White Paper

Medicaid Expansion and the Alaska Department of Corrections

April 3, 2015

In the United States inmates have a constitutionally protected right to evidence-based care that meets community standards. Prior to the Patient Protection and Affordable Care Act (PPACA), financial responsibility for securing these rights fell almost exclusively to the states. In Alaska, inmate health care comprises approximately 13% of the Alaska Department of Corrections (ADOC) budget and is largely funded through General Fund expenditures. The costs associated with providing health care to inmates are expected to rise due to an aging inmate population and increasing health care costs. Medicaid expansion in Alaska has the potential to bend this cost curve and shift a portion of inmate health care costs to federal sources of funding.

Prior to incarceration many prisoners do not receive regular medical, mental health or dental care. The ADOC is the largest provider of mental health services in the state and medical staff are responsible for more than 6,000 inmate-patients on any given day. The inmate population presents with significantly greater health care needs than the general population:

- Approximately 30% of the inmate population has Hepatitis C, compared to 1% of Alaska's general population (Department of Health & Social Services, Division of Epidemiology).
- 65% of ADOC inmates have a diagnosable mental health disorder (Trust Beneficiaries in Alaska's Department of Corrections, May 2014).
- As much as 80% of the Alaskan inmate population has struggled with substance abuse disorders (*Ibid*, 2014).
- 65% of the women at Hiland Mountain Correctional Center report having been sexually victimized (Alaska Department of Corrections survey, 2012).
- For every 100,000 Alaskans, there were 11.1 deaths due to liver disease (Alaska Bureau of Vital statistics, 2013). For every 100,000 individuals booked into ADOC, 15.3 die of liver disease while incarcerated.
- Compared to other Americans of the same age, prisoners are:
    - 31% more likely to have asthma;
    - 55% more likely to have diabetes;
    - 90% more likely to have a heart attack; and
    - 100%-300% more likely to have a serious mental illness (Harvard University, 2009).

Every individual who is arrested in Alaska receives a health care screening at remand; during this evaluation issues such as suicide risk, injuries, medications, illness, and mental status are assessed. Nearly 50% of inmates report having ongoing medical problems other than colds or viruses.

Intake nurses refer inmates to in-house clinics, medical and dental providers, mental health clinicians and psychiatrists. The Department maintains an 11-bed medical infirmary where staff provide care for pre-op, post-op and other medically complex cases; a 28-bed acute care psychiatric unit for men, an 18-bed acute care psychiatric unit for women, 40 beds for women with subacute psychiatric needs and 126 beds for men's subacute needs. When an inmate's medical needs exceed what can be provided in ADOC facilities, a referral is made to specialists in the community or the inmate is taken to a hospital.

The ADOC pays for all of these medical costs, including costs associated with transport and security for outside medical appointments and hospitalizations.

Because Alaska's jails and prisons contain the highest concentration of individuals in the state with mental health and substance use disorders, infectious diseases and chronic health conditions, there needs to be continued collaboration between the ADOC, the Department of Health and Social Services (DHSS), the Department of Law (DOL) and the Alaska Court System to ensure these individuals have appropriate access to health care services when they return to Alaskan communities.

Inmate Hospitalizations

There has been mounting interest in how Medicaid coverage will be handled for incarcerated individuals. The federal Centers for Medicare & Medicaid Services' (CMS) policy regarding coverage of inmates was clarified in a 1997 memorandum sent to states. The memorandum states that federal funding is not available for inmates of a public institution.

However, CMS provided additional guidance to states in 2007 clarifying that inmates who leave a correctional facility for more than 24 hours for in-patient treatment in a hospital or long-term care facility are no longer considered "inmates," and Medicaid can be billed for qualifying services. As such, the cost of eligible in-patient services provided to Medicaid-eligible inmates of prisons or jails can be supported by federal dollars.

States did not widely use this opportunity until after passage of the Affordable Care Act. Medicaid expansion extends Medicaid eligibility to a majority of inmates, greatly expanding states' potential for cost savings.

In order to receive federal funding for Medicaid-covered services to inmates receiving in-patient care at a hospital, the inmate must be determined eligible by the state. Currently, to be eligible for Medicaid an adult has to qualify as low-income, and must meet one of the following criteria: be a parent or caretaker of a dependent child; be age 19-20 or 65 or older; or be pregnant or disabled. Medicaid expansion will add a new category of adults who are not otherwise eligible for Medicare or Medicaid and whose income does not exceed 138% of the Federal Poverty Level (FPL).

The Government Accountability Office in September 2014 reported that a majority of inmates in the 27 states that had expanded Medicaid eligibility under PPACA were likely to be Medicaid-eligible under expansion. A March 2015 poll by ADOC of the departments of corrections in Expansion states puts that number consistently around 90%.

The only significant inmate group other states report finding ineligible is non-citizens. Medicaid eligibility requires that an individual have a Social Security number or have applied for one. In Alaska, 98.2% of offenders currently in correctional facilities have a Social Security number documented in the offender management system.

Following is a list of states that responded to inquiries regarding the percent of hospitalized offenders who qualified for Medicaid in Expansion states.

- Arizona "all except non-citizens"
- Arkansas 98%
- California 72%*
- Colorado 90%
- Connecticut 90-95%
- Delaware "virtually all"
- Hawaii 97%
- Michigan 97%
- Nevada "all except non-citizens"
- New York 80%*
- Ohio 95%
- Pennsylvania "virtually all"
- Rhode Island 95%
- Washington 90%

*California and New York reported lower inmate eligibility due to their states' high number of non-citizens and those who lack a Social Security number.

Medicaid will not cover health care services provided within ADOC facilities or outpatient medical appointments such as x-rays, orthopedic exams, specialty consults or emergency room visits. However, the cost of the qualifying hospitalizations is significant.

In FY14, 163 Alaskan inmates were hospitalized for more than 24 hours at a total cost of $8.5 million. Although less than 3% of the inmate population was hospitalized for more than 24 hours, the cost of these hospitalizations accounted for more than 25% of ADOC's inmate health care budget. Based on a conservative 80% of the population being eligible for Medicaid under expansion, this represents potential savings of approximately $6.8 million. Estimated savings rise to $7.6 million if 90% are eligible**. The following table lists prior-year data along with estimates of potential savings.

	# hospitalized for 24+ hours	**Total cost of hospitalizations**	**State savings if 80% eligible**	**State savings if 90% eligible**
FY12	128	$6,310,490	$5,048,392	$5,679,441
FY13	145	$6,221,409	$4,977,127	$5,599,268
FY14	163	$8,511,300	$6,809,040	$7,660,170
FY15*	113	$6,483,522	$5,186,817	$5,835,169

*FY15 billings through March 25, 2015

**It is important to note that cost reductions expected from the use of Medicaid can be estimated but not ensured, as inmate health care costs and number of hospitalizations can fluctuate significantly from year to year.

Experience in Expansion States

In states that have expanded Medicaid, departments of corrections have realized significant savings.

- Ohio saved $10 million in FY14 and expects to save $18 million a year from Medicaid-paid hospitalizations (Ohio Department of Medicaid, September 2014).
- Michigan expects to save $16.8 million in FY15 (The Council of State Governments, *Billing Medicaid for Inmate Care Saves California, Other States Millions*, September 2014).
- California reported $31 million savings the first year (FY13) and $52 million in FY14, and projects $69 million in FY15 (*Ibid*, September 2014).
- Kentucky reported $5.4 million in savings in FY14 (first year) and anticipates $11 million in 2015 (The Henry J. Kaiser Family Foundation, *The Effects of the Medicaid Expansion on State Budgets: An Early Look in Select States*, March 2015).

Regulation Changes

Several existing regulations must be addressed to ensure a simplified process for determining eligibility for the inmate population. This includes wording changes to 7 AAC 100.068 and 7 AAC 105.110(6) that will clarify language allowing Medicaid coverage for hospitalized offenders. DHSS and the ADOC have drafted these changes and they are currently out for public comment.

Once the ADOC is able to start using Medicaid for approved services, there is, at times, the challenge of securing inmate-patient cooperation. Other states that have gone through Expansion cite inmate resistance as a barrier to successful use of Medicaid funds for hospitalization and, as such, have implemented statutes and regulations to ensure such barriers are removed (Oregon HB2087, 2013; Arkansas HB1351, 2013; ADOC Listserve Inquiry, March 2015; https://www.ncdps.gov/div/Prisons/HealthServices/CC_ContinuityPatientCare/cc14.pdf; http://www.leginfo.ca.gov/pub/11-12/bill/asm/ab_0351-0400/ab_396_cfa_20110621_174445_sen_comm.html).

The ADOC is working with the Alaska Department of Law (DOL) to write a regulation that will allow a representative from the ADOC to apply for Medicaid benefits on behalf of an inmate who is either unwilling or unable to give consent. AS 33.30.028 provides the ADOC statutory authority to seek third-party payors for health care, and AS 33.30.021 provides authority to adopt regulations to implement the chapter. Until such regulations are in place in Alaska, the DOL will seek court orders allowing the ADOC to sign for hospitalized offenders who refuse to sign or who are incapacitated.

Suspension vs. Termination of Medicaid benefits

Currently, when an individual who is enrolled in Medicaid is detained, his or her Medicaid benefits are terminated at the end of the first full calendar month of incarceration. DHSS is working on changing internal policies so Medicaid-approved individuals who are incarcerated will have their benefits suspended rather than terminated. Benefits can be suspended for up to 12 months following incarceration. Suspended benefits can be reinstated more easily than terminated benefits in the event

an inmate is hospitalized. Suspending rather than terminating benefits will also make it easier to reinstate benefits for inmates who are released within 12 months of entering the corrections system.

Offender Reentry and Recidivism

A majority of those released from prison or jail each year are uninsured (Council of State Governments Justice Center, *Medicaid and Financing Health Care for Individuals Involved with the Criminal Justice System*, December 2013). As such, another important benefit of expansion is that inmates who enroll in Medicaid as part of their reentry plan will have coverage when they are released to the community.

There is growing evidence to suggest that offenders who are able to access medical and behavioral health services in the community have lower rates of recidivism compared to those who do not (Center for Health and Justice, *Leveraging National Health Reform to Reduce Recidivism and Build Recovery,* May 2013).

For example, a peer-reviewed study of ex-prisoners in a King County, Washington and Pinellas County, Florida, found: "Persons with severe mental illness who were enrolled in Medicaid at jail release had 16% fewer detentions and stayed out of jail longer, on average, than those who either did not have benefits or had them for a shorter time. Thus, in combination with our earlier work, the findings reported here suggest that Medicaid is associated with positive gains for the mental health system in keeping people engaged in services and for the criminal justice system in reducing recidivism." ("The Role of Medicaid Enrollment and Outpatient Service Use in Jail Recidivism Among Persons With Severe Mental Illness," *Psychiatric Services,* June 2007, pp. 794-801, v. 58 n. 6. Accessed online at http://ps.psychiatryonline.org/doi/abs/10.1176/ps.2007.58.6.794)

A Michigan project linking ex-prisoners to medical services found, "The overall recidivism rate for parolees has fallen since the program began, from 46 percent when the program began in 2007 to 21.8 percent in 2012 for 2-year parolees." (https://innovations.ahrq.gov/profiles/michigan-pathways-project-links-ex-prisoners-medical-services-contributing-decline)

Access to health care upon release is particularly important for inmates with serious chronic mental illness. Without continuity of care for the mentally ill population, they often quickly decompensate, become psychotic and commit another crime that brings them back into ADOC custody. Having Medicaid available immediately upon release improves their chances of remaining stable in the community because they can access critical resources without delay.

Conclusion

While the intent of Medicaid expansion is directed toward the expansion of health coverage, containment of rising health care costs, and improvement of health care delivery, the potential achievements of health care reform are not limited to the health and social services arena. Successful Medicaid expansion in Alaska has the potential for significant cost savings in inmate health care; improve the quality of health care delivery to inmates leaving correctional facilities; and improve the health and safety of communities by making critical treatment programs available to the offender population – ultimately reducing recidivism and helping to stem the growth of Alaska's crime and imprisonment rates.