alliance (MMCAP) and the federal 340B drug purchasing program for all of state government.

The Minnesota Multistate Contracting Alliance for Pharmacy (MMCAP) Program through the Department of Behavioral Health and Developmental Services (DBHDS)

Virginia is a member state of MMCAP and DBHDS is the only state agency taking advantage of the program. The VADOC would have to establish a pharmacy service or participate in a statewide pharmacy program in order to take advantage of MMCAP. According to NCSL, MMCAP reports that it achieves average savings of approximately 23.7% below average wholesale price for brand name pharmaceuticals and 65% below average wholesale price for generic drugs. The MMCAP program provides a full range of pharmaceuticals, and other healthcare products and services are available to members (i.e. medical supplies, influenza vaccine, dental supplies, drug testing, etc.) According to MMCAP, comparative analyses between MMCAP and other pharmaceutical distributors that were performed by different states and government entities reported actual drug cost savings from expenditures as follows:[38]

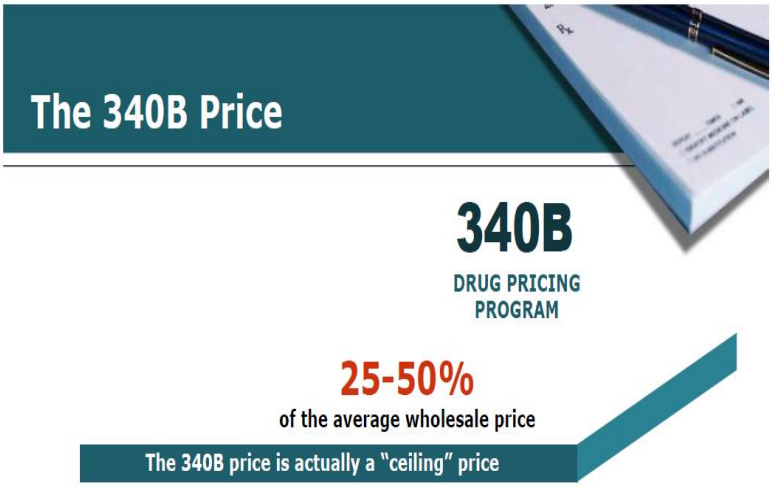
Entity Conducting Study	Savings
The State of Delaware Department of Corrections	5.94%
Cuyahoga County, Ohio	14.00%
The State of Tennessee	10.70%
The State of Indiana - comparative analysis between MMCAP and another distributor	
o state hospital	4.62%
o public health agency	46.29%
o university medical center	24.63%
The State of Florida evaluation	4.5% to 5.7%
Deschutes County Jail in Oregon MMCAP pricing to its Diamond Pharmacy	39.81%

The Federal 340B Drug Purchasing Program [39]

The Federal 340B Drug Pricing Program requires drug manufacturers to provide outpatient drugs to eligible health care organizations/covered entities at significantly reduced prices. Eligible health care organizations and covered entities include certain types of health care clinics (i.e. Federally Qualified Health Centers - FQHCs), Medicare/Medicaid Disproportionate Share Hospitals, children's hospitals, and other safety net providers. In Virginia, VCU is a 340B recognized organization. VADOC currently has a memorandum of agreement with VCU for 340B drug purchasing.

[38] Jeff Schimbeno MMCAP Comparisons. Minnesota Multistate Contracting Alliance for Pharmacy State of Minnesota, Department of Administration. Message to Stephen Weiss. September 16, 2016.
[39] 340B Drug Pricing Program. Office of Pharmacy Affairs Health Resources and Services Administration. https://www.hrsa.gov/opa/

VADOC may want to explore ways to expand the use of the 340B purchasing program for incarcerated offenders. The only diseases in which the 340B program is being used to purchase drugs are Hepatitis C, HIV and Hemophilia. For example, VADOC may be able to expand the use of the program to include psychotropic drugs for offenders with mental health conditions.



Disease Management Programs

According to a presentation at the UMass Correctional Health Conference in 2015, national data suggests that the health of incarcerated offenders is a public health issue because: [40]

- 12-18% of HIV infected Americans have been incarcerated;
- 30% of Hepatitis C infected Americans have been incarcerated; and
- 35% of Americans with active tuberculosis have been incarcerated. [41]

Taking aggressive action to use offender educators trained to provide current, medically correct health information on diabetes, heart disease and infectious diseases (such as HIV, hepatitis, Sexually Transmitted Diseases, Tuberculosis, Staph) could provide much needed assistance in implementing disease management within the state prison system. Such action may help defray future expenses and result in a healthier prison population. [42]

In addition, VADOC may consider implementing additional health related performance measures into the vendor contracts to insure that disease management programs are being implemented. The measures need to be carefully examined and monitored to insure that the vendors comply without dis-incentivizing appropriate health care services to offenders.

Data Availability and Information

Anthem BC/BS analysis of offsite claims is unique. VADOC was not able to provide the JCHC with the same level of analysis or details for all offenders being treated within its system because the facilities where the department provides health care services do not have electronic health records and VADOC does not produce a system-wide consolidated annual report. Much of the health care and medical information VADOC has is disparate and maintained within the various Department divisions where it is used or archived.

[40] Brockmann, J.D., Brad. Prison-Based Peer Health Education: Understanding Benefits to Inmates, Institutions and Communities. UMass Correctional Health Conference. March 19-20, 2015. Boston, MA.
[41] Ibid. (UMass); Slide 5
[42] Ibid. (UMass)

Current General Assembly Studies on Medical Costs: VADOC State Prisons

(See Appendix I for specific language)

Appropriations Bill Language 2015

- 2015 Budget Bill CH 665; Item 384.P.1.
  - Develop a request for information (RFI) concerning the comprehensive management and provision of health care services for offenders within the VADOC system
  - Report to the General Assembly summarizing the responses from the RFI
- 2015 Budget Bill CH 665; Item 384.P. and also 2016 Appropriation, CH 780; Item 393.N.
  - Report on the current health care system compared to alternative care management models including costs and benefits of the current system to alternative care management models
- 2016 Budget Bill CH 780; Item 284.B.
  - Multi Cabinet Review of High Cost Drug Purchases
- 2016 Budget Bill CH 780; Item 394. A.
  - Modernization of Current Data and Record Keeping Systems

On September 30, 2015 VADOC submitted a report to the General Assembly to comply with the 2015 budget bill language. VADOC contracted with the Department of Health Administration at Virginia Commonwealth University (VCU) to issue and compile recommendations for improvements to the VADOC health care system from a Request for Information (RFI). Nine organizations responded to the RFI with ideas, suggestions and recommendations.

Notable issues reviewed in the report included:

- creating a single system-wide pharmacy program through a medical school to access all pharmaceutical products at 340B drug prices;
- use a system-wide contracted medical system;
- allow an academic medical center to manage the DOC health system;
- improve the Medicaid eligibility process for offenders to avoid back-end administrative adjustments;
- adopt tele-pharmacy to allow offenders to access clinical pharmacy care without leaving a facility; and
- improve community outreach and re-entry programs for offenders with long term and/or chronic conditions to help reduce recidivism.

Conclusions

VADOC is legally responsible for providing health care services to all incarcerated offenders in the state prison system whether the prison health care services are provided by a vendor or by the state directly. While health care represents approximately 16% of the VADOC expenditures, costs in certain areas, such as pharmacy, have been rising. Some of the increases are due to the introduction of new prescription biologic drugs. Other health care cost increases are due to a changing prison population. The system has more offenders with mental health and substance use disorder issues now than it had five years ago. Also,

there is a growing incarcerated population of elderly offenders within the system and their health care needs are changing much the same as the health care needs of the civilian elderly population.

VADOC can control health care costs by managing offender health care within the system through the expansion, implementation and more thorough monitoring of offender disease management programs and pharmacy management programs. An actuary, hired by VADOC, may help reduce or control the cost of the vendor contracts, as well as advise the department of any services that may need attention. Having an independent actuary hired by VADOC will also provide the department with benchmark rates for services and may provide better alternatives concerning the development and setting of PMPM rates. For example, an independent actuarial analysis may be able to determine if a single, unified PMPM for all contracted facilities may be in the best interest of the state, or a single PMPM for infirmaries and special units and a single PMPM for the general population may be advantageous in managing the costs of the health care system. Based on the information provided, it cannot be determined if VADOC is getting the best price for pharmacy products distributed to offenders. A more thorough and complete analysis of pharmacy prices and expenditures on pharmacy products is warranted.

Finally, the costs of health care in the prison system need to be carefully monitored and better management tools need to be developed. Compliance with the Fluvanna settlement will need to be monitored carefully by the state as it has the potential of effecting the cost of health care in the prison system and any efforts made by VADOC to manage court ordered changes will be beneficial in controlling costs and complying with the settlement agreement.

Recommendations, Policy Options and Public Comments

One comment was received from Jill A Hanken, Health Attorney, Virginia Poverty Law Center on behalf of the VPLC and the Healthcare for All Virginians (HAV) Coalition.

The policy options for consideration are as follows:

Policy Options
Option 1: Take no action.
☑ 16-0 Option 2. *Request by letter of the JCHC Chair that* ~~Introduce legislation to amend Chapter 53.1-32 of the Virginia Code to require~~ the Department of Corrections to prepare and submit an annual report to the Governor and the General Assembly detailing the operations and expenditures for the entire state prison system's health care system. The report should include trend analysis of expenditures, trend analysis of the prison population including disease and illness profiles, new programs and services implemented and future plans. *Require the Department to report back to the Commission with results of its efforts by October, 2017.*
☑ 16-0 Option 3. *Request by letter of the JCHC Chair that* ~~Introduce legislation to amend Chapter 53.1-32 of the Virginia Code to require~~ the Department of Corrections to implement disease management programs within all of the department's facilities for diseases where there are established best practice models available. The department should explore the opportunity of establishing a comprehensive peer-to-peer program for incarcerated offenders where offenders can assist each other in managing their illnesses. *Require the Department to report back to the Commission with results of its efforts by October, 2017.*

Policy Options
☑ 16-0 Option 4. *Request by letter of the JCHC Chair that* ~~Introduce legislation to amend Chapter 53.1-32 of the Virginia Code to require~~ the Department of Corrections to hire an independent actuary to annually establish per-member-per-month benchmark reimbursement rates for offenders where the health care is provided by a vendor. *Require the Department to report back to the Commission with results of its efforts by October, 2017.*
☑ 16-0 Option 5. Request by letter of the JCHC Chair that the Department of Corrections explore all opportunities to partner with the Department of Behavioral Health and Development Services and VCUHS for the purchasing of pharmaceutical products through the multi-state purchasing agreements already in place and/or through the use and expansion of the 340B program. Require the Department to report back to the Commission with results of its efforts by October 1, 2017.

Public Comment Excerpt

Jill A. Hanken, Health Attorney,
Virginia Poverty Law Center and Healthcare for All Virginians

Ms. Hanken wrote on behalf of the Virginia Poverty Law Center and also on behalf of the Healthcare for All Virginians Coalition (HAV). The HAV coalition is comprised of over 100 Virginia organizations (see below).

The JCHC's comprehensive review of prison health care costs has one glaring omission. It fails to discuss in any way how Medicaid is currently used for a small amount of prison medical costs, and it ignores the possible impact of expanding Medicaid coverage to more low-income, uninsured adults – some of whom are justice involved. The opportunities to use Medicaid funding for the justice involved population should have been fully evaluated by the JCHC. We believe another policy option should be presented – namely – "Expand Medicaid Coverage to low-income, uninsured adults".

The JCHC should review the recent report from the Center for Health Care Strategies and the Milbank Memorial Fund, on "Coordinating Access to Services for Justice-Involved Populations".

http://www.chcs.org/resource/coordinating-access-services-justice-involved-populations

Here is a short description of the paper:

"States that expanded Medicaid coverage under the Affordable Care Act have unprecedented opportunities to connect adults released from prison or jail with needed physical and behavioral health services and social supports. This population – disproportionately male, minority, and poor – suffers from high rates of mental illness and substance use disorders. Providing critical health services and social supports for these individuals can potentially slow the revolving door of recidivism plaguing the justice system and reduce avoidable health care costs."

Ms. Hanken's writes that Virginia can and should use the opportunities provided through Medicaid to address many of the challenges in our mental health and criminal justice systems. She notes that the CHCS paper provides excellent information about potential strategies and projects in other states that more effectively and efficiently serve the mental health needs of the justice involved population.

Ms. Hanken's notes that the Medicaid expansion would greatly assist both jails and prisons and points out that many of the people served in prisons are uninsured in the community and – because of that - they are unable to access needed medical services to treat chronic conditions, mental health and SUD

problems. "For many, these untreated medical needs directly lead to their entanglement with criminal justice. With Medicaid expansion, hundreds of thousands of Virginians would gain access to health care. Some with mental health and substance use disorders could avoid criminal activity and incarceration. Moreover, there are very significant state and local financial savings to be gained by expanding Medicaid. For example, there could be Medicaid reimbursement for (1) jail offenders who require hospital care (which is now limited to those who meet current, restrictive Medicaid eligibility rules which cover only disabled, elderly and pregnant offenders) This alone could save about $20 million/year; (2) transportation to medically necessary services; and (3) necessary medical and pharmacy services before and after incarceration. For example, people could leave prison with an insurance card, and that would greatly assist in their successful transition/reentry efforts."

Organizational Members of HAV Coalition	
AARP Virginia	Mental Health America of Virginia
Adams Compassionate Healthcare Network	Mental Health America-New River Valley
Aloha Health, LLC	National Alliance on Mental Illness of Virginia
American Association of University Women of Virginia	National Assn. of Social Workers – Virginia Chapter
American Cancer Society – Cancer Action Network	National Multiple Sclerosis Society
American Heart Association	National Osteoporosis Awareness Health (NOAH) Project USA
Arlington County	National Physicians Alliance – Virginia
Arlington Free Clinic	New Virginia Majority
Blue Ridge Independent Living Center	Northern Virginia Family Service
Boehringer Ingelheim Pharmaceuticals	NOVA ScriptsCentral
Bon Secours Virginia	Nueva Vida
Brain Injury Association of Virginia	Otsuka America Pharmaceuticals, Inc.
Celebrate Healthcare	Patient Services, Inc.
Central Virginia Health Services	Parents as Teachers State Office
Chesapeake Care, Inc.	Partnership for People with Disabilities at VCU
CHIP of Virginia	Piedmont Access to Health Services, Inc. (PATHS)
City of Alexandria	Piedmont Regional Dental Clinic
Cornerstones, Inc.	Planned Parenthood Advocates of Virginia
Coverage Counts	Prevent Child Abuse Hampton Roads
Delta Sigma Theta Sorority, Inc. Virginia Beach Alumnae Chapter	Prevent Child Abuse Virginia
Endependence Center	ProgressVA
FACETS	Rappahannock Legal Services, Inc.
Free Clinic of the New River Valley	Rappahannock United Way, Inc.
Gloucester-Mathews Free Clinic	Richmond Orthopedics
Greater Prince William Community Health Center	Rx Partnership
Greene Care Clinic	SEIU – Virginia 512
HealthWorks for Northern Virginia	Social Action Linking Together (SALT)
Health Brigade	The Arc of Virginia
H.E.A.L.T.H. NOW, Virginia	The Commonwealth Institute for Fiscal Analysis
Hemophilia Assn. of the Capital Area	The Women's Initiative

Organizational Members of HAV Coalition	
Inova Health System	VCU – American Medical Student Association
Instructive Visiting Nurse Assn. (IVNA)	Virginia Adult Day Health Services Association
Jewish Community Relations Council of Greater Washington	Virginia AFL-CIO
League of Women Voters of Virginia	Virginia Association of Area Agencies on Aging
League of Women Voters, Richmond Metro Area	Virginia Association of Centers for Independent Living
Legal Aid Justice Center	Virginia Association of Community Psychiatric Nurses
Legislative Coalition of Virginia Nurses	Virginia Association of Community Services Boards
Leukemia & Lymphoma Society	Virginia Association of Free and Charitable Clinics

Letter to the Department of Corrections from JCHC

JOINT COMMISSION ON HEALTH CARE

Senator Charles W. Carrico, Sr., Chair Senator Rosalyn R. Dance, Vice Chair

June 22, 2017

Mr. Harold W. Clarke, Director
Virginia Department of Corrections
Director's Office
6900 Atmore Drive
Richmond, VA 23225

Dear Director Clark:

A recent Joint Commission on Health Care study on the costs of medical care provided in state prisons examined a variety of aspects of the health care system operated by the Department of Corrections. (The study presentation by Stephen Weiss is posted on the JCHC website within the October 5, 2016, meeting folder.) During the November 9, 2016, meeting of the JCHC the Commission voted to request by letter that you review the policy options presented, evaluate and analyze whether they are feasible for the Department to do, and provide the JCHC with a report detailing your evaluation and analysis by the October 2017 JCHC meeting.

The policy options from the presentation that we'd like a report on are as follows:

- Require the Department of Corrections to prepare and submit an annual report to the Governor and the General Assembly detailing the operations and expenditures for the entire state prison system's health care system. The report should include trend analysis of expenditures, trend analysis of the prison population including disease and illness profiles, new programs and services implemented and future plans.

- Require the Department of Corrections to implement disease management programs within all of the department's facilities for diseases where there are established best practice models available. The department should explore the opportunity of establishing a comprehensive peer-to-peer program for incarcerated offenders where offenders can assist each other in managing their illnesses.

- Require the Department of Corrections to hire an independent actuary to annually establish per-member-per-month benchmark reimbursement rates for offenders where the health care is provided by a vendor.

- Explore all opportunities to partner with the Department of Behavioral Health and Development Services and VCUHS for the purchasing of pharmaceutical products through the multi-state purchasing agreements already in place and/or through the use and expansion of the 340B program. Require the Department to report back to the Commission with results of its efforts by October 1, 2017.

Thank you for considering this request. Stephen Weiss or Dr. Michele Chesser will be happy to answer any questions you may have.

Sincerely,

Senator Charles W. Carrico, Sr
Chair

CC: Steve Herrick, Ph.D., M.S.H.A.
Director of Health Services
Virginia Department of Corrections

Appendix I. General Assembly Directed Study Language

Report on Costs and Benefits of Current Offender Health Care System compared to Alternative Care Management Models - 2015 Budget Bill CH 665; Item 384.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 offenders confined at facilities not covered by the August 4, 2014, solicitation for health care management services, and

(ii) all offenders 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.

Report on Costs and Benefits of Current Offender Health

Care System compared to alternative Care Management Models - 2015 Budget Bill CH 665; Item 384.P. and 2016 Appropriation, CH 780; Item 393.N.

- 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 offender 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 s.
    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 offender 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.

Multi Cabinet Review of High Cost Drug Purchases
2016 Appropriation; CH 780, Item 284.B.

The Secretary of Health and Human Resources, in consultation with the Secretary of Public Safety and the Secretary of Administration, shall convene a work group including, but not limited to, the Department of Medical Assistance Services, Department of Social Services, Department of Health, Department of Behavioral Health and Developmental Services, Department of Corrections, Department of Juvenile Justice, the Compensation Board, the Department of Human Resource Management and other relevant state agencies to examine the current costs of and protocols for purchasing high-cost medications for the populations served by these agencies. After conducting the review, the workgroup shall develop recommendations to improve the cost efficiency and effectiveness of purchasing high-cost medications in order to improve the care and treatment of individuals served by these agencies. The workgroup shall prepare a final report for consideration by the Governor and the Chairmen of the House Appropriations and Senate Finance Committees no later than October 15, 2016.

Modernization of Current Data and Record Keeping Systems
2016 Appropriation; CH 780, Item 394. A.

1. Any plan to modernize and integrate the automated systems of the Department of Corrections shall be based on developing the integrated system in phases, or modules. Furthermore, any such integrated system shall be designed to provide the department the data needed to evaluate its programs, including that data needed to measure recidivism.

2. The appropriation in this Item includes $2,868,500 the first year and $2,135,500 the second year from the Contract Prisoners Special Revenue Fund to defray a portion of the costs of maintaining and enhancing the offender management system, including the development of an

electronic health records system. In addition to any general fund appropriations, the Department of Corrections may, subject to the authorization of the Director, Department of Planning and Budget, utilize additional revenue deposited in the Contract Prisoners Special Revenue Fund to support the development of the offender management system.

Appendix II. Expenditures by Year 2012- 2016

VADOC Health Care System
Actual Expenditures: 2012 to 2016

Description	FY2012	FY2013	FY2014	FY2015	FY2016
Comprehensive Medical Services Contract – includes infirmaries	$72,310,858	$74,163,164	$76,291,856	$80,546,264	$80,240,212
Anthem	30,957,892	31,882,378	25,869,084	34,402,329	43,649,734
Diamond Pharmacy DOC only	7,154,184	7,134,501	5,782,534	7,527,699	8,819,740
Dialysis at Greensville and Sussex II	2,131,759	2,121,563	1,717,781	1,703,953	1,848,906
VCUHS Stipend					3,000,000
340B drugs – VCUHS	4,502,370	4,162,970	4,335,906	4,584,476	11,542,053
Personnel Services (salaries, benefits)	30,191,201	29,362,862	26,697,495	28,339,054	29,032,714
Other medical services (includes facilities and headquarters expenses)	7,763,209	10,234,055	10,644,811	13,899,638	13,528,013
Medical Equipment	167,466	142,655	406,044	278,535	524,197
TOTAL	**$155,178,939**	**$159,204,148**	**$151,745,511**	**$171,281,948**	**$192,185,569**
Amount of Change	$5,329,353	$9,354,562	$1,895,925	$21,432,362	$42,335,983
Percent Change	3.56%	6.24%	1.27%	14.30%	28.25%
Average Daily Population (ADP)					
Comprehensive Medical Services Contract: ADP	12,291	12,082	14,919	14,387	14,239
DOC Operated ADP:	17,380	17,905	15,169	15,959	15,967
Total ADP	**29,671**	**29,987**	**30,088**	**30,346**	**30,206**
Cost Per Inmate	$5,230	$5,309	$5,043	$5,644	$6,362
Amount of Change	$366	$79	-$266	$601	$718
Percent Change	7.51%	1.51%	-5.00%	11.91%	12.72%

Appendix III. Follow up question after the study

Secretary Hazel asked for clarification on the following statement in the October 5, 2016, presentation: "VADOC contracts with Anthem Blue Cross and Blue Shield to process all off-prison-site health care claims submitted by all health care providers regardless of the state prison facility the incarcerated offender is housed".

According to the Department of Corrections, all offsite hospital claims were processed by Anthem Blue Cross Blue Shield (BCBS) until July 1, 2016. Prior to July 1, 2016 the Department stated that Medicaid claims were processed retroactively through the Department of Corrections and hospital payments were adjusted accordingly after the fact. Beginning July 1, 2016, the policy was changed so that all Medicaid claims are now being processed directly through the Department of Medical Assistance (DMAS) by each hospital.

Anthem BCBS reported that there were 6,157 offenders with hospital claims equaling $51.3 million during the reporting period of April 2015 through March 2016.

According to DMAS, in SFY-2016 there were 217 incarcerated offenders that qualified for Medicaid with hospital claims totaling $5.1 million. The DMAS report by hospital is as following:

Medicaid Expenditures for Inmate Care FY-2016	
Provider Name	**Expenditures**
Medical College Of Virginia (VCU)	$3,598,936.86
Southside Regional Medical Center	$261,700.40
University Of Virginia Hosp (Uva)	$258,699.19
Chesapeake General Hosp	$100,896.00
Chippenham Johnston-Willis	$89,795.93
Sentara Norfolk General Hosp	$74,122.62
Franklin Hospital Corporation	$60,771.67
Virginia Baptist Hospital	$53,612.52
Carilion Medical Center	$33,752.45
Southern Virginia Regional Medical Ctr	$32,222.11
Henrico Doctors Hospital	$26,335.28
Community Memorial Hosp	$21,338.37
St Marys Hosp Of Rich	$15,203.71
Augusta Medical Center	$13,107.25
Bon Secours St Francis Medical Center	$9,018.80
Bon Secours Mem Reg Med Ctr	$7,883.03
Riverside Hospital	$3,460.77
Winchester Medical Ctr	$2,669.05
Fair Oaks Hospital	$2,293.52
Centra Specialty Hospital	$100.00
Other Provider Classes, Mainly Physicians	$406,868.79
SFY 2016 Total Expenditures	$5,072,788.32
Aid Category 109 (DOC)	
Number of Offenders w/ Medicaid	SFY16 Expenditures
217	$5,072,788.32
These are the expenditures for those in Aid Category 109, which was set up for the Department of Correction Members. Source: DMAS Message forwarded to Stephen Weiss. October 6, 2016.	