Commission on Enhancing Agency Outcomes

Proposal to Privatize Inmate Medical Services in Department of Corrections

Background. The Department of Correction (DOC) had 18,320 inmates (and an additional 4,789 persons under community supervision) on November 1, 2010. Adequate medical treatment for inmates is a federal constitutional requirement. In Connecticut, medical care for inmates occurs through contract with the University of Connecticut Health Center. The budgeted amount for inmate medical services in FY 10 was approximately $100 million, and approximately $98.6 million in FY 11.

Privatization of Inmate Medical Services. The Commission on Enhancing Agency Outcomes was asked to explore the privatization of inmate medical services in DOC, and what obstacles might exist to privatizing services. Some states have experienced difficulties following the privatization of inmate medical services:

- Florida outsourced inmate health care services in one region beginning in 2003, and experienced increased expenses and substandard inmate health care in some facilities due to repeated noncompliance with contract requirements, and inadequate contract management and medical oversight during the subsequent five years[1]
- California awarded 1,149 contracts with private medical service providers between 2001-2003 (most not competitively bid), and a state audit report found prisons may be overpaying inappropriate and invalid medical claims (due to inadequate contracting processes and oversight)[2]
- Due to poor fiscal monitoring, weak contract enforcement, inadequate inmate medical care, and increased costs, New Jersey recently cancelled an $85 million contract with a private vendor, and is now using the services of the state university medical and dental school (although privatization opportunities for inmate medical health services may be explored under the current governor)[3]
- Vermont's Department of Corrections has undergone multiple changes in private medical care vendors for inmates, and a state audit of the inmate medical services contract found ineffective financial oversight, insufficient quality assurance, and questionable procedures for contract bidding, amendment and assignments[4]

Based on the experiences of other states, privatization of inmate medical services would require careful contract management and oversight. States have also looked to *reduce inmate medical costs through the use of Medicaid for inmate inpatient services*.

Use of Medicaid for Inmate Inpatient Services. Generally, the federal government, via the Centers for Medicare and Medicaid Services (CMS) does not reimburse states for inmate

[1] Steps to Control Prison Inmate Health Care Costs Have Begun to Show Savings (January 2009), Florida Office of Program Policy Analysis & Government Accountability (Report No. 09-07).
[2] California Department of Corrections: It Needs to Ensure That All Medical Service Contracts It Enters Are in the State's Best Interest and All Medical Claims It Pays Are Valid (Report 2003-117 Summary – April 2004).
[3] The New Jersey Privatization Task Force Report to Governor Chris Christie, May 31, 2010.
[4] Keys to Success: Improving Accountability, Contract Management & Fiscal Oversight at the Department of Corrections, Vermont Office of the State Auditor, May 26, 2004.

medical care under the Medicaid program. An exception, however, is permitted when inmates are treated in a hospital not under the control of the state's correction system. When that occurs, the individual has "inpatient status" and is not considered an inmate of a public institution.[5] In FY 10, $8.5 of the approximately $100 million Department of Correction inmate medical care budget was used for inpatient care.

The North Carolina Office of the State Auditor recently evaluated whether that state's inmate health care costs could be reduced by requiring hospitals and other medical service providers to bill Medicaid for inpatient hospital and professional services for individuals who would otherwise be eligible for Medicaid. The auditor's office concluded that approximately $11.5 million could be saved annually by this change from the current system of the state Department of Correction paying for inmate health care.

The North Carolina state audit included a letter (dated May 4, 2010) received from CMS clarifying the Medicaid coverage policy for inmates of a public institution in any state. Specifically:

- "Eligibility must be determined for each inmate in accordance with the standard eligibility determination process used by [the state] Medicaid [system]"
- "Once determined Medicaid eligible, the inmates remain eligible and their cases should be placed in a suspension status during their incarceration"
- "While incarcerated, Medicaid payment is only available when the inmate is an inpatient in a medical institution not under the control of the corrections system. Such institutions include a hospital, nursing facility, juvenile psychiatric facility, or intermediate care facility."

In a four-state review of Medicaid payments for incarcerated beneficiaries, the Department of Health and Human Services Office of Inspector General (June 2004 A-04-02-06002) reported Medicaid claims paid on behalf of incarcerated beneficiaries in Florida, Massachusetts, Missouri, and North Carolina totaled over $130 million during a three-year period (October 1, 1998 through September 30, 2001).

Current Provision of Medical Services for Connecticut Inmates. Connecticut provides medical, dental, and mental health services for inmates through a contract with the University of Connecticut Health Center, which established the University of Connecticut Correctional Managed Health Care program.

Inmates who require inpatient care are usually admitted to a secured unit at the UConn Health Center John Dempsey Hospital (JDH) located in Farmington.[6] In emergency situations, inmates are admitted to the nearest hospital and subsequently transferred to JDH. Special arrangements have been made with Lawrence and Memorial Hospital for care of pregnant women at the

[5] Section 1905, 42 U.S.C. 1396d (Title XIX of the Social Security Act) states that Federal Financial Participation (FFP) is not available for services provided to inmates except when the inmate is not in a prison setting and becomes an inpatient in a medical institution.

[6] In 1995, a 12-bed correctional inpatient unit was opened at JDH. Recently reduced to a 10-bed unit, approximately six inmates are hospitalized at any one time at JDH (Source: University of Connecticut Health Center Correctional Managed Health Care Annual Report, July 2008-June 2009; Department of Correction Responses to Questions from CEAO staff, April 1, 2010.)

Niantic Prison. Currently, JDH does not apply for Medicaid reimbursement for these inpatient services.

Suspension of Medicaid Enrollment for Prisoners. In its response to North Carolina and elsewhere, CMS recommends suspension rather than termination of Medicaid benefits. CMS considers suspension of Medicaid enrollment for prisoners a best practice for reentry planning, as it particularly benefits prisoners who have mental illness and substance abuse problems or who are otherwise at risk of homelessness when released.[7]

In 2008, Florida law was amended (Fla. Stat. § 409.9025) to provide for suspension (rather than termination) of Medicaid while recipients are incarcerated, with Medicaid reimbursement sought for inpatient hospital services furnished to an inmate at a hospital outside of the inmate facility.

In Connecticut, DOC sends DSS a list of inmates who have been sentenced within the past 30 days. DSS then searches for matches with its database of Medicaid recipients, and terminates Medicaid at that time. Medicaid for eligible inmates imprisoned two years or less is reinstated prior to re-entry by DSS eligibility workers (funded by DOC for this re-entry work) who complete a shorter eligibility form.

Medicaid Reimbursement for Hospitalization of CT Inmates Outside of a Department of Correction Facility. As noted, in FY 10, $8.5 of the approximately $100 million budget was used for inpatient hospitalization.[8] The majority of the inpatient costs occurred at JDH ($8 million) with the remainder ($500,000) spread across all other state hospitals (CMHC pays the state hospitals at current Medicaid rates). A request was made to DSS for information on the percent of inmates who were Medicaid beneficiaries at time of incarceration, but to date, that information has not been received. If *all* JDH inpatient expenses were covered by Medicaid, the 50 percent match would result in as much as **$4 million in savings**.

[7] Returning Home: Access to Health Care After Prison, National Conference of State Legislatures, July 2009.
[8] Conference call with Gail Duncan of CMHC on October 7, 2010.