



Medical Care For Kentucky Inmates In Community Medical Facilities: Feasibility And Savings Are Uncertain

Research Report No. 426

Program Review And Investigations Committee

Medical Care For Kentucky Inmates In Community Medical Facilities: Feasibility And Savings Are Uncertain

Program Review and Investigations Committee

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Abstract

As the cost of prison health care increases, states are considering ways to provide acute hospital and long-term care in community medical facilities so that federal Medicaid funds may assist with the cost. Prison systems have been using community hospitals and billing Medicaid, and some states have reduced staffing costs by arranging for secured units inside hospitals. There is no corresponding approach for long-term care for inmates. Parolees may also be eligible for Medicaid, but nursing facilities are reluctant to accept them. Nursing facilities dedicated to accepting parolees and other hard-to-place individuals are being tried in other states, but none so far has received federal Medicaid funds. Technicalities of the medical parole process may prevent Medicaid funding, and medical parolees in an unsecured facility must be carefully screened to minimize the risk to public safety. Even with federal Medicaid funds, net savings to the state budget may be small or none in the short term because many prison costs are fixed, there are few inmates who qualify for nursing care, and there are even fewer who qualify for medical parole.

Foreword

The Legislative Research Commission was established in 1948 to provide the staffing essential to the smooth and efficient operation of the Kentucky General Assembly. Over the course of the last 70 years, this organization has evolved into today's LRC: a multifaceted organization filling the many needs of a modern state legislature. As Kentuckians, we are fortunate to have hundreds of knowledgeable and dedicated professionals who provide high levels of analysis, legislative support, and customer service.

The staff of the Program Review and Investigations Committee perform the important work of monitoring and evaluating governmental programs throughout the commonwealth. At the direction of the committee, they undertake a number of Research Reports every year, focusing on specific, well-defined questions of public policy.

Such work is done in collaboration with the community and within LRC. Program Review staff thank officials and staff of the Department of Corrections and the Cabinet for Health and Family Services for their extensive cooperation. Staff also wish to acknowledge the assistance of the Finance and Administration Cabinet, Kentucky Protection and Advocacy, and the Office of the Attorney General.

Members of the Kentucky Association of Health Care Facilities, the Kentucky Association of Hospice and Palliative Care, the Kentucky Hospital Association, LeadingAge Kentucky, and the Kentucky Domestic Violence Association met with staff to offer their perspectives. Corrections Corporation of America, Correct Care Solutions, CorrectHealth, CorrectCare Integrated Health, and Community Oriented Correctional Health Services provided valuable information and feedback.

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Thank you for your interest in this publication, and thank you to everyone who made this report possible.



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Legislative Research Commission
Frankfort, Kentucky
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Summary

This report covers the feasibility and potential savings of placing inmates who need medical care into secured community medical institutions. It also considers the placement of medical parolees into unsecured nursing facilities. Feasibility and savings depend on ensuring public safety, meeting all legal requirements, reducing overall cost to the state, having a willing facility, and obtaining community support.

This report refers to different options as models. The models described are acute care for inmates in a secured hospital unit, long-term care for medical parolees in existing nursing facilities, long-term care for medical parolees in a dedicated nursing facility, and long-term care for inmates in a secured nursing unit. Savings for acute care depend on reducing security costs, and savings for long-term care depend on receiving Medicaid federal financial participation (FFP). The availability of FFP and the amount of savings are uncertain for the long-term-care models. Many prison costs are fixed and do not decrease when an inmate is released. It is conceivable that correctional savings would not offset the state's added Medicaid expenses, at least in the short term.

Medicaid FFP has been available for inmates admitted as inpatients in community medical institutions for 24 hours or longer. Since 1997, guidance from the Centers for Medicare and Medicaid Services (CMS) has consistently stated that FFP is available in community hospitals and nursing facilities. In 2014, CMS began a reexamination of the definitions of *inmate* and *inpatient services* and of the requirements for medical institutions providing services to inmates. At this writing, CMS has not issued new guidance, so future FFP availability is unknown.

Acute-Care Model For Inmates

Many states, including Kentucky, receive Medicaid FFP for inmates admitted to hospitals. States that expanded Medicaid have found that almost all inmates are eligible, most of them at 100 percent FFP, falling by stages to 90 percent in 2020.

Several states have found additional savings by working with hospitals to build secured units within the hospitals. Each inmate placed in a regular hospital bed required one or two officers around the clock. The savings occur because a secured unit often requires only two officers for several hospitalized inmates. If Kentucky could find hospitals that agree to house secured units, the state might be able to save \$833,000 annually. However, it appears that CMS has explicitly approved only one such unit, and the rules for approval have not been published. Most states that operate secured hospital units appear to be using Medicaid FFP without explicit approval from CMS.

Long-Term-Care Models

When an inmate is paroled, the state is no longer responsible for that person's medical and other expenses. As such, a parolee is who is otherwise eligible for Medicaid and Medicare should be covered by the long-term-care benefits of these programs. Both programs, however, might have restrictions depending on the parole process and the nature of the nursing facility.

Even with Medicaid FFP and Medicare, the net savings to the state budget from paroling inmates in need of long-term care is not clear. Many prison costs are fixed and do not decrease when an inmate is released. Even though Kentucky pays a relatively small percentage of Medicaid costs, it is conceivable that the Department of Corrections' savings would not offset the state's added Medicaid expenses, at least in the short term.

As of the fall of 2015, only 52 inmates might qualify for nursing facility care, and at most 18 of them would be eligible for the medical parole pilot. The small number of possible medical parolees limits the overall savings to the state budget and the attractiveness of serving this group in a dedicated nursing facility.

Parolees With Other Nursing Facility Residents

Placing parolees with other residents in nursing facilities has been difficult for many states, including Kentucky. Nursing facility operators have concerns for the safety of other residents, and communities do not welcome parolees, especially sex offenders. The Department of Corrections reported that several potential parolees and some sex offenders who have completed their sentences remain in prison because there was no nursing facility willing to admit them.

Parolees In Dedicated Nursing Facilities

The state of Connecticut and an entrepreneur in Georgia are experimenting with nursing facilities dedicated to serving parolees and other hard-to-place individuals. The Connecticut facility is operational, and the Georgia facility plans to open in spring 2016. In order to qualify for Medicaid FFP, these facilities must abide by all nursing facility regulations, including residents' rights to come and go. There might be other CMS requirements that have yet to be published.

The state's medical parole process must also meet CMS expectations, which so far are not clearly specified. At this writing, CMS has denied certification to the Connecticut facility because of the state's medical parole process, and the state is appealing. Kentucky's medical parole pilot has some similarities to Connecticut's and some differences, and it is not possible to predict how CMS would rule on it.

Developing a dedicated facility in Kentucky has been considered. Options include new construction, conversion of a similar facility, and conversions of a dissimilar facility like a former prison. Conversion of a dissimilar facility might require expensive renovations.

Inmates In Secured Nursing Facility Units

Although CMS guidance since 1997 has stated consistently that FFP is available for inmates admitted to nursing facilities, the agency has never explained how an inmate could be a resident in such a facility. Officials with CMS and state Medicaid agencies, as well as other experts, stated that an inmate in a nursing facility must be able to exercise the same rights as other residents. Permitting an inmate to have free movement within the facility and to leave the facility at will would violate the state's responsibility for confining the inmate and would endanger public safety.

Based on the implicit CMS approval of FFP for secured hospital units, Program Review staff developed a speculative legal argument for a secured nursing facility unit for inmates. The legal argument has not been tested.

Addendum

On May 12, 2016, Program Review staff became aware of new guidance from the Centers for Medicare & Medicaid Service (CMS). The guidance consisted of two documents: A State Health Official letter and a State Survey Agency Directors memorandum.

The statement that appears to underlie the new guidance is

FFP is available ... when ... members of the general public may be admitted to receive services and admission to the medical institution or **into specific beds** within the institution is not limited to [inmates] [emphasis added].¹

The general effects of this provision, as elaborated in the CMS guidance, are:

- Inmates and the general public may not be segregated into separate units.
- Separate units might be created to address specific medical or behavioral needs of both inmates and other patients, such as violent behavior.²
- Separate units might be designated as primarily for inmates but must not be exclusively for inmates.
- The staff of the medical institution must not be responsible for maintaining custody of inmates or enforcing any conditions of parole for parolees.³
- To ensure an inmate remains in custody, correctional staff must be physically with the inmate.⁴

Hospital Guidance

New CMS guidance offers the example of a unit specialized for patients with violent behavior.⁵ However, inmates are not always predictably violent, so only some inmates would qualify for such a unit. It would also be a risk for corrections if inmates, especially violent inmates, were on the same unit as members of the general public.

In fact, the main objective of secured units seems to be to prevent escape, which is a correctional concern, not a medical one. It seems unlikely that a secured unit would ever be considered necessary for medical reasons, particularly for members of the general public. It remains for CMS to reconcile this new guidance with its August 2010 letter authorizing FFP for a secured unit at Denver Health Medical Center.⁶

At this time, it seems unlikely that CMS would approve the creation of secured units for inmates in community hospitals. Therefore, the savings shown in the report and in Appendix D probably are not available.

Nursing Facility Guidance

As with secured hospital units, the new guidance clearly rules out secured nursing facility units for inmates as described in Chapter 2.

In addition to the general principles outlined above, the new guidance specifies that residents of nursing facilities must be accorded all the rights required by law and that correctional and parole personnel may not be integrated into the operations of the nursing facility.⁷ However, it does not explicitly rule out nursing facilities that offer services to parolees and individuals who are difficult to serve, as described in Chapter 2. It seems clear from the guidance that such a nursing facility must offer services to the general public, may admit a parolee only when it is able to provide appropriate services and ensure the safety of other residents, and must not enforce any parole conditions.⁸

At the time of this addendum, the Georgia facility described in Chapter 2 was not yet completed. Connecticut's specialized nursing facility had not received CMS certification; the state was waiting for another certification review and was prepared to appeal any adverse ruling. The concerns noted in Chapter 2 about the parole process and conditions remain unresolved.

Chapter 1

Providing And Funding Medical Care For Inmates

At its December 2014 meeting, the Program Review and Investigations Committee voted to conduct a study of the feasibility and potential savings of moving medical prisoners to secured facilities.

This report covers the medical placement of inmates who are still in custody and medical parolees in community medical institutions, both secured and open.

This report covers the medical placement of inmates who are still in custody into secured community medical institutions. It also considers the placement of medical parolees into open facilities as an alternative to secured ones. Appendix A describes how the study was conducted. Appendix B lists other possible opportunities for cost savings.

Feasibility depends on meeting legal requirements, cost savings, participation by facilities, and acceptance by the community.

Feasibility of placing inmates or parolees in community medical facilities depends on whether

- public safety can be ensured,
- the facility and its services meet all legal requirements,
- the cost relative to prison care is beneficial to the state,
- the facility finds it worthwhile to participate, and
- it is acceptable to the community.

Conclusions

This report has eight conclusions.

- Federal Medicaid funds have been available for eligible inmates admitted as inpatients to a community medical institution for 24 hours or longer, but the Centers for Medicare & Medicaid Services is preparing new guidance on this process.
- Federal Medicaid funds have been used in other states for eligible inmates admitted to secured hospital units, but it appears that only one such unit has explicit federal approval.
- Through reduced security costs, Kentucky might be able to save up to \$833,000 annually by arranging for secured hospital units in the Louisville area.
- Availability of federal Medicaid funds for eligible parolees in general is well established, but in one state funds were denied for medical parolees in a nursing facility dedicated to parolees and other hard-to-place individuals.
- Kentucky and many states reported difficulty finding nursing facility placements for former inmates. Indiana appears to have

a successful program for placing parolees and ex-offenders in nursing facilities.

- Even with Medicaid reimbursement, it is conceivable that correctional nursing care savings would not offset the state's added Medicaid expenses, at least in the short term.
- Few Kentucky prison inmates would qualify for nursing facility level of care, and not all of them qualify for parole. A business converting an existing building or constructing a new nursing facility intended for former inmates would have to consider the small number of available residents, the cost of meeting nursing facility regulations, and the uncertainty of Medicaid reimbursement.
- Availability of federal Medicaid funds for current inmates residing in a secured unit in a community nursing facility is untested and unknown, but federal and state officials and outside experts doubt that it would be permitted.

Rationale For Using Community Medical Facilities For Inmates

States must provide reasonable health care for inmates, though they may try to recover some of the cost from inmates.

The US Supreme Court has ruled that states are responsible for ensuring reasonable health care services are available to prison inmates. States can satisfy this requirement by providing care in the prison itself or in community facilities. In either case, states are responsible for paying for inmates' health care, though states may try to recover some of the cost from the inmates.

The cost of inmate health care, the number of inmates, and the average age of inmates have increased.

The cost of providing medical treatment and health care for inmates has increased significantly. As of 2009, the United States prison population had quadrupled over the prior 25 years, and approximately 2.3 million US inmates had their health care provided by correctional institutions.⁹ There were 22,089 Kentucky inmates as of October 15, 2015—11,640 in state prisons and the remainder in local jails and halfway houses.¹⁰

The inmate population also appears to be aging more rapidly than the general public, and inmates may have more acute and long-term medical treatment needs than typical citizens of the same age. The Urban Institute reported that the number of federal inmates age 50 or older increased 330 percent from 1994 to 2011, a greater rate than among the general public. The institute also cited research suggesting that inmates have the health care needs of members of the general public 10 to 15 years older.¹¹ A North Carolina study found that health care costs per inmate age 50 and older were four times as high as for a younger inmate.¹²

Medicaid And Inmate Health Care Costs

Medicaid does not cover inmate care except when the inmate is admitted as an inpatient in a community medical institution.

Medicaid does not cover health care provided to inmates in prisons. It does cover care for eligible inmates while they are inpatients in medical institutions, meaning that an inmate has to be admitted as an inpatient for at least 24 hours. In such cases, *medical institution* is defined to include hospitals, nursing facilities, and intermediate care facilities.^a

Kentucky's inmate hospitalization costs decreased significantly in 2014 when Medicaid eligibility requirements changed to include childless adults below 138 percent of the poverty level.^b Federal Medicaid funds now pay 100 percent of inpatient medical claims for eligible childless adults under 65 years old. This percentage will decrease by stages to 90 percent in 2020. Federal funds continue to cover approximately 70 percent of inpatient claims for eligible individuals aged 65 and over and adults with children or who are blind or have a disability.

Most Kentucky inmates qualify for Medicaid, most of them at the 100 percent federal rate (falling to 90 percent) and the rest at the 70 percent rate.

Because they typically have no income and few assets, most Kentucky inmates are eligible for Medicaid. Most of them qualify for the 100 percent federal rate, decreasing in stages to 90 percent; the remainder are eligible at the 70 percent rate, as they were before 2014.

Hospital Care For Inmates

Prison systems obtain hospital care in community hospitals, in both regular rooms and secured units. Savings in secured units come from reduced security cost because Medicaid typically covers both situations, but it is not clear that all secured units would be covered.

Because it can be very expensive to retain medical staff and facilities to provide hospital-level care for the few inmates who need it, prison systems typically seek such care in community hospitals. Inmates may be admitted to regular hospital rooms or to secured units within a hospital.¹³ An inmate admitted to a regular hospital room requires one or two correctional officers at all times. Many states use secured units and report substantial savings by using fewer officers per inmate. Federal Medicaid funds cover care in both settings, with the possibility that some features of secured units might disqualify them for coverage. So far, no states have reported Medicaid denial.

^a An intermediate care facility is a residential facility to serve individuals with intellectual or developmental disabilities.

^b The nominal percentage is 133, but the method of calculating income disregards an additional 5 percent for most applicants.

Nursing Facility Care For Inmates

States have provided nursing care within their prisons. The increasing numbers of inmates and medical needs have led states to look at other options.

States generally have found it more cost effective to provide nursing care within the prison system than in a community nursing facility. With an increasing number of older inmates and their additional medical needs, however, long-term care has become more of a burden on prison systems. This and the potential availability of federal Medicaid funds for nursing care have caused states to revisit the cost effectiveness of providing nursing care in the community instead.

Inmates could be placed under guard among other nursing facility residents or in a secured unit. No state appears to be using either approach.

In addition to medical parole, described later, it is theoretically possible to place inmates directly into nursing facilities. Two approaches are placing inmates under guard among other nursing facility residents or placing them in a secured unit. Placing inmates using either approach, however, remains speculative and risky. As of this writing, Program Review staff are unaware of any state that is doing so.

The cost of providing security officers to guard inmates among other nursing facility residents is likely prohibitive.

The primary obstacle to placing inmates among other residents is that doing so would require a correctional officer to guard each inmate constantly, which would be cost prohibitive.^c Placing inmates in a secured nursing unit potentially reduces the cost of officers but entails two other obstacles.

Obstacles to a secured nursing facility unit include likely denial of Medicaid and uncertain savings over prison care.

One obstacle is that officials with the Centers for Medicare & Medicaid Services (CMS), state Medicaid agencies, and other experts reported that an inmate placed in a nursing facility must be afforded the same rights as other residents. One of these rights is freedom of movement. Permitting an inmate to have free movement within the facility and to leave the facility at will, however, would violate the state's responsibility for confining the inmate and would endanger public safety. Based on the implicit CMS approval of federal Medicaid funds for secured hospital units, Program Review staff developed a speculative legal argument for a secured nursing facility unit for inmates, but it has not yet been tested.

Another obstacle is that, unlike hospital care, which prisons cannot provide at a reasonable cost, prisons can provide nursing care within their infirmaries. It is unclear whether prison- or community-based nursing care is less expensive, even with Medicaid reimbursement.

^c A California corrections official stated that a few inmates in the past had been placed in nursing facilities, but the cost of keeping officers with them around the clock was prohibitive.

Rationale For Medical Parole

An alternative to providing community care for inmates is medical parole. Parolees are responsible for their own expenses, including health care, and may be eligible for Medicaid.

Parole is a process by which inmates who have served a portion of their sentences may be released. Typically, a parole board reviews a request for parole and considers several factors, including whether the inmate is likely to reoffend or be a danger to the public. If approved for parole, the inmate is released subject to supervision by a parole officer. The parolee is responsible for following the conditions of parole, including standard conditions and special conditions that a court or the board may set. Violation of parole conditions may result in a return to prison.

The costs and benefits to the state for a parolee are the same as those of a free citizen, except for the cost of the parole officer. Parolees must pay their own expenses and may hold jobs and pay taxes. The corrections agency is no longer responsible for a parolee's health care costs; all such costs are shifted to the parolee or an insurer. Medicaid-eligible parolees receive the full range of benefits, unlike inmates, who receive benefits only as inpatients.

Several states have created versions of parole that take age and health into account. Often referred to as geriatric, compassionate, or medical parole, the programs may consider whether the inmate has a terminal illness or is so infirm or debilitated as to no longer present a danger to the public.

In Kentucky, statutory medical parole may be granted even if nursing care is not needed. The medical parole pilot requires placement in a health facility. None of the 15 inmates certified for the pilot in 2014 found a placement.

Kentucky has a medical parole statute and a medical parole pilot program. Statutory medical parole may apply to inmates with terminal or debilitating medical conditions, regardless of whether the inmate needs nursing care. The pilot program was designed for inmates with severe infirmities and requires that they be paroled to a health facility, while statutory medical parole does not. In 2014, the Department of Corrections (DOC) commissioner certified 15 inmates for the pilot program, none of whom found a nursing facility placement. As of November 2015, seven of these inmates remained in DOC custody.

Few inmates need nursing care, and the savings to corrections might not offset the increased state Medicaid cost, at least in the short term.

In the fall of 2015, DOC identified 52 inmates who might need nursing care, and only 18 were potentially eligible for the medical parole pilot.^d It is not certain how many would meet medical criteria for the Medicaid long-term-care benefit. A review of inmate costs suggests that many correctional costs are fixed costs and do not decrease when the number of inmates declines. The same is true for many correctional medical care costs, except

^d The 18 inmates included the remaining 7 inmates certified in 2014 for the pilot program.

prescriptions and outpatient care. It is conceivable that savings to DOC would not offset the state's added Medicaid expenses, at least in the short term.

Nursing Facility Options For Parolees

States have reported difficulty placing parolees in nursing facilities. Another option is facilities dedicated to hard-to-place individuals, but federal Medicaid officials had concerns about the medical parole law in the one state that tried the option.

States have attempted to place parolees in nursing facilities among other residents. Kentucky DOC officials reported that parolees needing nursing care had to be kept in prison because there was no facility that would accept them. The same has been true for sex offenders who completed their sentences but needed nursing care. Correctional officials in several other states reported difficulty finding nursing facilities to accept parolees and sex offenders.

Another option for parolees is nursing facilities dedicated to hard-to-place individuals. They could be state-contracted or independent private facilities. Connecticut contracted with a private company to open a facility to care for a mix of medical parolees, individuals with mental illness, and others. After review, CMS denied certification of the facility for reimbursement because of concerns about the medical parole process. At this writing, an entrepreneur in Georgia is constructing a nursing facility intended for parolees and other hard-to-place individuals but not linked to a specific medical parole program. Certification for Medicaid has not yet been sought.

Nursing home operators expressed concerns about liability and adverse publicity. New construction and conversion of existing facilities are options. Converted facilities might be similar or dissimilar to nursing facilities, which would affect the investment required.

Nursing home industry representatives in Kentucky were open to discussing separate units or buildings but expressed concerns about liability and the effect of adverse publicity, whether or not parolees left or harm occurred. New facilities could be built or existing facilities converted. Conversion options include converting an unused intermediate care facility or a former prison. Intermediate care facilities, according to the Cabinet for Health and Family Services, already meet most nursing facility certification requirements and would be relatively easy to convert. Conversion of a former prison might require a significant investment to meet nursing facility requirements. In any case, the relatively low number of inmates eligible for medical parole would have to be considered. Appendix C describes some of the challenges for different nursing facility construction options.

Chapter 2

Medical Treatment Alternatives For Inmates

This chapter discusses the feasibility and potential cost savings of some models of medical treatment for inmates. These models cover hospital care for inmates and nursing care for inmates and medical parolees.

Medicaid Coverage For Inmates And Parolees

Medicaid federal financial participation (FFP) reduces states' medical care costs significantly for inmates receiving inpatient treatment in hospitals. FFP might be available for medical parolees in nursing facilities.

Medicaid is central to potential cost savings for inmate health care both while in prison and through medical parole. The federal contribution to Medicaid, called federal financial participation (FFP), reduces the state's cost of care substantially.

Medicaid FFP is available for

- inmates in standard hospital rooms,
- inmates in secured units in community hospitals that meet certain conditions, and
- general parolees in standard community nursing facilities.

Medicaid FFP might be available for

- medical parolees in community nursing facilities, depending on the parole process and parole conditions, and
- current inmates in secured community nursing facilities, but only if residents' rights can be waived.

Inmates

The Social Security Act generally prohibits Medicaid FFP for inmates.

The Social Security Act prohibits the use of Medicaid FFP for medical care for inmates. However, the Act and federal regulations explicitly permit FFP to be used for inmates' care when they are admitted to a "medical institution" for 24 hours or longer (Social Security Act sec. 1905(a)(29)(A); 42 CFR 435.1010).

Since 1997, the Centers for Medicare & Medicaid Services (CMS) has stated that inmates are eligible for FFP while inpatients in medical institutions including hospital, nursing facilities, and intermediate care facilities.

Since 1997, CMS has issued consistent guidance stating that FFP is permissible for services that eligible inmates receive when admitted as inpatients for 24 hours or longer in a medical institution.^c Specific examples include hospitals, nursing facilities,

^c For this report, Program Review staff refer to the Medicaid agency as the Centers for Medicare & Medicaid Services, even though in 1997 it was the Health Care Financing Administration.

and intermediate care facilities. This covers not only charges for the inpatient stay itself but also charges for any Medicaid-covered services received while an inpatient.¹⁴ The guidance does not permit the states to privatize or contract out medical services for inmates in order to obtain FFP for care on prison grounds.¹⁵

One objective of this Program Review study was to assess the feasibility and potential savings of placing inmates in secured facilities. The only interpretation that seemed feasible is a secured unit within or perhaps on the campus of a medical institution. In order to receive FFP, the unit must be considered a medical and not a correctional institution.^f

Inmates sometimes refuse to sign the application for Medicaid. The Department of Corrections (DOC) does not have the authority to apply on their behalf.

Occasionally, an inmate might refuse to sign the application for Medicaid. Many inmates in California reportedly refused to apply for Medicaid.¹⁶ In response, California modified its statutes to permit the corrections agency to apply on their behalf (California Penal Code sec. 5072(e)(3)). Indiana has done the same (Indiana Code sec. 11-10-3-7(b)). The Kentucky Department of Corrections reported that three inmates refused from August 2014 to May 2015. Although Kentucky statute permits local jailers or DOC to apply on behalf of jail inmates, the statute does not cover inmates of state prisons (KRS 441.045(5)(b)).

Parolees

CMS letters in 1997 and 2013 establish that FFP is available for parolees, but CMS has denied FFP for some medical parole programs and other inmate release programs.

Parolees are not mentioned in federal Medicaid eligibility regulations, but CMS issued letters in 1997 and 2013 stating that FFP is available for parolees.¹⁷ It appears that a key element of this decision is that a parolee is not an inmate of a correctional institution and, consequently, the state is not responsible for the parolee's health care and other expenses.

It seems clear that FFP is available for traditional parolees, but CMS has denied FFP for some other inmate release programs, including some medical parole programs and placement in halfway houses. The guidance so far is unclear, and CMS is working on changes, but it is uncertain when they will be made public.

Federal Medical Assistance Percentage

Until 2014, Medicaid was not available in most states for childless adults under the age of 65. Even with this limitation, some states, such as North Carolina, found it cost effective to seek Medicaid

^f CMS and federal regulations use the term *public institution*, but for this report, Program Review staff use the term *correctional institution* to improve clarity.

reimbursement for inpatient care for the inmates who were eligible.¹⁸

In 2014 Kentucky expanded Medicaid in a way that made most inmates eligible. Most of them receive 100 percent FFP (falling by stages to 90 percent in 2020), and the rest receive 70 percent.

In 2014, Kentucky expanded Medicaid to cover childless adults under age 65 whose income fell below 138 percent of poverty. As a result, almost all inmates are now eligible for Medicaid, either in the traditional or expansion groups.

The amount of FFP, the federal medical assistance percentage, for traditional Medicaid in Kentucky is approximately 70 percent.^g The percentage for expansion members is currently 100 percent, falling by stages to 90 percent in 2020.¹⁹ Most inmates are eligible via the expansion, meaning the state share is currently zero, and the state share for other eligible inmates is approximately 30 percent.

Medicare For Inmates And Parolees

Medicare may play a limited role in reducing the state's cost of care.

Medicare may play a limited role in supplementing Medicaid and encouraging nursing facilities to take parolees. Because Medicare is a federal program with no state contribution, any Medicare payments would reduce the state's cost of care.

Inmates

Medicare payments are prohibited for inmates unless the state requires inmates to pay the full cost of their medical care and pursues collections as with any other debt.

With limited exceptions, Medicare is not available for inmates. Section 1862 of the Social Security Act, as interpreted in 42 CFR 411.4 and 411.8, prohibits Medicare payments for anyone in custody of corrections. This blanket rule appears to exclude nursing facility care and almost all hospital and outpatient care.

The regulation allows Medicare payments for inmates if the state has a law requiring inmates to repay the entire cost of their medical care and if the state pursues collections from inmates "in the same way and with the same vigor that it pursues the collection of other debts" (42 CFR 411.4(b)). Kentucky does not have such a law.

^g The federal fiscal year 2015 rate was 69.94 percent. In federal fiscal year 2016, it is 70.32 percent.

Parolees

Parolees generally are eligible for Medicare, but parole conditions might affect eligibility.

Although there does not appear to be an explicit statement in any Medicare guidance, under most circumstances parolees are eligible for Medicare. However, 42 CFR 411.4 states that individuals required to reside in mental health facilities, required to reside in halfway houses, required to live under home detention, or confined completely or partially in any way under a penal statute or rule may not receive Medicare payments. This might exclude medical parolees if a condition of parole were to stay in a nursing facility, as Kentucky's medical parole pilot appears to establish.^h

In addition to reducing the state's Medicaid costs, Medicare for parolees could encourage nursing facilities to accept or to commit to accepting parolees. Nursing care recipients are hospitalized more frequently than the general public and often require skilled nursing care after returning from the hospital. Medicare Part A would cover most of the hospital cost and would pay the nursing facility a rate higher than the Medicaid rate for up to 100 days if the resident required skilled nursing care related to the hospital stay.ⁱ

Medicare Part B. Medicare Part A covers hospitalization and subsequent skilled nursing. There is no premium for this coverage. Part B covers other outpatient medical care, but there is a premium requirement. If a person is an inmate while otherwise eligible for Part B and fails to pay the premium, the inmate will face a premium penalty if seeking Part B after release. However, a state that has a Medicare buy-in program, as Kentucky does, can use Medicaid to pay an eligible parolee's Part B premium, which eliminates the penalty and allows the state to benefit from Medicare payments for outpatient care.

Acute-Care Models

Acute-care models are care in regular hospital rooms and in secured units within hospitals. Prisons obtain care in hospitals because it is too expensive to provide that care in prison.

This section discusses two acute-care models. These are treatment provided in regular community hospital rooms and treatment provided in secured units within community hospitals. The former

^h Chapter 16 of the Medicare Benefit Policy Manual asserts that in some situations a parolee might be considered to be in custody, although it does not provide examples. CMS stated, "If a State or local government believes that it has no legal obligation to pay for the care ..., it should be prepared to prove that to Medicare" (72 FR 47406).

ⁱ Medicare Part A pays 100 percent for 20 days, after which there is a copayment that Medicaid would have to cover.

model is employed by every state correctional system to some degree and involves sending inmates to nearby hospitals for medical treatment when the inmate's medical needs exceed a prison infirmary's capabilities. The latter model requires the construction of a secured medical unit that segregates inmates from other patients at the hospital.

Every state is constitutionally responsible for the health care of its inmates. Most prison facilities, therefore, include some level of infirmary care, and the majority of treatment occurs there. Inmates are transferred to community hospitals when their medical needs exceed the abilities of prison infirmaries. Under the federal Emergency Medical Treatment and Labor Act, hospitals with an emergency department cannot refuse medically necessary treatment to anyone, including inmates. Hospitals must at least evaluate patients and transfer them elsewhere if they are unable to appropriately treat them.

Kentucky DOC reported that it is more expensive for prisons to conduct most acute medical procedures in-house despite the costs of transportation and security associated with moving an inmate to an external medical facility. This is primarily because providing a fully staffed and fully equipped hospital-level infirmary is prohibitively expensive. Another factor is the federal Medicaid funding available for inmates receiving inpatient care at hospitals.

Hospital Acute Care

All states for which information was available send inmates to regular hospital rooms. The need for one or more officers per inmate strains DOC staffing and budget.

All states for which information was available placed inmates in hospitals. Even states that had multiple secured hospital units sent inmates to regular hospital rooms when secured hospital units were at capacity or not located nearby or when emergencies required.

Kentucky DOC and other state correctional agencies reported that the primary challenge of this model is providing security during an inmate's inpatient stay. DOC reported that its procedure is to send one or two correctional officers to accompany each inmate for the duration of the stay, to ensure that the inmate remains in custody and causes no harm to the public. This places a strain on DOC staffing and budget.

Secured Acute Care

Establishing a secured unit in a hospital saves security costs by not assigning security officers to every inmate.

Treating inmates in secured hospital units is the alternative model to treatment among other hospital patients. In this approach, the

inmate is transferred to a hospital unit that has been secured to prevent escape and harm to others.

Program Review staff obtained information about such facilities in Colorado, Indiana, Ohio, New York, Wisconsin, and other states. The facilities have secure windows, doors, ceilings and walls; sally ports; suicide proofing; and a central control center.^j They range in capacity from 8 to 23 beds. Security for these units is provided by either correctional officers or a local law enforcement agency. Medical personnel are provided by the hospital.

Secured Unit Savings. In states operating secured hospital units, correctional staffing ranged from two to nine officers, depending on the state's protocol and the number of inmates present. This arrangement can produce significant savings for corrections over assigning one or two officers to each inmate. When an inmate can occupy a bed in a secured unit, corrections saves on officer costs, whether the inmate is admitted and receives Medicaid or not.

Kentucky had secured units at Baptist La Grange and University of Louisville Hospitals. They might have closed because they were not profitable, but DOC might be able to save \$833,000 annually if such units were available.

DOC officials reported that at some time in the past there were secured hospital units at Baptist Northeast (now Baptist La Grange) and at the University of Louisville. None of the officials contacted by Program Review staff could give a definitive explanation for the closure of the units, but some speculated that it was not economically viable for the hospital.

Based on FY 2015 data, Program Review staff found that only the Louisville area had enough inmate hospitalizations to consider a secured hospital unit. Staff estimated that a 9-bed community hospital unit and an 11-bed tertiary care unit would have been able to serve all the inmates from Louisville area prisons who were admitted to the two most frequently used hospitals, for a total savings of nearly \$833,000.^k At roughly half those capacities, 4-bed and 6-bed units would still have saved DOC more than \$742,000 while forgoing less than \$91,000 in potential savings. Appendix D provides details of the calculations. DOC might consider entering into discussions with these or other nearby hospitals.

Other benefits include lower risk, better coordination of procedures, and improved relations between prisons and hospitals.

Other Benefits. Some states mentioned additional benefits of secured units. One is reduction of risk because inmates are segregated from other hospital patients. Another is that hospital

^j A sally port is a secure area with two sets of doors that can be locked in sequence to prevent escapes while entering or leaving.

^k Tertiary care is specialized or intensive care not usually available at a community hospital.

medical staff and officers develop greater familiarity with inmate medical treatment procedures. Finally, an improved relationship was reported between corrections and the hospital because of agreed-upon rates and procedures.

Challenges include construction cost, benefit to the hospital, and hospital charges. Some states reported that hospitals in financial difficulty were more open to having secured units.

Construction And Hospital Cooperation. The primary challenges reported were the cost of construction of the unit and the limited benefit to the hospital of dedicating beds solely for inmates. Some states reported that the hospital paid for construction of the secured units, while others reported that the state paid for the units.

Some hospitals were reported to require a supplement to the Medicaid rate. Indiana DOC reported paying a 4 percent supplement at one of its secured units. California corrections also pays a supplement to its hospital providers. Other hospitals, including Denver Health, accept the Medicaid rate.

Officials in some states reported that hospitals with financial difficulties were likely to be more receptive to a secured unit. Empty bed-days in a secured unit would not be a problem if a hospital already had many empty beds. Indiana corrections recently relocated a secured unit to a regional hospital to obtain a more favorable rate. The Kentucky Auditor of Public Accounts conducted an analysis of rural hospitals in the state in 2015 and found several in poor financial health.²⁰ Although there were no rural hospitals near Louisville, it might be worthwhile for DOC to seek suburban or urban hospitals in need of revenues.

A secured unit should be located reasonably close to a sufficient number of inmates and must be able to provide adequate treatment.

Location. A hospital's receptiveness to housing a secured unit must be weighed against choosing a location that is accessible by a significant number of inmates. This is important to both the hospital and corrections. If the hospital sets aside a unit for the sole use of corrections, there must be enough inmates to satisfy the hospital's financial needs. For corrections, the secured unit must be close enough to be practical for staff to transport and accompany inmates and to provide emergency care, or the inmates will be diverted to closer facilities.

Treatment Capability. The treatment capability of the hospital is important for determining where to place a secured unit. Various state correctional agencies reported that, at a minimum, a secured unit must be able to provide trauma treatment, or some inmates will be diverted to more appropriate facilities. The wider the range of treatment possibilities, the more utilization, which benefits both the hospital and corrections.

States have billed Medicaid for care in secured hospital units, but only one, Denver Health, was known to have explicit approval from CMS.

Medicaid Participation. Inmates who are admitted for inpatient stays of 24 hours or more in community hospitals may be eligible for Medicaid reimbursement. All of the secured hospital units reviewed were currently receiving Medicaid reimbursement. However, several states had received no explicit approval from CMS.

Program Review staff found one example of such a unit receiving explicit approval from CMS. In 2010, CMS sent a letter to Colorado Medicaid approving FFP for inmate inpatient claims from the Denver Health Center's Correctional Care Medical Facility.²¹ The letter appeared to set up these criteria for FFP:

- The larger facility must be a medical institution as defined in 42 CFR 435.1010,
- the medical institution must not have been created for the purposes of law enforcement and incarceration,
- the medical institution must not be under the authority of any correctional entity,
- the correctional medical unit must be part of the medical institution, and
- the correctional medical unit must operate under the license of the medical institution.

It is possible that CMS might not be aware of many states' secured acute care units. Because CMS is working on guidance related to these units, it is not certain they would be approved if they differed in any way from Denver Health.

According to a Government Accountability Office report, CMS usually does not know whether a Medicaid claim was for an inmate. In fact, the report noted that even the state Medicaid agency might not know which claims were for inmates, and the state correctional agency might not know the number or cost of claims filed for inmates.²² Because CMS is unaware whether a recipient is an inmate, CMS might not be aware of all the secured hospital units and the specific arrangements under which they operate. Therefore, it is not certain that CMS would approve these arrangements if they differed in any way from Denver Health's.

The arrangements in most other states are similar to those of Denver Health, with one possible difference. The Denver unit was built as an integral part of a new hospital tower, probably with no funds from any correctional agency. CMS has not clearly addressed whether the source of construction funding would affect its decision to permit FFP for these units, but in many states, the correctional agencies provided the funds to build or convert the units.

CMS might change the rules in the near future. The same report included a note that

CMS officials reported that, as of July 2014, the agency was working on additional guidance to clarify the definition of inmates, the exception of federal matching funds being allowed for inpatient services for inmates, and the requirements for inpatient hospitals providing such services to inmates.²³

If having a secured hospital unit caused CMS to deny Medicaid FFP, some or all of the correctional staff savings would be negated.

Long-Term-Care Models

Long-term-care models attempt to reduce the number of inmates receiving nursing facility level of care in prisons, if the cost to the state is less than the cost of providing the care in prison.

There are several potential models for long-term care for medical parolees and current inmates. All of them would reduce the number of inmates receiving nursing facility level of care in prisons.

In order to be beneficial, the care provided in community nursing facilities must cost the state less than care provided in prison and it must be at least of equal quality to that care. Program Review staff did not attempt to assess the relative quality of care.

Despite possible Medicaid reimbursement, savings in corrections might not offset the increase in the state's Medicaid costs, and the number of inmates needing care in nursing facilities is small. CMS might not approve FFP for all of these models.

Exact cost comparison is difficult, and it is not certain that there is a savings to the state budget if inmates receive care in community nursing facilities, either as inmates or as parolees. Despite possible coverage by Medicaid, the correctional budget might not experience enough savings to offset the cost to the state's Medicaid budget, at least in the short term.

The number of inmates who would qualify for nursing care is small. DOC identified 52 inmates who might need nursing care, and only 18 were potentially eligible for the medical parole pilot. It is not certain how many would meet medical criteria for the Medicaid long-term-care benefit.

Some of the long-term-care models push the limits of Medicaid regulations, and it is not clear that Medicaid FFP would be available. Depending on upcoming CMS guidance and decisions, a state that attempted to implement one of these models should be prepared for prolonged negotiation with CMS and possible litigation.

State Savings For Long-Term Care Are Uncertain

Unlike hospital care, which prisons cannot provide at a reasonable cost, prisons do provide nursing care within their infirmaries. It remains unclear whether it is less expensive to provide nursing care in a community nursing facility, even with Medicaid reimbursement.

Most of a prison's costs are fixed and do not decline when an inmate is placed elsewhere.

Most discussions of prison nursing facility savings assume that there is a specific cost associated with caring for an inmate in the prison that can be cut and replaced with a Medicaid payment to a nursing facility. However, this assumption is only partly correct, mainly because most of the prison's costs are fixed and do not decline when an inmate is placed elsewhere. A simplified cost model includes the facility cost (building and land), nonmedical staff, medical and dental care, utilities, consumables, and prescriptions and outpatient care.

The facility cost is largely fixed, though it might increase as a facility ages and requires more maintenance. Major changes occur only over decades as prisons are decommissioned, replaced, or modernized. If a prison is half full, the facility costs are approximately as great as if it were full. The correctional budget for facilities does not decrease when an inmate is released. Likewise, utilities are largely fixed because they are required for operating the facility, and the amount used for an individual inmate is small.

Prison nonmedical staff include correctional officers and administrative staff. The number and cost of staff do not change immediately when an inmate is released, although they might fall gradually over time if enough inmates were released.

Medical and dental costs do not change immediately but only incrementally. Savings probably require renegotiating or rebidding the medical services contract.

Medical and dental costs also do not change immediately when an inmate is released. Doctors, dentists, nurses, and other medical employees cost the same whether they are caring for 200 or 199 inmates with chronic care needs. The provider can reduce staff only if enough inmates are released over time, but the number of inmates who could be placed in a nursing facility is small. Savings would be realized over a period of years, probably by renegotiating or rebidding the medical and dental services contracts.

Prescriptions and outpatient care are variable costs and should generate savings. Savings from outpatient care would have to be negotiated.

Prescriptions and outpatient medical care are variable costs for the prison system because they are paid when the medications and services are provided. The state would benefit from Medicaid savings on both. DOC might negotiate an immediate reduction in

the prison medical provider's per diem if an inmate with high outpatient care expenses were placed outside prison. Consumables, such as food and clothing, are also variable but are a small portion of the total cost.

Savings from cost avoidance are difficult to measure and, because the number of eligible inmates is small, seem unlikely. Costs avoided might include construction of new prison medical facilities or new prison space. Also, DOC or the medical provider might avoid hiring additional staff.

Almost half of Kentucky's state inmates are in local jails, and each inmate placed in a nursing facility will be replaced by one from a jail, leaving most prison costs the same.

Almost half of Kentucky's state inmates reside in local jails, for which DOC pays \$31.34 per day. Whenever prison inmates are released, state inmates from local jails replace them, leaving all the prison costs except medical the same. Further, Kentucky's prison medical costs will decline more slowly than expected because the inmates coming from local jails also need medical care, though probably less of it.¹ DOC will continue to pay the medical and dental per diems to the providers and should discuss cost reductions whenever renegotiating the amount.

The short-term reductions for DOC would be the jail per diem and the cost for prescriptions and outpatient care. Medium-term savings should come from the medical care contract.

In the short term, the only reductions in the DOC budget would be the local jail per diem for each inmate transferred from a local jail and the DOC cost for prescriptions and negotiated reductions on outpatient care. Over the medium term, DOC should experience some savings on its medical care contract.

Medicaid payments to nursing facilities duplicate some of DOC's costs. Savings depend on whether FFP covers more than duplicated costs.

On the other side, the Medicaid payment to a nursing facility has to cover all of that facility's costs, many of which duplicate the prison's costs. Government funds effectively pay for those costs twice—through DOC and Medicaid. Savings to the state accrue only if the FFP is large enough to cover more than the duplicated fixed costs.

As Table 2.1 shows, the Medicaid budget would immediately increase to cover the full cost of the inmate or parolee in a nursing facility. The following discussion shows how the jail per diem, prescriptions and outpatient care, and medical costs might reduce the DOC budget enough to offset that increase.

¹ The portion of the local jail per diem for health care is \$1.91, compared with \$10.03 that DOC pays to its medical provider.

Table 2.1
Effect Of Inmate Or Parolee Nursing Facility Placement On State Budget

Cost Factor	Effect On Dept. Of Corrections Budget	Effect On State Medicaid Budget	Net Budget Effect
Facility cost	No change until prison facilities are downsized or modernized*	State pays up to 30%	Increase for foreseeable future
Utilities	No change until all inmates are in prisons; slow decrease thereafter*	State pays up to 30%	Increase for foreseeable future
Nonmedical staff	No change until all inmates are in prisons; incremental decrease thereafter*	State pays up to 30%	Increase for foreseeable future
Medical care	Incremental decrease	State pays up to 30%	Increase in short term
Dental care	Incremental decrease	State pays up to 30%	Increase in short term
Prescriptions	Decrease	State pays up to 30%	Decrease
Outpatient care	Decrease**	State pays up to 30%	Decrease
Consumables	No change until all inmates are in prisons; decrease thereafter*	State pays up to 30%	Increase for foreseeable future
Jail per diem	Decrease	Not a factor	Decrease

*If 10 inmates were placed in nursing facilities each year, it would take at least 994 years to transfer all state inmates from jail to prison. This assumes no increase in the number of state inmates.

**To see savings immediately, the Department of Corrections would need to negotiate with the prison medical provider for a reduction in per diem.

Source: Program Review staff compilation.

Only 52 inmates might qualify for nursing care, and of them only 18 might qualify for the medical parole pilot.

DOC officials identified 52 inmates who might qualify for nursing facility care under Medicaid based on their need for assistance with two or more activities of daily living or a diagnosis of dementia, including Alzheimer's. Most of these inmates would qualify for Medicaid financially, but Kentucky Medicaid's contracted nursing facility gatekeeper would have to determine whether these inmates were medically qualified for the benefit.

Among the 52 screened inmates, only 18 met the technical criteria for the medical parole pilot program, which excludes sex offenders, inmates with death sentences, and those who have served less than half their sentences or have not reached their parole eligibility dates. In order to receive parole, the DOC commissioner would have to certify that the inmates also met the

medical criteria and posed a low risk of danger to society.^m Table 2.2 shows that the number of inmates is almost evenly split between the two nursing needs.

Table 2.2
Inmates Screened As Needing Nursing Facility Care By Type Of Need And Potential Eligibility For Medical Parole Pilot

Nursing Need	Screened Inmates	Potential Medical Pilot
Activities of daily living	24	9
Dementia	23	7
Both	5	2
Total	52	18

Note: All inmates screened would have to be confirmed as qualifying for the Medicaid long-term-care benefit. Inmates were identified as potentially eligible for the medical parole pilot solely on past offenses and time served; they would require further certification by the commissioner of the Department of Corrections.

Source: Program Review staff analysis of data provided by the Department of Corrections.

Medicaid FFP would pay 70 percent for inmates age 65 and over and 100 percent (falling by stages to 90 percent in 2020) for the rest.

As of October 1, 2015, the average daily Medicaid payment to a nursing facility was \$182.90, and the maximum rate was \$221.51. Given the likelihood of behavioral and complex medical needs, it seems likely that the higher rate would apply. Federal funds are available at different rates depending on the recipient's age.ⁿ FFP pays 70 percent for recipients age 65 and older and 100 percent for those under 65, dropping by stages to 90 percent in 2020.

Table 2.3 shows the number of screened inmates and potential medical parole pilot inmates in each FFP rate group along with the resulting average FFP percentages for 2016 and 2020. Potential pilot inmates were on average younger than screened inmates overall, so the FFP average is higher for them. The FFP averages in 2020 assume that the mix of younger and older inmates remains the same, but it seems likely to change unpredictably.

^m In 2014, the commissioner certified 15 inmates, none of whom were placed in nursing facilities. Seven of them remained in November 2015 and were counted among the 18 who met the technical criteria for the medical parole pilot.

ⁿ The rate is also different for recipients who are blind or have a disability, but only age was considered for these inmates.

Table 2.3
Inmates Screened As Needing Nursing Facility Care By Medicaid
Rate Group And Potential Eligibility For Medical Parole Pilot
Showing Average Federal Medicaid Percentages

Medicaid Rate Group	Screened Inmates	Average FFP 2016 / 2020	Potential Medical Pilot	Average FFP 2016 / 2020
Adult under age 65	30	87.3% / 81.5%	13	91.7% / 84.4%
Adult age 65 or older	22		5	

Note: FFP is federal financial participation. All inmates screened would have to be confirmed as qualifying for the Medicaid long-term-care benefit. Inmates were identified as potentially eligible for the medical parole pilot solely on past offenses and time served; they would require further certification by the commissioner of the Department of Corrections.

Source: Program Review staff analysis of data provided by the Department of Corrections.

Considering only the jail per diem, the state would experience a loss sometime before 2020 in most scenarios.

Using the percentages from Table 2.3, Table 2.4 shows the state Medicaid cost for 2016 and 2020, when the state share reaches its maximum. The rows are based on the current average and high Medicaid nursing facility rates. Because the local jail per diem is the primary savings for DOC, the table shows net savings when the Medicaid cost is less than \$31.34. Assuming the current mix of inmates continues, the state will ultimately see a loss in most cases. If all inmates possibly needing nursing care could be placed in a nursing facility, the loss in 2020 for each inmate would be between \$2.43 and \$9.55 per day. Considering only inmates who might qualify for the medical parole pilot, the loss would be \$3.12 per day unless a lower-cost facility could be found.

Table 2.4
State Share Of Daily Medicaid Nursing Facility Reimbursement And State Savings
Over Local Jail Per Diem For Inmates Screened As Needing Nursing Care

Medicaid Rate Level	Daily Rate	All Screened Inmates				Potential Medical Parole Pilot			
		2016		2020		2016		2020	
		State Share	Savings (Loss)	State Share	Savings (Loss)	State Share	Savings (Loss)	State Share	Savings (Loss)
Average	\$183	\$23.21	\$8.13	\$33.77	(\$2.43)	\$15.24	\$16.10	\$28.45	\$2.89
Maximum	222	28.11	3.23	40.89	(9.55)	18.46	12.88	34.46	(3.12)

Note: The 2020 numbers assume that addition and attrition maintain the current proportion of younger and older inmates. All inmates screened would have to be confirmed as qualifying for the Medicaid long-term-care benefit. Inmates were identified as potentially eligible for the medical parole pilot solely on past offenses and time served; they would require further certification by the commissioner of the Department of Corrections.

Source: Program Review staff calculations based on published nursing facility reimbursement rates from October 2015 and inmate information from the Department of Corrections.

Savings from prescriptions and outpatient care might offset the loss. Medium-term savings from the medical contract would likely generate net savings. Savings would be limited because the state would continue to pay twice for many of the costs and the number of qualifying inmates would be small.

Both DOC and nursing facility residents pay for prescriptions and outpatient care separately from the residential costs. There would be some additional state savings on these expenses. DOC was able to provide prescription costs for a subset of nursing care inmates, averaging \$6.53 per day. Outpatient costs were insignificant for this group. If these costs were approximately the same for all 52 screened inmates, the state would save \$5.70 per day at the current FFP rates, falling by stages to \$5.32 in 2020. For potential pilot medical parolees, the daily savings would be \$5.98 in 2016 and \$5.51 in 2020. By itself, this would not offset the loss on the jail per diem for all screened inmates, but it would offset the loss for potential pilot medical parolees.

Finally, the addition of medium-term savings to DOC from the medical and dental care contracts is likely to generate net savings for the state. That amount is unknown at this time. The final savings to the state in any case will be limited because of the double payment by DOC and Medicaid for fixed costs at prisons and nursing facilities and because the number of inmates who might qualify for the medical parole pilot is small.

Medicaid For Medical Parolees In Long-Term Care Is Uncertain

Legal technicalities might affect FFP availability for medical parolees.

In all models for placing parolees or inmates in community nursing facilities, state savings, if any, depend on the availability of Medicaid. CMS guidance specifically states that FFP may be used for eligible parolees. The number of potential medical parolees is small, however, and three legal technicalities might affect FFP availability for medical parolees.

In Connecticut, CMS recently denied certification to a nursing facility operated under a state contract to care for medical parolees and others. One reason given was that the state's medical parole statute, like Kentucky's medical parole pilot, provides for the parolee to be sent back to prison if the parolee no longer requires nursing care. Although this sounds like a typical condition of parole, it is actually unusual because it is beyond the control of the parolee. CMS asserted that the individuals were still under control of corrections and were not parolees.

Another factor in the denial might have been the process of medical parole. Connecticut's process permits the commissioner to release an inmate without review by the parole board. One expert asserted that a medical parole statute should require parole board review, as Kentucky's pilot program does. However, it directs the

board to grant parole, giving the board no discretion, which CMS might consider an inadequate review.

Kentucky's medical parole pilot also states that the inmate "shall be paroled to a health facility."²⁴ This provision appears to make remaining at the facility a condition of medical parole, creating two possible issues. First, CMS might rule that if the parolee could not exercise the right of a resident to come and go, then it was not a bona fide parole. Second, if the parolee's condition improved, the parolee would lose Medicaid coverage and would appear to be a greater risk to others, so the facility would want to discharge the parolee. The result would be effectively the same as revoking parole if the parolee's health improved, which might cause CMS to deny FFP as it did in Connecticut.

To be certain of avoiding all the possible technicalities, a medical parole program would have to include parole board review and permit the parolee to leave the nursing facility regardless of health care needs. These conditions might present risk to society and liability to the facility.

In order to avoid the problems described above, a medical parole program would have to meet all the following conditions. Some of these conditions might present risk of harm to society and liability for the facility:

- If the parolee's health improves, the parolee leaves the nursing facility and remains on parole.
- The medical parole process includes parole board review.
- The parolee is not required to stay at the nursing facility even while qualifying for nursing care.

Medicaid For Inmates In Long-Term Care Is Unlikely

If inmates could be placed in nursing facilities, more of them could be moved there, but it would be too expensive to assign an officer to each inmate. A secured nursing unit would be needed. Although CMS guidance on inmates has included nursing facilities, residents' rights appear to be a barrier.

If inmates could be placed in a nursing facility, it would not matter whether they were eligible for parole, so more of them could be moved there. Unlike hospital care, the cost would be prohibitive to assign even one correctional officer constantly to each inmate, who might stay for weeks, months, or years. The only practical solution would be to have a secured unit for inmates within a larger nursing facility in the same manner as secured hospital units for inmates.

CMS guidance since 1997 has consistently included nursing facilities as medical institutions at which eligible inmates could receive Medicaid FFP. However, even if the same conditions as a secured hospital unit could be met, nursing facility residents have a federal and state guarantee of certain rights, such as the right to come and go, that conflicts with restrictions on inmates. Program Review staff analysis of the laws and regulations suggests a possible solution, but CMS would probably deny coverage, and the state could file an appeal.

Certificate Of Need Requirements

A certificate of need would likely be necessary to create a nursing facility dedicated to inmates or medical parolees.

Parolee and inmate models that anticipate a facility dedicated to their admission would probably need a certificate of need for new nursing facility beds. At this time, new beds are not being approved. Officials at the Cabinet for Health and Family Services noted the following methods of obtaining a certificate:

- Convert an existing intermediate care facility, and use its approved beds.
- Submit an emergency application.
- Include authorization in a budget bill.

Location Considerations

Some rural areas might be advantageous.

Rural areas have some advantages because rural nursing facilities generally receive lower Medicaid rates and there might be less opposition from the community. A community that has had a prison might agree to hosting parolees or inmates in a nursing facility. Disadvantages include difficulty hiring and retaining nursing staff and distance from hospitals.

Any facility willing to accept sex offenders would have to be far enough away from schools, day care centers, and playgrounds to meet statutory requirements. There might also be parole conditions that would prevent a parolee from living at a particular facility.

Long-Term-Care Models For Parolees

A medical parolee in this report is any parolee who needs nursing care, regardless of the type of parole granted.

In addition to regular parole, Kentucky has a medical parole statute and a medical parole pilot program. For this report, the following groups are considered medical parolees:

- Inmates eligible for regular parole who need nursing care upon release
- Inmates paroled under KRS 439.3405 who need nursing care upon release
- Inmates certified for the medical parole pilot authorized by the 2014 budget bill²⁵

Parole under KRS 439.3405 requires a physician to certify that the inmate has less than a year to live or has other listed medical conditions. Inmates may be considered for parole under this statute regardless of their offenses or time remaining on their sentences. The Parole Board then determines whether to approve parole for these inmates.

The medical parole pilot permits the DOC commissioner to certify inmates who are “physically or mentally debilitated, incapacitated, or infirm” and meet other criteria to be paroled to a health facility. The bill directs the Parole Board to approve parole for these inmates. Inmates on death row and sex offenders are not eligible.²⁶

Parolees may be placed in typical nursing facilities or in facilities dedicated to accepting them. Both methods have reported difficulties.

Two possibilities for placing medical parolees in community-based long-term care are placing parolees with other residents in typical nursing facilities and dedicating a nursing facility to medical parolees. Many states reported having difficulty finding typical nursing facility beds for medical parolees. However, Program Review staff are aware of only one dedicated facility in operation nationally, and it has been denied Medicaid reimbursement so far.

With all forms of parole, there is a chance that the parolee will harm someone. When a parolee is placed in a nursing facility among vulnerable residents, this concern is even greater. The state must balance the number of inmates eligible for some form of medical parole against the possible danger to society.

CMS might deny FFP for parolees under Kentucky’s medical parole pilot because its conditions might violate residents’ rights or indicate that the parolee is still an inmate.

Kentucky’s medical parole pilot appears to make residence in a medical facility a condition of parole. This seems to be a desirable condition, especially if the parolee could wear a location monitoring device but otherwise be treated as any other nursing facility resident. However, there are suggestions that CMS would consider such a condition to be a violation of residents’ rights or to be evidence that the person is not really a parolee but rather an inmate.

Medical Parole With Other Nursing Facility Residents

Medicaid FFP should be available for parolees placed with other residents in nursing facilities, depending on the parole process. Kentucky and most states reported difficulty placing parolees, but Indiana seemed to have some success.

Medicaid is generally available for eligible parolees. Unless CMS found problems with the parole process, FFP would be available for parolees placed in nursing facilities alongside other residents.

Correctional officials in Kentucky and several other states reported that finding a nursing facility that would agree to take medical parolees was difficult. According to the Kentucky Medicaid Nursing Facility Services Manual, facilities are permitted to deny admission, and federal regulations permit a facility to transfer or discharge a resident if it cannot meet the resident’s needs or ensure the safety of others (42 CFR 483.12).²⁷ It is especially difficult to place sex offenders, partly because the facility’s address will appear in the sex offender registry. Nursing facilities reported concerns about the perception by other residents, their families, and the community; safety; and liability. Neighbors, community

members, and crime victims often object to placement of parolees, especially sex offenders.

Kentucky DOC officials stated that it has been unable to place any of the 15 inmates certified for the medical parole pilot in 2014. They also reported that the agency was unable to find placements for other parolees who needed nursing facility care. In both cases, the parolees continued to be housed in prisons while awaiting placement.

Other states have had limited success. Two nursing facilities in Georgia were reported as accepting medical parolees, and one accepted some sex offenders.²⁸ However, Program Review staff were told that a large number of inmates could not be placed. California reported placing some parolees, but the state paid the nursing facilities a supplement above the Medicaid payment.

Only one of the states contacted by Program Review staff reported regular success in placing medical parolees. Indiana's reentry coordinator reported placing 10 to 15 offenders needing nursing care each year. Some sex offenders were placed out of state. Because Medicaid is well established for nursing facility placements under typical parole procedures, Kentucky DOC might benefit from discussions with Indiana inmate reentry officials.

Medical Parole To A Dedicated Nursing Facility

To ensure Medicaid FFP, a dedicated nursing facility must be a medical institution and the parolees must be bona fide parolees.

It seems possible that a facility dedicated to accepting parolees would help resolve placement difficulties. Two criteria must be met in order to ensure Medicaid reimbursement. First, the facility must clearly be a medical institution, not a correctional one. Second, as discussed earlier, the parolees must be bona fide parolees, so that CMS does not consider them to be under correctional control.

A dedicated facility would probably have to include residents other than parolees. Other hard-to-place individuals are candidates. There would have to be enough residents to make the commitment worthwhile.

In order to be a medical institution, the facility must be licensed as a nursing facility and must not be under the direct or indirect control of a correctional agency. It almost certainly must be open to the general public, and, considering CMS guidance in an analogous area, it is possible that CMS would require the facility to have some portion, possibly more than half, of nonparolee residents. Because it would be difficult to attract members of the general public, the two examples described below include other hard-to-place individuals, such as former regular parolees; former inmates; and persons with mental illness, brain injury, or a history of violence.

There would have to be enough medical parolees and other hard-to-place residents to make it worthwhile for a nursing facility to commit to taking them. DOC identified 52 inmates who might qualify for nursing care.^o Of these, only 18 were potentially eligible for the medical parole pilot because of their offenses, sentences, and time served. Making more inmates eligible for medical parole would increase the portion who could be paroled, but loosening the requirements might also increase the risk of harm to other residents or society.

Connecticut may have the only dedicated nursing facility. It is operated under contract with the state and accepts medical parolees, people with mental health and criminal histories, and other residents.

Connecticut Experiment. Connecticut appears to have the only operating nursing facility dedicated to accepting medical parolees. The state issued a request for proposals and selected a provider to open and operate a nursing facility. The Connecticut General Assembly passed enabling statutes, including a new medical parole procedure and an exemption from the nursing facility bed moratorium and certificate of need requirements (Connecticut General Statutes sec. 18-100i; sec. 17b-372a).

The contracting agency was Department of Mental Health and Addiction Services. The purpose of the nursing facility was to provide nursing care to individuals who were difficult to place in other facilities. These included people with mental health or criminal histories.

The new medical parole process permits the commissioner to release inmates if the medical director determines that they have a terminal condition or that they are so debilitated that they need continuous care or are physically incapable of being a danger to society. The parolee is supervised by the department. The statute permits the department to return the parolee to custody if the parolee's health improves (CGS sec. 18-100i).

The viability of the facility will depend on Medicaid FFP, which is currently being withheld and is under appeal. CMS appeared to object to the condition that parolees must return to prison if their health improves.

The viability of this facility hinges on whether it obtains certification for Medicaid. As of this writing, CMS has declined to certify the facility. The state corrected several initial deficiencies, most of them related to residents' rights, but CMS refused to certify the facility because of concern that the provision for return to custody meant the parolees were still under the control of corrections. Connecticut has appealed the finding.

A Connecticut official mentioned the following nursing facility and Medicaid requirements:

- Opening the facility to public referrals

^o A Medicaid nursing care gatekeeper would have to determine whether their needs actually required nursing-facility level of care.

- Establishing that residents who leave the facility are not considered escapees
- Keeping gates and doors unlocked/unsecured
- Implementing security features that are no more extensive than those of a typical nursing facility
- Not requiring parolees to wear location monitoring devices
- Adhering to all residents' rights

The Connecticut facility has faced objections from the town and community.

These requirements limit the ability of the facility to restrict parolees' movements, visitors, and packages. The facility was able to place some controls over incoming packages as part of its routine safety protocol. However, the perception of risk to the community is high, and the facility has drawn local opposition. The city of Rocky Hill filed lawsuits against the nursing facility in an attempt to shut it down. Community members filed an independent lawsuit and protested the opening of the facility.²⁹

An entrepreneur in Georgia is building a nursing facility intended for hard-to-place residents.

Pending Georgia Project. A similar project is under way in Georgia. A private entrepreneur purchased property and is building a new nursing facility intended for parolees and other hard-to-place individuals. It is scheduled to open in spring 2016. The project was granted a certificate of need.³⁰

Georgia will probably use its regular parole process, making it more likely to receive Medicaid FFP. The location was selected to minimize community opposition.

Unlike the Connecticut facility, the Georgia facility will not operate under contract with the state, and medical parole will presumably be granted under the same rules that apply to parolees already residing in nursing facilities. With these assumptions, it appears that Medicaid reimbursement is possible, but CMS has not yet made a determination.

In order to avoid the community objections found in Connecticut, the Georgia provider chose a former state prison site. The community was relatively comfortable with the idea of having parolees nearby and was interested in having additional jobs.³¹

Kentucky DOC has approached nursing facilities inquiring about the possibility of reserving a wing for correctional use with no success. Some other possibilities are discussed in Appendix C.

Kentucky Options. Kentucky DOC officials reported that the department approached existing nursing homes and other facilities asking to have dedicated use of a wing or portion of the facility, but all facilities turned down the request. The possibility of developing a facility in Kentucky has been raised.

New facilities could be built or existing facilities converted. Conversion options include converting an unused intermediate care facility or a former prison. Intermediate care facilities, according to the Cabinet for Health and Family Services, already meet most nursing facility certification requirements and would be relatively

easy to convert. Conversion of a former prison might require a significant investment to meet nursing facility requirements. Appendix C addresses some of the development options from a logistical perspective.

Any entity planning to develop such a facility would have to consider the relatively small number of inmates who would be eligible for medical parole. Other potential residents are regular parolees and offenders who have served their sentences. The Connecticut and Georgia facilities include residents with mental illnesses, but Kentucky has two nursing facilities for individuals with mental illness. Program Review staff were unable to determine how many hard-to-place individuals there might be.

If a new facility were developed, it would need to have reasonable access to emergency transportation. It also should be located within a reasonable distance of a hospital capable of meeting the needs of the residents.

Long-Term-Care Model For Current Inmates

A nursing facility with a secured unit, similar to hospital secured units, is hypothetical.

This section describes a hypothetical model for inmates who remain in custody. A new or existing nursing facility that also served the general public could include a secured unit for inmates, similar to the secured units found in some hospitals. Program Review staff were unable to find any examples of this approach, so it remains speculative.

A secured facility could admit any inmate regardless of parole eligibility or risk of violence. To be viable, the savings would have to cover the cost of officers to staff the unit. However, Medicaid FFP is doubtful.

The number of inmates that might be placed using this model is greater than the number of medical parolees because there would be no restrictions on the inmate's offense, sentence, or physical mobility. DOC identified 52 inmates who might qualify for nursing care.^P

Like secured hospital units, a secured nursing unit would probably need to have one or more correctional officers assigned to it at all times. In order to justify the expense of construction and operation, the unit would have to save enough DOC funding to cover the cost of the officers. However, Medicaid FFP availability is doubtful and, as with the parolee models, there is some question about the actual amount of savings.

^P DOC also identified two local jail inmates who were receiving care in the prison system under KRS 441.560. If qualified for nursing facility care, they could be placed in a secured unit.

Medicaid Availability For A Secured Nursing Unit Is Unlikely

To obtain Medicaid FFP, residents' rights would have to be waived, and CMS would have to consider it a medical institution.

There are some barriers to Medicaid FFP for inmates in a secured nursing facility. These include residents' rights and establishing that the facility is a medical institution, not a correctional one.

Residents' Rights. Medicaid experts, including officials at the Kentucky Department for Medicaid Services, expressed the opinion that CMS would not approve FFP for a secured nursing unit because it would violate the residents' statutory rights. LRC Budget Review staff reported a conversation with a CMS representative who affirmed that residents' rights would be an issue.

Among other rights, a nursing facility resident has "a right to ... communication with and access to persons and services inside and outside of the facility" (42 CFR 483.10). Kentucky also protects residents' rights in KRS 216.515 and 902 KAR 20.300. Full exercise of these rights by inmates in a nursing facility would violate the state's responsibility for confining the inmate and would endanger public safety. However, there is a possible legal argument that limiting an inmate's nursing facility rights does not violate federal or state law.

Though not specific to a nursing facility, a US District Court case, *Gawreys v. D. C. General Hospital* (1979), addressed the issue of inmate rights in medical facilities outside prisons. The case alleged violation of a jail inmate's rights as a hospital patient. Local policy allowed seclusion or restraints if medically necessary or essential for the protection of others. Despite finding that the plaintiff's restraints were unnecessary in this case, the court agreed with the underlying principle and stated,

It is clear that a valid criminal conviction constitutionally deprives an individual of liberty. While a convicted criminal retains at least a modicum of his Due Process liberty interest, "the State may confine him and subject him to the rules of the prison system so long as the conditions of confinement do not otherwise violate the Constitution."³²

An argument could be made an inmate does not regain the rights of a free individual when admitted to a medical institution. It seems likely that a state making this argument should expect prolonged negotiation and perhaps litigation with CMS.

Because hospital patients' rights are similar in some ways to nursing facility residents' rights, an argument could be made that an inmate does not regain the rights of a free individual when admitted to a medical institution. An inmate in a nursing facility need not be afforded nursing facility resident rights that conflict with the rules of the prison system as long as the prison system's rules do not violate the Constitution. However, it seems likely that a state making this argument should expect prolonged negotiation and perhaps litigation with CMS.

Several criteria might have to be met for a secured unit to be considered a medical institution.

Medical Institution Status. Just as a secured hospital unit must establish that it is a medical institution, so would a secured nursing unit. If the residents' rights barrier could be overcome, the following criteria might also need to be met, based on previous CMS guidance about secured hospital units and institutions for mental diseases:

- The nursing facility as a whole must be a medical institution as defined in 42 CFR 435.1010.
- The nursing facility must not have been created for the purposes of law enforcement and incarceration.
- The nursing facility must not be under the authority of any correctional entity.
- The secured unit must be part of the larger nursing facility.
- The secured unit must operate under the license of the larger nursing facility.
- The larger nursing facility must be open to the general public.
- The proportion of inmates must be less than some portion of all residents, probably less than half.

Other Nursing Facility Requirements

Other requirements might need to be met or waived.

A secured nursing unit would likely have to meet other requirements in order to be part of a licensed nursing facility. Some of these might be waived, and others might be met with proper design. Appendix C describes some of these in greater detail. Requirements include:

- National fire codes, especially related to locked doors and emergency exits
- Nursing facility regulations specifying, for example, the size of rooms, location of nursing stations, positive and negative air flow, and amount of common space

Eligibility And Asset Requirements For Inmates

If Medicaid FFP were available, Medicaid long-term-care eligibility requirements might prevent some inmates from qualifying because of DOC's obligation to pay for inmate health care.

If CMS approved Medicaid FFP for inmates in a secured nursing unit, the Medicaid eligibility requirements would have to be met. Because inmates are unlikely to have any income, they would meet income requirements. However, the long-term-care benefit also looks at assets and resources, including those of a community spouse. According to Kentucky Medicaid officials, any inmate with assets and resources above the eligibility limit would have to spend those down to the eligibility level before receiving Medicaid.

KRS 197.020(2) permits DOC to charge a fee payable from an inmate's account, but DOC may not refuse care for lack of funds. The statute does not authorize DOC to require the inmate to access outside assets or resources. Therefore, DOC would be responsible for any nursing facility charges not covered by an outside payor. For this reason, it would not be possible for the inmate to spend down assets and resources and become eligible for Medicaid.⁹

In order to make full use of this model, the General Assembly could consider amending state law to permit some access to inmates' outside assets and resources. Further analysis would be needed to determine how to make this provision equitable and constitutional.

Inmates' Rights In Long-Term Care

Because inmates in a secured nursing facility would remain in custody, they would continue to have the rights of inmates as outlined in Chapter 14 of DOC's policies and procedures. It seems likely that these rights could be sustained in a nursing facility, including the right to access attorneys, courts, and electronic law publications.

⁹ It is unclear whether an inmate could voluntarily pay for nursing facility care until eligible for Medicaid.

Appendix A

How This Study Was Conducted

Program Review staff interviewed officials and experts to obtain information for this report. The following is a partial list.

- Kentucky Department of Corrections
- Cabinet for Health and Family Services
- Finance and Administration Cabinet
- Kentucky Protection and Advocacy
- Kentucky Office of the Attorney General
- Kentucky Association of Health Care Facilities
- Kentucky Association of Hospice and Palliative Care
- Kentucky Hospital Association
- LeadingAge Kentucky
- Kentucky Domestic Violence Association
- Corrections Corporation of America
- Correct Care Solutions
- CorrectHealth
- Correct Care Integrated Health
- Community Oriented Correctional Health Services
- Connecticut Department of Correction
- Connecticut Office of Policy and Management
- Connecticut Department of Social Services
- Indiana Department of Corrections
- New York Department of Corrections and Community Supervision
- Denver Health
- Colorado Department of Corrections
- Wisconsin Department of Corrections
- California Department of Corrections and Rehabilitation
- San Joaquin General Hospital
- Kansas Department of Corrections
- Maine Department of Corrections
- Ohio Department of Rehabilitation and Correction
- Utah State Auditor

Staff also conducted an ongoing review of literature, news articles, and federal and state laws and regulations related to prison medical care, Medicaid, Medicare, parole, inmates' rights, and patients' rights.

Staff analyzed information provided by the Department of Corrections using the SAS System version 9.3 and Microsoft Excel 2013.

Counts of inmates who might need nursing facility care were obtained from the Department of Corrections in two groups. Those potentially needing nursing care for assistance with activities of daily living were identified in August 2015, and those with a diagnosis of dementia were identified in November 2015. The groups were identified at different times and had five inmates in common, but they were combined for statistical purposes, assuming they were representative of the prison system's needs at the time.

Appendix B

Other Correctional Health Care Savings Opportunities

This report discusses community-based inpatient care for inmates and parolees. Based on information compiled by Program Review staff, there are other possibilities for obtaining Medicaid reimbursement for or lowering the costs of inmates' health care. The Department of Corrections and possibly the Department for Medicaid Services would have to determine the feasibility of each.

Opportunities Involving Medicaid With Federal Financial Participation

The following sections briefly describe potential options for use of Medicaid federal financial participation.

Inpatient Stays Less Than 24 Hours

Federal Medicaid regulation 42 CFR 435.1010 states that someone is considered an "inpatient" if admitted and

Is expected by the institution to receive room, board and professional services in the institution for a 24 hour period or longer even though it later develops that the patient dies, is discharged or is transferred to another facility and does not actually stay in the institution for 24 hours.

It might be worthwhile to confirm with the Centers for Medicare & Medicaid Services whether this provision applies to inmates and, if so, to ensure that DOC's medical services vendor and hospitals bill Medicaid in applicable situations.

Nonurgent Outpatient Care

FFP appears to be available for all professional medical services provided while an inmate is an inpatient in a medical institution. Therefore, if other services (typically outpatient) were needed at the time the inmate was admitted, they could be provided while in the hospital and covered by Medicaid. On average, it probably would be a small savings for DOC, but for some inmates, the savings could be substantial. This would need to be confirmed with CMS.

Voluntary Inmates

Medicaid guidance permits FFP to pay for health care for individuals who are staying in a prison voluntarily. The example given was "voluntarily living in a public institution [for example, a prison] while other living arrangements appropriate to the individual's needs are being made."³³ This exception might apply to sex offenders who had served their sentences but were being held because there was no acceptable place to live in the community. Also, it is conceivable that federal Medicaid funds would be available for someone who was granted parole and then housed in prison while awaiting a suitable community placement.

House Arrest

Medicaid guidance permits FFP for health care for individuals on house arrest, except on occasions that they are required to report to a prison overnight. House arrest is probably inappropriate for ambulatory individuals who were convicted of violent crimes or who otherwise might present a serious danger to others.

Medicaid Administrative Claiming

It appears that correctional authorities might be able to participate in Medicaid administrative claiming to offset administrative costs for helping inmates apply for Medicaid. This would need to be confirmed with CMS.

Medicaid Targeted Case Management (Parole)

It appears that parole officers might be able to bill Medicaid targeted case management for time spent connecting parolees with needed services. This would need to be confirmed with CMS and would require a Medicaid state plan amendment.

Electronic Health Records “Meaningful Use” Incentives

According to the National Commission on Correctional Health Care, inmates whose Medicaid enrollment has been suspended are still considered Medicaid eligible, so they count toward federal incentives for electronic health records.³⁴ This would need to be confirmed with CMS.

Inpatient Hospice In The Community

Inpatient hospice is infrequently used but is covered by Medicaid in Kentucky. A hospice industry focus group expressed support for placing inmates or parolees in general or secured inpatient hospice facilities in the community. FFP should be available for eligible parolees in general inpatient hospice facilities. For current inmates, however, it is not known whether CMS would consider an inpatient hospice facility to be a medical institution, particularly if it were secured.

Other Options For Health Care Cost Reduction

The following potential savings options do not directly involve Medicaid funds.

Statutory Caps On Medical Rates

Several states have statutes requiring providers to accept lower rates for outpatient treatment and for inpatient treatment not covered by any insurer. Typically, the rates are capped at the Medicaid rate. Kentucky already caps local jail medical expenses at the Medicaid rate (KRS 441.053). If the current inmate medical contract costs more than the Medicaid rate for the same services, it might generate savings to place a cap on DOC's expenses.

Personal Care Homes

If an inmate needed personal care assistance but not nursing facility care, and if the inmate were otherwise eligible for Supplemental Security Income, and if the inmate could be safely paroled and placed in a personal care home, the state might experience cost savings. Parole for this purpose would have to be regular parole or statutory medical parole because these inmates would not qualify medically for the medical parole pilot.

Pay To Stay

States may require individuals in custody to pay for their own health care, except for care covered by insurance or another outside source. Federal regulation 42 CFR 411.4 provides that if a state does this, and if the state actually pursues collections with the same vigor as any other debts, then Medicare will cover medical care for inmates who are otherwise eligible for Medicare. An effective pay-to-stay law, however, must make all inmates responsible for their own medical care payments, not just those eligible for Medicare.

Specialized Nursing Care Prison

Some states have experimented with specialized prisons for nursing facility level of care. As correctional institutions, they are not eligible for Medicaid FFP. Savings from these facilities are not clear.

Program Review staff discussed this approach with the Kansas Department of Corrections. The agency converted a work camp into a special nursing facility for medium-security inmates and transferred selected elderly or infirm inmates to this lower-security facility. Agency officials asserted that there were savings over using beds in traditional prison infirmaries, though they were unable to provide savings numbers.^{r,35} They listed some possible sources of savings:

- Avoided costs of expanding or building new infirmary space in higher-security prisons
- Freed infirmary beds in other prisons for other inmates
- Lower facility costs because the nursing prison has no cells and only a perimeter fence
- Fewer correctional officers needed
- Inmates selected who are less likely to need hospitalization
- Fewer falls and injuries because of design for infirm inmates
- Lower medical staffing costs because most care can be provided by nurses
- Infirmary staffed and equipped to handle the inmates' most frequent needs, avoiding hospitalization
- Less inmate-on-inmate violence
- Better individualized diet management
- More appropriate activities

Virginia operates a similar facility in Deerfield, but Virginia officials reported that the facility is more expensive to operate than other prison facilities in the state. Both Virginia and Kansas

^r A Kansas corrections press release stated that the facility's services were provided at \$5 per day less than the national average but did not compare that with the average or typical cost of services in Kansas prisons.

officials reported that the primary motivation for the facilities was not cost savings but capacity relief for other prisons.

Appendix C

Considerations For Converting Structures To Nursing Facilities

This appendix is based on information compiled by Program Review staff.

When considering nursing facilities dedicated to parolees and other hard-to-place individuals, a decision must be made whether to build new or convert old facilities. In order of difficulty and expense, the options for conversion include

- reopening a former nursing facility;
- converting a similar facility, such as an intermediate care facility; or
- converting a dissimilar facility, such as a school or prison.

General considerations include

- building codes for different kinds of facilities that can differ significantly and
- older structures that might require more repairs and more modifications to meet current codes.

In addition to the discussion below, any attempt to develop a secured nursing facility for inmates would involve additional costs to add security features. These would be similar to the features required for secured hospital units described in the report.

Former Nursing Facility

Connecticut's selected nursing care provider purchased and reopened a former nursing home, which required very little investment. A nursing facility that was operational not too long ago would probably require little repair and few or no modifications.

Similar Facility

Facilities intended for residential health care would likely require fewer modifications than other types of facilities. In particular, officials at the Cabinet for Health and Family Services noted that intermediate care facilities meet almost the same requirements as nursing facilities. They also noted that intermediate care facilities are downsizing across the state as their residents are shifted into less restrictive settings, so appropriate buildings should be available for conversion.

There are some ways that nursing facility requirements are more stringent than those for intermediate care facilities, meaning that an intermediate care facility might have to be upgraded in order to provide nursing care. Some of these differences are

- toilet locations,
- required air filtration systems,

- heating and cooling requirements,
- hot water plumbing fixtures for patient use with anti-scald valves, and
- electrical systems, including the emergency electrical systems required.

Dissimilar Facility

Former prison facilities have been mentioned for reuse as nursing facilities. In Georgia, an entrepreneur purchased a former prison with the intent of converting it to a nursing facility. He later determined that it was more cost effective to demolish the prison and build a new nursing facility. He cited difficulty meeting nursing facility specifications, high upkeep and maintenance costs, and inefficient staffing patterns. According to available sources, the prison was built in 1951 and was closed in 2010.

Facility Size Mismatch

Former prisons in Kentucky that might be candidates for conversion had a much higher inmate capacity than the number of inmates or parolees who might be placed in a nursing facility. The number of other hard-to-place individuals who would be needed to fill out the population of a facility dedicated to these groups is unknown. As mentioned in the report, Kentucky already has two nursing facilities for individuals with histories of mental illness, so it seems likely that the number of beds needed would be less than the space available in the former prisons, even with a lower density of residents than the original design. However, it is possible that an individual building, perhaps an administration building instead of a prison dormitory, would be a suitable size and more economical to convert.

Regulatory Requirements

The following issues might be relevant to conversion of any building not originally constructed for residential health care to a nursing facility, but would likely be especially important for conversion of a former prison. The discussion is based on information provided by the Cabinet for Health and Family Services and on the nursing facility regulation 902 KAR 20:310.

Prison buildings use different construction standards from nursing or intermediate care facilities. Differences between the two would occur in all areas, including architectural, structural, mechanical, plumbing, electrical, and fire protection. The following selections from nursing facility regulations seem likely to be problematic for conversion, but all other regulatory requirements must also be met.

For nursing facilities, patient rooms shall be designed to permit no more than two beds side by side parallel to the window wall. Not less than a 4-foot space shall be provided between beds, and at least a 3-foot space between the side of a bed and the nearest wall, fixed cabinet, or heating/cooling element. A minimum of 4 feet is required between foot of bed and opposite wall, or foot of opposite bed in multibed rooms (902 KAR 20:310 sec. 7(1)(b)).

All patient rooms must have windows opening to the outside. Sill heights shall not be higher than 3 feet above the floor and shall be above grade. Window area shall be at least 8 percent of patient room floor area. In single and two-bed rooms with private toilet room, the lavatory may be located in the toilet room. Where two patient rooms share a common toilet, a lavatory shall be provided in each patient room (902 KAR 20:310 sec. 7(1)(c), (d)).

No patient room shall be located more than 120 feet from the nurses' station, the clean workroom, and the soiled workroom. No room shall be used as a patient room where the access is through another patient's room (902 KAR 20:310 sec. 7(1)(g)).

A toilet room shall be directly accessible from each patient room and from each central bathing area without going through the general corridor. One toilet room may serve two patient rooms but not more than four beds. The minimum dimensions of any room containing only a toilet shall be 3 feet by 5 feet (902 KAR 20:310 sec. 7(2)(a)).

One shower stall or one bathtub required for each 15 beds not individually served. There shall be at least one freestanding bathtub in each bathroom. Grab bars or patient lift with a safety device shall be provided at all bathing fixtures. Each bathtub or shower enclosure in central bathing facilities shall provide space for a wheelchair and attendant. Showers in central bathing facilities shall not be less than 4 feet square, without curbs, and designed to permit use from a wheelchair (902 KAR 20:310 sec. 7(3)(j)).

In general, central toilets, at least one for each gender, are required. Other required room functions and service areas include nursing stations, staff lounge areas, visitor's toilet rooms, clean workrooms, soiled workrooms, medicine rooms, clean linen storage rooms, nourishment stations, equipment storage rooms, stretcher alcoves, janitor closets, and bedpan washing facilities (902 KAR 20:310 sec. 7(2)(c), 7(3)).

Patients' dining, TV viewing, and recreation areas must be of the appropriate sizes as required for the number of patients (902 KAR 20:310 sec. 7(4)(a)). Laundry services with separate soiled and clean linen rooms (both with lavatories accessible to those rooms) and linen cart storage shall be provided (902 KAR 20:310 sec. 11).

All facilities with patient beds or residential facilities located on any floor other than the first floor shall have at least one hospital-type elevator and such additional elevators as determined by the licensure agency from a study of the facility plan and the estimated vertical transportation requirements. Cars of hospital-type elevators shall have inside dimensions that will accommodate a patient's bed and attendants and shall be at least 5 feet wide by 7 feet and 6 inches deep. Car doors shall have a clear opening of not less than 3 feet and 8 inches. Cars of all other required elevators shall have a clear opening of not less than 3 feet (902 KAR 20:310, sec. 7(14)).

Section 16 of the regulation specifies numerous mechanical requirements, including air filtration systems, ventilation systems, individual room air supplies, and plumbing and piping. Section 18 specifies relative positive and negative pressure requirements for ventilation systems.

All electrical requirements must be met, which would probably involve extensive new wiring and rewiring. Each patient bedroom shall have duplex receptacles on each side of the head of each bed (for parallel adjacent beds, only one receptacle is required between the beds), receptacles for luminaries, television, and motorized beds, if used, and one receptacle on another wall. Duplex receptacles for general use shall be installed approximately 50 feet apart in all corridors and within 25 feet of ends of corridors. A nurses' calling station shall be installed at each patient bed and in each patient toilet, bath, and shower room. The nurses' call in toilet, bath, or shower rooms, shall be an emergency call. All calls shall actuate a visible signal in the corridor at the patients' door, in the clean workroom, soiled workroom, and nourishment station of the nursing unit. Emergency electrical service, including emergency or redundant heating systems, is required (902 KAR 20:310 sec. 17).

The Centers for Medicare & Medicaid Services requires all nursing facilities to have fire protection systems with automatic sprinkler systems installed and operational (42 CFR 483.70). Kentucky regulation requires an alarm system including fire alarm actuated at manual stations, water-flow alarm devices of sprinkler system if electrically operated, fire-detecting and smoke-detecting systems, paging or speaker systems if intended for issuing instructions during emergency conditions, and alarms required for nonflammable medical gas systems, if installed (902 KAR 20:310 sec. 17(7)(d)2.b).

Finally, a nursing facility must meet all other applicable codes, including the following list from 902 KAR 20:310 sec. 5(3):

- Requirements for safety pursuant to 815 KAR 10:020, as amended
- Requirements for plumbing pursuant to 815 KAR 20:010 through 20:190, as amended
- Requirements for air contaminants for incinerators pursuant to 401 KRS 59:020 and 401 KAR 61:010
- Requirements for elevators pursuant to 815 KAR 4:010
- Requirements for making buildings and facilities accessible to and usable by the physically handicapped, pursuant to KRS 198B.260 and administrative regulations promulgated thereunder

Appendix D

Secure Hospital Unit Savings

This appendix is Program Review staff's analysis of information from the Department of Corrections.

Kentucky Department of Corrections (DOC) officials reported that at some time in the past there were secure hospital units at Baptist Northeast (now Baptist La Grange) and at the University of Louisville. None of the officials contacted by Program Review staff could give a definitive explanation for the closure of the units, but some speculated that they were not economically viable for the hospital.

Program Review staff looked at the FY 2015 DOC hospitalizations and the prisons and hospitals involved. The Louisville area, because of its three prisons in La Grange and one in Pewee Valley, was the only area that sent enough inmates to a hospital to consider a secure unit feasible. Another likely reason for the number of hospitalizations there is that the Kentucky State Reformatory and Kentucky Correctional Institution for Women have the most intensive medical capabilities. Prisons outside the Louisville area were not included in this analysis because hospital transportation would be impractical.

Louisville Area Hospitalizations

DOC provided detailed information about inmate hospital trips for FY 2014 and FY 2015. Although the information did not indicate whether the inmate was admitted as an inpatient for 24 hours, it did show how long the inmate was outside the prison. Program Review staff counted all trips that lasted 26 hours or more, allowing 24 hours at the hospital and an hour for transportation each way. It is possible that some of these trips did not represent admissions, but even if not, the inmate might have been able to stay in a secure facility, which would have saved the cost of accompanying officers.

The DOC data included the hospital to which the inmate was taken. Review of the data showed that most trips were to either a community hospital or a tertiary care hospital.^s Program Review staff created a model of secure unit bed use and correctional cost for two hospitals, the community and tertiary hospitals having the most visits during the fiscal year. This accounted for approximately 80 percent of all hospital visits.

Staff then counted the number of complete 24-hour periods as the number of inpatient days, throwing out any partial days. Analysis of the data showed that the number of inpatient days in a community or tertiary hospital from prisons in the Louisville area increased 34 percent from FY 2014 to FY 2015. Based on this increase, it seemed conservative to calculate future savings based on the number of hospitalizations in FY 2015.

^s Tertiary care is specialized or intensive care not usually available at a community hospital.

Savings To Corrections

Because DOC is enrolling eligible inmates in Medicaid, the cost of care is the same whether an inmate is in a standard hospital room or a secured hospital unit. However, DOC assigns at least one and sometimes two correctional officers day and night to each inmate in a standard room. Assuming two officers were needed to staff a secure unit, savings to the prison system would accrue on any day that more than one inmate was an inpatient in the unit. The model also assumed that if no inmates were present, then no officers would staff the unit.

In the following tables, a bed-day is a bed for a day, so a six-bed unit would have 6 bed-days per day or 2,190 bed-days per year. A hospital would have income only for bed-days used. Empty bed-days might represent a liability to the hospital, and the hospital would have to decide how many it could afford.

DOC's savings come from the reduction in the number of officers needed to accompany inmates. Forgone savings occur whenever the unit is full and inmates must stay elsewhere in the hospital with one or two officers.

Table D.1 shows estimated bed-days and the savings to DOC if there were a secure hospital unit in the community hospital with four, six, or nine beds. These numbers were chosen because in FY 2015 there were at most nine inmates listed as being in the community hospital on any day. The percentage of empty bed-days would vary from 54 to 79 percent.

Table D.1
Hypothetical Secure Hospital Unit For Louisville-Area Inmates
Projected Bed Use And Savings By Number Of Beds
Community Hospital
Hospital Trip Data For Fiscal Year 2015

Beds	Bed-Days Empty		Bed-Days Used	DOC Savings	Bed-Days Over Capacity	Forgone Savings
	Number	Percent				
4	787	54%	673	\$170,068	25	\$19,538
6	1,496	68	694	186,480	4	3,126
9	2,587	79	698	189,606	0	0

Note: The Department of Corrections stated that approximately one-third of the time worked by officers is overtime. Using an average of entry and midpoint salaries and adding overtime and benefits, the cost of one officer for a 24-hour period would be approximately \$600. This table assumes that, on average, 1.3 officers currently accompany a hospitalized inmate. Savings are net after deducting the cost of two officers to staff the unit except when the unit is empty.

Source: Program Review staff analysis of data provided by the Department of Corrections

Table D.2 shows estimated bed-days and the savings to DOC if there were a secure hospital unit in the tertiary care hospital with 6, 8, or 11 beds. These numbers were chosen because in FY 2015 there were at most 11 inmates listed as being in the tertiary care hospital on any day. The percentage of empty bed-days would vary from 43 to 66 percent.

Table D.2
Hypothetical Secure Hospital Unit For Louisville-Area Inmates
Projected Bed Use And Savings By Number Of Beds
Tertiary Care Hospital
Hospital Trip Data For Fiscal Year 2015

Beds	Bed-Days Empty		Bed-Days Used	DOC Savings	Bed-Days Over Capacity	Forgone Savings
	Number	Percent				
6	935	43%	1,255	\$572,004	91	\$71,117
8	1,590	54	1,330	630,617	63	12,504
11	2,669	66	1,346	643,121	0	0

Note: The Department of Corrections stated that approximately one-third of the time worked by officers is overtime. Using an average of entry and midpoint salaries and adding overtime and benefits, the cost of one officer for a 24-hour period would be approximately \$600. This table assumes that, on average, 1.3 officers currently accompany a hospitalized inmate. Savings are net after deducting the cost of two officers to staff the unit except when the unit is empty.

Source: Program Review staff analysis of data provided by the Department of Corrections

From DOC's perspective, there is no downside to having a larger secure unit. Based solely on FY 2015 data, a 9-bed community hospital unit and an 11-bed tertiary care unit would have been able to serve all inmates sent to those hospitals from Louisville-area prisons for a total savings of nearly \$833,000. At roughly half those capacities, four-bed and six-bed units would still have saved DOC more than \$742,000 while forgoing less than \$91,000 in potential savings. Additional savings might be realized if inmates sent to other area hospitals could be sent to one of these hospital units.

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