Oregon

John A. Kitzhaber, MD, Governor

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February 5, 2014

The Honorable Richard Devlin, Co-Chair
The Honorable Peter Buckley, Co-Chair
Joint Committee on Ways and Means
900 Court Street NE
H-178 State Capitol
Salem, OR 97301-4048

Dear Co-Chairpersons:

On behalf of the members of the Workgroup for Corrections Health Care Costs, I am pleased to provide you with the workgroup's report as directed by Senate Bill 843.

Correctional health care costs are of national concern. Oregon's intention is to remain at the forefront of those states that look to evidence-based practices in an effort to provide high-quality, constitutionally-mandated health care with the least amount of economic impact to the taxpayers of Oregon.

The workgroup used a very short amount of time to first develop an understanding of the legal/constitutional background and mandates that apply to correctional health care in Oregon, and quickly moved on to become familiar with the current Oregon Department of Corrections system. Finally, the group worked to create recommendations included in this report for your review.

I would like to acknowledge the workgroup members' and content experts' dedication to adhering to the tight timelines, and for their genuine effort to work collaboratively and efficiently towards this important endeavor.

I am pleased to present this report to you.

Sincerely,

Colette S. Peters
Department of Corrections Director
Workgroup for Corrections Health Care Costs Chair

Workgroup on Corrections Health Care Costs

Report to the Interim Committee of the Legislative Assembly

February 5, 2014

Members

Director Colette S. Peters
Oregon Department of Corrections, Chair

Chief Financial Officer Kelly Ballas
Oregon Health Authority, Vice Chair

Senator Alan Bates
Appointed by the Senate President

Senator Jackie Winters
Appointed by the Senate President

Representative Kevin Cameron
Appointed by the Speaker of the Oregon House of Representatives

Representative Jennifer Williamson
Appointed by the Speaker of the Oregon House of Representatives

Director Fariborz Pakseresht
Oregon Youth Authority Member

Washington County Sheriff Patrick Garrett
Appointed by Governor Kitzhaber

Multnomah County Chief Deputy District Attorney Chuck Sparks
Appointed by Governor Kitzhaber

Oregon Criminal Defense Lawyers Association Board Member Celia Howes
Appointed by Governor Kitzhaber

Oregon Health and Science University Doctor Norwood Knight-Richardson
Appointed by Governor Kitzhaber

AOCE Labor Representative Carl Miller
Appointed by Governor Kitzhaber

AFSCME Labor Representative Mary Botkin
Appointed by Governor Kitzhaber

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Introduction

In 2013, the Legislature sponsored Senate Bill 843, which created a workgroup to address rising health care costs within the Oregon Department of Corrections. Under the direction of the Governor, the workgroup was tasked with recommending legislation to be introduced in the 2014 Session of the Legislative Assembly to establish appropriate mechanisms to significantly lower the health care costs of the Department of Corrections.

The Legislature's Charge to the Workgroup

The Legislature asked the workgroup to prioritize legislative concepts that:

- Produce the greatest value for the department's health care expenditures;
- Consolidate health care functions as appropriate; and
- May be integrated into other initiatives in this state to reduce health care costs.

The workgroup was represented by bipartisan membership from the House and Senate; the directors or designees of the Oregon Department of Corrections, the Oregon Health Authority, and the Oregon Youth Authority; as well as six members appointed by the Governor who have expertise in health care, health care costs, and corrections, including one member from a labor organization representing corrections officers, and one county sheriff.

This report outlines the efforts of the workgroup, identifies the parameters of health care within the prison system, presents findings, and includes recommendations for consideration.

The Workgroup's Process

Legal and Constitutional Background

The workgroup recognized the need to first understand the legal and constitutional boundaries of the health care cost issue. The workgroup turned to the Oregon Department of Justice General Counsel Jef Van Valkenburgh to describe state and federal constitutional mandates as well as both federal and state case law.

Of most worthy to note are the Eighth Amendment to the United States Constitution, and Article I, Section 16 of the Oregon Constitution:

> *"Excessive bail shall not be required, nor excessive fines imposed, nor cruel and unusual punishments inflicted."*
>
> *"Cruel and unusual punishments shall not be inflicted."*

In the early 1970s, the federal courts began to interpret and apply the Eighth Amendment to establish that the amendment require states to provide "*the minimal civilized measure of life's necessities*" which included medical care.

Also important to the workgroup was to understand applicable case law. General Counsel Van Valkenburgh shared key cases such as Estelle v. Gamble, 1976 ("*deliberate indifference to the serious medical needs of*

prisoners constitutes the unnecessary and wanton infliction of pain"), and Plata v. Brown, 2001 (*"deficiencies in prison medical care violated prisoners' Eight Amendment rights"*).

Both the constitutional mandates (Federal and State) as well as Case Law were used as guides and boundaries when considering remedies to the health care cost issue. Without the reversal of these legal truths, it is imperative that a cost solution hold these paramount.

National Perspective and Trends

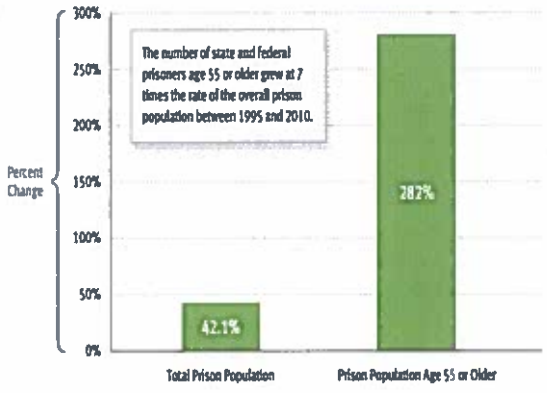
Throughout the nation, corrections agencies are struggling to manage health care costs while maintaining a level of care that meets legal requirements.

In 2011, the California Department of Corrections and Rehabilitation's health care system fell under federal receivership after demonstrating an inability to provide a legal standard of health care. This federal intervention resulted in millions of dollars in costs to reinforce, and in some regard rebuild, its health care system for prisoners.

A network of administrators across the country continually meet and strategize together to find cost-effective solutions to the prison's health care budget problems in the midst of declining budgets.

To compound the budget issue, nationally, prisoners are coming to prison unhealthy and in need of geriatric care. In addition, those prisoners who may not be considered "elderly" present medically at an average of ten years beyond their chronological age.[i] Between 1995 and 2010, the number of state and federal prisoners age 55 or older nearly quadrupled (increasing 282 percent). Oregon's population for this same age group increased by 330 percent (413 Adults in Custody in 1995 and 1,780 in 2010)[ii].

GROWTH IN STATE AND FEDERAL PRISON POPULATION, BY AGE, 1995-2010



Source: Bureau of Justice Statistics, Prisoner Series, 1995-2010
Note: Based on number of sentenced prisoners under jurisdiction of federal and state correctional authorities with sentences of more than one year.

Figure 1

Oregon's Experience

Currently, the Oregon Department of Corrections houses more than 14,600 adults in custody. Fourteen institutions across the state offer varying levels of health care, ranging from infirmary level to small medication rooms. Health care professionals such as medical doctors, psychiatric nurse practitioners, and dentists provide services at a rate of thousands of health care encounters per year. A combination of state employees and contracted providers deliver the health care program with a budget of approximately $200 million per biennium. This budget represents approximately 15 percent of the agency's total allocated funds.

When complex or hospital-level care is required, patients are transported to community hospitals and facilities under constant supervision.

The department uses a Third Party Administrator to deliver the following:

- Offsite medical bill processing
- Data storage and retrieval/reporting
- Offsite case management
- Discounted provider network

Many in Oregon's prisons suffer from chronic medical illnesses as well as mental illness.

The charts below display the number of patients suffering from major illnesses. The overall increase in the number of inmates diagnosed with severe medical conditions between 2006 and 2012 was significant (see figures #2 and #3 below). However, the rates of increase for the entire inmate population were generally modest, ranging from 0 to 4 percent, except for Cardiovascular Disease which increased 24 percent.

Special Health Care Need	Number of Patients Diagnosed					
	12/06	12/08	12/09	12/10	12/11	12/12
Hep C	1,402	1,793	1,735	1,651	1,742	1,804
HIV / AIDS	52	57	64	63	58	61
Diabetes	544	648	689	721	822	807
Respiratory	754	1,005	1,054	1,220	1,273	1,446
Cardiovascular	1,914	2,667	3,163	3,487	4,608	4,967

Figure 2

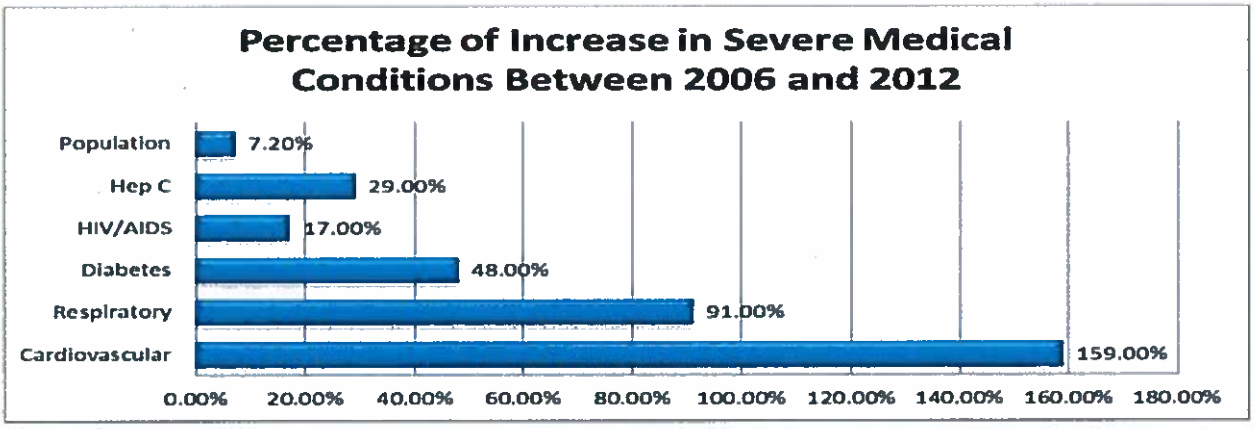


Figure 3

Inmates with Current Mental Health Diagnoses as of 10/21/2013

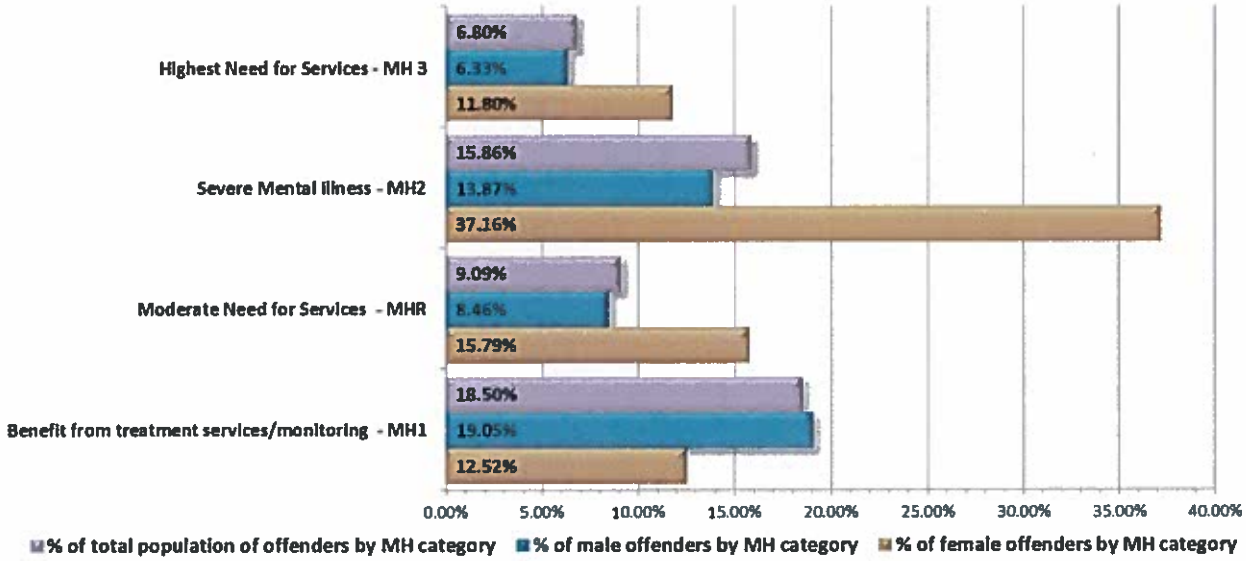


Figure 4

Workgroup Meetings

The workgroup began meeting in October of 2013. The public meeting format and rules were observed with all meetings recorded and made available publicly. All meeting presentations, materials, and recorded minutes are available on the Department of Corrections website at: http://www.oregon.gov/doc/Pages/corrections_HC_costs_WG.aspx

A summary of the four meetings held to date are provided as follows.

- **Meeting 1 - October 28, 2013 – Salem, Oregon**

  Agenda Items:

  Department of Corrections Health Care Presentation – An overview of the current structure of the Department's Health Care Program was delivered by Bill Hoefel, Health Services Administrator.

  Roles, responsibilities, and next steps – A detailing of roles and structure was provided by Chair Colette S. Peters.

- **Meeting 2 - November 18, 2013 - Salem, Oregon**

  Agenda Items:

  Responses to questions from the October 28th meeting were provided.

  The PEW Report on Correctional Health Care Costs was examined.

  Legal Framework was provided by DOJ General Counsel Jef Van Valkenburgh.

- **Meeting 3 - November 25, 2013 – Salem, Oregon**

  Agenda Items:

  Responses to questions from the November 18th meeting were provided.

  The Oregon Revised Statute for Early Parole Release for Severe Medical Conditions was reviewed.

  The DOC Medical Panel – Therapeutic Levels of Care – and Diagnosis and Treatment Definitions/Decisions were detailed by Health Services Administrator Bill Hoefel.

  The PEW Health Care Report/DOC's Response to expenditure data was provided by DOC Budget Manager Steve Robbins.

  Oregon State Penitentiary Minimum and Overview of Future Junction City Prison was provided by DOC Program Coordinator Doug Young.

  Recommendations received to date were reviewed.

- **Meeting 4 - December 9, 2013 – Salem, Oregon**

  Agenda Items:

  Responses to questions from past meetings were reviewed.

  Transition to Release Health Care Planning and Agency Connectivity was detailed by Don Ross, Oregon Health Authority.

- **Meeting 4 - December 9, 2013 – Salem, Oregon Cont.**

  Agency Legislative Recommendations for changes to current legislation (House Bill 2087) were discussed. Suspension of Medicaid benefits versus termination were determined to be essential.

  Recommendations and associated costs and committee approval to include Items in the Report were also reviewed.

  Next steps for the workgroup were determined to be: Final report reviewed via email and the Workgroup will reconvene in April of 2014 to review legislative actions based on the report.

Findings

Cost Avoidance in Other States

The workgroup sought out information, evidence, and data from other states in an effort to find best practices and to benefit from collective knowledge. Several states were contacted and in addition, the PEW report on Managing Prison Health Care Spending (released in October 2013) was used as a reference. From these sources, prevalent cost-saving ideas emerged, as follows. Note: ODOC had concerns with the PEW report with respect to Oregon per-inmate health care spending from 2001 to 2008. An internal analysis determined inaccurate data was provided to PEW. In addition ODOC had questions about data provided to PEW by the Bureau of Justice Labor and Statistics.

Use of Tele-Health

Correctional health care systems found televideo technology useful and cost efficient especially in the areas of mental health. Use of

health peripherals, such as blood pressure cuffs and ultrasound, furthers the use of telemedicine in the health care field. Cost avoidance spreads beyond the health care budgets and throughout the agency as security and transport resources are used less for the movement of patients.

Medicaid Financing

Many states are tapping into the resource of the Federal Financial Participation funds, which provide monies to state correctional agencies when inmates are admitted into qualified facilities as inpatients. Oregon begins use of the program in January 2014. Furthermore, the Affordable Care Act provides expanded coverage to individuals upon release from prison. The department has committed resources to coordinate benefits for adults in custody as part of the pre-release transition.

Early Parole Release of Geriatric or Medically Fragile

Like many states around the country, Oregon law provides for early release for those who meet the criteria provided in the law (ORS 144.126). Currently, few inmates qualify under this statute due to strict sentencing guidelines. Sentencing requirements are strictly *followed—as the law requires*—and have prohibited *some* releases.

Discounted Provider Networks for Offsite Care

As with public and commercial insurance policies, discounts on health services are available through contracts with health care networks. In addition to the contract strategy, some states around the country have written/prescribed specific discounts in law and penal code. Correctional health care budgets can be very negatively impacted by paying 100 percent of offsite providers and facility charges. Oregon's use of a Third Party Administrator, which includes access to a discounted provider network, has had a very positive effect on its health care budget.

Use of Third Party Administrators

Many states are recruiting the help of Third Party Administrators. The level of services and involvement vary but the reason for their use has a common theme: Correctional agencies are designed for a very specific mission – custody and rehabilitation. Health systems, with all their technicalities and specificities, are complex and vastly different from the prison industry. Correctional agencies simply do not have the staff, expertise, or resources to maintain themselves without the health industry's partnership.

Drug Formularies

Use of generics as a basic health care practice is recognized universally as a cost-savings strategy. Oregon's use of a formulary has resulted in a very positive budget impact. Regular review and adjustment of the formulary is conducted by medical providers in an effort to maintain current and effective formulary strategies.

Pharmacy Purchasing via Group Purchasing Organizations

Drug prices available through Group Purchasing Organizations such as the one Oregon uses – Minnesota Multistate Contracting Alliance for Pharmacy (MMCAP) – are significantly lower than retail. These discounted rates are only available to qualifying agencies such as state correctional systems.

Health Care Case Management

Case management as a concept is used in many fields including corrections. Health care case management is used to identify patients with complex and severe needs in an effort to manage and maintain the health and associated costs of patients. If patients are managed well, fewer medical interventions such as emergency room visits and hospitalizations will be needed, fewer

medications are needed, and better overall health outcomes can be achieved.

Use of Electronic Health Records Systems

Similar to case management, electronic health records systems allow closer, more careful management of patients. With electronic information, we can draw data more easily and better understand the health of our overall population. While the cost of electronic health records systems must be considered, the better health outcomes can pay dividends. In addition, resources devoted to the use and maintenance of paper records could be preserved for more productive work.

Ten-Year Forecast by Age

With geriatric care on the forefront of most correctional agencies budget concerns, the workgroup wanted a better understanding of what the future might hold in terms of the numbers in this population. [iii] (Note: the average deviation between the 10 year forecast and actual population is -7.8% over the past five years)

Age Distribution of DOC Inmates

Age Cohort	2/1/2013 ACTUAL	6/1/2023 FCST
Under 17	0.01%	0.01%
18-24	11.34%	7.63%
25-30	19.31%	17.40%
31-44	38.28%	35.24%
45-60	25.46%	31.44%
61+	5.60%	8.28%
Grand Total	100.00%	100.00%

Number of Inmates

Age Cohort	2/1/2013 ACTUAL	6/1/2023 FCST	Difference
Under 17	2	2	0
18-24	1,666	1,177	-489
25-30	2,838	2,684	-154
31-44	5,626	5,436	-190
45-60	3,741	4,850	1,109
61+	823	1,277	454
Grand Total	14,696	15,425	729

Figure 5

Recommendations and Next Steps

The workgroup presents the following recommendations along with a suggestion to extend the work of the group until March 2014. This follow-up/extension period allows the group to review the legislative actions based on this report and also provides an opportunity for implementation as well as review and adjustment as necessary.

- **Electronic Health Records that best fit the needs of the department**

  The department is currently working towards this recommendation. A project manager will be identified in 2014 and estimates of electronic health records as a leased service have been obtained. Initial estimates provided are $2 million per biennium, not including start-up costs.

- **Nutritional review of food and associated costs**

  The department can use its own resources for this review and no legislative action is necessary. A determination of health costs avoided because of this change would include establishing a baseline of current health care costs and review and analysis of costs in the future.

- **Explore providing healthier food options through commissary and associated impacts to health care as well as the safety and security of prisons**

  This recommendation could be accomplished with current resources and requires no legislative action. If commissary was limited, there is a potential impact to the safety and security of prisons, which can also have a budget impact.

- **Track and measure health care coverage upon release**

  The department is currently engaged in this process and will continue to manage it with existing resources in partnership with Oregon Health Authority. No legislative action is necessary

- **Early mental health intervention to prevent incarceration including mental health courts for both DOC and OYA populations**

  This recommendation would require additional resources in the community and beyond. Legislative action may be necessary to enact mental health courts for both DOC and Oregon Youth Authority (OYA) populations. The cost to implement is undetermined at this time, as well as cost avoidance.

- **Proposed legislation to prohibit insurance companies from terminating insurance coverage while incarcerated in both state prison and county jails**

  This recommendation would require legislative action. The workgroup also recommends that this legislation include counties as well as state facilities. Cost avoidance to be determined. Variables would include a current analysis of the number of adults in custody entering the system with insurance coverage and a statistically significant sample of health care costs of a similar population in terms of health, age, and condition.

- **Ongoing analysis for possible Early Parole Release restructure by this workgroup**

  This recommendation could be accomplished with existing resources and would require no legislative action.

  Cost avoidance to be determined. Considerations include restructure of Early Parole Release Statute. Variables include numbers/volume of adults in

custody with the potential to release and associated costs.

Workgroup recommends further study and discussion commence in April of 2014 by this workgroup.

- **Prison-to-community connection for all aspects of health care**

  This recommendation would require additional resources and may require legislative action. Cost avoidance and costs to implement to be determined. Variables include cost of staff to assist adults in custody in transition before, during, and after incarceration.

- **Legislatively mandated exercise programs**

  This recommendation would require additional resources and would require legislative action upfront. Costs are to be determined. Variables would include cost of staff to run programs as well as development of program.

  A 2010 study in the Journal of Health Affairs showed that every dollar spent on wellness programs reduced corporate medical costs by $3.27.

  An August survey by the National Business Group on Health found that 61 percent of firms found wellness initiatives to be one of the three most effective tools to keep down health care costs.

  A 2010 study in the American Journal of Health Promotion showed that workers highly engaged in a wellness program have fewer hospital admissions, shorter hospital stays and lower overall costs.

- **Create a Case Management Program with Health Classifications and Clinical Guidelines**

  This recommendation can be accomplished with the department's resources and may require additional staff. No legislative action is necessary.

- **Legislative remedies for HB 2087 to enable suspension vs. termination of Medicaid eligibility**

  This recommendation requires legislative action that the Oregon Health Authority is currently engaged in with the department's cooperation.

- **Health Incentive Programs for Adults in Custody**

  This recommendation may require additional resources and legislative action. Incentive programs similar to the State's Health Engagement Model could be implemented.

[i] Old Behind Bars, The Aging Prison Population in the United States, Human Rights Watch
[ii] Oregon Department of Corrections Research
[iii] Department of Administration, Office of Economic Analysis