



State Prisons and the Delivery of Hospital Care

How states set up and finance off-site care for incarcerated individuals

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The Pew Charitable Trusts is driven by the power of knowledge to solve today's most challenging problems. Pew applies a rigorous, analytical approach to improve public policy, inform the public, and invigorate civic life.

Overview

Delivering adequate medical care to the more than 1 million adults in state prisons is a growing challenge for states, in part because of the high costs and complex logistics required to hospitalize people who are incarcerated.

While most care for incarcerated individuals is delivered on-site, some of them periodically need to be hospitalized for acute or specialized care. As is true generally, this treatment is expensive because of the labor-intensive and sophisticated services provided. And hospitalizing someone who is in prison brings added expenses, such as providing secure transportation to and from the hospital and guarding the patient round-the-clock. State officials nationwide are under increasing pressure to contain hospitalization costs while also ensuring the constitutional right to “reasonably adequate” care.

Hospitalization expenses are already a significant portion of correctional health care spending and are likely to grow if prison trends continue. The average age of those behind bars is rising, and the health needs of these individuals—like older people outside of prison—are more extensive than those of younger cohorts, including more hospitalizations. State officials are also noting an increase in the amount of care required for all adults entering correctional facilities. Looming over these considerations is the future direction of national health care policy, especially the role of Medicaid, the federal-state program for low-income individuals.

With these challenges in mind, The Pew Charitable Trusts explored hospital care for people incarcerated in state prisons, tapping data from two nationwide surveys conducted by Pew and the Vera Institute of Justice and from interviews with more than 75 state officials. This first-of-its-kind analysis of hospital care for this patient population is part of a broader [examination](#) by Pew of correctional health care in the United States.

This report will discuss the ways states arrange and pay for hospital care for their incarcerated population and how such care supplements on-site prison health services. Its findings include:

- Off-site care costs are a significant part of correctional health budgets. For example, Virginia spent 27 percent of its prison health care budget on off-site hospital care in 2015, while New York spent 23 percent.
- The health care delivery model that state prisons use to provide on-site services informs decisions they must make regarding hospitalization arrangements, including who holds authority to send someone off-site, how the care is coordinated and reviewed, and which entity pays the bill.
- The federal Affordable Care Act (ACA) offers state policymakers who elect to expand their Medicaid programs’ eligibility a way to reduce inpatient hospital spending.
- Though incarcerated individuals always will need to be treated at hospitals for certain conditions or tests, some states have promising practices to avert some off-site care, saving money and mitigating public safety risks.

The report’s discussion of state approaches to providing care to incarcerated individuals is designed to help the officials involved in setting hospitalization policy—lawmakers, prison and hospital medical staff and administrators, correctional officers, and sometimes private contractors—better manage costs while working toward or maintaining a high-performing prison health care system.

States look to hospitals to provide range of services

States have a constitutional mandate to provide people in prisons with necessary health care. Prisons typically provide on-site primary care and basic outpatient services. Departments of corrections also usually arrange for some prisons within their system to house specialized clinics or units.¹ Such facilities are designed for people with acute or chronic illnesses that do not require highly specialized off-site services; can provide recurring care, such as kidney dialysis; or can house patients recuperating after a hospital stay. However, every correctional system's on-site facilities and equipment are limited, so all states rely on hospitals for some specialist consultations, diagnostic tests, surgery, and other services.²

Types of Health Care Outside Prisons

- **Off-site care:** Any care provided off the prison's premises. It could be provided at a hospital, surgical center, or specialty clinic, such as for radiology or dialysis services.
- **Inpatient hospitalization:** An admission to a medical institution, such as a hospital, for longer than 24 hours. This is the only type of care for which state Medicaid agencies may provide coverage for incarcerated individuals, if they are eligible and enrolled in the program.
- **Outpatient care:** Emergency, diagnostic, or therapeutic services that do not require the patient to be admitted to a hospital.

Off-site care represents a sizable portion of corrections departments' health expenditures. Hospital care accounted for about 20 percent of health spending in 10 states between 2007 and 2011, according to Pew research. More recent data from two additional states, New York (23 percent) and Virginia (27 percent), showed the proportion may now be greater.³

While the ACA lowered inpatient hospital expenses for corrections departments in states that expanded their Medicaid programs, off-site care remains a financial challenge, especially when considering ancillary transportation and security costs. (A discussion of how some states' hospital payment policies have changed due to the ACA's optional expansion of Medicaid eligibility can be found in the "Medicaid expansion has helped cut costs" section.)

Older individuals have more need for specialized care because of a greater prevalence of chronic conditions such as heart disease, cancer, and diabetes.⁴ In the community, older people have significantly higher rates of hospitalization and make more emergency room visits than do others, raising health care costs for this sector.⁵ Prison populations are also aging, with similar implications for spending. From fiscal year 2010 to 2015, the share of incarcerated people 55 and older increased by a median of 41 percent in the 44 states that reported this statistic, indicating that corrections departments face rising health care costs for the foreseeable future.⁶ Moreover, most incarcerated individuals experience the effects of age sooner than people outside prison because of such issues as substance use disorder, often inadequate preventive and primary care before incarceration, and stress linked to isolation and the sometimes violent environment in prison.

Virginia's corrections department illustrates these patterns. The cost of off-site care for incarcerated adults 55 and older is nearly double that for younger individuals. While 12.2 percent of the state's prison population was in

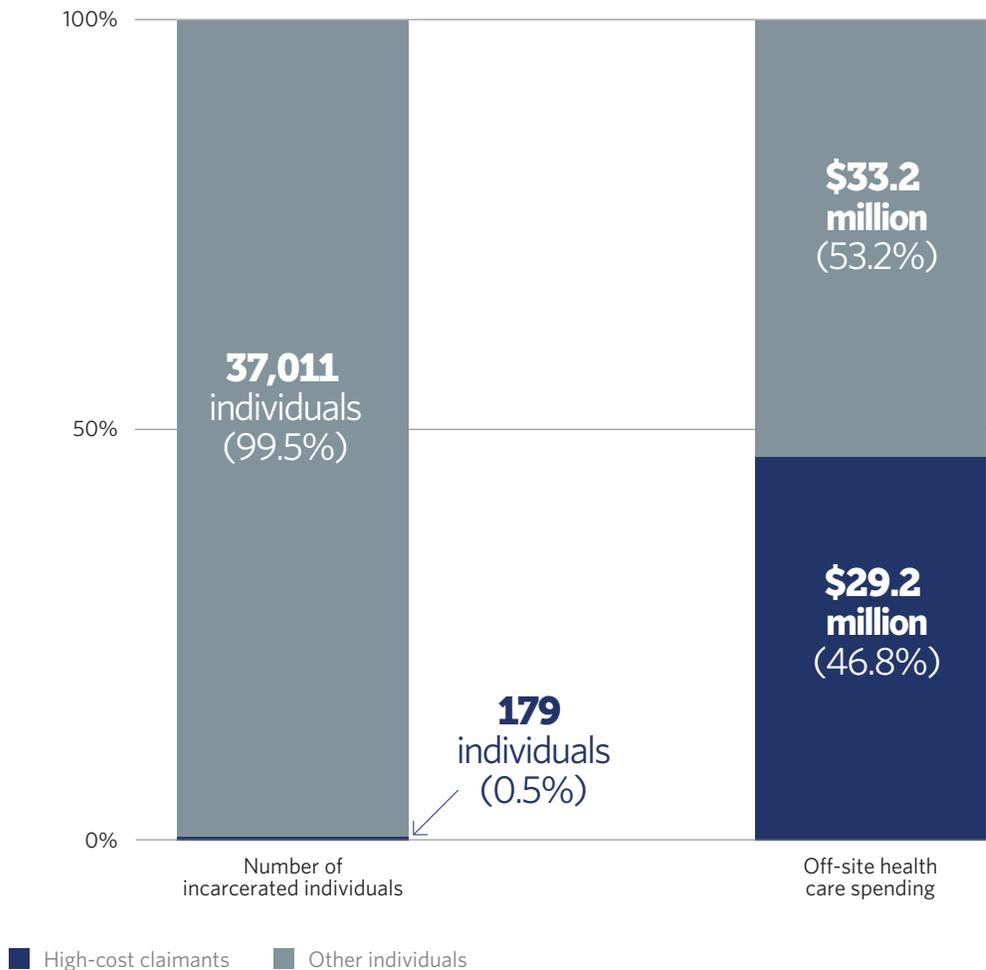
the 55-plus age bracket in fiscal 2016, they made up 28 percent of those receiving off-site care that year. Their treatment accounted for 40 percent of the department's hospital bill.⁷ States that have an even higher proportion of aging inmates than Virginia probably spend a larger proportion of their corrections department health dollars on off-site services.

In addition to those who are aging, a relatively small subset—disproportionately but not exclusively older than 55—is a particular cost challenge. (See Figure 1.) They most commonly have cancer, heart disease, and other severe conditions. Nearly half of the \$62 million that Virginia spent on off-site health care in fiscal 2016 was for 179 people, who made up less than 1 percent of the state's prison population.⁸

Figure 1

Small Subset of Virginia's Prison Population Accounts for Nearly Half of Off-Site Costs

Outside health care spending for incarcerated individuals, April 1, 2015-March 31, 2016



Source: Virginia Joint Commission on Health Care

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Models states use to structure prison hospital care

Creating a prison health system starts with designing on-site access to primary care and common outpatient services. Off-site services supplement such care. (See Table 1.) Pew and Vera’s research revealed that state corrections departments deliver on-site care using one of four systems:

- Direct model. State-employed corrections department clinicians provide all or most on-site care.
- Contracted model. Clinicians employed by one or more private companies deliver all or most on-site care.
- State university model. The state’s public medical school or affiliated organization is responsible for all or most on-site care.
- Hybrid model. On-site care is delivered by some combination of the other models.

Table 1

Delivery System Organization Structures, Fiscal 2015

Delivery system	States	Number of states
Direct	Alaska, California, Hawaii, Iowa, Nebraska, Nevada, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, South Carolina, South Dakota, Utah, Washington, and Wisconsin	17
Contracted	Alabama, Arizona, Arkansas, Delaware, Florida, Idaho, Illinois, Indiana, Kansas, Kentucky, Maine, Maryland, Massachusetts, Mississippi, Missouri, New Mexico, Tennessee, Vermont, West Virginia, and Wyoming	20
State university	Connecticut, Georgia, New Jersey, and Texas	4
Hybrid	Colorado, Louisiana, Michigan, Minnesota, Montana, Pennsylvania, Rhode Island, and Virginia	8

Note: New Hampshire did not provide data.

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States select a model based on historical patterns, staffing needs, policy preferences such as privatization, and other factors. The model officials choose is significant in part because of the impact it has on hospitalization arrangements. For example, in the contracted-provision model, state officials must incorporate rules into a vendor’s contract that delineate who has authority to send someone for nonemergency hospital care. Those rules cover such questions as, Can the contractor’s medical employees decide on their own to send a person to a hospital or do they need approval from a state official, such as the corrections department’s medical director? The agreement must also clarify whether the contractor, the corrections department, the state Medicaid agency, or a combination of the three pays the off-site care bill.

Which model is followed also affects the way payments are tied to care. Most corrections departments that outsource their on-site care negotiate a contract with their health vendor that establishes a capitation—a fixed per-person, per-month payment—that vendors receive for caring for the individuals in the prison system.⁹ Corrections departments weigh how best to obtain good-quality care at a reasonable cost while balancing the contractor’s financial obligations.

The contract between the corrections department and the vendor must detail what services the capitation covers. Because of the potential to incur substantial and unpredictable expenses, vendors can be apprehensive about assuming financial responsibility for patient hospitalizations. Thus, some states agree to exclude completely (carve out) or partially (risk share) such expenses from the vendor’s contract, retaining that responsibility fully or in part. Such arrangements may apply only to off-site outpatient care and any inpatient care not eligible for coverage by other payers such as Medicaid. States that expanded their Medicaid eligibility under the ACA might also choose to carve inpatient care out of their vendors’ contracts since so many hospital stays will qualify for coverage under that law.

Arkansas, Illinois, Pennsylvania, Vermont, and Virginia fully or largely contract out their on-site prison health care but carve out inpatient hospitalization costs. At the other extreme, Arizona, Delaware, Florida, Indiana, Kansas, Kentucky, Massachusetts, and Missouri hold vendors completely responsible for such care through an all-inclusive capitation rate. States that use the risk-share model include Maryland, Michigan, Minnesota, Tennessee, West Virginia, and Wyoming, but their arrangements vary.

The 17 states that deliver on-site prison health care directly and the four that use a state university model pay for the cost of off-site care in varying ways. For example, lawmakers in Connecticut and Iowa appropriate funds to cover the cost of inmate patient medical services at the University of Connecticut hospital (the state correction department’s primary hospital partner) and the University of Iowa Hospitals and Clinics, respectively. But when Iowa’s corrections department uses a community hospital, it pays for the care out of its own budget.¹⁰ Hospitals bill the New York state Medicaid agency for inpatient care of Medicaid-enrolled individuals but charge the corrections department for outpatient care and the inpatient care of offenders who are not enrolled in Medicaid.¹¹

Custody Arrangements

Nearly 9 in 10 individuals under the legal authority of state departments of correction in fiscal 2015 were housed in state-run prisons. The operation of these facilities, including health care, is directly managed by state officials and carried out by a mix of state employees and private vendors.

A majority of states also put some of their incarcerated population under the physical custody of privately owned and operated institutions or local jails. Private prisons are for-profit entities that manage all correctional functions. Jails primarily contain people awaiting trial and those convicted of misdemeanors who are serving sentences of less than one year.

State decisions about when and how best to make use of these alternative settings result from a number of considerations, including cost and space. States retain legal liability for health care provided to those under their jurisdiction, even when the services are provided outside state-run facilities. States lose some direct control and influence over the care that is provided—though they can seek to track performance against established quality requirements—and typically have less access to detailed cost and spending data, as health care costs are incorporated into correctional per diem payment totals.

How officials approve and review hospitalizations

Nonemergency hospital care requires authorization in advance by a corrections department to ensure there is not an appropriate, less expensive treatment available. In this way, officials attempt to control costs while complying with required standards of care. All states have a system to ensure case review for such authorization, regardless of whether the state or a private contractor manages on-site health care. Most states authorize the contractor's medical director and/or the medical director of the state corrections agency to consider requests from the prison medical staff for preapproval for such nonemergency treatments as a hip replacement or hernia repair.¹² The director may approve the proposed procedure, reject it, or suggest an alternative treatment.¹³

Hawaii, a direct-provision state, is a good example of how such reviews are conducted for the portion of its prison population housed in the state. The department of corrections' medical director heads a panel of state physicians and nurse practitioners who review requests from prison medical providers to send a person to a hospital or specialist outside the prison. The panel makes a decision based on clinical findings and other criteria, such as community standards of practice for the service and the person's remaining time in prison. If the request is approved, the corrections security staff is told to arrange screening, transportation, and supervision during the off-site stay. After the treatment, the off-site hospital and specialist must inform the committee of their diagnosis, test results, treatment provided (including medications), and future recommendations.¹⁴

Other states generally do much the same for nonemergency care. In Connecticut, physicians from the University of Connecticut and the correction department conduct the review, in part because the university—which is providing on-site health care until mid-2018—also operates a 10-bed inmate unit at the university hospital. The

state requires the university to report the number of requests for off-site care and the percentages of those that are approved and denied, and for what reasons.¹⁵

Hospitals must also preapprove inpatient hospitalizations that corrections departments expect their state Medicaid agency to cover to ensure that the admission meets Medicaid guidelines.

State corrections officials can also review hospitalizations retrospectively. As in nonprison settings, a rise in “preventable hospitalizations”—admissions due to conditions that are generally treatable in a primary care setting—could indicate that a vendor or its staff at a facility is not providing timely, effective primary care or using prescription drugs effectively. Pennsylvania corrections officials, for example, scrutinize each incarcerated individual’s treatment that preceded hospitalization to learn if it could have been averted.

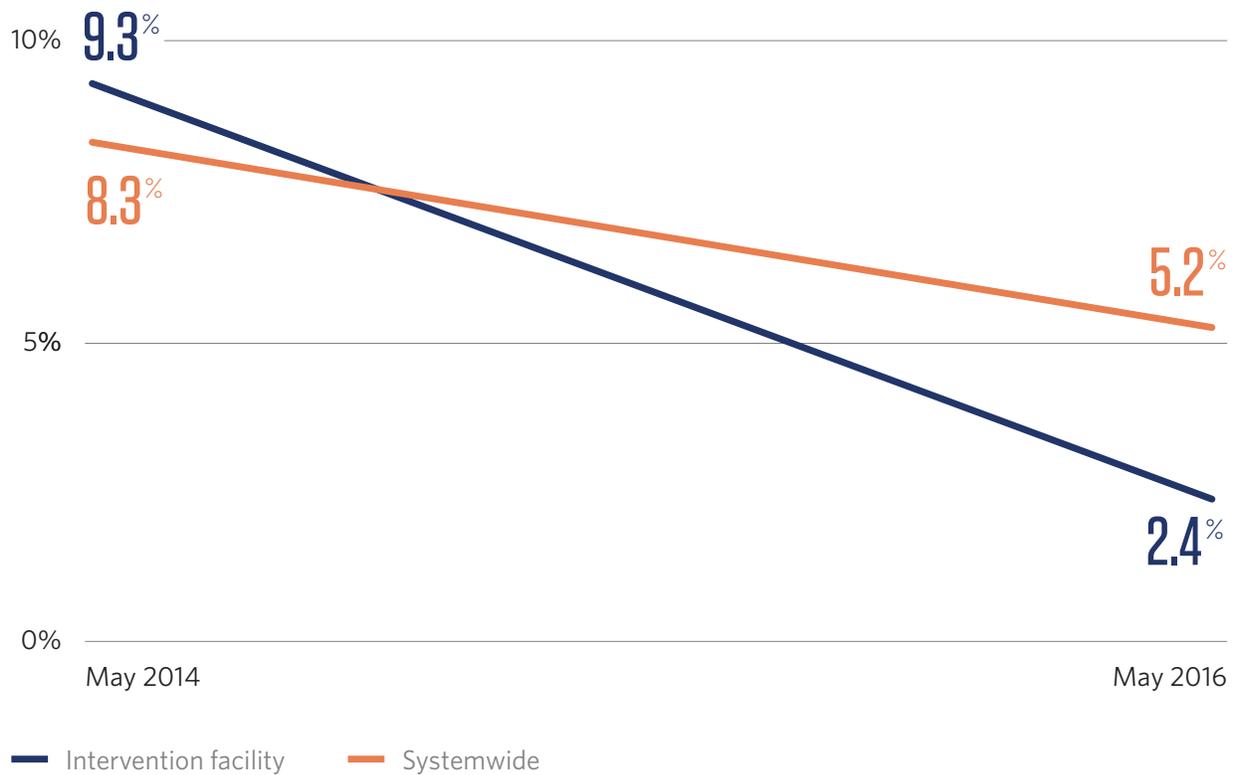
Another area of review involves hospital readmissions. Repeat trips to the hospital following initial treatment increase costs and may indicate inadequate care in the hospital or during the patient’s recuperation. In 2012, the federal government made readmissions a focal point for improving care after finding that nearly 1 in 5 Medicare patients returned to a hospital within 30 days of discharge.

Attempting to reduce avoidable readmissions, California officials chose to focus on the state prison with the highest rate. (See Figure 2.) They developed an algorithm to identify patients most at risk for readmission¹⁶ and then required a registered nurse to check on them within one business day after they returned from the hospital. Doing so meant that incarcerated individuals who had had surgery, for example—and might be prone to an infection—would be treated at the first sign of one, reducing the likelihood of rehospitalization. Over two years, the hospital readmission rate for this prison dropped from 9.3 to 2.4 percent.¹⁷

Figure 2

Interventions Reduce Community Hospital Readmissions in the California Department of Corrections and Rehabilitation

Hospital readmissions, May 2014-May 2016



Source: Clarence Cryer Jr., "Reducing Hospital Readmissions Among Incarcerated Patients," *Journal of Correctional Health Care* 24, no. 1 (2018): 5, <http://dx.doi.org/10.1177/1078345817745054>

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Corrections departments can contract with independent third parties to review hospitalizations, as Ohio, Nevada, and Virginia do, but such reviewers and hospital and corrections officials need to consider incarcerated individuals' special circumstances when applying standards to admissions and lengths of stay. For example, a hospital should not be penalized for a longer-than-average stay if it stems from a lack of available correctional staff to transport the patient back to prison. Or a person might need to remain in the hospital longer than a general patient would if the prison to which he will return lacks proper recuperative services, such as would ordinarily be provided by a visiting nurse or a community rehabilitation facility.¹⁸

Deciding When to Hospitalize

Requests for hospitalization generally fall into three categories, depending on the urgency of the treatment. Florida, for example, defines the categories as follows:

- **Emergencies:** Life- or function-threatening conditions that require immediate treatment, such as a heart attack. In these situations, the formal request process is not used. A 911 responder can decide to take the incarcerated individual to the hospital, collaborating with a medical official or, if one is not available, deciding on their own to take the patient to a hospital.
- **Urgent:** Conditions that must be treated within 21 days to avoid becoming emergencies.
- **Routine:** Conditions that can tolerate a treatment delay of 45 days. For nonurgent diagnostic tests or surgery, such as a hip replacement, some states allow even more time to determine whether a procedure is needed and, if so, whether it must be performed before the end of the person's sentence.¹⁹

State strategies vary in locating hospitals

Regardless of the on-site health care delivery model, corrections departments need to identify hospitals capable of providing supplemental services and willing to treat incarcerated individuals. Their efforts are complicated by the fact that correctional institutions are scattered throughout a state, often in rural areas, and vary in size, security level, and the age and gender makeup of the incarcerated population. They also differ in their on-site capabilities.

Hospitals, too, are dispersed throughout a state and have varying capabilities that do not necessarily mesh with the needs of those incarcerated nearby. States often place their oldest, sickest inmates in correctional institutions with the greatest on-site capabilities or those closest to a major medical center.

State corrections officials can choose to contract with some or all community hospitals near prisons or may concentrate inpatient treatment at one or two hospitals within the state if geographically possible. While officials try to keep off-site care within the state, the closest appropriate hospital may in some cases be in another state. As Jared Brunk, chief financial officer of the Illinois Department of Corrections, said, "Certain institutions are so [near] the border that it is closer for inmates to go to another state for hospitalization services."

When States Build Their Own Prison Hospitals

On the grounds of North Carolina's maximum security prison near the state Capitol in Raleigh sits a five-story building that is rare in correctional health care. It is an on-site hospital with 120 inpatient medical/surgical beds and another 216 beds for those with mental illness.

The General Assembly spent \$180 million to build the medical center and hired more than 300 employees to consolidate health care and inpatient hospitalization for many of the state's incarcerated adults. Opened in 2011, the hospital was designed with security in mind. For the many patients coming for treatment at Central Prison, elaborate off-site transportation planning is not needed. And since most are serving long sentences, they will probably need more medical care over the course of their stays than those serving shorter sentences.

Incarcerated individuals at the 54 other North Carolina institutions do come to the Raleigh prison campus for nonemergency services, including ultrasounds, X-rays, CT scans, and same-day surgical procedures. The state buses patients from facilities around the state to the Raleigh facility.²⁰

Unlike North Carolina, Texas located its free-standing prison hospital on the campus of the University of Texas Medical Branch in Galveston. Staffed by university employees and correctional officers, the teaching hospital includes 172 inpatient beds secured by a locked gate.²¹ Given the size of the state, most acute and emergency care is delivered at the hospital closest to the patient's prison, but once stabilized, he or she is transferred to the Galveston prison hospital.

Georgia also consolidates most specialized care at a state-owned hospital in Grovetown that treats only incarcerated adults.

All three states have the potential to provide seamless care between their prisons and hospitals. In Georgia and Texas, the same university that provides most in-prison health care also runs the correctional hospital, allowing for common protocols and easier coordination. North Carolina's corrections department oversees in-prison care and its dedicated hospital. With the recent addition of electronic health records by the Texas corrections department, patient data can be shared effortlessly among settings.²²

Some counties have also constructed on-site correctional medical centers, allowing local jails to offer more expansive services. Dallas County, Texas, built a \$50 million medical center at its jail, staffed by clinicians from its county safety net health care provider, Parkland Hospital, to handle most inmates' health needs.²³ And Los Angeles County built an urgent care center at its jail to reduce hospital bills and cut transportation costs.²⁴ After the LA facility opened, about five fewer patients a day, on average, were sent to a hospital. After six months, the jail had saved over \$1 million in transportation costs and a nearly identical amount from fewer visits.²⁵

Transporting and securing correctional patients at hospitals

Moving someone between a prison and a community hospital and guarding them during treatment involves a unique set of considerations. The geography of a state, the locations of its prisons and hospitals, and the preferences of state lawmakers all play a role in determining a corrections department's transportation and security strategy.

Underlying the planning for secure transportation and hospital security is the risk an incarcerated individual may attempt to escape the vehicle or the hospital, posing a threat to corrections staff, health care workers, and the community. One state corrections medical director recalled a prisoner fleeing two officers in a community hospital. The facility was placed on lockdown until the escapee was recaptured. "The hospital is not going to take that very well," he said.²⁶ In 2017, a rape suspect in Ohio overpowered a sheriff's deputy while being transported between a psychiatric hospital and the jail, stole the officer's gun, and fled after demanding that the deputy remove his leg shackles and handcuffs.²⁷

The logistics of a hospital trip are intricate.²⁸ Many states have specially trained transportation units within the corrections department, supplemented by state or local police during staffing shortages. Security personnel at the prison and the hospital must be notified of the planned trip and the person's custody level—minimum, medium, or maximum. At least two officers usually accompany an individual when he or she is being taken to a hospital. Distances between correctional institutions and hospitals can be a challenge, especially during inclement weather. Alaska corrections officials, who usually transport incarcerated individuals off-site in buses and vans, sometimes fly someone to a hospital on a charter or commercial flight.²⁹ The arrangement between Texas' corrections department and the University of Texas Medical Branch includes a specialized cadre of nurses to handle the logistics of moving patients from hospitals around the state, where they are initially stabilized, to the state corrections department's hospital in Galveston.³⁰

Once at the hospital, the patient's security must be coordinated between the state corrections system and the hospital. Several states, including Connecticut, Colorado, Louisiana, New York, New Jersey, Ohio, Texas,³¹ Virginia, and Wisconsin, have converted, or "hardened," a floor or section of one or more hospitals to an inmate-only wing for minor procedures and noninvasive in- and outpatient care. For surgery and other specialized care, the person is transported to other public areas of the hospital but returned to the secure unit for observation and recuperation. Hospital nurses and doctors staff such secure areas, but state correctional officers guard them. The hospital rooms are modified to meet strict security standards—including bolted-down television sets and no windows or toilet seats—but must still meet the rigorous standards of hospital accrediting organizations. Although these units require a sizable upfront investment, they may be cost-effective over the long run compared with housing each sick adult in a single room guarded by two officers round-the-clock.

Corrections officials report that special training and scheduling add to hospitalization costs and challenges. State corrections security personnel and state troopers transporting sick patients usually undergo training to prevent their guns from being grabbed. Hospital security, nurses, doctors, and other personnel must also be taught how to deliver care to incarcerated individuals who may be shackled and handcuffed during treatment.

When a patient must be moved off-site for nonurgent care and it can be scheduled in advance, state officials must arrange for transport and 24-hour-a-day security at the hospital. This often requires overtime pay because of chronic staff shortages.³²

In Alaska, corrections officials have reported extensive overtime costs, a lack of relief staff, having to pull nontransportation officers off their shifts to take patients to off-site medical visits, and staff turnover. "Despite

the fact that thousands of staff hours are spent each month supervising inmates in outside community hospitals, facilities do not have dedicated posts for this function. As a result, facilities must reassign staff from critical facility posts to provide hospital supervision or rely on overtime to provide required supervision,” officials said in a 2016 staffing analysis.³³ Virginia and Nevada corrections officials, among others, have warned lawmakers that a shortage of officers has hurt patient care.³⁴ “Transport occurs, but often there are no officers to escort the patient to their appointments or procedures,”³⁵ causing delays, officials said. The same staffing shortages can also postpone an individual’s timely discharge from a hospital.

Paying the hospital bill

Corrections officials or vendors reimburse hospitals using a variety of rates for inpatient and outpatient care. As correctional health care costs per inmate are rising in many states, according to Pew research,³⁶ state officials aim to pay the lowest rates possible without discouraging hospitals from providing care to those who are incarcerated. (Hospitals are legally required to accept and at least stabilize emergency patients but can then terminate treatment.)

Corrections officials often try to piggyback on an existing fee schedule or a percentage thereof, such as the one used by their state Medicaid agency,³⁷ the federal Medicare program,³⁸ the state employee health insurance plan,³⁹ or a large insurer’s negotiated rates.⁴⁰ States that concentrate off-site care at one or two hospitals have different considerations, given their volume, than corrections departments that use hospitals throughout their state, since the latter’s effect on any one hospital is somewhat diluted. Similarly, states that invest in hardening a unit at a hospital must ensure that the corrections department and the hospital are both satisfied with the rates since corrections officials cannot easily move the care to another facility without wasting the state’s investment in the infrastructure modifications. Texas—which has both a corrections department-only hospital in Galveston, in the southern part of the state, and a hardened unit at a hospital in East Texas—reported that opening the latter unit not only benefited prisoners, but the volume of patients from correctional facilities also has helped stabilize the finances of this rural hospital.⁴¹

Because a state’s Medicaid program typically negotiates the lowest rates of any payer in a state, a corrections department that uses this fee schedule usually pays less for services than corrections departments in states that use other schedules. Agencies that use a Medicaid or Medicare rate do so regardless of the patient’s insurance status. Usage simply relieves the corrections department from having to negotiate its own rates.

Given the significant accommodations that must be made when treating incarcerated individuals, hospitals may seek a premium over the Medicaid rate. Some corrections departments and private vendors are willing to pay this fee, especially if the hospital locks in a contract with them. For example, in addition to paying the Medicaid rate, New Jersey’s department of corrections pays a hospital a fixed monthly supplement for these costs. Mississippi’s corrections department pays hospitals 200 percent of Medicaid rates for inpatient care, partly in recognition of the special conditions imposed on the staff by such patients, and as an incentive for the institution to willingly accept them. If the hospital or specialist does not have a contract with the corrections department, the state reimburses at only 100 percent of the Medicaid rate. Laws in Utah and North Carolina also require that a lower rate be paid to hospitals that do not contract with their corrections departments. New York does the same, although the practice is not required by state law.

Medicaid expansion has helped cut costs

The ACA allowed states to expand their eligibility criteria for Medicaid coverage for all individuals under age 65 who earn up to 138 percent of the federal poverty level (\$16,643 for a single adult in 2017).⁴² This expansion made many more incarcerated individuals eligible for Medicaid coverage, as income for nearly all falls below this threshold while they are in jail or prison. Thirty-one states and the District of Columbia have expanded their criteria in accordance with the ACA.

States have never been precluded from enrolling those who are incarcerated in Medicaid. However, most of these individuals historically could not enroll because, as nondisabled adults without dependent children, they did not meet many states' eligibility criteria despite their low income.

States may not provide Medicaid coverage for health care services provided to incarcerated individuals unless the care is delivered outside of correctional facilities, such as at a hospital, and the eligible adult has been admitted for 24 hours or more.⁴³ In these cases, state Medicaid agencies can obtain federal reimbursement that covers at least half of off-site inpatient costs—and substantially more if the person is newly eligible—as long as he or she is enrolled at the time of the hospitalization or soon thereafter.

This policy change has caused a large shift of eligible inpatient hospital costs from state corrections agencies to the Medicaid program. It has also allowed expansion states that use contracted vendors—and that, like Massachusetts, hold those vendors financially at risk for off-site inpatient care—to lower their capitation rate.⁴⁴

Officials in states that expanded Medicaid say they have achieved millions of dollars in savings because most corrections hospitalizations have qualified for coverage. Alaska and Ohio are among states that reported significant correctional cost savings due to ACA expansion.

Some state corrections departments also benefited by shifting the processing of hospital claims to their state Medicaid agencies, which is required before claiming federal matching funds. After Nevada and Indiana expanded their eligibility, both turned over their billing operations for inpatient care to their Medicaid agencies. This relieved corrections officials of a function that Medicaid agencies routinely had carried out.

Georgia, North Carolina, and Texas, the states that operate a corrections-only hospital for most of their off-site prison care, are not able to charge the Medicaid program when a prisoner is admitted to one of these hospitals because they are not open to the public, a condition for Medicaid participation.⁴⁵ However, that exclusion is of less concern to these states because none has expanded Medicaid eligibility under the ACA.

Promising approaches to reducing costs

While states will always have to send some prisoners to hospitals, corrections officials can reduce inpatient stays and costs by expanding programs such as telemedicine and mobile services. By examining people by video or in a mobile van, doctors may be able to diagnose illnesses and injuries and prevent a trip to the hospital.

Texas arranges 11,000 patient-doctor video conferences a month—second only to the U.S. military.⁴⁶ Telemedicine produces savings by reducing the need for transportation and staff supervision. An off-site medical specialist may also help to identify subtle medical problems that might otherwise be overlooked, resulting in improved care and fewer emergency room visits.⁴⁷

In addition to cutting transportation and security costs, this use of technology gives corrections departments more choice of specialists. Several state corrections departments reported challenges recruiting clinicians

stemming from prisons' often remote locations and the correctional environment itself. These variables either drive up what corrections departments must pay to recruit and retain skilled clinicians or extend the time and effort required to fill each vacancy. Widening the field of potential medical consultants gives the state a stronger negotiating position on compensation costs. Telemedicine also provides an opportunity for a prison's primary care provider to participate in a video session with a medical specialist and patient, improving the coordination of care.

Corrections agencies in South Carolina and Wisconsin are partnering with their state universities to carry out telemedicine programs. "We're buying some new equipment that actually can do heart sounds and lung sounds and EKGs," and the results can be sent directly to the subspecialist, said James Greer, director of the Wisconsin Corrections Department's Bureau of Health Services.

Other states are bringing mobile technology to prisons, saving them the cost and logistics of having to transport patients to hospitals or other off-site diagnostic facilities. One such use is mammography. A number of states periodically lease a mobile mammography van to administer these screening tests.⁴⁸ When Montana sent a mobile van to its women's prison in 2016, some of the individuals said it was the first time they had had the procedure.⁴⁹

Another way to reduce inpatient hospital days is to set up palliative care and hospice programs within prisons for those who are dying, along with a process for compassionate release.⁵⁰ However, some states report difficulty finding suitable community placements for people who are sick enough to qualify.⁵¹

Conclusion

State corrections departments will always need to send people in their prison systems off-site for specialized care. This report shows the complexity of arranging for and managing such services, whether the department or a private vendor oversees them.

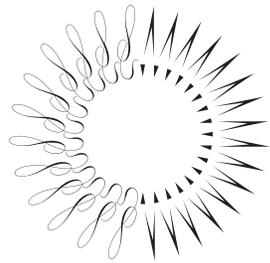
State policymakers must continue to look for ways to trim costs, especially as their prison population ages and requires more intensive and frequent care. Periodically, corrections officials should evaluate the expense of using specialized services off-site instead of on-site. But off-site care will always have to be designed—and have its costs analyzed—within the context of an effective and efficient prison health care system. Understanding how other state corrections departments arrange and pay for hospital care can help policymakers make better decisions on this important and expensive category of care.

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