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Corrections Health Care Overview and Potential Medicaid Savings **By Dan O'Connor, Fiscal Analyst**

The 1976 United States Supreme Court ruling in *Estelle v. Gamble* (429 U.S. 97) established that "deliberate indifference to serious medical needs of prisoners constitutes the 'unnecessary and wanton infliction of pain'" proscribed by the Eighth Amendment to the United States Constitution, which prohibits cruel and unusual punishment. Part of the reasoning behind this decision is that prisoners must rely on prison authorities to provide for their medical needs because they lack the freedom to seek out care for themselves. As a result of *Estelle*, prisoners are one of the few classes of individuals who are constitutionally guaranteed "reasonably adequate" health care services in the United States.

As a result of this requirement, the cost of health care for inmates is a major cost to the prison system. Compounding the cost is this population's disproportionately high representation of at-risk individuals. Approximately 18% of inmates have a diagnosed mental illness, and 8% of that 18% are categorized as having severe mental illness. A majority of inmates have a history of substance abuse, whether alcohol, drugs, or both. Before their incarceration, many inmates engaged in high-risk behavior that has resulted in their higher-than-average incidence of HIV, Hepatitis C, and other chronic conditions. Inmates also were likely to have been poor and lacking health insurance, so they were very unlikely to have been receiving any type of preventative care and their nutritional needs may have been neglected due to food insecurity or homelessness. Perhaps the only variable that is favorable in terms of medical costs for prisoners is that they are younger on average than the overall population. However, even that variable is trending in the opposite direction as the "baby boomer" generation of lifers enters their elderly years in prison, at great taxpayer expense.

To meet inmates' needs for physical and mental health care, the Michigan Department of Corrections (MDOC) spends approximately \$300.0 million each year, which represents approximately 15% of the Department's \$2.0 billion budget.

In February 2013, when Governor Rick Snyder released his Executive Budget Recommendation, he proposed that the State of Michigan elect to expand Medicaid eligibility up to 133% of the poverty level in accordance with the Federal Patient Protection and Affordable Care Act. One of the significant fiscal impacts of the proposed eligibility expansion would be realized in the Department of Corrections, where the State Budget Office estimated that expanded eligibility would result in \$24.2 million in savings for fiscal year (FY) 2013-14. These savings were estimated based on the assumption that 80% of prisoners and parolees would become newly eligible under the proposed rules.

These potential savings brought up a number of questions, such as:

- If the State spends \$300.0 million on corrections health care and 80% of prisoners and parolees would become eligible, why would the savings be only \$24.2 million instead of something closer to 80% of \$300.0 million?
- Which specific areas of the Corrections health care budget would be affected?



- Are some prisoners already eligible for Medicaid under current eligibility rules? If so, is the Department taking advantage of those partial Federal reimbursement opportunities?

This article seeks to answer these questions by providing a detailed explanation of the potential savings in the MDOC associated with Medicaid expansion. The article also provides some general information about health care spending in corrections in order to put the savings in context.

Current Corrections Health Care Spending

Health care spending for those in MDOC custody can be categorized in a number of ways, the primary one being between physical health and mental health. The second way that spending can be categorized is by whether the service is being provided by a vendor or by MDOC civil service employees. In the FY 2012-13 Corrections budget, health care spending is mostly contained within three line items: Prisoner Health Care Services, Clinical Complexes, and Mental Health Services and Support.

The first two, Prisoner Health Care Services and Clinical Complexes, are both part of the physical health category, but they represent different components of it. Prisoner Health Care Services provides any needed off-site care as well as the on-site specialty care for physical health needs; all of these services are currently provided through a private third party vendor, Corizon Health, Inc. For off-site care, such as inpatient hospitalization, Corizon manages the placement and payment for services rendered by civilian hospitals near MDOC facilities. For on-site specialty care, Corizon directly employs medical service providers (physicians, physician assistants, and nurse practitioners), who treat inmates and parolees who are temporarily held in custody in the clinical environments inside the secure facilities. Because this line item represents the cost of the contract with Corizon, it does not have any full-time equated employees (FTEs) from the perspective of the State Civil Service Commission. This also means that the medical service providers working for Corizon are not confined to the civil service pay structure that would be in place if they worked directly for the State.

The Clinical Complexes line item consists of all the remaining physical health services that are provided within the secure facilities, which includes 24-hour-a-day nursing staff coverage, pharmacy services (both the pharmaceuticals and the staff who manage their distribution), dentistry and hygienist care, on-site diagnostics such as x-rays, and administrative staff to handle the scheduling and medical record-keeping. The primary cost of this line item is for the 1,145.0 civil service FTEs who provide the services just described. However, this line item also contains the cost of a vendor contract for pharmacy services, which are currently being delivered by Maxor National Pharmacy Services Corp. For FY 2012-13, the Maxor pharmacy contract is projected to cost \$27.6 million, about 17% of the \$158.4 million Clinical Complexes line item. The pharmacy contract also includes the psychotropic drugs prescribed by the mental health service providers.

The Mental Health Services and Support line item accounts for all the personnel needs associated with providing mental health services (but, as stated, the pharmaceutical cost component is contained in the Clinical Complexes line item as part of the vendor contract). The majority of workers in this area are civil service employees, so this line contains 494.0 FTEs

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who work directly for the State. Primary examples of jobs the civil service workers fill include psychologists, clinical social workers, and administrative staff. There are also approximately eight psychiatrists who work directly for the State. However, this line also funds a vendor contract for mental health medical service providers, which are currently serviced by MHM Correctional Services, Inc. MHM currently provides 38 psychiatrists, 10 psychiatric nurse practitioners, and two physician assistants (most but not all of whom are full time) through a contract that is projected to cost \$13.0 million for FY 2012-13.

Table 1 provides a six-year spending history of the three cost areas discussed above.

Table 1

SPENDING HISTORY OF MDOC INMATE HEALTH CARE				
Fiscal Year	Physical Health Specialty/Offsite	Physical Health Clinical	Mental Health Services	Total
2007-08	\$92,534,900	\$140,153,900	\$25,538,200	\$258,227,000
2008-09	104,274,645	160,805,300	24,754,800	\$289,834,745
2009-10	112,722,637	142,352,848	44,061,946	\$299,137,431
2010-11	104,693,220	140,038,209	46,644,254	\$291,375,683
2011-12	89,862,770	143,001,936	54,671,633	\$287,536,339
2012-13	91,851,700	158,448,900	62,412,700	\$312,713,300

Source: MDOC Legislative Boilerplate Reports, pursuant to Section 802(a)

Potential Savings from Medicaid Expansion

As noted above, one of the significant budgetary impacts of the proposed expansion of Medicaid under the Patient Protection and Affordable Care Act is potential savings of \$24,212,200 in the MDOC budget. While \$24.2 million represents a substantial amount, some are curious why the savings would not be higher, if 80% of inmates and parolees would become eligible under the proposed rules and the State currently spends approximately \$300.0 million on corrections health care. The reason is that reimbursement would still be only possible for care rendered outside of the secure perimeter of a facility. Federal Medicaid eligibility specifically excludes all incarcerated individuals; however, a Federal rule adopted in 1997 allows Federal reimbursement for instances in which an inmate is admitted to an inpatient facility. (To count as inpatient the inmate must stay at least 24 hours, which generally means at least one overnight stay.) Therefore, the care that occurs within the clinical complexes inside the secure facilities (which represents the majority of the care provided) would continue to be fully paid for by the Department, with no Federal reimbursement if Medicaid were expanded.

This brings up what at first glance may appear to be a loophole in the rules for Medicaid reimbursement: If services provided outside of the secure facility become reimbursable, why not send more inmates out for services? There are a number of reasons why this is not current policy (or why it would not become policy if Medicaid eligibility were expanded). First, the inmates must be admitted to an inpatient facility for at least 24 hours; therefore, if the medical need is not serious, they will not be required to stay long enough to qualify as a reimbursable expense. Second, if the State tried to take advantage of the rules by sending out inmates who

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have medical needs that could be easily taken care of inside a facility, then the Federal government would likely reject these claims as not being bona fide. Finally, each time an inmate leaves a secure facility he or she must be escorted by two armed, specially trained corrections officers. So, not only does taking an inmate outside the secure perimeter represent a security risk, but it also has substantial staffing costs that may outweigh the cost of the medical service being provided. Therefore, despite the potentially expanded opportunities for reimbursement, services outside of a secure facility will continue to be used only in situations that go beyond the medical capabilities of the clinical complexes, such as emergencies and advanced specialty care.

Another question that often comes to mind regarding Medicaid eligibility for inmates is how many inmates are eligible under current (nonexpanded) Medicaid eligibility standards. Michigan, like most states, limits Medicaid to juveniles, pregnant women, the elderly, individuals with disabilities, and low-income caretaker relatives. The primary demographic of MDOC inmates is able-bodied, single, adult males, who under current rules are not Medicaid-eligible. Despite this the MDOC knows that at least 2,431 inmates are currently Medicaid-eligible. The Department also knows that there are 2,481 inmates who are age 20 or less who would also likely be eligible (unless their parents have insurance that could cover them). It is not known how much overlap there is between these groups. Thus, at a minimum, there are 2,431 eligible inmates, or about 6% of the population, but the number eligible could be as high as 4,912, or about 11%. The MDOC budget currently has a \$100,000 interdepartmental grant to the Department of Human Services (DHS) to compensate the DHS for staff time associated with determining inmate eligibility for Medicaid.

From the 6% to 11% of inmates who are currently Medicaid-eligible, the Department estimates that it saves \$1.0 million per quarter in what it otherwise would have to pay for inpatient hospitalization if it were not taking advantage of this Medicaid reimbursement opportunity. The reason the Department does not know the exact figure is that it finds out who is eligible for Medicaid only in the event that a potentially reimbursable event occurs. Many inmates never will have health care needs that require them to leave the secure perimeter, so it would not be cost effective to screen the entire potentially eligible population. If an inmate is determined to be Medicaid-eligible, then, when a local hospital providing the inmate care sends the bill to Corizon, Corizon will reject the payment and instruct the provider to seek payment through Medicaid. At this point, the MDOC (through Corizon) does not track the amount that is eventually paid to the provider, although the Medicaid reimbursement rate is generally less than what the hospital would have received if reimbursement were paid through Corizon.

The proposed expansion would allow anyone, including able-bodied adults below 133% of the poverty line, to become eligible for Medicaid, and because nearly all prisoners make very small wages during their time incarcerated, the Governor's budget estimates that the percentage of eligible inmates would increase by 80%, taking the overall eligibility rate up to at least 86%. It is important to note that because the currently eligible inmates are the more youthful offenders who are less likely to need hospitalization, the newly eligible older offenders would be likely to create more opportunities for reimbursement per prisoner. The specific areas that the \$24.2 million in GF/GP savings would come from are shown in Table 2.

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Table 2

AREAS OF MDOC GF/GP SAVINGS FROM MEDICAID EXPANSION			
Spending Area	Expected GF/GP Savings in FY 2013-14 Based on Partial Year (Nine Months)	Expected GF/GP Savings from Annualization in FY 2014-15	Total Expected Full-Year GF/GP Savings
Prisoner Health Care Services	(\$12,579,500)	(\$4,193,200)	(\$16,772,700)
Prisoner Re-Entry Services and Programming	(\$3,566,600)	(\$1,188,800)	(\$4,755,400)
Substance Abuse Testing and Treatment	(\$8,066,100)	(\$2,688,700)	(\$10,754,800)
Total	(\$24,212,200)	(\$8,070,700)	(\$32,282,900)

Source: State Budget Office

As shown in Table 2, the \$24.2 million anticipated to be saved in FY 2013-14 would represent only three-quarters of the savings that would ultimately be realized due to Medicaid expansion. This is because the Medicaid expansion under the Patient Protection and Affordable Care Act would not go into effect until January 1, 2014, which already will be one-quarter the way through the 2013-14 fiscal year. As a result, expansion would save another \$8.1 million in FY 2014-15 in addition to the savings taken out of the base in FY 2013-14. The newly eligible inmates would be 100% federally funded for the first three years, 2014-2016, but in 2017 the State would begin taking on a portion of the cost, eventually picking up 10% (with the Federal government covering 90%) in 2020. Therefore, starting in FY 2016-17, it could be necessary to add a small portion of these savings to the budget to cover the State share. However, unlike with the civilian population who could become newly eligible, this State share is a cost that the State already faces under the status quo because the State currently covers 100% of the medical expenses for non-Medicaid-eligible inmates.

As also shown in Table 2, roughly half of the savings would be generated from the Prisoner Health Care Services line item, while the other half would be generated from Prisoner Re-Entry and Substance Abuse testing and treatment. The Prisoner Health Care Services savings would accrue from reduced payment responsibility for inpatient hospitalization, for which the State currently pays approximately \$24.5 million annually through its contract with Corizon. Unlike inpatient hospitalization, prisoner re-entry and substance abuse testing and treatment are items that the State is not necessarily mandated to pay for, but the State has opted to because it believes that investment in these items will lead to reduced recidivism. Because parolees would be outside of a secure perimeter absent a technical violation, they likely would continue to be Medicaid-eligible (unless their earnings eclipsed 133% of poverty), which would allow the MDOC to help enroll them in preventative health care and substance abuse treatment services without funding those items directly with Department dollars. If expansion were implemented, then, when the State began cost sharing in 2017, the State share of the cost for services to parolees likely would be a part of the traditional Medicaid budget within the Michigan Department of Community Health.