Costs Savings and Care Innovations for Prisoner Health Care

NCSL Webinar
November 1, 2013
NCSL is committed to the success of state legislators and staff. Founded in 1975, we are a respected bipartisan organization providing states support, ideas, connections and a strong voice on Capitol Hill.
Presenters

- Matt McKillop, Senior Associate, State Health Care Spending Project, The Pew Charitable Trusts
- Owen Murray, D.O., MBA, University of Texas
- Aaron Edwards, Senior Fiscal and Policy Analyst, Legislative Analyst’s Office, California
Managing Prison Health Care Spending
Matt McKillop
November 1, 2013
Managing Prison Health Care Spending
In 42 of the 44 states, total prison health care spending increased. The median growth was 52 percent from 2001 to 2008.

A dozen states saw their inmate health care bills grow 90 percent or more.

Per-inmate health care spending went up in 35 of the 44 states. The median growth was 32 percent.
The number of sentenced state and federal prisoners grew 15 percent from 2001 to 2008.

This rise was part of a trend that spanned four decades.

Note: Annual figures prior to 1977 reflect the total number of sentenced prisoners in custody. Beginning in 1977, all figures reflect the jurisdictional population as reported in the Bureau of Justice Statistics’ “Prisoners” series.

Sources: Sourcebook of Criminal Justice Statistics, University at Albany; U.S. Department of Justice, Bureau of Justice Statistics
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Elderly prisoners push up states’ per-inmate health care expenses.

Like peers outside prison, they’re more likely to have chronic medical and mental illnesses.

The number of inmates age 55 and older rose 94 percent from 2001 to 2008.

More than 120,000 state and federal prisoners were 55 or older in 2011.

Note: The Bureau of Justice Statistics estimates the age distribution of prisoners using data from the Federal Justice Statistics Program and statistics that states voluntarily submit to the National Correcions Reporting Program. State participation has varied, which can cause year-to-year fluctuations in the Bureau’s estimates but does not affect long-term trend comparisons. Between 2000 and 2010, the number of states submitting data increased substantially.

Source: U.S. Department of Justice, Bureau of Justice Statistics
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A legal standard for care
Strategic use of telehealth

• More than half the states have used telehealth technologies in prisons.

• This strategy can help improve prisoners’ access to primary care doctors and specialists while reducing transportation and guarding expenses.

• There can be public safety benefits, too, because inmates likely need fewer trips off prison grounds for medical care.

• In Texas one study found that telehealth, combined with other measures, contributed to lower average blood sugar rates for diabetic inmates and a reduction in AIDS-related deaths. Another study estimated that telehealth saved Texas $780 million between 1994 and 2008.
Effective management of outsourcing agreements

• Effective management and oversight is critical.

• **New Jersey** partners with University Correctional Health Care, which is based at Rutgers University.

• This partnership achieved improved health outcomes for **prisoners with hypertension and HIV** and a **reduction in inmates’ medical complaints**.

• Expenses were **$10 million below budget** in 2008, and have remained mostly flat since.
Enrolling eligible prisoners in Medicaid

• Qualifying services limited to inpatient care delivered outside of prison.

• Medicaid does not cover health care delivered inside prisons.

• States can obtain federal Medicaid reimbursement.

• States expanding Medicaid eligibility under the ACA likely to benefit most. But even in these states, Medicaid will still cover only inpatient health care provided outside of prison.

• Ohio may save a total of $273 million from 2014 to 2022.

• California stands to save nearly $70 million a year on inmates’ health care due to Medicaid expansion.
Using medical or geriatric parole policies

• Paroling offenders who qualify reduces expensive round-the-clock guarding and transportation costs.

• Significant obstacles, my some states have employed policies, while preserving public safety.

• From 2010 to October 2012, California granted medical parole to 47 inmates, reducing its correctional health care expenses by more than $20 million.
The University of Texas Medical Branch

Correctional Managed Care Overview

Owen J. Murray, DO, MBA
Vice President, Offender Services
Correctional Managed Care
The University of Texas Medical Branch
UTMB Correctional Managed Care

- Legislatively created partnership in 1994
- FTEs: 3,000
- Patients: 120,000
- 83 facilities: full medical, dental and psych
- 2 inpatient medical and mental health units
- Dialysis, infectious disease, geriatric and assistive disability programs
- Medical transportation
- EMR, telemedicine and radiology
- Pharmacy
- Hospital Galveston and Free World hospital network
Revenue vs. Expense PMPD

UTMB - Correctional Managed Care
Total Revenue vs Expense Per Member Per Day
TDCJ Contract - Medical & Mental

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Working Together to Work Wonders
Keys to Success

• State Commitment to a Model of Care
• Hospital Galveston
• 340B Pharmaceutical Pricing
• Strategic Technology Investments
• Dedicated Staff
Commitment to a Model of Care

• Improves staff continuity and security
• Provides a discernible career path
• Improves dialogue with Legislature
• Allows for investment in the program
Hospital Galveston

• Manages tertiary hospital and planned offender care
• Secure facility accommodating all custodies
• Utilizes corrections knowledgeable staff
• Allows care to be balanced with available resources
• All specialty clinical services are available
• Reduces risk and litigation
340B Pharmacy Pricing

- Unique to the state of Texas
- UTMB is the eligible entity
- Disproportionate share hospital, employ prescribers, manage the medical record
- FY12 savings - $50M
- Benefit will grow due to Hepatitis C and new generation treatment
340B Savings

Working Together to Work Wonders
Strategic Technology

- Telemedicine has increased access to care, decreased offender movement, and increased public safety
- Provided 100K encounters in FY13
- Primary care services drives of volume
- Improved recruitment and retention
- EMR has improved productivity and continuity of care
- EMR has and improved patient outcomes and reduced state risk
- Pharmacy systems, DMGs, and formulary have reduced cost
Dedicated Staff

• Texas has the lowest staff per offender ratio in the nation
• CMC has had to reduce FTEs by 33% since 1994
• All facilities are ACA accredited
• Clinical outcomes remain exemplary
• Commitment to the delivery model has improved retention
Texas PMPD Cost Compared to Other States

- UTMB CMC FY 12: 9.01
- Mississippi: 9.03
- Oklahoma: 9.48
- Georgia: 10.16
- Maryland(2): 11.16
- Tennessee(2): 11.85
- Delaware(2): 12.31
- Avg (not incl CA): 13.70
- Florida: 14.50
- North Carolina: 15.75
- New Mexico: 17.22
- Vermont: 29.50
- California: 44.00

(2) CMS Data
Obtaining Federal Funds for Inmate Medical Care

Legislative Analyst’s Office

Presented to:
National Conference of State Legislators Webinar
November 1, 2013

www.lao.ca.gov
Presentation Overview

- Background on California’s prison medical care program and Medicaid.
- New opportunities for prison medical care savings created by the Affordable Care Act (ACA).
- Update on efforts in California to obtain federal Medicaid reimbursements for inmate medical care.
California’s Prison Medical Care Program

- In 2001, inmates filed suit in federal court alleging that the state failed to provide a constitutional level of medical care.
- In 2006, a federal court appointed a Receiver to take over operation of the state’s prison medical care system.
- In 2011-12, the Receiver spent $263 million for off-site contract medical services including $109 million for inpatient care.
Medicaid and Inmate Eligibility

- Medicaid is a joint federal-state program providing health insurance to certain low-income populations.
- Currently, California receives one dollar of federal funds for each dollar it spends on services for its Medicaid enrollees.
- Inmates are generally excluded from Medicaid except when receiving off-site inpatient care.
- Because many California inmates are childless adults, most California inmates have not qualified for Medicaid, even when receiving off-site inpatient care.
ACA Allows States to Expand Their Medicaid Programs

- The Legislature has exercised its authority under the ACA to expand its Medicaid program.
  - Coverage extended to low-income childless adults beginning in 2014.
  - Federal match increases to 100 percent initially, steps down to 90 percent by 2020.
- It also approved the Low-Income Health Plan (LIHP) to extend temporary coverage to low-income childless adults in participating counties in the years preceding the expansion.
ACA Creates Opportunities for Prison Medical Care Savings

- Because the state extended coverage to low-income childless adults, the number of Medicaid eligible inmates will increase significantly.
- Most will be newly eligible and qualify for a 100 percent federal match.
- The state could offset a significant share of General Fund costs for off-site inpatient medical care for inmates.
Potential Increase in Federal Reimbursement for Inmate Care
Current Process of Obtaining Federal Funding for Inmate Care

Service
- Inmate receives off-site inpatient care and Receiver pays provider in full. If inmate appears likely to qualify for Medi-Cal or a LIHP, Receiver submits application to DHCS.

Eligibility Determination
- The DHCS reviews application to determine if inmate is eligible for a LIHP or Medi-Cal.

Eligibility Determination
- If inmate is eligible for Medi-Cal, DHCS enrolls inmate.
- If inmate is eligible for a LIHP, DHCS notifies inmate’s county of residence which then enrolls inmate.
- If inmate is not eligible for a LIHP or Medi-Cal, DHCS notifies the Receiver that no federal reimbursement is available.

Enrollment
- Receiver submits a claim to DHCS for eligible services provided to inmate. DHCS ensures that expenditures are allowable.
- Receiver sends invoice for care to inmate’s county, which submits a claim to DHCS on behalf of the Receiver. DHCS ensures that expenditures are allowable.

Claiming
- The DHCS obtains federal match and authorizes payment of claims submitted by Receiver or county.
Additional Materials

- For more information see our recently released reports:
Questions?

- **My contact information:**
  
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The webinar archive and powerpoints will be available online at: http://www.ncsl.org

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