Approved: ____________________
Date February 26, 2002

MINUTES OF THE HOUSE COMMITTEE ON HEALTH AND HUMAN SERVICES.

The meeting was called to order by Chairperson Garry Boston at 1:30 p.m. on February 14, 2002 in Room 210 Memorial Hall

All members were present except: Representative Nancy Kirk, Excused

Committee staff present: Dr. Bill Wolff, Kansas Legislative Research Department
Norman Furse, Revisor of Statute's Office
Renea Jefferies, Revisor of Statute's Office
June Evans, Secretary

Conferees appearing before the committee: Charles Simmons, Secretary of Corrections
Roger Hayden, Deputy Secretary of Corrections
Jesse P. Hubling, Regional Vice President, Prison Health Services, Inc.
James R. Baker, M.D., Rp.H. Kansas Regional Medical Director, Prison Health Services, Inc.

Others attending: See Attached Sheet

The Chairman stated the Department of Corrections are appearing today at our request and we appreciate that opportunity. This is different as we do not have a bill. This is not a witch hunt, but this is to gather information to see what needs to be done regarding health care and costs.

The following items were distributed: (1) a response from Secretary Schalansky responding to questions asked at our January 28th meeting (Attachment #1) and (2) information from Sharon Huffman, Legislative Liaison, Kansas Commission on Disability Concerns regarding Assistance Animals (Attachment #2).

The reason for our meeting today is an explanation of the Department of Correction's prison health care. Secretary Chuck Simmons is in the audience, also Jesse Hubling that represents the Prison Health Services and Dr. James Baker and Roger Haden is going to give the presentation. This is the first of four presentations that we have scheduled. There will be a similar response from SRS, Department on Aging, and the Health Care Commission. This is just looking at the methodology, programs, depth of coverage, costs and any icebergs we might be running into in the future because of the aging of not only this population but also as it affects these other departments. We are trying to be pro-active and make sure if there is something out there that the appropriations committee needs to be aware of, that we get a handle on it and give them a little bit of a heads up because this is an appropriate process is more than just adding numbers in columns but we have to be aware of what is coming up in the future. This is certainly not a witch hunt, but want the members to be comfortable in asking any type of questions and believe we will all end up much wiser.

Roger Haden, Deputy Secretary of Corrections, stated by statute and court rulings it is a well-established principle that the State is obligated to provide access to adequate and necessary health care to the persons housed within its correctional facilities (K.S.A. 75-5201; 75-5210 ©)).

Since 1988, the Department of Corrections has provided for inmate health care through contracts with qualified health care providers developed pursuant to the state's negotiated procurement process. The current contractor is the Prison Health Services (PHS) a subsidiary of America Service Group (ASG). The current contract term began July1, 1999 and will expire June 30, 2005. The contractor accepts full liability and provides full indemnification to state. The contract provides for full coverage, comprehensive health care services, including medical, dental, optical, mental health care and prescription drugs, for the inmate population. Generally the contract is consistent with Managed Care approaches to health care. The inmates pay

Unless specifically noted, the individual remarks recorded herein have not been transcribed verbatim. Individual remarks as reported herein have not been submitted to the individuals appearing before the committee for editing or corrections.

$2.00 co-pay for initial sick call visits.

Recent trends has been health care costs for inmates have been increasing and are expected to continue to do so. Inmates are generally less healthy than the general public, often have issues with poor nutrition, substance use effects, high risk sexual and drug lifestyles, more mental health issues, and greater acuity in both physical and mental health issues. Treatment of inmates with infectious diseases has increased by over 125% (includes HIV, Hep C. Et.al.) TB patients have decreased by 14%. The number of inmates 55 years of age or older being seen in clinics has increased by 25%. The number of inmates aged 55 and older has increased 134% in the past 10 years; the number of inmates over age 70 has increased 207% (Attachment #3).

The Chairman stated this is cadillac coverage and maybe at a cadillac cost. Other states structure their coverage on medicaid. What is adequate coverage? The prisoners are receiving cadillac coverage.

Assistant Secretary Haden said they are required to not ignore problems. Inmates come into prison with needs. There are some with infectious diseases: hepatitis C costs $12,000 per year and is not curable. Few are diagnosed early.

It was asked what hepatitis C is contributed to?

Mr. Haden replied it is lifestyle.

It was asked what coverage is adequate? It is wrong that convicted felons get better health care than persons paying for coverage.

Representative Palmer requested more information on minimum benefits state needs to provide and what other states are providing.

Secretary Simmons said if care isn't given they can go to court interpreted in the 8th Amendment. Other states are doing the same thing we are doing. All are having the same issues of costs contracting out best deal we ever made. Have not had any problems since we have contracted out the insurance.

Representative Palmer asked if the court had been challenged.

Secretary Simmons said the courts make the decision. We are providing the minimum coverage now. When inmates are taken into custody the Department of Corrections is responsible for their well-being. Contracting out is the best decision we ever made. We have not had any problems since contracting out.

Representative Palmer asked if they had considered a higher co-pay? In Medicaid it has shown if there is a higher co-pay, people don't go to the doctor as much.

Secretary Simmons replied, no, the inmates don't get that much money and it comes from their money they make. Some states do charge a $3, $4 or $5 co-pay.

It was asked if services are offset and Mr. Simmons replied services for hospitals and doctors are competitive. Services are discounted by not as low as medicaid. They are between the highest charge and medicaid. Some don't get any discount.

Representative Merrick asked what the percentage of smokers were? How much do you charge for cigarettes?

Mr. Simmons replied, well over one-half are smokers. Cigarettes are the same price as outside

Representative Merrick said then co-pay is no issue.

The Chairperson thanked the Department of Corrections for coming and presenting information to the Committee.

The Chairperson said if the members had more questions to present them to the secretary and they would be sent to the Department of Corrections.

The meeting adjourned at 3:10 p.m. and the next meeting will be February 18.

HEALTH AND HUMAN SERVICES

DATE February 14, 2001

NAME	REPRESENTING
[illegible]	Rep Burton
~~Carolyn Middendorf~~	~~Ks St Nurses Assn~~
James Baker MD	Prison Health Services
Jesse Hobley	Prison Health Services
Roger Haden	KDOC
Bud Burke	Prison Health Service
Michael T. West	1-800-CONTACTS
Florence Perry	KDOC
S D Vandyhorst	KDOC
G Goehring	KDOC
Rosalie Ann Bower	KAAP
Mary Ellen Conlee	Via Christi
Jennifer Orth	Conlee Consulting, Inc.

BILL GRAVES, GOVERNOR OF THE STATE OF KANSAS

KANSAS DEPARTMENT OF SOCIAL
AND REHABILITATION SERVICES

915 SW HARRISON STREET, TOPEKA, KANSAS 66612

JANET SCHALANSKY, SECRETARY

February 12, 2002

The Honorable Garry Boston, Chair
House Committee on Health and Human Services
Room 156-E. Statehouse
Topeka, Kansas 66612

Dear Representative Boston:

This information is being provided in response to questions that were raised during the SRS agency overview before your committee on January 28. We have also received your request for information dated February 5, and are scheduled to provide testimony in response on February 25.

Have comparisons been done of our expenditures for child welfare service since privatization to what we had before?

Please see Attachment A for this information. We've also attached an information sheet that outlines the enhanced services in the new system.

What is the average cost of the births that are paid by Medicaid?

Current rates for normal births and deliveries are as follows:

Hospital stay for the mother	$1,929 (this varies slightly by hospital)
Hospital stay for the baby	635 (this varies slightly by hospital)
Physician Services	1,327
Total standard payment	$3,911

These amounts assume the newborn is normal and the delivery is vaginal. The amount shown for the physician includes all routine obstetric care, including pre- and post-partum care and normal delivery.

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What is the average cost of prenatal care?

Most prenatal care is paid as part of a package of services to the physician. The payment to the physician would include all routine obstetric care including prenatal care, vaginal delivery, and postpartum care. This encourages the physician to see the patient throughout the pregnancy to ensure better birth outcomes. This also simplifies the billing for the physician. However, the result is less information available on the actual costs of prenatal care.
There are additional, distinct procedure codes for prenatal care, but they are used less frequently than the package of services described above. For instance, if prenatal care only is billed, the reimbursement is $192 for 4 to 6 visits and $425 for 7 or more visits. If fewer than 4 visits occur, office visit codes would be billed. There are several possible procedures that could be billed as well.

In addition, several distinct tests might be billed. These would include such things as amniocentesis, chorionic villus sampling, fetal non-stress tests, and fetal monitoring, at prices ranging from $13.84 to $150. During FY 2001, the fetal non-stress test was billed for about half of all deliveries, at $32, and the other codes were used much less frequently.

Please explain the increases in costs from FY 2001 to the 2003 Governor's Budget Recommendation.

Detailed information about those cost increases is provided in testimony the Department provided recently regarding consensus caseload estimates (see Attachment B).

When a child goes into foster care, how much does SRS pay the contractor? How much of that is federal funds?

The average cost for a child served by the foster care contracts is $2,305 per child, per month. We do not receive a set percentage of federal match for foster care, as is the case in many programs. The amount of federal funding we can claim depends on the array of services provided to each child. Our historical experience for FY 2001 was that on average, 54.8 percent, or $1,263 of the per child, per month amount, was covered by federal funding, from four sources: IV-B and IV-E (foster care funds), Medicaid, and TANF.

What are the estimated increases in waiting lists for the PD and DD waiver at the Governor's Green Book Budget (existing resources) level of funding?

At the existing resources level of funding, we estimate that the service access management list for the developmental disability (DD) waiver will increase from 430 individuals at the end of FY 2002 to 680 individuals at the end of FY 2003. The service access management list for the physically disabled (PD) waiver is expected to grow from 325 to 682 individuals during that same time frame.

Have federal funding formulas changed in such a way that Kansas is disadvantaged because it of its rural nature?

In general, no. The federal funding formula that has the greatest effect on Kansas is the one for the Medicaid program. This formula is described in the Federal Funds Information for States Issue Brief that is provided in Attachment C. The primary factor involved in this formula is per capita income.

What are the reasons children are removed from their homes?

During FY 2001, the primary reasons for removing children from their homes were as follows:

Reason for Removal	Number of Children Removed	Percent of Children Removed
Physical Abuse	1,494	19.0%
Neglect	2,257	28.6%
Sexual Abuse	432	5.5%
Abandonment	314	4.0%
Parent's Substance Abuse	318	4.0%
Child's Behavior	1,615	20.5%
Other *	*1,449	*18.4%
Total	7,879	

Source: FACTS data system

*Other includes parent's incarceration, caretaker's inability or disability to care for the child, child's alcohol or drug abuse, death of a parent, inadequate housing, and relinquishment.

The FACTS data system records one reason for removal for each episode a child is placed outside the home while in SRS custody. The reason for removal may not reflect all risk factors associated with a child's removal into foster care. For the 7,499 children who experienced out-of-home placement, FACTS reflects 7,879 reasons for removal, indicating some children had more than one removal episode recorded in FY 2001.

I hope this information is helpful to you. If you need any additional clarification or have follow-up questions, please let me know.

Sincerely,

Janet Schalansky, Secretary
Department of Social and Rehabilitation Services

attachments (3)
cc: committee members
Bill Wolff, KLRD
Norman Furse, Revisor of Statutes Office

Attachment A

Social & Rehabilitation Services
Children and Family Services
Analysis of Expenditures for Foster Care & Adoption: Pre and Post Privatization

Several changes have been made which makes it difficult to compare expenditures pre-privitization and post-privitization. This chart details the adjustments made to allow a comparison. Expenditures for adoption are included in foster care for FY 1996. Additional expenditures that were shifted into the Foster Care & Adoption categories are show as additions in FY 1996. Expenditures for services that were transferred to other agencies are shown as deletions in FY 1996.

Category	Adjustments for Program Shifts/Transfers	FY 1995 Actual	FY 1996 Actual	FY 1997 Actual	FY 1998 Actual	FY 1999 Actual	FY 2000 Actual
Foster Care *		64,317,031	63,592,540	72,857,897	83,517,298	118,805,745	87,553,737
	Privatization Adjustment	0	0	(15,000,000)	0	0	0
	Mental Health/Child Care Expenditures	0	0	(4,062,386)	(11,410,122)	(11,410,122)	(11,410,122)
	JJA Expenditures	0	0	0	8,574,117	8,574,117	8,574,117
	Risk Share Contract Expenditures	0	0	0	0	0	0
Total Adjusted Foster Care		***64,317,031***	***63,592,540***	***53,795,511***	***80,681,293***	***115,969,740***	***84,717,732***
Adoption *		0	0	7,068,807	9,899,778	25,708,098	21,876,347
	Mental Health/Child Care Expenditures	0	0	(358,463)	(541,629)	(541,629)	(541,629)
Total Adjusted Adoption		***0***	***0***	***6,710,344***	***9,358,149***	***25,166,469***	***21,334,718***
Adoption Support *		***4,942,737***	***6,574,124***	***8,143,025***	***10,617,402***	***13,537,066***	***15,960,346***
All Other *		61,694,176	59,917,977	57,995,891	20,970,369	22,744,360	43,178,027
	KDHE Licensing Expenditures	0	0	0	530,016	530,016	530,016
	Adult Protective Services Expenditures	0	0	2,117,193	2,181,484	2,181,484	2,181,484
	Long Term Care Expenditures	0	0	0	1,720,367	1,720,367	1,720,367
	JJA Expenditures	0	0	0	7,052,156	7,052,156	7,052,156
	Field Staff Transfer	0	0	0	29,990,605	29,990,605	29,990,605
Total Adjusted All Other		***61,694,176***	***59,917,977***	***60,113,084***	***62,444,997***	***64,218,988***	***84,652,655***
Total CFS		**130,953,944**	**130,084,641**	**128,761,964**	**163,101,841**	**218,892,263**	**206,665,451**

Summary		FY 1995	FY 1996	FY 1997	FY 1998	FY 1999	FY 2000
	Foster Care	64,317,031	63,592,540	53,795,511	80,681,293	115,969,740	84,717,732
	Adoption	0	0	6,710,344	9,358,149	25,166,469	21,334,718
	Adoption Support	4,942,737	6,574,124	8,143,025	10,617,402	13,537,066	15,960,346
	All Other	61,694,176	59,917,977	60,113,084	62,444,997	64,218,988	84,652,655
Total CFS		***130,953,944***	***130,084,641***	***128,761,964***	***163,101,841***	***218,892,263***	***206,665,451***

* Actual FY 95 - 00 expenditures per STARS, the State accounting system.

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Kansas Department of Social and Rehabilitation Services
Marilyn Jacobson, Assistant Secretary
Children and Family Policy

Child Welfare: Then and Now
February 12, 2002

1995 Children in foster care were often placed on waiting lists for services they need. Foster parents received $10.12 a day to care fo some of the most severely damaged children in our state, we were adopting about 250 children a year from our system, child welfare was available 8:00 a.m. to 5:00 p.m., and family preservation was available in 44 counties. Kansas did not have the resources to do thorough child protective investigations.

Today

- Since the first contract for family preservation began, we have measurable outcomes for safety, permanency and well-being.
- Child abuse/neglect substantiations went from 11 percent, well below the national average, to 33 percent then leveled off at 28 percent–30 percent more child protective services workers investigating.
- Family preservation is available 24/7 in all 105 counties; foster care and adoption workers are available to families 24/7.
- Foster families receive $18-20 a day up to $70 a day for some specialized therapeutic children.
- 85 percent of children in need of care are in family foster homes rather than group homes or institutions–67 percent just two years ago.
- Adoptions increased 78 percent during first four years of the contracts.
- The dissolution rate for adoptions in Kansas is 2.4 percent compared with 12 percent nationally.
- In Kansas, 92 percent of the children who enter foster care are entering for the first time; nationally 78 percent. Means Kansas - 8 percent are returning to the system; nationally - 22 percent.
- 70 percent of the children in foster care in Kansas are in their home or contiguous county.
- Increased timeliness for permanency.
- More children placed closer to home and with their siblings.
- Outcomes documented with data rather than anecdotes.

C:\MyFiles\WP\2002\Child welfare then & now.wpd

COMMONLY ASKED QUESTIONS ABOUT
SERVICE ANIMALS IN PLACES OF BUSINESS

1. Q: What are the laws that apply to my business?

A: Under the Americans with Disabilities Act (ADA), privately owned businesses that serve the public, such as restaurants, hotels, retail stores, taxicabs, theaters, concert halls, and sports facilities, are prohibited from discriminating against individuals with disabilities. The ADA requires these businesses to allow people with disabilities to bring their service animals onto business premises in whatever areas customers are generally allowed.

2. Q: What is a service animal?

A: The ADA defines a service animal as <u>any</u> guide dog, signal dog, or other animal individually trained to provide assistance to an individual with a disability. If they meet this definition, animals are considered service animals under the ADA regardless of whether they have been licensed or certified by a state or local government.

Service animals perform some of the functions and tasks that the individual with a disability cannot perform for him or herself. "Seeing eye dogs" are one type of service animal, used by some individuals who are blind. This is the type of service animal with which most people are familiar. But there are service animals that assist persons with other kinds of disabilities in their day-to-day activities. Some examples include:

_ Alerting persons with hearing impairments to sounds.

_ Pulling wheelchairs or carrying and picking up things for persons with mobility impairments.

_ Assisting persons with mobility impairments with balance.

A service animal is <u>not</u> a pet.

3. Q: How can I tell if an animal is really a service animal and not just a pet?

A: Some, but not all, service animals wear special collars and harnesses. Some, but not all, are licensed or certified and have identification papers. If you are not certain that an animal is a service animal, you may ask the person who has the animal if it is a service animal required because of a disability. However, an individual who is going to a restaurant or theater is not likely to be carrying documentation of his or her medical condition or disability. Therefore, such documentation generally may not be required as a condition for providing service to an individual accompanied by a service animal. Although a number of states have programs to certify service animals, you may not insist on proof of state certification before permitting the service animal to accompany the person with a disability.

4. Q: What must I do when an individual with a service animal comes to my

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business?

A: The service animal must be permitted to accompany the individual with a disability to all areas of the facility where customers are normally allowed to go. An individual with a service animal may not be segregated from other customers.

5. Q: I have always had a clearly posted "no pets" policy at my establishment. Do I still have to allow service animals in?

A: Yes. A service animal is not a pet. The ADA requires you to modify your "no pets" policy to allow the use of a service animal by a person with a disability. This does not mean you must abandon your "no pets" policy altogether but simply that you must make an exception to your general rule for service animals.

6. Q: My county health department has told me that only a seeing eye or guide dog has to be admitted. If I follow those regulations, am I violating the ADA?

A: Yes, if you refuse to admit any other type of service animal on the basis of local health department regulations or other state or local laws. The ADA provides greater protection for individuals with disabilities and so it takes priority over the local or state laws or regulations.

7. Q: Can I charge a maintenance or cleaning fee for customers who bring service animals into my business?

A: No. Neither a deposit nor a surcharge may be imposed on an individual with a disability as a condition to allowing a service animal to accompany the individual with a disability, even if deposits are routinely required for pets. However, a public accommodation may charge its customers with disabilities if a service animal causes damage so long as it is the regular practice of the entity to charge non-disabled customers for the same types of damages. For example, a hotel can charge a guest with a disability for the cost of repairing or cleaning furniture damaged by a service animal if it is the hotel's policy to charge when non-disabled guests cause such damage.

8. Q: I operate a private taxicab and I don't want animals in my taxi; they smell, shed hair and sometimes have "accidents." Am I violating the ADA if I refuse to pick up someone with a service animal?

A: Yes. Taxicab companies may not refuse to provide services to individuals with disabilities. Private taxicab companies are also prohibited from charging higher fares or fees for transporting individuals with disabilities and their service animals than they charge to other persons for the same or equivalent service.

9. Q: Am I responsible for the animal while the person with a disability is in my business?

A: No. The care or supervision of a service animal is solely the responsibility of his or her owner. You are not required to provide care or food or a special location for the

animal.

10. Q: What if a service animal barks or growls at other people, or otherwise acts out of control?

A: You may exclude any animal, including a service animal, from your facility when that animal's behavior poses a direct threat to the health or safety of others. For example, any service animal that displays vicious behavior towards other guests or customers may be excluded. You may not make assumptions, however, about how a particular animal is likely to behave based on your past experience with other animals. Each situation must be considered individually.

Although a public accommodation may exclude any service animal that is out of control, it should give the individual with a disability who uses the service animal the option of continuing to enjoy its goods and services without having the service animal on the premises.

11. Q: Can I exclude an animal that doesn't really seem dangerous but is disruptive to my business?

A: There may be a few circumstances when a public accommodation is not required to accommodate a service animal--that is, when doing so would result in a fundamental alteration to the nature of the business. Generally, this is not likely to occur in restaurants, hotels, retail stores, theaters, concert halls, and sports facilities. But when it does, for example, when a dog barks during a movie, the animal can be excluded.

If you have further questions about service animals or other requirements of the ADA, you may call the U.S. Department of Justice's toll-free ADA Information Line at 800-514-0301 (voice) or 800-514-0383 (TDD).

DUPLICATION OF THIS DOCUMENT IS ENCOURAGED.

7/96

U.S. Department of Justice
Civil Rights Division
Disability Rights Section

Americans with Disabilities Act

ADA Business BRIEF:

Service Animals

Service animals are animals that are individually trained to perform tasks for people with disabilities – such as guiding people who are blind, alerting people who are deaf, pulling wheelchairs, alerting and protecting a person who is having a seizure, or performing other special tasks. Service animals are working animals, not pets.

Under the Americans with Disabilities Act (ADA), businesses and organizations that serve the public must allow people with disabilities to bring their service animals into all areas of the facility where customers are normally allowed to go. This federal law applies to all businesses open to the public, including restaurants, hotels, taxis, grocery and department stores, hospitals and medical offices, theaters, health clubs, parks, and zoos.

Businesses that serve the public must allow people with disabilities to enter with their service animal

- Businesses may ask if an animal is a service animal or ask what tasks the animal has been trained to perform, but cannot require special ID cards for the animal or ask about the person's disability.
- People with disabilities who use service animals cannot be charged extra fees, isolated from other patrons, or treated less favorably than other patrons. However, if a business such as a hotel normally charges guests for damage that they cause, a customer with a disability may be charged for damage caused by his or her service animal.
- A person with a disability cannot be asked to remove his service animal from the premises unless: (1) the animal is out of control and the animal's owner does not take effective action to control it (for example, a dog that barks repeatedly during a movie) or (2) the animal poses a direct threat to the health or safety of others.
- In these cases, the business should give the person with the disability the option to obtain goods and services without having the animal on the premises.
- Businesses that sell or prepare food must allow service animals in public areas even if state or local health codes prohibit animals on the premises.
- A business is not required to provide care or food for a service animal or provide a special location for it to relieve itself.
- Allergies and fear of animals are generally not valid reasons for denying access or refusing service to people with service animals.
- Violators of the ADA can be required to pay money damages and penalties.

Service animals are individually trained to perform tasks for people with disabilities

If you have additional questions concerning the ADA and service animals, please call the Department's ADA Information Line at (800) 514-0301 (voice) or (800) 514-0383 (TTY) or visit the **ADA Business Connection** at www.usdoj.gov/crt/ada/adahom1.htm.

Duplication is encouraged. October 2001

Animal Welfare Information Center Newsletter, Summer 1996, Vol. 7 No. 2

No Dogs Allowed?

Federal Policies on Access for Service Animals

by
Kelly Henderson, M.Ed.,
Department of Special Education, University of Maryland, College Park, Maryland

- Introduction
- Policy Overview
- The Air Carrier Access Act of 1986 (ACAA)
- The Fair Housing Amendments Act
- The Americans With Disabilities Act (ADA)
- Implementation of the ADA
- ADA Complaint Resolution
- Other Implementation Concerns
- References

- Related Article: Service Animal Information

For ages, humans have explored the potential healing benefit of animal companions for people who are ill or who have disabilities. The use of animals to assist their ailing human counterparts dates to the early Greeks who gave horseback rides to raise the spirits of people who were incurably ill, and documentation from the seventeenth century makes medical reference to horseback riding as treatment for gout, neurological disorders, and low morale (6). Even the famous nursing pioneer Florence Nightingale testified to the benefits of pet animals for the sick (11).

Since the middle of this century, the physical and emotional needs of disabled people in Western societies have became more visible and demanded more public attention (13). A variety of methods have been sought to increase the personal independence of people with disabilities. Since the 1960's, use of companion animals to increase physical mobility has contributed to logistical and emotional independence for many people with sensory, health, and other physical impairments. Probably the first systematic use of companion animals to assist disabled Americans was the training of dogs to guide people who are blind and visually impaired. While the earliest formal training of guide dogs in the United States dates back 65 years (8), widespread training has only occurred during the last three decades. Sixteen major guide dog training facilities operate in the United States (20). Each is administered independently. Guide dog training techniques are similar across schools, but policies, such as applicant requirements and types of dogs used, vary.

While guide dogs for the blind are the most commonly identified companions for people with disabilities, a number of other partnerships have been initiated. In 1975, Canine Companions for Independence (CCI) pioneered the concept of the service dog, a highly trained canine used to assist people who have disabilities with specialized services. CCI classifies specific types of service dogs by function. Service dogs perform tasks such as operating light switches, retrieving items, pulling wheelchairs, and opening doors. Hearing dogs assist people who are deaf or hearing impaired by alerting them to sounds such as telephone rings, crying infants, alarms, and people calling them by name.

The largest of service animal training organizations, CCI has four training centers across the United States. Several other groups operate training facilities either nationally or regionally. Policies vary by organization though many

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facilities prepare dogs to serve both mobility-impaired people and those with hearing impairments. Throughout the United States, nearly 70 organizations train service dogs, and about 45 providers train hearing dogs (19). Assistance Dogs International, Inc., a nonprofit association of training programs, establishes standards that member organizations must meet.

While canine assistants have great potential for improving the quality of life for many disabled people, the use of service animals remains an exception to the rule. In its 20-year history, CCI has trained only 600 animals. At least 9 million Americans live with significant physical and sensory impairments (14), but there are only 10,000-12,000 assistance dogs at work, of which 7,000 are guide dogs (5).

Social animals, those used to address animal-assisted therapy goals, are trained and used in a wide variety of settings including hospitals, nursing facilities, schools, and other institutions. While several national organizations provide structured training and certification programs for these animals, most are not recognized as "service animals" under Federal law. Therefore, this category of assistance animals will not be referenced in this review of service animal policy.

Policy Overview

Federal policy dictating access and training rights for disabled people who have service animals has, but for the past decade, been virtually nonexistent (1,2, 9,12). In its absence, many individual States did address rights for service animals through laws providing disabled people access to public facilities and housing. To date, all States and the District of Columbia have to some extent legislated such access rights. However, the extent of coverage varies considerably State to State and many State codes do not include reference to service dogs other than guide and hearing dogs.

In two major pieces of Federal transportation and housing legislation, provisions to prohibit discrimination against people with disabilities were interpreted to include access for service animals. Regulations implementing the Air Carrier Access Act of 1986 (1) and the Fair Housing Act of 1988 (9) clarify that anti-discrimination protections extend to people who use service animals.

The Air Carrier Access Act of 1986 (ACAA)

The first Federal legislation to directly address public access rights of people with disabilities who have service animals was the Air Carrier Access Act of 1986 (1). The act amended the Federal Aviation Act of 1958 to provide that prohibitions of discrimination against handicapped people apply to air carriers. Regulations clarify that air carriers must permit "dogs and other service animals used by handicapped people to accompany the people on a flight" (16). As a result of these 1986 stipulations regarding air transport, the 1990 Americans with Disabilities Act does not reference air carriers in its Title II and III transportation requirements.

The ACAA regulations provide one of the most specific statements of Federal policy regarding accommodation of service animals. While efforts to implement other Federal laws, such as the Americans with Disabilities Act, rely largely on technical assistance guidance, regulatory examples, and settlements to guarantee access and accommodation rights for disabled people who have service animals, the ACAA directly regulates these rights. The act requires air carriers to permit service animals to accompany people with disabilities on flights (14 CFR 382.55 (a)) (16).

(1) Carriers shall accept as evidence that an animal is a service animal identification cards, other written documentation, presence of harnesses or markings on harnesses, tags, or the credible verbal assurances of the qualified handicapped person using the animal.

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(2) Carriers shall permit a service animal to accompany a qualified handicapped individual in any seat which the person sits, unless the animal obstructs an aisle or other area that must remain unobstructed in order to facilitate an emergency evacuation.

(3) In the event that special information concerning the transportation of animals outside the continental United States is either required to be or is provided by the carrier, the information shall be provided to all passengers traveling outside the continental United States with the carrier, including those traveling with service animals.

Service animals are also referenced in the act's regulations regarding seat assignments and clarifies that in the case that the service animal cannot be accommodated at the seat location of his/her human companion, the carrier must offer the passenger the opportunity to move with the animal to another seat as an alternative to requiring the animal to travel with checked baggage (14 CFR 382.37(c)).

The Fair Housing Amendments Act

In a comprehensive housing rights bill, Congress provided specific rights to accommodations for people with disabilities. The Fair Housing Amendments Act of 1988 prohibits discrimination in the sale or rental of a dwelling based on handicap (9). The act defines discrimination to include:

a) A refusal to permit, at the expense of the handicapped person, reasonable modifications of existing premises occupied or to be occupied by such person if modifications may be necessary to afford such person full enjoyment of the premises...; or

b) a refusal to make reasonable accommodations in rules, policies, practices, or services, when such accommodations may be necessary to afford such person equal opportunity to use and enjoy a dwelling.

The implementing regulations restate the law with regard to the policy on reasonable accommodations, and contribute an illustration by example (10):

Example (1): A blind applicant for rental housing wants to live in a dwelling unit with a seeing eye dog. The building has a no pets policy. It is a violation of Section 100.204 for the owner or manager of the apartment complex to refuse to permit the applicant to live in the apartment with a seeing eye dog, because without the seeing eye dog, the blind person will not have an equal opportunity to use and enjoy a dwelling.

The illustration does make clear that at least in the case of a guide dog for the blind, reasonable accommodations in rules, policies, practices, or services include special consideration for housing of service animals.

The Americans With Disabilities Act (ADA)

National access rights for service animals (28 CFR 36.104 defines the term "service animal" as "any guide dog, signal dog, or other animal individually trained to provide assistance to an individual with a disability.") across settings became a reality with the passage of the Americans with Disabilities Act of 1990 (2). Title I, administered by the Equal Employment Opportunity Commission (EEOC), prohibits employment discrimination against qualified individuals with disabilities. Under Title I, discrimination includes not making reasonable accommodations to the known physical or mental limitations of an otherwise qualified individual who is an applicant or employee unless such covered entity can demonstrate that accommodation would impose an undue hardship on the operations of the business of such covered entity. (42 USC 12112(b)(5)(A))

Regulations (18) clarify the types of reasonable accommodations for which an employer is responsible. A sizable list of

reasonable accommodations is noted in 29 CFR 1630.2(o) including modifications or adjustments to the work environment, or to the manner or circumstances under which the position held or desired is customarily performed, and acquisition or modifications of equipment or devices (29 CFR 1630.2(o)(2)(ii)).

Title II, Section 12132, of the ADA prohibits discrimination against qualified disabled people in public services including public transportation. Though the Title II regulations (28 CFR 35.130) do require "reasonable modifications" to avoid discrimination, they do not directly acknowledge access rights of service animals.

Of all sections of the Americans with Disabilities Act, Title III references service animals most directly. Title III prohibits discrimination of people with disabilities in public accommodations and services operated by private entities. Section 12182(b)(2)(A) clarifies specific prohibitions on discrimination on the basis of disability, and includes in the definition of discrimination:

> *a failure to make reasonable modifications in policies, practices, or procedures, when such modifications are necessary to afford such goods, services, facilities, privileges, advantages, or accommodations to individuals with disabilities, unless the entity can demonstrate that making such modifications would fundamentally alter the nature of such goods, services, facilities, privileges, advantages, or accommodations. (42 USC 12182(b)(2)(A)(ii))*

The U.S. Department of Justice (DOJ) implementing regulations (15) clarify "modifications in policies, practices, or procedures." 28 CFR Section 36.302(c) specifically addresses service animals and clarifies that "Generally, a public accommodation shall modify policies, practices, or procedures to permit the use of a service animal by an individual with a disability" (see *AWIC Newsletter* vol. 6 #2-4--Americans with Disabilities Act and its Applicability to Zoos). The regulation further clarifies that public accommodations are not required to supervise or care for a service animal.

Implementation of the ADA

The EEOC and the DOJ, Civil Rights Division, use several reference aids to clarify the legislative intent of the ADA. Both agencies publish technical assistance manuals (21,22) that provide clarifications of the code and regulation through explanations and examples. Both agencies also have authority to take a variety of actions in response to complaints and charges filed. Service animal policy is thus affected by the lawsuits, amicus briefs, and formal and informal settlement agreements brokered by the agencies.

EEOC technical assistance guidelines (21) support the Title I regulatory language and define employers' responsibilities to make modifications for people with disabilities who have service animals in the workplace.

It may also be a reasonable accommodation to permit an individual with a disability the opportunity to provide and utilize equipment, aids or services that an employer is not required to provide as a reasonable accommodation. For example, it would be a reasonable accommodation for an employer to permit an individual who is blind to use a guide dog at work, even though the employer would not be required to provide a guide dog for the employee. (29 CFR 1630.2 App)

Title III prohibits discrimination on the basis of disability in public accommodations. U.S. Department of Justice regulations do specifically define service animals and require public accommodations to modify policies and procedures to permit use of service animals. The *Title III Technical Assistance Manual* (22) clarifies the definition of service animal by listing tasks typically performed by service animals: guiding people who have impaired vision, alerting individuals with impaired hearing to the presence of intruders or sounds, providing minimal protection or rescue work, pulling a wheelchair, or retrieving dropped items (III-4.2300).

The manual reinforces the access policy via illustration.

An individual who is blind wishes to be accompanied in a restaurant by her guide dog. The restaurant must permit the guide dog to accompany its owner in all areas of the restaurant open to other patrons and may not insist that the dog be separated from her (III-4.2300).

The manual offers additional guidance regarding responsibilities of the service animal owner and of the public accommodation (III-4.2300).

The care or supervision of a service animal is the responsibility of his or her owner, not the public accommodation. A public accommodation may not require an individual with a disability to post a deposit as a condition of permitting a service animal to accompany its owner in a place of public accommodation, even if such deposits are required for pets.

In these cases, the technical assistance and interpretive guidance helps to secure public access and employment accommodation rights for people with disabilities who have service animals. However, in a recent manual supplement, the guidance describes situations in which it would permissible for health and safety reasons to not allow access to service animals. The DOJ *Title III Technical Assistance Manual* (22) attempts to clarify these provisions by acknowledging that in rare circumstances, if the nature of the goods and services provided or accommodations offered would be fundamentally altered or the safe operation of a public accommodation jeopardized, a service animal may not be allowed to enter (III-4.2300, 1994 Supplement).

In practice, health concerns have given rise to conflicts about the access of service animals in medical facilities. Though many hospitals work to negotiate satisfactory access policies, some institutions remain less flexible, leaving disabled people with service animals to pursue legal remedies through State or Federal channels.

ADA Complaint Resolution

Both the EEOC and DOJ investigate charges of ADA violations. The DOJ has been involved in a number of recent lawsuits, briefs, and settlements that address access and accommodation rights for service animals. One case, *Crowder v. Kitigawa* (7), went to trial on constitutional, as well as ADA, Title II (prohibition of discrimination in activities of state and local government) claims. In February 1994, the U.S. District Court for the District of Hawaii ruled against the plaintiff, a visually disabled guide dog user who protested Hawaii's canine quarantine. In June 1994, the U.S. Department of Justice filed an amicus brief (23) supporting an appeal of the case, which is currently under review by the U.S. Court of Appeals.

Several additional complaints regarding access rights for people with disabilities who have service animals have been pursued by the Department of Justice. In at least two formal and several informal settlement agreements with the DOJ under Title III of the ADA, owners and operators of private businesses agreed to modify policies with respect to access for service animals. Upon negotiation with the DOJ, most public accommodations and facilities agreed to take steps to ensure that disabled people who use service animals are provided access to the facilities. For example, an inn modified its policy to permit people with disabilities accompanied by service animals to stay without paying the $25 flea extermination service fee. In another settlement, a drugstore chain agreed to modify its "no animals" policies by making exceptions for service animals.

Other Implementation Concerns

Beyond the regulatory enforcement and judicial interpretations of Federal law, access and accommodation rights for service animals are further affected by several other factors. To date, Federal policies fail to address a number of aspects related to service animals.

The training of service animals is currently not regulated by Federal agencies. No Federal law or regulation includes

reference to access for animals in training, although 21 States do secure such rights in State code (4). No guidelines for service animal trainers or for certification of the animals themselves is found in Federal policy. Though a number of service animal training organizations do maintain membership in Assistance Dogs International, Inc., and meet ADI standards for training, each organization may still maintain its own certification and evaluation criteria. While no federally recognized certification or training standards have yet been established, two Federal laws address certification or other proof of service animal status. Regulations implementing the ACAA require air carriers to accept as evidence that an animal is a service animal identification cards, other written documents, presence of harnesses or other markings on harnesses, tags or the credible verbal assurances of the qualified handicapped person using the animal (14 CFR 382.55(a)(1)). Department of Justice ADA technical assistance indicates that a number of States have programs to certify service animals; however, a private entity cannot insist on proof of State certification before permitting the entry of a service animal to a place of public accommodation. The importance of training and use of service animals to people with disabilities has yet to be recognized by the health insurance industry (3). For example, the time a parent of a child with a disability or an adult with a disability invests to attend a service animal training session (some as long as 6 weeks) is not covered by Federal Family and Medical Leave Act criteria of "serious illness" (17).

The use of service animals has improved the quality of life for people with sensory and physical disabilities. While people with disabilities in America still confront barriers erected by ignorance and misinformation, the three major Federal laws reviewed above work to defeat such discrimination by guaranteeing access and accommodation rights to people with disabilities who use service animals.

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ISSUE BRIEF 01-56

2003 FMAPs: Bureaus Meet Their Match

October 19, 2001

Summary

The October 17 decision of the U.S. Census Bureau not to adjust the 2000 decennial census count cleared the way for the Bureau of Economic Analysis (BEA) to release per capita personal income estimates for 1998-2000 on October 19. This release permits the calculation of 2003 state Medicaid matching rates (the Federal Medicaid Assistance Percentage—FMAP). Formal promulgation of these FMAPs by the federal Department of Health and Human Services is expected during November 2001.

The new FMAPs provide 23 states with increases and 17 states with declines. Based on budgeted Medicaid spending levels for 2002, FFIS estimates that using the 2003 rates would provide an additional $808 million in federal Medicaid funds to the 23 states with increases. The 17 states with lower FMAPs would lose an estimated $597 million, with most of that loss in California and Michigan. On net, the shift is estimated to cost the federal government $211 million. Since Medicaid continues to grow and since the FMAP is used for other programs, the net impact in 2003 will be larger than these estimates.

Enhanced FMAPs for the State Children's Health Insurance Program (SCHIP) and the new Medicaid cervical and breast cancer option also are provided.

These FMAPs are quite similar for most states to those estimated by FFIS in April and updated in September. FFIS reports will provide additional FMAP projections in the months to come.

FMAP Definition and Data Issues

Medicaid is the largest federal grant program, accounting for more than 41 percent of total federal grant-in-aid funds. The costs of the Medicaid program are shared between the federal government and the states. The federal share of program costs—the FMAP—is based on the relationship between each state's per capita personal income and the national average per capita personal income over three calendar years. The FMAP is recalculated each year. The formula is designed to give a state with average per capita personal income a federal share of 55 percent. The minimum FMAP for wealthier states is 50 percent and the matching rate for U.S. territories is statutorily set at 50 percent. The District of Columbia and Alaska FMAPs are enhanced to reflect special federal interests in those two jurisdictions.

The 2003 FMAPs are affected both by changes in personal income and by the first-time use of 2000 decennial census counts in calculating per capita income amounts. This combined effect produces more substantial changes than usual.

Uncertainties as to whether the Census Bureau would adjust population data based on the Accuracy and Coverage Evaluation (ACE) survey has delayed publication of the relevant per capita personal income data necessary to

calculate the 2003 FMAPs. The Census Bureau's decision not to adjust *at this time* permits BEA to proceed. Adjusting the population count would have reduced the FMAPS in the states with smaller undercounts, primarily those in the Plains and Great Lakes regions. Two future Census actions will have further impacts on the per capita personal income data: the formal publication of intercensal population data for 1999, which will affect the 2004 FMAP, and the final ACE-related adjustment, if it occurs.

FFIS published initial projections of FMAPs for federal fiscal year 2003 on April 25, 2001, and published an update on September 5 (See *Issue Briefs 01-24* and *01-53*). FMAPs presented in this brief will be promulgated for 2003 under current law, probably in November 2001.

Per Capita Personal Income Shifts

Table 1 shows 1998-2000 per capita personal income data. U.S. per capita personal income grew 5.7 percent in 2000, compared to 3.5 percent in 1999. The New England, Far West and Rocky Mountain regions continued to lead the nation in growth, though the fastest-growing states were regionally diverse—Massachusetts (9.4 percent), California (8.1 percent), New Hampshire (7.7 percent), North Dakota (7.5 percent), Colorado (7.3 percent), New Jersey (7.1 percent) and Virginia (6.4 percent).

The slowest-growing regions were the Great Lakes and the Southeast. However, the slowest-growing states were also regionally diverse— Nevada (2.3 percent), Alabama (3.3 percent), Louisiana and Mississippi (each 3.4 percent), Arkansas (3.6 percent), Nebraska (3.7 percent), Kansas (4.2 percent), Michigan (4.3 percent) and Hawaii (4.4 percent).

These rates are substantially different from rates of growth of total personal income (see FFIS *Issue Brief 01-53)*. For example, Nevada and Arizona have among the fastest 2000 total personal income growth but their population growth is even greater. Similarly, North Dakota had total personal income growth at about the national growth rate, but its low rate of population growth resulted in high per capita growth rates.

Rates of per capita growth may change somewhat in April 2002, when Census Bureau intercensal data for 1998 and 1999 are expected to become available.

Projected FMAPs

Table 2 displays actual FMAPs for 1999-2002 and FFIS calculations for FY 2003. In 2003, 23 state FMAPs will increase and 17 will decline. In general, northern states will lose and southern states will gain.

The most substantial FMAP increases will be in Rhode Island (2.95 percentage points), Florida (2.40), Nevada (2.39), Hawaii (2.43), Arizona (2.27), Arkansas (1.64), New Mexico (1.52), Utah (1:24), North Carolina (1.10), Louisiana (0.98), Oregon (0.96), Tennessee (0.95) and Alaska (0.89). The most substantial losses will be suffered by North Dakota (-1.51), California (-1.40), Michigan (-0.94), Virginia (-0.92), Vermont and Wyoming (each -0.65) and South Dakota (-0.64).

Alaska's FMAP was set at 59.80 for fiscal years 1998-2000. That provision expired after fiscal year 2000. It was replaced by a similar provision in the omnibus budget bill for fiscal years 2001-2005 that reduces Alaska's per capita income in calculating its FMAP.

Enhanced FMAPs

The State Children's Health Insurance Program (SCHIP) created an enhanced FMAP. The federal share for that program is increased by reducing each state's own-source contribution by 30 percent from its FMAP state share. Table 3 displays the enhanced match for 2003. For example, New York's state share is reduced from 50 percent to 35 percent. This enhanced matching rate has also been applied to a new Medicaid option for breast and cervical cancer treatment for women identified under a Centers for Disease Control and Prevention screening program (see *Issue Brief 01-19)*. As shown in Table 3, 32 states already have had Medicaid plan amendments for the program approved by the federal government.

Possible Impact of 2003 FMAPs on Medicaid Grants

Table 4 displays August 2001 state projections of 2002 Medicaid vendor payment grants, as reported to the federal Centers for Medicare and Medicaid Services. These grants are based on 2002 FMAPs. For illustrative purposes, Table 4 then displays the impact on Medicaid grants of using the 2003 FMAPs if all state 2003 Medicaid programs increase 8 percent over 2002 levels.

As can be seen, states would gain an estimated $211 million net in their Medicaid programs in 2003. The biggest losses would be experienced by California (-$397 million), Michigan (-$73 million), Virginia (-$40 million), Texas (-$25 million) and Washington (-$22 million). The most substantial gains would be realized by Florida ($246 million), Arizona ($81 million), North Carolina ($77 million), Tennessee ($59 million), Louisiana ($46 million), Rhode Island ($42 million) and Arkansas and Georgia (each $35 million).

Possible Stimulus Proposals

A number of proposals for providing federal economic stimulus involve temporarily adjusting the FMAP. While there are too many proposals to list here, Table 4 also illustrates the potential impact of three such proposals: increase all state's 2003 FMAPs by one percentage point, hold states losing FMAP in 2002 harmless for the second half of the year and increase FMAPs by one percentage point for states with unemployment rates more than 10 percent higher than the national average.

It is far from certain that any such proposals will be adopted, or that if one is adopted that it will be among those discussed here. In addition, readers should be aware that these calculations are based on currently available 2002 Medicaid data, which *will* change differentially in 2003. Nonetheless, illustrative impacts of these alternatives are presented to show the type and magnitude of changes being discussed.

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Table 1

Per Capita Personal Income of States and Regions, 1998-2000

(calendar years; dollars in millions)

	Per Capita Personal Income			Percent Change	
	1998	1999	2000	1998-1999	1999-2000
Alabama	$21,913	$22,706	$23,460	3.62%	3.32%
Alaska	27,610	27,947	29,597	1.22%	5.90%
Arizona	23,121	23,738	24,991	2.67%	5.28%
Arkansas	20,531	21,191	21,945	3.21%	3.56%
California	28,277	29,818	32,225	5.45%	8.07%
Colorado	28,783	30,225	32,441	5.01%	7.33%
Connecticut	37,190	38,506	40,870	3.54%	6.14%
Delaware	28,649	29,625	31,074	3.41%	4.89%
District of Columbia	35,568	36,254	38,374	1.93%	5.85%
Florida	26,159	26,560	27,836	1.53%	4.80%
Georgia	25,481	26,522	27,790	4.09%	4.78%
Hawaii	26,135	26,658	27,819	2.00%	4.36%
Idaho	21,622	22,387	23,640	3.54%	5.60%
Illinois	29,491	30,274	31,842	2.66%	5.18%
Indiana	24,908	25,682	26,838	3.11%	4.50%
Iowa	24,531	24,945	26,376	1.69%	5.74%
Kansas	25,538	26,312	27,408	3.03%	4.17%
Kentucky	22,123	22,712	24,057	2.66%	5.92%
Louisiana	21,954	22,292	23,041	1.54%	3.36%
Maine	23,352	24,220	25,399	3.72%	4.87%
Maryland	30,496	31,860	33,621	4.47%	5.53%
Massachusetts	32,748	34,482	37,710	5.29%	9.36%
Michigan	26,870	27,886	29,071	3.78%	4.25%
Minnesota	29,109	30,127	31,913	3.50%	5.93%
Mississippi	19,674	20,180	20,856	2.57%	3.35%
Missouri	25,176	25,815	27,186	2.54%	5.31%
Montana	21,235	21,511	22,541	1.30%	4.79%
Nebraska	25,558	26,663	27,658	4.32%	3.73%
Nevada	28,190	28,883	29,551	2.46%	2.31%
New Hampshire	29,297	30,690	33,042	4.75%	7.66%
New Jersey	33,646	34,666	37,112	3.03%	7.06%
New Mexico	20,520	20,920	21,883	1.95%	4.60%
New York	31,522	32,620	34,502	3.48%	5.77%
North Carolina	24,667	25,314	26,842	2.62%	6.04%
North Dakota	22,785	23,053	24,780	1.18%	7.49%
Ohio	25,918	26,725	27,914	3.11%	4.45%
Oklahoma	21,966	22,576	23,582	2.78%	4.46%
Oregon	25,406	26,192	27,649	3.09%	5.56%
Pennsylvania	27,005	27,971	29,533	3.58%	5.58%
Rhode Island	26,870	27,813	29,158	3.51%	4.84%
South Carolina	22,127	22,903	23,952	3.51%	4.58%
South Dakota	23,484	24,491	25,993	4.29%	6.13%
Tennessee	24,106	24,722	25,878	2.56%	4.68%
Texas	25,426	26,266	27,722	3.30%	5.54%
Utah	21,624	22,335	23,364	3.29%	4.61%
Vermont	24,557	25,514	26,904	3.90%	5.45%
Virginia	28,032	29,208	31,065	4.20%	6.36%
Washington	28,287	29,783	31,129	5.29%	4.52%
West Virginia	20,235	20,720	21,767	2.40%	5.05%
Wisconsin	26,018	26,863	28,066	3.25%	4.48%
Wyoming	24,687	25,960	27,436	5.16%	5.69%
New England	*31,870*	*33,296*	*35,824*	*4.47%*	*7.59%*
Mideast	*30,583*	*31,660*	*33,549*	*3.52%*	*5.97%*
Great Lakes	*26,984*	*27,832*	*29,122*	*3.14%*	*4.63%*
Plains	*26,010*	*26,780*	*28,219*	*2.96%*	*5.37%*
Southeast	*24,258*	*24,940*	*26,179*	*2.81%*	*4.97%*
Southwest	*24,373*	*25,128*	*26,477*	*3.10%*	*5.37%*
Rocky Mountain	*25,058*	*26,122*	*27,775*	*4.25%*	*6.33%*
Far West	*27,998*	*29,402*	*31,491*	*5.01%*	*7.10%*
United States	**$26,909**	**$27,859**	**$29,451**	**3.53%**	**5.71%**

Table 2

Federal Medical Assistance Percentages, 1999-2003

(federal fiscal years; federal share as percent)

State	1999	2000	2001	2002	Projected 2003	Percentage Point Change 1999-00	2000-01	2001-02	2002-03	Addendum: 2003 FMAP Without Floor
Alabama	69.27	69.57	69.99	70.45	70.60	0.29	0.42	0.46	0.15	70.60
Alaska*	59.80	59.80	60.13	57.38	58.27	0.00	0.33	-2.75	0.89	58.27
Arizona	65.50	65.92	65.77	64.98	67.25	0.42	-0.15	-0.79	2.27	67.25
Arkansas	72.96	72.85	73.02	72.64	74.28	-0.11	0.17	-0.38	1.64	74.28
California	51.55	51.67	51.25	51.40	50.00	0.12	-0.42	0.15	-1.40	48.24
Colorado	50.59	50.00	50.00	50.00	50.00	-0.59	0.00	0.00	0.00	46.94
Connecticut	50.00	50.00	50.00	50.00	50.00	0.00	0.00	0.00	0.00	13.80
Delaware	50.00	50.00	50.00	50.00	50.00	0.00	0.00	0.00	0.00	49.35
District of Columbia*	70.00	70.00	70.00	70.00	70.00	0.00	0.00	0.00	0.00	22.96
Florida	55.82	56.52	56.62	56.43	58.83	0.71	0.09	-0.19	2.40	58.83
Georgia	60.47	59.88	59.67	59.00	59.60	-0.59	-0.21	-0.67	0.60	59.60
Hawaii	50.00	51.01	53.85	56.34	58.77	1.01	2.84	2.49	2.43	58.77
Idaho	69.85	70.15	70.76	71.02	70.96	0.30	0.60	0.27	-0.06	70.96
Illinois	50.00	50.00	50.00	50.00	50.00	0.00	0.00	0.00	0.00	46.76
Indiana	61.01	61.74	62.04	62.04	61.97	0.73	0.30	0.00	-0.07	61.97
Iowa	63.32	63.06	62.67	62.86	63.50	-0.26	-0.39	0.19	0.64	63.50
Kansas	60.05	60.03	59.85	60.20	60.15	-0.02	-0.18	0.36	-0.05	60.15
Kentucky	70.53	70.55	70.39	69.94	69.89	0.02	-0.16	-0.45	-0.05	69.89
Louisiana	70.37	70.32	70.53	70.30	71.28	-0.06	0.21	-0.23	0.98	71.28
Maine	66.40	66.22	66.12	66.58	66.22	-0.18	-0.10	0.46	-0.36	66.22
Maryland	50.00	50.00	50.00	50.00	50.00	0.00	0.00	0.00	0.00	41.56
Massachusetts	50.00	50.00	50.00	50.00	50.00	0.00	0.00	0.00	0.00	30.13
Michigan	52.72	55.11	56.18	56.36	55.42	2.39	1.07	0.18	-0.94	55.42
Minnesota	51.50	51.48	51.11	50.00	50.00	-0.02	-0.37	-1.11	0.00	47.29
Mississippi	76.78	76.80	76.82	76.09	76.62	0.02	0.02	-0.74	0.53	76.62
Missouri	60.24	60.51	61.03	61.06	61.23	0.26	0.52	0.03	0.17	61.23
Montana	71.73	72.30	73.04	72.83	72.96	0.58	0.73	-0.20	0.13	72.96
Nebraska	61.46	60.88	60.38	59.55	59.52	-0.58	-0.50	-0.83	-0.03	59.52
Nevada	50.00	50.00	50.36	50.00	52.39	0.00	0.36	-0.36	2.39	52.39
New Hampshire	50.00	50.00	50.00	50.00	50.00	0.00	0.00	0.00	0.00	45.09
New Jersey	50.00	50.00	50.00	50.00	50.00	0.00	0.00	0.00	0.00	29.49
New Mexico	72.98	73.32	73.80	73.04	74.56	0.34	0.48	-0.76	1.52	74.56
New York	50.00	50.00	50.00	50.00	50.00	0.00	0.00	0.00	0.00	38.27
North Carolina	63.07	62.49	62.47	61.46	62.56	-0.58	-0.02	-1.01	1.10	62.56
North Dakota	69.94	70.42	69.99	69.87	68.36	0.47	-0.42	-0.12	-1.51	68.36
Ohio	58.26	58.67	59.03	58.78	58.83	0.41	0.36	-0.24	0.05	58.83
Oklahoma	70.84	71.09	71.24	70.43	70.56	0.25	0.15	-0.81	0.13	70.56
Oregon	60.55	59.96	60.00	59.20	60.16	-0.59	0.04	-0.80	0.96	60.16
Pennsylvania	53.77	53.82	53.62	54.65	54.69	0.04	-0.20	1.03	0.04	54.69
Rhode Island	54.05	53.77	53.79	52.45	55.40	-0.27	0.02	-1.34	2.95	55.40
South Carolina	69.85	69.95	70.44	69.34	69.81	0.10	0.49	-1.10	0.47	69.81
South Dakota	68.16	68.72	68.31	65.93	65.29	0.56	-0.42	-2.37	-0.64	65.29
Tennessee	63.09	63.10	63.79	63.64	64.59	0.01	0.69	-0.15	0.95	64.59
Texas	62.45	61.36	60.57	60.17	59.99	-1.09	-0.79	-0.40	-0.18	59.99
Utah	71.78	71.55	71.44	70.00	71.24	-0.23	-0.11	-1.44	1.24	71.24
Vermont	61.97	62.24	62.40	63.06	62.41	0.27	0.15	0.67	-0.65	62.41
Virginia	51.60	51.67	51.85	51.45	50.53	0.07	0.17	-0.39	-0.92	50.53
Washington	52.50	51.83	50.70	50.37	50.00	-0.67	-1.13	-0.33	-0.37	49.52
West Virginia	74.47	74.78	75.34	75.27	75.04	0.31	0.56	-0.07	-0.23	75.04
Wisconsin	58.85	58.78	59.29	58.57	58.43	-0.07	0.51	-0.72	-0.14	58.43
Wyoming	64.08	64.04	64.60	61.97	61.32	-0.04	0.57	-2.64	-0.65	61.32

* The FMAPs for the District of Columbia and Alaska were statutorily set in the BBA of 1997 and Alaska's was reset for FY 2001-2005 by the omnibus budget bill of 2000.

Source: FFIS analysis of Bureau of Economic Analysis data, U.S. Department of Commerce.

Table 3

Enhanced FMAPs, 1998-2003

(federal fiscal years; federal share as percent)

State		1998	1999	2000	2001	2002	Projected 2003	Percentage Point Change 1998-00	2000-01	2001-02	2002-03
Alabama	1/	78.52	78.49	78.70	78.99	79.31	79.42	0.18	0.30	0.32	0.11
Alaska	1/	71.86	71.86	71.86	72.09	70.17	70.79	0.00	0.23	-1.92	0.62
Arizona	1/	75.73	75.85	76.14	76.04	75.49	77.08	0.42	-0.10	-0.55	1.59
Arkansas	1/	80.99	81.07	80.99	81.11	80.85	82.00	0.01	0.12	-0.26	1.15
California	1/	65.86	66.09	66.17	65.88	65.98	65.00	0.31	-0.29	0.10	-0.98
Colorado		66.38	65.42	65.00	65.00	65.00	65.00	-1.38	0.00	0.00	0.00
Connecticut	1/	65.00	65.00	65.00	65.00	65.00	65.00	0.00	0.00	0.00	0.00
Delaware		65.00	65.00	65.00	65.00	65.00	65.00	0.00	0.00	0.00	0.00
District of Columbia		79.00	79.00	79.00	79.00	79.00	79.00	0.00	0.00	0.00	0.00
Florida	1/	68.96	69.07	69.57	69.63	69.50	71.18	0.61	0.07	-0.13	1.68
Georgia	1/	72.59	72.33	71.91	71.77	71.30	71.72	-0.67	-0.15	-0.47	0.42
Hawaii	1/	65.00	65.00	65.71	67.70	69.44	71.14	0.71	1.99	1.74	1.70
Idaho	1/	78.71	78.89	79.11	79.53	79.72	79.67	0.40	0.42	0.19	-0.05
Illinois	1/	65.00	65.00	65.00	65.00	65.00	65.00	0.00	0.00	0.00	0.00
Indiana	1/	72.99	72.71	73.22	73.43	73.43	73.38	0.23	0.21	0.00	-0.05
Iowa	1/	74.63	74.32	74.14	73.87	74.00	74.45	-0.49	-0.27	0.13	0.45
Kansas	1/	71.80	72.03	72.02	71.90	72.14	72.11	0.22	-0.12	0.24	-0.03
Kentucky		79.26	79.37	79.38	79.27	78.96	78.92	0.13	-0.11	-0.31	-0.04
Louisiana		79.02	79.26	79.22	79.37	79.21	79.90	0.20	0.15	-0.16	0.69
Maine	1/	76.23	76.48	76.36	76.28	76.61	76.35	0.13	-0.07	0.33	-0.26
Maryland	1/	65.00	65.00	65.00	65.00	65.00	65.00	0.00	0.00	0.00	0.00
Massachusetts		65.00	65.00	65.00	65.00	65.00	65.00	0.00	0.00	0.00	0.00
Michigan	1/	67.51	66.91	68.58	69.33	69.45	68.79	1.07	0.75	0.12	-0.66
Minnesota		66.50	66.05	66.04	65.78	65.00	65.00	-0.46	-0.26	-0.78	0.00
Mississippi	1/	83.96	83.75	83.76	83.77	83.26	83.63	-0.20	0.01	-0.51	0.37
Missouri	1/	72.48	72.17	72.36	72.72	72.74	72.86	-0.12	0.37	0.02	0.12
Montana	1/	79.39	80.21	80.61	81.13	80.98	81.07	1.22	0.52	-0.15	0.09
Nebraska	1/	72.82	73.02	72.62	72.27	71.68	71.66	-0.20	-0.35	-0.59	-0.02
Nevada		65.00	65.00	65.00	65.25	65.00	66.67	0.00	0.25	-0.25	1.67
New Hampshire	1/	65.00	65.00	65.00	65.00	65.00	65.00	0.00	0.00	0.00	0.00
New Jersey		65.00	65.00	65.00	65.00	65.00	65.00	0.00	0.00	0.00	0.00
New Mexico		80.83	81.09	81.32	81.66	81.13	82.19	0.49	0.34	-0.53	1.06
New York		65.00	65.00	65.00	65.00	65.00	65.00	0.00	0.00	0.00	0.00
North Carolina		74.16	74.15	73.74	73.73	73.02	73.79	-0.42	-0.01	-0.71	0.77
North Dakota	1/	79.30	78.96	79.29	78.99	78.91	77.85	-0.01	-0.30	-0.08	-1.06
Ohio		70.70	70.78	71.07	71.32	71.15	71.18	0.37	0.25	-0.17	0.03
Oklahoma		79.36	79.59	79.76	79.87	79.30	79.39	0.40	0.11	-0.57	0.09
Oregon		73.02	72.38	71.97	72.00	71.44	72.11	-1.05	0.03	-0.56	0.67
Pennsylvania		67.37	67.64	67.67	67.53	68.25	68.28	0.30	-0.14	0.72	0.03
Rhode Island	1/	67.22	67.83	67.64	67.65	66.72	68.78	0.42	0.01	-0.93	2.06
South Carolina	1/	79.16	78.89	78.96	79.31	78.54	78.87	-0.20	0.34	-0.77	0.33
South Dakota	1/	77.43	77.71	78.11	77.82	76.15	75.70	0.68	-0.29	-1.67	-0.45
Tennessee		74.35	74.16	74.17	74.65	74.55	75.21	-0.18	0.48	-0.10	0.66
Texas		73.60	73.72	72.95	72.40	72.12	71.99	-0.65	-0.55	-0.28	-0.13
Utah	1/	80.81	80.25	80.08	80.01	79.00	79.87	-0.72	-0.08	-1.01	0.87
Vermont	1/	73.53	73.38	73.57	73.68	74.14	73.69	0.04	0.11	0.46	-0.45
Virginia	1/	66.04	66.12	66.17	66.30	66.02	65.37	0.13	0.13	-0.28	-0.65
Washington	1/	66.51	66.75	66.28	65.49	65.26	65.00	-0.22	-0.79	-0.23	-0.26
West Virginia	1/	81.57	82.13	82.35	82.74	82.69	82.53	0.77	0.39	-0.05	-0.16
Wisconsin		71.19	71.20	71.15	71.50	71.00	70.90	-0.04	0.35	-0.50	-0.10
Wyoming	1/	74.11	74.86	74.83	75.22	73.38	72.92	0.71	0.40	-1.84	-0.46

1/ State Medicaid amendment for cervical and breast cancer coverage has been approved by the Centers for Medicare and Medicaid Services

Source: FFIS analysis of Bureau of Economic Analysis data, U.S. Department of Commerce.

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Table 4

Potential Impact of 2003 FMAP Shift; Alternative Stimulus Proposals

(federal fiscal years; dollars in thousands; federal share as percent)

	FMAPs				Possible Stimulus Package Proposals		
State	Actual 2002	Calculated 2003	2002 Grants for Vendor Payments	Illustrative 2003 Grant Impact	Increase 2003 FMAP by 1%	Hold Harmless Half of 2002	High Unemployment
Alabama	70.45	70.60	$2,021,905	$4,750	$30,930	$0	$0
Alaska	57.38	58.27	357,133	5,983	6,619	8,167	0
Arizona	64.98	67.25	2,163,316	81,448	34,742	12,982	0
Arkansas	72.64	74.28	1,453,801	35,398	21,138	3,748	0
California	51.40	50.00	13,538,588	-397,186	292,434	0	0
Colorado	50.00	50.00	1,128,792	0	24,382	0	0
Connecticut	50.00	50.00	1,677,912	0	36,243	0	0
Delaware	50.00	50.00	301,163	0	6,505	0	0
District of Columbia	70.00	70.00	685,983	0	10,584	0	10,584
Florida	56.43	58.83	5,337,385	245,648	97,984	9,043	0
Georgia	59.00	59.60	3,184,049	34,991	57,698	17,767	0
Hawaii	56.34	58.77	372,819	17,360	6,851	0	0
Idaho	71.02	70.96	570,673	-562	8,686	0	0
Illinois	50.00	50.00	4,163,182	0	89,925	0	0
Indiana	62.04	61.97	2,718,124	-3,336	47,371	58	0
Iowa	62.86	63.50	1,253,327	13,755	21,316	0	0
Kansas	60.20	60.15	1,052,445	-1,031	18,897	0	0
Kentucky	69.94	69.89	2,381,760	-1,889	36,805	7,570	0
Louisiana	70.30	71.28	3,065,949	46,319	46,454	5,008	0
Maine	66.58	66.22	979,407	-5,768	15,973	0	0
Maryland	50.00	50.00	1,744,378	0	37,679	0	0
Massachusetts	50.00	50.00	3,883,898	0	83,892	0	0
Michigan	56.36	55.42	4,022,784	-72,739	78,394	0	0
Minnesota	50.00	50.00	2,200,505	0	47,531	23,920	0
Mississippi	76.09	76.62	1,986,181	15,056	27,996	9,523	0
Missouri	61.06	61.23	3,363,852	9,908	59,333	0	0
Montana	72.83	72.96	449,956	850	6,661	624	0
Nebraska	59.55	59.52	765,793	-367	13,895	5,282	0
Nevada	50.00	52.39	394,988	20,391	8,143	1,411	0
New Hampshire	50.00	50.00	469,180	0	10,134	0	0
New Jersey	50.00	50.00	4,053,789	0	87,562	0	0
New Mexico	73.04	74.56	1,225,684	27,499	17,754	6,293	0
New York	50.00	50.00	19,046,092	0	411,396	0	0
North Carolina	61.46	62.56	4,000,668	77,416	69,065	32,472	0
North Dakota	69.87	68.36	320,537	-7,500	5,064	271	0
Ohio	58.78	58.83	5,470,987	4,844	100,436	11,353	0
Oklahoma	70.43	70.56	1,633,400	3,239	25,001	9,302	0
Oregon	59.20	60.16	1,528,553	26,647	27,441	10,154	27,441
Pennsylvania	54.65	54.69	6,745,144	5,442	133,201	0	0
Rhode Island	52.45	55.40	697,066	42,325	13,589	8,676	0
South Carolina	69.34	69.81	2,335,173	17,230	36,126	18,258	36,126
South Dakota	65.93	65.29	342,676	-3,614	5,668	5,949	0
Tennessee	63.64	64.59	3,678,304	59,281	61,504	4,295	0
Texas	60.17	59.99	7,922,483	-25,213	142,628	26,294	0
Utah	70.00	71.24	653,037	12,486	9,900	6,569	0
Vermont	63.06	62.41	412,991	-4,612	7,147	0	0
Virginia	51.45	50.53	2,073,258	-40,083	44,313	7,896	0
Washington	50.37	50.00	2,819,257	-22,230	60,896	9,312	60,896
West Virginia	75.27	75.04	1,218,715	-3,937	17,540	584	0
Wisconsin	58.57	58.43	2,077,358	-5,473	38,397	12,639	0
Wyoming	61.97	61.32	161,395	-1,822	2,843	3,294	0
Total			**$136,105,795**	**$210,905**	**$2,602,664**	**$278,713**	**$135,047**

Note: Assumes each state's 2003 Medicaid program will cost 8 percent more than 2002.

STATE OF KANSAS

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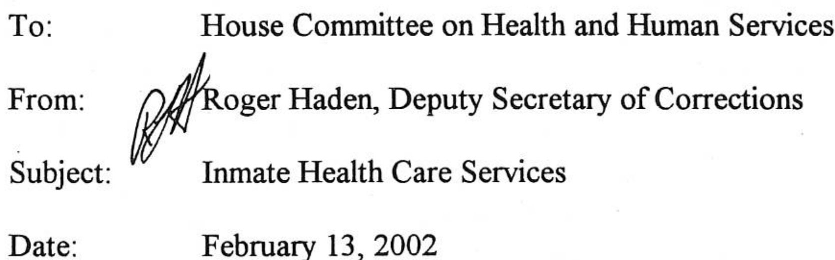

To: House Committee on Health and Human Services

From: Roger Haden, Deputy Secretary of Corrections

Subject: Inmate Health Care Services

Date: February 13, 2002

By statute and court rulings it is a well-established principle that the State is obligated to provide access to adequate and necessary health care to the persons housed within its correctional facilities. (K.S.A. 75-5201; 75-5210 (c)). The Eighth Amendment to the United States Constitution and § 9 of the Kansas Constitution prohibit the infliction of cruel and unusual punishment. Due to these constitutional requirements, states are required to provide medical treatment for the serious illnesses and injuries of inmates. "An inmate must rely on prison authorities to treat his medical needs; if the authorities fail to do so, those needs will not be met. In the worst cases, such a failure may actually produce physical 'torture or a lingering death,' In re Kemmler, supra, the evils of most immediate concern to the drafters of the Amendment. In less serious cases, denial of medical care may result in pain and suffering which no one suggests would serve any penological purpose." Estelle v. Gamble, 429 U.S. 97 (1976). The infliction of such unnecessary suffering is inconsistent with contemporary standards of decency and is constitutionally prohibited.

Since 1988, the Department of Corrections has provided for inmate health care through contracts with qualified health care providers developed pursuant to the state's negotiated procurement processes. (K.S.A.75-5205; 75-37,102) Below is a brief summary of the contracting history and major features of the current health services contract:

Contracting History:

- Current Contractor: Prison Health Services (PHS) a subsidiary of America Service Group (ASG)
- Current contract term began July 1, 1999 and will expire June 30, 2005.
- Four vendors submitted proposals during RFP process: Correctional Medical Systems, Wexford Health Sources, Inc., Health Professionals, LTD, and Prison Health Services

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- PHS has had contract since July 1, 1991
- From December, 1988 to June 30, 1991, Correctional Medical Systems (CMS) had the initial 3-year contract term
- PHS has been in the correctional health care industry since 1978 and provides contracted health care services to over 100 agencies in approximately 25 states with a total of over 190,000 correctional clients.
- Department also has a contract with Kansas University Physicians, Inc. (KUPI) to provide consulting and contract monitoring services to the Department for the health services contract.

Contract Cost Data:

- Contract cost is based on a per capita cost by correctional facility. Payment is based on monthly Average Daily Population (ADP) by facility. (Copies of the FY 2002 and 2003 per capita rates are attached)

- The data below provides cost data for FY 2001-2003 with an average per-inmate costs based on ADP for each year. The last line gives a cost comparison of the average per-inmate cost with the single rate insurance rate paid by the state for employees.

FY 2001: (actual)		FY 2002 (Gov. Rec.)		FY 2003 (Gov. Rec.)	
PHS:	$22,625,083	PHS:	$23,984,412	PHS:	$24,545,772
KUPI:	$ 183,401	KUPI:	$ 194,000	KUPI:	$ 194,000
ADP:	8435	ADP:	8505	ADP	8602
Average:	$ 2682	Average:	$ 2,820	Average:	$ 2,854
Employee:	$ 2,553	Employee	$ 2,783	Employee	$ 3,531

- While the average cost per inmate represents total cost for the health care services, the employee insurance rate represents only one portion and does not include additional costs for deductibles, co-pays, etc.

- Contract provides for adjusting per capita rates to account for changes in facility populations when these changes are in 10% increments. That is, if a facility population increases or decreases by 10%, 20%, 30%, etc. pre-negotiated adjustments in the per capita rate for that facility will be applied.

- Inmates in work release programs are responsible for their own medical care costs once they are employed. The Department has 246 work release slots, 198 in Wichita and 48 in Hutchinson. All other inmates are covered by the contract.

Contract Staffing: The contract contains a minimum staffing pattern. This may be adjusted by mutual agreement and contract amendment based on changes in patient need, facility populations, etc.

- Current Staffing: 304.95
  - Regional Administrative: 8.50
  - Medical: 212.65
  - Mental Health: 83.80

- As you can see by the staffing pattern attached, medical staffing includes 6.55 physicians, 9.95 dentists, 5.9 PA/NP/ARNP positions, 7 DON positions, and 121.75 nursing positions. Mental health staffing includes 4.8 psychiatrists, 3.5 registered psychiatric nurses, 29 psychologists, and 21.5 social workers.

- Staffing plan provides for 24-hour clinic staffing at all central unit sites including El Dorado, Ellsworth, Hutchinson, Hutchinson East, Lansing, Larned, Norton, Topeka, and Winfield.

Contract Features and Services:

- Contract provides for full coverage, comprehensive health care services, including medical, dental, optical, mental health care and prescription drugs, for the inmate population. Generally the contract is consistent with Managed Care approaches to health care.
- Contractor accepts full liability for services and provides full indemnification to State
- Required accreditation by American Correctional Association (ACA) and National Commission on Correctional Health Care (NCCHC)
- Most recent NCCHC accreditation was completed Fall 2001. All sites were accredited.
- No deductibles
- No caps on services or contractor expenditures
- No co-pays from Department. (Inmates pay $2.00 co-pay for initial sick call visits.)
- No exclusions or exempted services consistent with "Community Standards of Care" approach
- No provision for re-negotiation of costs or contractor early termination
- Medical Services include:
  - Health screening and assessment,
  - Off-site services as needed (hospitalization, emergency care, specialty consults, etc.,)
  - Infirmary care,
  - Sick-call,
  - Medication management,
  - Chronic care clinics,
  - Special needs clinics,
  - Infection control,
  - Ancillary services (x-ray, laboratory, etc.,)
  - Utilization Review to ensure timely access to care,

- Electronic Medical Records (EMR), implementation and maintenance of system,
- Acquisition, replacement and repair of medical equipment (up to $65,000/year)

- Dental services include:
  - Dental screenings and examinations
  - Emergency dental care
  - Dental treatment consistent with maintaining inmate's health status

- Mental Health Services include:
  - Psychological and Psychiatric assessment and diagnosis
  - Medication management
  - Individual and group counseling services
  - Case management
  - Crisis intervention
  - Activity therapy,
  - Release planning for mentally ill offenders
  - Forensic evaluation services.
  - In addition beginning with the transfer of the male Reception and Diagnostic Unit from Topeka to El Dorado in the March, 2001, contract also provides for intake psychological assessment and evaluation services.

Contract Monitoring:

- Contractor must provide an internal quality improvement program directed by a Regional level professional. EMR data should begin to enhance this function as it is fully implemented.
- Kansas Foundation for Medical Care (KFMC) provides peer review for health care practitioners
- Health care services must maintain accreditation standards by the National Commission on Correctional Health Care (NCCHC) and the American Correctional Association (ACA). Each facility has a three-year audit cycle.
- Kansas University Physicians Incorporated (KUPI) Medical Contract Consultants Monitoring Team:
  - 2 Registered Nurse Monitors (one with an MS in health services administration) App.1/2 time Physician services for case review and monitoring
  - Biennial site audits
  - Direct input into annual review and final approval of contractor's policies and procedures
  - Mortality and morbidity reviews (deaths or serious cases)
  - Review of audit issues
  - Review of grievances and outside complaints related to inmate health care services

- Advise the Department regarding specifications and standards for health care services and of contractor's performance.

Recent Trends: Generally, the health care costs for inmates have been increasing and are expected to continue to do so. Inmates are generally less healthy than the general public, often have issues with poor nutrition, substance use effects, high risk sexual and drug lifestyles, more mental health issues, and greater acuity in both physical and mental health issues. In addition the number of older inmates is increasing. Often these inmates experience greater health care problems at a relatively younger age than the general public.

Medical Indicators Calendar Year 1998 – 2001

- Sick call visits reduced by app 16% (there are still over 132,000 per year)
- Infirmary days increased by 18% (doesn't include nursing home patient days)
- Off-site in-patient days have remained fairly consistent at app 600 days per year (these, obviously, represent high cost services)
- Off-site Outpatient services have increased nearly 22% (this includes surgical, ex-ray, labs, ER visits, etc.)
- Off-site Physician consultations have increased 65%
- Chronic Care inmates have increased by 33%
- Treatment of inmates with diabetes has increased by 19%
- Treatment of inmates with infectious diseases has increased by over 125% (includes HIV, Hep C, et.al.) (TB patients have decreased by 14%)
- Cardiac Vascular/Hypertension encounters have increased 42%
- Chronic Obstructive Pulmonary Disease encounters are up 14%
- Number of inmates 55 years of age or older being seen in clinics has increased by 25%
- The number of inmates aged 55 and older has increased 134% in the past 10 years; the number of inmates over age 70 has increased 207%.

Mental Health Indicators – Calendar Years 2000-2001

- Psychiatry contacts have increased nearly 20% in two years. These include initial and follow-up interviews, medication reviews, crisis case management, etc.
- High Risk Indicators which include deaths, suicide gestures and attempts, involuntary medication, forced medication, etc., have increased nearly 18%;
- The number of inmates to whom various therapeutic interventions are provided has increased nearly 30% . These interventions include individual and group counseling, sex offender treatment, domestic abuse counseling, aftercare counseling, etc.
- The number of cases managed on crisis level by mental health staff has increased 6%.
- The number of inmates prescribed psychotropic medications averages approximately 16%-18%.

Significant Cost Escalations: (Attachment: PHS cost projections. Attachment: PHS White Paper)

Staffing costs (nursing shortage)

- PHS estimates that its staffing costs have increased 32% since the beginning of the current contract term.

Pharmaceuticals

- PHS estimates that the pharmacy costs of the contract have increased more than 65% in the past year.

Off-site costs

- Off-site costs, including both inpatient and outpatient, have increased over 25% in the past year.

Cost Control Alternatives: A 1997 study commissioned by the National Institute of Corrections (NIC), outlined several alternatives to controlling medical care costs for correctional systems. Among those ideas were the following:

- Telemedicine: use of videoconferencing equipment for specialty treatment or consultations. Currently PHS provides some psychiatric services to the Larned Correctional Mental Health Facility by this method. Cost effectiveness of this method depends on the volume of consultations or referrals. Michigan estimates a minimum of 83-124 per month is needed for their system to break even.
- Implement inmate co-pays – the Department has implemented inmate co-pays since 1995: $2.00 charge for initial sick call; inmate purchase of certain OTC medications. FY 2001 the Department collected $37,384 from inmate co-pay and has collected $211,718 since 1995.
- Implement Computerized Records Management – we are nearing full implementation of an electronic medical records (EMR) system;
- Implement a Managed Care model – Kansas, though its providers, utilizes such a managed care approach;
- Contracting with professional providers – Kansas has employed this method since 1989;
- Consolidation of services where feasible – currently PHS employs a "Center of Excellence" concept to accomplish this where feasible. Oncology patients primarily are located in EDCF; dialysis patients at LCF, etc.
- Bulk rate purchasing of pharmaceuticals – ASG, PHS' parent company also owns Secure Pharmacy, as a means of managing pharmacy costs;
- Implement system of Utilization Review to ensure pre-authorization of off-site care, etc. – this is a feature of our contract;
- Pre-negotiate rates for off-site hospitalization and specialty care – PHS has established a provider network of local providers which includes negotiated rates for care;
- Use of medical furloughs or early release – this is used sparingly by most states and must be consistent with public safety risk. Department is currently working with other state agencies, SRS and Aging, to explore this issue. SB 339 is a possible legislative vehicle for accomplishing this.

ATTACHMENT

Contract No. 33158

Core Base Bid

Comprehensive Medical/Mental Health Services

FY2002

Capacity	Facility	Per Capita Charge	Total
2,335	Lansing- Central, East Osawatomie	$ 6.73	$ 5,736,862.00
1,590	Hutchinson-Central, South, East	$ 7.08	$ 4,113,276.00
1,164	El Dorado- Central, North, East	$ 9.77	$ 4,150,613.00
812	Norton- Central, Stockton	$ 5.28	$ 1,565,326.00
632	Ellsworth	$ 5.62	$ 1,297,064.00
825	Topeka, RDU, Central, West	$ 11.27	$ 3,393,160.00
720	Winfield- Wichita Work Release	$ 4.46	$ 1,171,892.00
279	Larned Correctional Mental Health Facility	$ 21.16	$ 2,155,432.00
		TOTAL	$ 23,583,625.00

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Core Base Bid
Comprehensive Medical/Mental Health Services

FY2003

Capacity	Facility	Per Capita Charge		Total	
2,335	Lansing- Central, East Osawatomie	$	6.93	$	5,915,308.00
1,590	Hutchinson-Central, South, East	$	7.29	$	4,232,302.00
1,164	El Dorado- Central, North, East	$	10.05	$	4,270,720.00
812	Norton- Central, Stockton	$	5.43	$	1,610,621.00
632	Ellsworth	$	5.79	$	1,334,597.00
825	Topeka, RDU, Central, West	$	11.69	$	3,491,348.00
720	Winfield- Wichita Work Release	$	4.59	$	1,205,803.00
279	Larned Correctional Mental Health Facility	$	21.78	$	2,217,804.00
			TOTAL	$	24,278,503.00

PRISON HEALTH SERVICES

Staffing Summary

03-30-01

	R.O.	LCF	TCF	LCMHF	HCF	EDCF	WCF	ECF	NCF	TOTAL
Regional Vice President	1.0									1.00
Regional Medical Director	1.0									1.00
Regional Dental Director	0.5									0.50
Regional Director of Nursing	1.0									1.00
Regional Mental Health Director	1.0									1.00
Regional QI Coordinator	1.0									1.00
Office Manager	1.0									1.00
Secretary	1.0									1.00
Medical Admin Assistant	1.0									1.00
MEDICAL PROGRAM										
HSA		1.0	1.0	0.4	1.0	1.0	0.5	0.6	0.5	6.00
Medical Director/Physician		1.0	0.8	0.25	1.75	1.3	0.2	0.5	0.75	6.55
Dental Director/Dentist		2.5	0.7	0.25	2.5	2.0	0.5	0.5	1.0	9.95
Medical Secretary		1.0	0.0	0.5	1.0	1.0	0.0	0.9	1.0	5.40
Medical Record Clerk		3.8	2.0	1.0	2.75	2.0	2.0	1.0	0.0	14.55
Ward Clerk		1.0	0.0	0.0	1.0	2.0	0.0	0.0	0.9	4.90
Dental Assistant		2.5	0.7	0.25	2.5	2.0	0.5	0.5	1.0	9.95
Lab Technician		0.5	0.0	0.0	0.5	0.0	0.0	0.0	0.0	1.00
X-ray Technician		0.5	0.25	0.0	0.5	1.0	0.0	0.1	0.0	2.35
Director of Nursing		1.0	1.0	1.0	1.0	1.0	0.5	1.0	0.5	7.00
PA/NP/ARNP		2.05	1.0	0.25	1.0	1.0	0.6	0.0	0.0	5.90
RN		8.85	7.2	7.0	10.4	13.0	5.5	5.0	6.8	63.75
LPN		17.60	6.6	1.0	11.8	10.0	4.0	3.0	4.0	58.00
CMA		2.8	2.8	0.0	2.8	6.95	0.0	0.0	0.0	15.35
Archives ART		0.0	1.0	0.0	0.0	0.0	0.0	0.0	0.0	1.00
Archives Records Clerk		0.0	1.0	0.0	0.0	0.0	0.0	0.0	0.0	1.00
MENTAL HEALTH										
Psychiatrist		1.0	0.5	1.0	1.0	1.05	0.1	0.1	0.05	4.80
Psychologist (Ph.D.)		2.0	1.0	1.0	1.5	0.3	0.1	0.1	0.0	6.00
Psychologist (MA)		7.0	2.0	4.0	3.0	4.0	1.0	2.0	0.0	23.00
Social Worker (MSW)		4.0	4.0	2.0	3.0	2.0	1.0	1.0	2.0	19.00
Social Worker (BSW)		1.0	0.5	1.0	0.0	0.0	0.0	0.0	0.0	2.50
Mental Health Secretary		2.0	1.5	1.0	1.5	1.0	1.0	1.0	1.0	10.00
Office Assistant		0.0	0.0	1.5	0.0	0.5	0.0	0.0	0.0	2.00
Activity Treatment Director		0.0	0.0	1.0	0.0	0.0	0.0	0.0	0.0	1.00
Activity Therapist		3.0	1.0	6.0	1.0	1.0	0.0	0.0	0.0	12.00
Psychiatric RN		1.0	0.0	2.0	0.0	0.5	0.0	0.0	0.0	3.50
TOTAL	8.5	67.1	36.6	32.4	51.5	54.6	17.5	17.3	19.5	304.95

KDOC FACILITY INFORMATION

FACILITY	LOCATION	CAPACITY	SERVICES	SECURITY LEVEL	
				MALE	FEMALE
Lansing Correctional Facility-Central	Lansing	1,783	19 bed infirmary, 3 of which are negative air-flow and 3 MH observation cells; sick call x 2; dental operatory; optometry; x-ray	Max./Med	—
Lansing Correctional Facility-East	Lansing	472	sick call	Min.	—
Lansing Correctional Facility-South	Osawatomie	80	sick call	Min.	—
Hutchinson Correctional Facility-Central	Hutchinson	1,000	4 bed ward and 3 single bed negative air-flow isolation cell infirmary; sick call; MH observation cell; dental operatory*	All	—
Hutchinson Correctional Facility-South	Hutchinson	192		Min.	—
Hutchinson Correctional Facility-East	Hutchinson	398	4 bed ward infirmary; sick call	Med.	—
El Dorado Correctional Facility-Central	El Dorado	992	Two 3 bed ward and 17 single cell infirmary, 4 of which are negative-air flow and 2 that are MH observation cells; sick call; dental operatory; optometry; x-ray	Max./Med.	—
El Dorado Correctional Facility-North	El Dorado	102	sick call	Min.	—
El Dorado Correctional Facility-East	Toronto	70	sick call	Min.	—
Norton Correctional Facility-Central	Norton	700	3 bed ward and one single bed negative air-flow isolation cell infirmary; MH observation cell; sick call; dental operatory; optometry; x-ray	Med./Min,	—
Norton Correctional Facility-East	Stockton	112	sick call	Min.	—
Ellsworth Correctional Facility	Ellsworth	632	3 bed ward and one single bed negative air-flow isolation cell infirmary; MH observation cell; sick call; dental operatory; x-ray	Med./Min.	—
Topeka Correctional Facility-Reception & Diagnostic Unit	Topeka	236	Sick call; dental operatory; x-ray	Max./Med.	Max.
Topeka Correctional Facility-Central	Topeka	478	5 bed ward, one negative air-flow, and one MH observation cell in the infirmary. Dental operatroy; optometry	—	All
Topeka Correctional Facility-West	Topeka	111	Sick call	Min.	—
Winfield Correctional Facility	Winfield	522	Sick call; one observation bed.**	Min.	—
Wichita Work Release Facility	Wichita	198	sick call for permanent party inmates- up to 16 inmates.	Min.	—
Larned Correctional Mental Health Facility	Larned	279	5 single infirmary beds, one of which is negative air-flow and one equipped with restraints; sick call; dental operatory	All	—

* The clinic at HCF is closed for renovation. The temporary clinic space allows for sick call, dental operatory, optometry, and two observation beds.
** The WCF infirmary renovation is scheduled for completion 12/98. Upon completion will have a 3 single bed infirmary ; dental operatory; x-ray.

Inmate Health Care Services
Calendar Years 1998 - 2001

Indicator	1998	1999	2000	2001	Difference %
Sick Call Visits	135450	142891	132398	113301	-16.4%
Chronic Care Visits	26475	21703	20280	18735	-29.2%
Total	161925	164594	152678	132036	-18.5%
Dental Visits	34034	32204	29107	26080	-23.4%
Infirmary Days (doesn't include nursing home patient days)	5369	5607	6592	6314	17.6%
Off-Site In-Patient Days	610	598	576	605	-0.8%
Off-site Out-patient (surgical, ER visits, labs, proc/x-rays)	946	1036	905	1156	22.2%
Off-site Physician Consultations	1010	1208	1363	1668	65.1%
Chronic Care encounters	20305	23269	25704	27039	33.2%
Diabetes care	2621	2735	2841	3128	19.3%
Infectious Disease/Hep C/Other	3415	3607	4142	7718	126.0%
TB	2914	3933	3195	2478	-15.0%
CV/Hypertension	8285	9600	10272	11727	41.5%
Seizure	1307	1371	1441	1213	-7.2%
COPD/Asthma	6070	7121	7333	6913	13.9%
Immune Suppressed/CA	382	481	454	411	7.6%
HIV Positive (12/31)	35	37	43	34	-2.9%
AIDS	3	4	6	7	133.3%
Total	38	41	49	41	7.9%
Inmates age 55 and older	3736	4327	4434	4688	25.5%
Special Needs inmates (12/31) blind, deaf, walkers, crutches limb protheses, HOH	151	172	180	156	3.3%
Pregnancies					
Delivered	4	21	14	7	75.0%
Transferring In	NA	NA	27	28	

Inmate Health Care Services
Calendar Years 1998 - 2001

Indicator	1998	1999	2000	2001	Difference %
Psychiatry Contacts (Initial interviews, follow-up interviews mediction reviews, crisis cases, etc.)			15722	18771	19.4%
High Risk Indicators (deaths, suicide attempts, involuntary medications, forced medications, etc.)			408	480	17.6%
Therapy Provided (individual counseling, group counseling, aftercare, SOTP, domestic abuse, etc.)			7175	9317	29.9%
Crisis Cases			718	761	6.0%

PHS Healthcare Costs

For 2000, Estimated 2001, and Projected 2002

(numbers in 000's)

	2000	**2001**	**2002**
Salaries and Benefits: All medical and administrative salaries and benefits . This number includes temporary services and penalties	14,204	16,426	16,706
Contract Services: Costs for contracted providers who provide Services on-site . incl. Primary and specialty care Physician services	745	606	589
Hospitalization: Hospital and physician costs for patients Admitted as inpatients	1,793	1,829	1,629
Outpatient Services: Facility and physician costs for off-site Emergency, Outpatient Surgery, Office visits, MRIs, CTs, and on-site dialysis at LCF	1,462	1,899	1,793
Pharmacy: Cost of drugs, dispensing and shipping	1,031	1,520	2,188
Other: Costs for Medical and Dental Supplies Malpractice Insurance, Bonding, Recruitment fee And other related costs (i.e. advertising), Equipment (includes telemedicine and EMR computers) Licensing and Accreditation fees , In-service education and training costs for staff, Communication costs (i.e. telephone). Rental and lease costs on office space and equipment.	1,965	2,759	2,763
TOTAL COSTS:	21,200	25,039	25,668

Note: 2000 is actual PHS fiscal year costs. 2001 is estimated cost based on 11 month totals. 2002 costs are budget projections

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Kansas Department of Corrections

Inmates Aged 55 and Over: Age Distribution on Selected Dates [June 1992 - Dec. 2002]
Number of Inmates and % of Total Inmate Population

	Age Grouping											
Date	55-59		60-64		65+		Subtotal 55+		70+		Total Inmate Pop.	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
06/30/1992	84	1.36%	52	0.84%	38	0.61%	**174**	**2.81%**	14	0.23%	6,193	100.00%
06/30/1993	97	1.55%	61	0.98%	36	0.58%	**194**	**3.11%**	10	0.16%	6,240	100.00%
06/30/1994	107	1.76%	51	0.84%	35	0.57%	**193**	**3.17%**	13	0.21%	6,091	100.00%
06/30/1995	104	1.50%	55	0.79%	48	0.69%	**207**	**2.99%**	17	0.25%	6,926	100.00%
06/30/1996	116	1.56%	63	0.85%	57	0.76%	**236**	**3.17%**	25	0.34%	7,455	100.00%
06/30/1997	143	1.83%	63	0.81%	67	0.86%	**273**	**3.50%**	32	0.41%	7,795	100.00%
06/30/1998	160	1.99%	60	0.75%	82	1.02%	**302**	**3.76%**	30	0.37%	8,039	100.00%
06/30/1999	160	1.89%	76	0.90%	83	0.98%	**319**	**3.76%**	33	0.39%	8,486	100.00%
06/30/2000	185	2.11%	86	0.98%	89	1.01%	**360**	**4.10%**	38	0.43%	8,784	100.00%
06/30/2001	183	2.14%	102	1.19%	103	1.21%	**388**	**4.54%**	48	0.56%	8,540	100.00%
12/31/2001	200	2.33%	109	1.27%	98	1.14%	**407**	**4.75%**	43	0.50%	8,574	100.00%

* *Prepared 11 Feb. 2002, Kansas Department of Corrections, Research and Planning Unit.*
Source of Information: SAS end-of-year inmate population reports on file. EXCEL document "age55plusbyyear.xls"

White Paper on Healthcare Costs

December 2001

New Parameters for Partnerships in Correctional Healthcare

EXECUTIVE SUMMARY

The dramatic and continuing rise in healthcare costs impacts correctional facilities and their contracted healthcare providers along with all private and public employers who provide healthcare coverage to employees. This translates into higher costs for correctional healthcare contracts that have typically contained high levels of provider risk and multi-year terms with limited renegotiation provisions.

Over a relatively short period of time, these factors have created an imbalance in the contracting relationship that must be addressed to insure best value, viable client-vendor partnerships continue. These changes to business-as-usual do not reduce the substantial savings and benefits that correctional facilities can realize through contracted healthcare services.

New contracting arrangements are required to maintain partnership relationships that provide clients with 'best value' and a win-win for both parties. Several alternatives exist to correctional administrators seeking ways to reduce healthcare costs and limit risk including innovative risk/cost-sharing provisions, alternative pricing structures and mutual provisions for renegotiation based on predefined changes in costs or operating assumptions.

PERSPECTIVE

The last time the country experienced a similar rise in healthcare inflation, with annual increases in the 12-15% range and healthcare costs approaching 13% of the GNP, was in the mid 1980's. In response, the market developed the now-familiar elements of managed care that characterize both our private and public healthcare delivery systems. Such mechanisms as utilization review and case management, provider networks and contracted payment terms were successful in dramatically lowering the rate of growth in healthcare spending. Indeed, during much of the 1990's, the rate of increase in healthcare costs slowed to a range of 3-4% annually.

The decision to contract correctional healthcare is fundamentally the search for accountability for an acceptable standard of healthcare at an acceptable price. The contracting solutions that provide the best value to clients are those that demonstrate long-term viability by balancing cost containment and liability provisions with adequate provider payments. Clients do not want to be gouged on pricing; neither is it in their interests to buy healthcare 'on the cheap' and face incremental liability and operational problems resulting from vendor failure. The old adage of "lowest bid does not necessarily mean lowest cost" remains true.

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CURRENT TRENDS

Following a decade-long period where healthcare costs have been under relative restraint, several market-based factors have recently converged to once again exert a sustained, system-wide pressure on costs. Health plans in the private sector are seeing pressures on their medical loss ratios (the percentage of premium revenues going directly to provision of care) leading to rate increases for employer-sponsored medical plans in the 10-13% range. Major elements contributing to this rise in costs that directly impact correctional healthcare providers are outlined below.

Nursing Shortage

The economics of supply-and-demand are being felt throughout the country as fewer people enter the nursing profession at the same time that many existing nurses are either retiring or leaving the field for quality-of-work reasons. Simultaneously, the demand for nursing personnel and related functions is increasing as the baby boomer generation enters the period of life when consumption of healthcare services begins to rise. The net effect is a dramatic and continuing rise in the compensation package required for healthcare providers to attract and retain a sufficient number of qualified nursing personnel.

Correctional healthcare providers are competing with private, community and teaching hospitals, physicians' offices, skilled nursing facilities and other organizations in the same local and regional labor pools for these staff. The depth and scope of the nursing shortage will likely force a re-tooling of current clinical models that allows nurses to focus more exclusively on clinical care while other tasks are handled by other personnel.

Pharmaceuticals

It has been determined that a significant source of escalating health care costs is due to rising medication expenditures. This is due in part to the development of newer and more enhanced therapies, the increasing acuity of the patient population and expansion of formularies to include newer generation medications per community standards.

Overall prescription medication costs have been increasing nation wide at a rate of over eight percent (8%) annually; in 2000 the Average Wholesale Price of pharmaceuticals increased by over 16%. The correctional system, however, is experiencing an even greater increase due to the significantly higher population ratios of Hepatitis C, HIV, and mental illness, all of which produce a per patient per month cost ranging from $300 to as much as $1,600. While there are cost savings achieved through use of medications in such areas as reduced hospitalization and more effective disease management strategies, the annual increase in medication expenditures is expected to continue for the next decade, particularly with the aging of the inmate population.

Physician and Hospital Rates

Payors today, no matter how large, no longer have the ability to dictate terms and prices to hospitals. In fact, many hospitals are forcing payors to renegotiate reimbursement rates upward or risk termination of their existing contracts. These new contracts have significant price escalators and overall hospitals have now found themselves in stronger market position while becoming more risk adverse.

According to a study by the Center for Studying Health System Changes, healthcare spending increased 7.2% in 2000 - the largest

jump in a decade - with inpatient and outpatient hospital care accounting for 47% of the overall increase. The primary cause for this is a combination of the increased demand for hospital services and rising labor costs. Hospitals are now paying more for nursing staff, pharmaceuticals, blood processing, new technology, regulations, patient safety initiatives and information system demands.

Spending for physician services, which accounts for 25% of the overall cost associated with the increase in healthcare spending, is also accelerating. Physician reimbursement based on Medicare methodology has increased almost 16% through 2001. In many cases, this increase still fails to meet the physician's actual costs in providing care. The end result is that more physicians are unwilling to accept reimbursement based upon Medicare. Physicians who accept new patients generally are only willing to do so under a discount arrangement from the standard billed charges.

Utilization & Acuity

As described in the Institute of Medicine report "Crossing the Quality Chasm: A New Health System for the 21st Century", the health needs of the American population have been shifting from predominately acute, episodic care to care for chronic conditions. Chronic conditions are now the leading cause of illness, disability and death. Chronic illnesses affect almost half of the U.S. population and account for the majority of healthcare expenditures. This phenomenon is even more prevalent in the correctional setting. Individuals admitted to correctional facilities today have a high rate of chronic physical and mental conditions that have gone untreated.

Additionally, correctional healthcare programs act as extensions of the local public health department, performing communicable disease surveillance and disease management. As a result, individuals admitted to correctional facilities are sicker and require more intensive service upon admission. The end result is an increased number of healthcare events that must be provided and paid.

The cost of providing healthcare services to incarcerated individuals has also been adversely affected by changes in reimbursement and contracting trends. In the past, many states provided Medicaid reimbursement for enrolled individuals until the time at which they were sentenced. Now, in many states eligibility stops once an individual is housed in a correctional setting. Medicaid has made a focused effort to shift costs for those patients charged with a crime back onto the corrections funding base. Additionally, today healthcare agencies are less able to negotiate discounted rates with hospitals for incarcerated individuals. Therefore, the cost of each healthcare event is steadily increasing.

In simple terms, the overall cost of healthcare is equal to the number of events times the average cost. In the correctional setting both elements of the equation continue to increase.

Insurance

The United States is the most litigious country in the world, and prisoners are the nation's most litigious group. Prisoners bring more than 25% of all civil actions filed in federal district court; in other words, a group comprising less than 1% of the nation's population files a quarter of this litigation. The rate and cost of medical litigation have increased dramatically over the past decades and the impact on corrections, both from private suits as well as court-ordered public actions, has been profound.

The cost of this litigation in the area of corrections is not lost on insurance markets. Few industry leaders in insurance are interested in bidding on corrections business and those who do are pushing through rate increases not seen in years. Insurers are now increasing rates for medical malpractice liability coverage from 30% to 100% and at the same time raising policyholders' co-pays and deductibles in an effort to restore profitability. Those insurers are experiencing deteriorating underwriting results and rising costs on medical malpractice lines which are caused largely by high jury verdicts against medical practitioners and the inability to raise rates in the previous soft market. These factors were all pressing even before the events of September 11th which have now placed losses in other lines of insurance by these carriers and which they are trying to spread over their entire portfolio.

Employee Healthcare Costs

As a result of the factors above, employers nationwide are experiencing on average a 10-15% increase in the annual premiums charged by insurance companies to provide employee medical and related plans. No private insurance company in the marketplace provides the type of multi-year, fixed price contract typical in the corrections field, due to the risk and inflationary factors described here.

Healthcare providers and companies such as PHS, which employs over 6500 personnel, are not immune from these cost increases. Ultimately, these fundamental costs of doing business must be reflected in the pricing of services to customers. Multi-year correctional healthcare contracts that contain fixed annual inflators of 3-5%, an amount manageable during a period of low cost inflation, have rapidly become unsustainable.

IMPLICATIONS FOR CONTRACTING

Higher Risk = Higher Cost

The net effect of these sustained cost increases on what have typically been multi-year, fixed cost correctional healthcare contracts translates into significantly greater risk to the provider. Not surprisingly, there must be a 'pass through' of these costs to the potential client as no provider, public or private, can continue to absorb cost increases at this rate. What was feasible in an environment of stable, predictable healthcare cost behavior becomes increasingly expensive and untenable as the premium needed to cover such risk rises.

Benefits of Contracting Remain

Correctional facilities have been choosing to contract their healthcare services for almost 25 years for the simple reason that it saves money while improving quality, limiting liability and freeing correctional administrators to focus in issues of custody, security and control. The current turbulence in healthcare costs combined with increasing budget shortages in the public sector only increase the potential benefits of contracting for these services.

At the same time, there will be situations where existing contracts become unsustainable in the face of rising costs and risks. Contracts with no provision for renegotiation, low fixed annual inflators, high levels of vendor risk (e.g. no catastrophic limits or carve-out of high cost treatments) set the stage for a lose-lose scenario. Contractors continue to incur financial losses, potentially to the point of insolvency and clients lose the assurance of a well-functioning contract and service delivery system designed to meet their original objectives.

The options open to a client in a situation where an existing contract structure is no longer tenable are:

- Return to self operation
- Rebid the project
- Renegotiate contract terms

Self-op
Return to self-operation is an option for the contracting authority at anytime, with the assumption of all operating, direct and indirect costs and liabilities that lead to the original decision to contract the service.

Rebid
Rebidding the project will provide both parties with the chance to 'test the market' for the services and recalibrate the contract terms and pricing to reflect current realities.

Renegotiation
It is in neither party's interest for an existing contractor to be forced, because of sustained financial losses, to fold or prematurely end an otherwise beneficial contract. The issue is not one of increasing profits to the contractor (in many cases it is a matter of 'stopping the bleeding'), but rather of finding win-win solutions to the contracting process that appropriately reflect the new environment. Renegotiation of key contract terms in the context of an open working dialogue utilizing some of the elements described below can provide such an outcome.

CONTRACT ALTERNATIVES

The following section briefly describes several elements that can be utilized in the contracting process to re-establish balance in the cost vs. risk trade-off and provide benefits to both the client and provider. Some variation or combination of these factors will be most appropriate depending upon the unique circumstances of each contract (e.g. prison system vs. jail, facility size and annual intakes, detainee health status profile, etc.).

Cost Plus Percentage or Fixed Fee

In contrast to more traditional capitation or per diem-driven pricing models, an alternative long favored by many federal and other agencies utilizes a structure of actual operating costs plus a percentage or fixed fee component. Not only does this approach mitigate criticism leveled at capitated contracts regarding incentives to withhold services, but utilizing a 'fixed fee' (set amount) also takes away any supposed incentive to drive up costs in order to realize a larger fee. In essence, clients retain the expertise and resources of an experienced healthcare manager to control costs and improve quality for a pre-determined management fee.

For this approach to be successful it requires a clear definition of allowable costs, including a percentage or fixed fee allocation of necessary overhead expenses assigned to the contract (e.g. professional liability premiums, accounting, legal and other support functions). Regularly scheduled audits are used to verify the actual expenses and make whatever adjustments may be appropriate as agreed by the parties.

To address concerns about this model's ability to control costs, another variation would be to set a range or sliding fee scale that would be determined, in part, by actual costs obtained (lower costs mean higher fee) as well as achieving quality of care or other operationally defined indicators of success. Such a scenario provides for clear provider accountability for cost control and quality care while also avoiding the incrementally high costs that bidders must build into a full- or high-risk contract.

Risk Pools and Variations

Aggregate Limits
Currently utilized in some correctional healthcare contracts, this mechanism establishes pre-determined cost levels for certain categories of service. Usually calculated on an annual basis, categories typically included are off-site care, pharmaceuticals and specialized diagnostic tests. Cost thresholds are usually determined through an analysis of actual experience and comparisons to similarly sized sites/contracts. Often, there are cost-sharing provisions whereby savings achieved below the threshold are shared between client and vendor and costs incurred over the limit are shared to a certain point beyond which the client is responsible.

This approach can save clients significant up-front expense that results from having to price all potential aspects of healthcare costs into a bid. Aggregate pools also provide a clear cost- and risk sharing mechanism that focuses both parties' on effective management and regular reporting on major cost drivers within the contract.

Carve-outs
Under this variation, certain high risk and/or high cost services are either paid for directly by the client (pass-through) or paid by the vendor for reimbursement by the client. Typically this would be applied to procedures that are pre-existing, relatively infrequent and/or exceptionally expensive (organ transplants, Factor 8 treatment for hemophiliacs) or treatments that are still in a state of flux regarding clinical protocols, cost-effectiveness and outcome (Hepatitis C).

For example, ten years ago this exemption was frequently applied to the treatment of HIV patients. However, as clinical protocols and standards of care have emerged, this has became a reasonably predictable cost given appropriate prevalence data, and it is not uncommon for HIV to now be included as a risk factor. Hepatitis C is now the disease where such a carve-out is best applied. Again, the client saves on the front-end of the process where potentially excessive and still unpredictable costs must be priced into an all-risk proposal.

Catastrophic Limits
By defining upper limits of provider responsibility for medical costs incurred on a per inmate basis, there are client savings in avoiding the incremental pricing for a 'worst case scenario' or actuarial pricing where the provider must bear full-risk for the occasional but exceptionally high-cost case.

These limits may be set on either an episode of care basis (e.g. a course of hospitalization or course of treatment for a disease state) or more commonly for an annual total per inmate. The amounts typically range from $10,000 to $20,000 with the degree of savings inversely related to the catastrophic limit. In rare instances the amount may be set as high as $50,000, effectively nullifying the savings effect.

Defining Up- and Down-side Risks

Focusing directly on the financial structure of the contract, there are mechanisms that can more precisely define the risk and return to both the client and provider. For instance, a contract may be constructed such that the overall profit is capped at a certain percentage of the annual revenues. In return for limiting its upside return on the contract, the provider is guaranteed a 'floor' under which its operating results will not be allowed to fall (either a lower percentage or break-even when allocated indirect costs are included).

Similar to cost-plus arrangements, this requires a clear definition of all costs, includ-

ing an allocation of necessary overhead expenses assigned to the contract (e.g. professional liability premiums, accounting, legal and other support functions). Regularly scheduled audits (semi-annually) are used to 'true-up' the numbers and make whatever adjustments are appropriate as approved by the parties. In essence, this approach allows the parties to define the risk-return balance of the contract under a "concept of reasonableness" that minimizes surprises and adds stability to the contract.

Contract Re-openers

These elements provide pre-determined points or events under which the parties may review and renegotiate key terms of the agreement. Examples may include:

- Market-based inflation or deflation of nursing rates over a defined threshold, after the provider has been at risk for certain amounts and verified through audit
- Renewal years at both parties option, allowing for negotiation of annual increases or decreases based on actual costs and experience
- Mutual notice of termination whereby either party may end the contract without cause by providing appropriate advance notice, typically of 90days.

Again, the intent is not to relieve the provider of all risk, but to define the risk and identify up front those cost drivers that are either to a large degree outside of the provider's control and/or of such volatility that it is not in the client's best interest to price these costs into a bid for a multi-year, no-out contract. Mutual termination provisions become an option of last resort since triggering this clause implies that one of the parties is in a losing situation where continuation of the contract is not feasible. The inclusion of contract provisions described here minimizes the possibility of this outcome.

OFF-LOADING RISK TO PROVIDERS

The desire of clients to off-load risk onto the healthcare provider is one of the fundamental needs driving the contracting decision. In response to potential criticism that these variations take the provider 'off the hook' for any risks and obviate the need to consider contracting, there remain several elements of substantial size and risk that the provider must successfully manage, including:

- Personnel costs/rates, particularly for nursing staff in a continued period of shortage across the country
- Employee health and welfare costs currently increasing at rates of 10-15%
- Staffing levels and service performance, often defined through corresponding staffing and performance indicators with attached financial penalties or liquidated damages
- Costs for professional liability (malpractice) insurance, bonding and related risk management costs which have been increasing at annual rates of 20-50%
- Medical, dental and other supply costs increasing annually in the 5-7% range

Beyond these specifics, the client is retaining the expertise and resources of an experienced correctional healthcare management team to effectively control not only costs, but also the mechanics and effectiveness of the healthcare delivery process. Freeing the administration

to focus in issues of custody, security and control while an accountable partner manages this complex system reduces overall facility risk and liability.

SUMMARY

The market factors and client needs creating the private correctional healthcare field over 20 years ago remain valid today. This is especially true during this inflationary period in the country's healthcare costs and public sector budget shortfalls. Adopting alternative contract terms and conditions to reflect the increased costs and risk that accompanies this inflation is required to 'rebalance' the risk vs. cost trade-off that form the basis for successful partnerships to manage these services.

Client objectives for off-loading risk while insuring cost-effective services that meet community standards of care are best met through contractual relationships that provide a continuity of care through long-term partnerships.