MINUTES
CORRECTIONAL MANAGED HEALTH CARE COMMITTEE
February 8, 2010

Chairperson: James D. Griffin, M.D.

CMHCC Members Present: Ben G. Raimer, M.D., Gerard Evenwel, Lannette Linthicum, M.D, Bryan Collier

CMHCC Members Absent: Elmo Cavin, Desmar Walkes, M.D., William Elger, Cynthia Jumper, M.D.

Partner Agency Staff Present: Lauren Sheer, Ron Steffa, Robert Williams, M.D., Jerry McGinty, Rick Thaler, Bobby Lumpkin, Texas Department of Criminal Justice; April Zamora, TDCJ-TCOOMMI; David Nelson, Texas Board of Criminal Justice; Allen Hightower, David McNutt, Lynn Webb, Stephanie Harris, CMHCC Staff.

Others Present: Kyle Mitchell, Governor's Office; Susan Dow, Angela Isaack, John Newton, LBB; Frank Fletcher, J.Kevin Bice, Jeff Winter; Correctional Medical Services (CMS); Lois Kolkhorst, State Representative Dist. 13

Location: West Pickle Research Building, 3925 West Braker, The Hill Country Rm. 3.1004, Austin, Texas

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I. Call to Order - **James D. Griffin, M.D.**	Dr. Griffin called the CMHCC meeting to order at 10:00 a.m. then noted the meeting would be conducted in accordance with Chapter 551 of the Texas Government Code, the Open Meetings Act.		
II. Recognitions and Introductions - **James D. Griffin, M.D.**	Dr. Griffin asked that the Correctional Managed Health Care Committee members, J. David Nelson, Texas Board of Criminal Justice, the university providers, the LBB staff and Governor's Office staff introduce themselves.		
III. Public Testimony on - **HB4586 Section (16b.)** - **Legislature** - **James D. Griffin, M.D.**	Dr. Griffin then noted that there was one party registered to present testimony before the Correctional Managed Health Care Committee.	Mr. David Nelson asked if the testimony was being recorded and if the testimony would be in writing. Dr. Griffin responded that it was being recorded.	
- **Correctional Medical** - **Services** - **Jeff Winter**	Mr. Jeff Winter with Correctional Medical Services if you would step forward and make your presentation. Mr. Jeff Winter thanked the committee for the opportunity to be here today. I am Jeff Winter and the Vice President, New Business Development for Correctional Medical Services. And with me here today		
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- **HB4586 Section (16b.)** - **Legislature (cont.)**	is Kevin Bice. Kevin is our area Vice President, Operations and runs half of the United States for CMS. And Frank Fletcher is our Senior Director, Business Development. I am going to give you an overview on the industry as well as CMS and a brief company history on CMS. We are going to talk about the mechanisms to lower costs and or increase quality in the industry and then have questions. As we look at the industry on page 3 and see the industry as a whole. There are 19 whole states that have converted in the market. There is another 5 that are associated with teaching hospitals and there 8 sites/services that are partially converted which gives you 32 states that are fully or partially outsourced and leaving 18 states that are still self-operated mainly on the west coast. On page 4 gives you an idea of CMS's presence across the United States. We are currently in 11 states system. So we are the largest provider of prison healthcare in the United States. Those are identified by the blue states on the map. And we are also present in the taupe brown area, that's either where it involves a jail business in those states and significant jail business which I'll call some of the mega jails as well as in Texas that we should have marked. We recently entered back into Galveston six months ago. Also, the states marked green is where we have state pharmacy business. CMS has three business lines; one is a fully encompassed in the medical portion which is dental and mental health. We have another division which is Pharmacorr which serves the pharmacy side of the equation which are the two states listed on the map Oklahoma and recently awarded the Louisiana correctional facility. In the orange category is our substance abuse division which is utilized Wisconsin. We are the largest provider of prison healthcare and have more than doubled than any other competitor in the market right now with revenues in excess of $800 million. CMS serves healthcare to 275,000 inmates, 215,000 pharmaceutical inmates at any given time and we operate in 336 facilities in 32 separate contracts across the United States.		
III. Public Testimony on	Go to the next page and by the way we are based out of		

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- **HB4586 Section (16b.)** - **Legislature (cont.)** - **Kevin Bice** **III. Public Testimony on**	St Louis, Missouri. Just to give you a feel of our experience in the market, we've been in this market 30 years. Our sole purpose is correctional healthcare. That's all we do. We have a full service provider with in-house pharmacy and behavioral health services. Our management team is well trained; we have in excess of 20 years of experience in healthcare/correctional experience in our executive management team. Last if you look at our staffing ratios which are always problematic because most prisons in the United States are found in rural America. We maintain staffing levels greater than 95% in all of our contracts. I would like to hand it over to Kevin Bice, and let Kevin talk about cost containment strategies and how we deliver better healthcare outcomes. Kevin Bice then reported on how CMS outlines their healthcare model from the perspective of Cost Containment Strategies. We have four areas I want to talk about today which include utilization management, focus on clinical outcomes, our business intelligence/best practices and our enhance onsite services/staffing. So if you look at our utilization management our model is basically built on inner fault criteria. Plus evidence based on medicine, different criteria protocol as delivered for that method. The combination of the criteria and the medical knowledge comes up most cost effective and quality driven treatment plans that are available for the treatment of these states. Our focus on clinical outcomes in business intelligence comes together. It's all based on the fact that all of us in healthcare collect a lot of data. At CMS we have internalized and built out a very robust sophisticated data warehouse with a reporting tool or data mining capability called Ingauge. We use our health economics group to mind the data to work with our operations and clinical teams to really predict where our potential high case cost patients may begin to emerge in a particular population, so we can really get on the front side and begin wellness programs in that population. The next advantage we have within our data is our ability		

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- **HB4586 Section (16b.)** - **Legislature (cont.)**	to benchmark. Because we operate 11 statewide systems we do a lot of benchmarking practices to stimulate the competition the knowledge shared within our organization. To develop best practices on treating whether its high case cost or different type of cases that presents it to be very difficult. Our area on enhanced onsite services and staffing are really enhanced to a CQI process that most of you in healthcare understand. We have a very robust CQI program at CMS. We also accentuate our CQI program with a new methodology that we're subscribing to business process management. For those of you who are familiar sick sigma lean practices, we are starting to deploy that methodology into our capabilities to enhance onsite services by deficiencies and improvement of quality within our system. We also deploy specialty clinics depending on the patient population within a particular prison setting. Based on the needs of the population a lot of times we will develop specialty clinics over health solutions to really focus on specific these states may be driving a lot of the cost, a lot of the offsite transports and things of that nature. And lastly we leverage the infirmaries. The infirmary model that we utilize really helps us attack admissions and length of stay, which as you know is a very costly driver in the healthcare system in corrections. We did look at CMHCC's fourth quarter report on costs and did a high level comparison and did observe about a 15% lower offsite cost that CMS experiences in our 11 statewide systems versus the data that this group reported in the fourth quarter of 2009. And we can certainly share that comparison if that's a benefit to the group. On page 7 delivering better health outcomes, is the result of our strategy on cost containment. The documentation health improvement through complex case management is really the data warehousing and our reporting capabilities not only internally but externally. We utilize our data capabilities to energize and share information. Develop the best practices with our medical team		
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- **HB4586 Section (16b.)** - **Legislature (cont.)**	internally but we also realize it's a collaborative effort with our clients. We share and mind this data and collaborate with our clients through 40 processes so that our medical staff operations team is on the same page with our clients. Second, is the superior care and reduced cost for diabetes, and I would like to add hypertension, asthma, Hep C and HIV to name a few areas of our chronic care clinics. We subscribe heavily to Chronic Care. We're very preventative wellness based. We're constantly looking at the data and potential cases that are going to emerge, that are going to be very costly to ourselves and to our clients in the future. Third we talk about suicide rates. The national average within corrections suicide rates is 16 per 100,000 inmates per year. At CMS and our Genesis Division, which is our behavioral health group, we are currently at 9.5 suicides per 100,000 inmates per year. Our cost of our entire bulk of business. That's basically the outcome of Genesis a division within our company with psychiatrists, psychologists, behavioral health individuals specializing for many years in corrections healthcare. They understand the nuances of challenges. And has developed a protocol of standards that all of our sites practice. Fourth we have prescription fills that are 99.98% accuracy. That's driven from our Pharmacorr division. Pharmacoor has two locations, one in Oklahoma City and one in Indianapolis. For those of you that are familiar with mail order, it's a centralized automated distribution model of medications flow in and flow out with a 24 hr. turnaround to our sites. But also our whole methodology that we've developed around business process management, lean processes. The medication administration process on sites is very cumbersome and very labor intensive. We've devoted a lot of resources to really figure this out on our behalf and our client's behalf. So, it's not only the delivery of medication but it's a group process from the filling of the prescriptions to the administration of the prescriptions to the patients.		
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- **HB4586 Section (16b.)** - **Legislature (cont.)**	And last we've achieved favorable clinical outcomes, we benchmarked against Medicare, Medicaid and HEDIS studies. Some of our clients required HEDIS studies to measure the quality. So we participated, we helped organize on behalf of our clients as well as our own personal needs to really measure the quality of outcome. So with that being said, that's a five minute discussion about our processes to deliver cost containment and quality. I would like to turn it over to Frank Fletcher, who is going to discuss our recommendations for the group's consideration.		
- **Frank Fletcher**	I have been asked to conduct a study to look at can cost be reduced, how can cost be reduced, how can quality be improved, so how do you do that? So, our recommendation for how to do that is to conduct a pilot study where you would look at out sourcing a portion of your system to an organization such as CMS and obviously you would go through your standard procurement process however you would do that to obtain contracts. And in our recommendation we have included some parameters in terms of what that pilot project might look like. The first suggestion is that it be over a 2 year period. That would really give you enough time to evaluate it, to look at cost, to look at quality, to compare that to the rest of your system. It would give the contractor an opportunity to get the systems in place, get efficiencies in place then you can really evaluate whether or not their worth efficiencies in cost and or improve in quality. We need to include a representative sample of your overall population. Obviously you wouldn't put all the high acuity patients in the study or the low acuity patients in the study. So, it would reflective of your overall population in terms of facility missions, age/gender mix, mental health, and our suggestions that it would include approximately 15% of your population. Again, a big enough sample size to really be able to evaluate the efficiency, cost effectiveness, and the overall quality of care.		

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	I think TDCJ is operating in six operating regions if you will. Divided into six operating regions for purposes of how you manage your security business and the rest of your day to day business maybe not necessarily health care but the rest of your business. So, our thought is to take one those geographic regions of the state and to consider the pilot project and consider out sourcing in one of the six geographic regions of the state approximately 15% or so, depending on which region you would select. Why the pilot if you look on the next page. The first thing is obviously it would introduce competition into your existing model. I've think you've been operating under the current system for the past 10 or 15 years. I'm not aware of any in any way of any competition really that's has been introduced into the model during that time. So, we believe competition is good, we believe like introducing some competition into the model. You're automatically going to get some efficiency; you're going to get some innovations as a result of just introducing that competition. That could come from an outside organization, thru the pilot project or thru a contracting entity. It might come from within your existing system. I believe if you introduce competition that UTMB and Texas Tech would step up their game a notch if you will, just because of the result of the competition, it's just human nature. I think you'll see efficiencies and innovations introduced into your system whether or not you ultimately enter into a contract just by introducing a competition into the model. Financial risk assumed by a contractor. Most of our contracts are on a full risk capitated basis. So, that you will know exactly what your cost will be up front. Certainly we have contracts that are fixed over a two year period with some kind of an inflator to be built in within the second year. So, you could actually fix your cost thru the entire two year pilot project. Again for the pilot itself. You'll know exactly what your cost is going to be. Really achieved budget certainty within the pilot project. If there are cost overruns that occur in the pilot, it would be the responsibility of the contractor, they would not be		

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	the responsibility of the state and the taxpayers. We also think that by introducing a pilot in the geographic area of the state, it could potentially provide some relief to Galveston and the services that are provided there currently. Our thought is to go to more a community based model where we would use community providers to provide services that can't be provided within the institutions themselves. We think they are providers through out the state that are interested in this business that are hungry for this business, that want this business and we would be able to negotiate very favorable rates with those providers. We think there is interest in providers to secure wards within some of those community hospital providers. So, it would relieve some of the pressure off Galveston a little bit I think. And it would also obviously the hurricane was devastating and I think things have gotten up to speed for the most part. With some catch up still to do there. But going to this type of model that also introduces kind of a back up plan if you will. In the event anything like that should happen again. Or some type of other similar emergency should happen again, you would have another system in place that you could use as a back up in the event of an emergency. We also think ultimately that's going to reduce your transportation costs, because obviously you wouldn't have to transport them as far potentially as you are now. Depending on the region that you might select for the purposes of the pilot. The bottom line is if you would go through this process, if would you select a geographic region of the state for the pilot, then you would go thru procurement for that. And if you ultimately don't realize savings thru the pilot project, you've satisfied yourselves that the system you have is the most sufficient, you've satisfied the requirement of the study, you've satisfied the legislature, and the taxpayers that the system that you have is in fact the most efficient system that there is out there, then ultimately you don't enter into a contract. So, if you don't generate the savings, then you don't enter into a contract and you don't owe anything for the pilot. We	Dr. Griffin would like to see if any of the committee members have any questions. And he would like to recognize Dr. Raimer and Representative Kolkhurst for coming to this meeting. David McNutt also pointed out that some members of the LBB, Susan Dow, Angela	

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	believe there is opportunity for savings and we would love the opportunity to demonstrate that to you. We're available for questions.	Isaack and John Newton were in attendance. Dr. Griffin asked about staffing being at a 95% level. And certainly if we look at those individual skill providers through out a number of different types of healthcare delivery systems whether it is a private entity or a university base practice or if it's a correctional practice that having those skilled providers in certain areas is a challenge and has been and it seems like you all have some type of solution or at least a strategy or methodology. Can you address that personnel type of procurement and how you maintain those staffing levels? Mr. Winter responded that one of the benefits of CMS is that we are a national provider. And based on that we are able to reach all over the United States for staff. The ability to do that we found, not that rural locations where prisons are, are always problematic. Frank Fletcher adds that they also do a lot of training and orientation with their staff. It's about finding them obviously but it's also about keeping them. It's about finding the right kind of person that's going to be successful in the environment in which we work and then training them properly. I think we have a tendency certainly in corrections healthcare in general, definitely in corrections to kind of let people learn on the job. We work very hard to orientate our folks, train them properly, and use a mentor system, a buddy system if you will so they are working with somebody until they are fully prepared. Until they think they're fully prepared or until we think they're fully prepared to go on the block and pass out medications every day. I think that's important on retaining your staff on a long term basis. Mr. David Nelson asked about what the average cost for offender per day in Texas.	

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		Frank Fletcher responded that they were not prepared to give a figure as it relates to our systems today. We certainly don't know enough about your system to really be able to do that today. Would be happy to provide that figure at a later time. Every system is different. Our costs are significantly different from contract to contract. Our former CEO used to say, you've seen one prison, and you've seen one prison. Because they are all different and every system is different. Our cost is significantly different from contract to contract. Mr. Nelson asked about Galveston. Frank Fletcher answered that they had a contract with Galveston for 10 years prior to about 2 ½ years ago and another contractor was in there for about a couple of years. We were just awarded a contract starting in September of last year. I don't know off the top of my head what the cost of that contract is. Jeff Winter and Frank Fletcher added that in general it is more when we go into self operating systems, self managed systems, where we generate savings of a net worth of 10-15%. And what Kevin talked about when we looked at our 4th quarter financial report, we did identify where we thought there was an opportunity for savings. Again, just based on what our cost are in other contracts. We don't know enough about your system to really be able to tell you what savings are going to be generated in your system. Mr. Nelson asked if they had a contract with Galveston. Jeff Winter responded yes, we do. Mr. Nelson asked does the contract refer to	

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		offender cost per day or are you at grandeur to talk about that. Jeff Winter answered yes you can derive the cost out of that contract. More discussions from the CMS staff. It's a fixed price contract actually based on population. Question was asked by Dr. Linthicum. Jeff Winter and Frank Fletcher responded with the one thing about that he would say in addition to what was talked about multiple contracts within states. We also have a number of states that they operate in where different service components have been broken out into different contracts. For example, we might for mental services contract on a statewide basis in .which we are. They are on a separate mental health component contract on a statewide basis, there is also a separate dental contract on a statewide basis, and there is also a separate pharmacy contract on a statewide basis. That's not unusual really for states to operate with different contracts for different service components with different providers. So, we're very confident to work with those kinds of systems and working with multiple vendors of different services. It's a little bit different, but not really too much different I think than what you're talking about in terms of working with different providers. Additional discussions. Dr. Griffin noted that the crossroads with medical delivery lines, you know like psychiatrists. Do you think those savings are consistent or have you all found a specific one that may have more advantages in terms of say Texas realizing more cost savings in prosthetics with you all versus dental services versus you	

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		say you have substance abuse specific expertise in certain areas. Jeff Winter answered as they look at individual states, you would think there would be more standard debation across the United States. It's about team work for us. How do you collaborate with a common rule to solve your problems at the end of the day. How do we permit the reentry cycle or what do we do to be more effective, which could be a number of different areas. I hate to be vague on that. Dr. Griffin answered with Texas is large and diverse and we see it across our system as well. I think in your handout, you have 48 by Michigan and that system is a littler bit smaller than a third, 51,000 inmates or so and we're certainly way over 160,000. So that is the largest that you get to and it's very difficult to get a feel for those types of differences and are there micro service lines that may be more beneficial to the state for you all to give us a proposal on. Is there any specific one that you have considered or you just need to talk to our staff? We encourage you to do that to see if there is a specific area of service that you might be able to provide. Dr. Raimer stated that his interest has been since we have a unique form of sentencing here we expect our offenders serve their sentence and we have a really large population. In your acuity will you adjust for that? We all recognize that jail healthcare and prison healthcare are two different things. Costs associated with those have attempted to deliver both in your survey and cost model on different issues. Jails typically want to get people in and out. In our prison times, a few chronically ill, those that we ship off to prisons need psychiatric processing. Will you be able to look in this 15% population and will you be able to do a forecast with about 2,400 HIV positive patients, etc.	

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		2,400 HIV positive patients, etc. Additional discussions were had. Dr. Griffin thanked the CMS group for coming down. It was refreshing to hear that you can't segregate your business because it's hard to beat 340B federal, 340B pricing on pharmacy. That is extremely difficult for private entity to save Texas there. And we are fortunate to have that. Hopefully it will exist with all the changes in Washington. But, thank you and is there any other questions. I don't think we have anybody else registered to give testimony.	
IV. Adjourn **- Dr. Griffin**	Dr. Griffin asked if anybody else wished to register to give public testimony. Hearing none, meeting is adjourned. Thank you for your attendance.		

James D. Griffin, M.D., Chairman
Correctional Managed Health Care Committee

Date: 6/8/10