State Senate
State of Tennessee

News Release

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New law will result in savings to local governments in prisoner health care costs

NASHVILLE, Tenn. -- Legislation recently approved by the General Assembly and implemented into law will provide relief to government budgets in mandated healthcare costs for inmates according to Senator Mike Bell (R-Riceville) and Anderson County Mayor Terry Frank. Bell and Frank held a news conference in Knoxville today, where they were joined by Candace Allen from the Helen Ross McNabb, in talking about the benefits to taxpayers as result of the legislation.

The legislation was a result of a brainstorming session sponsored by the Tennessee Association of Professional Bail Agents (TAPBA) in East Tennessee late last year. Sheriffs, district attorneys, county executives, judges, corrections administrators, health professionals and bail bondsmen representing over 32 Tennessee counties gathered to discuss the shared concern of jail overcrowding and costs threatening county budgets across the state.

"This new law sets out a framework and legal basis for counties to reduce medical expenses for inmates who receive medical care outside of a jail," said Senator Bell, who is Chairman of the Senate Government Operations Committee. "While it does not solve all the issues surrounding the rapidly-increasing costs of incarceration in Tennessee, it will provide some immediate relief to government budgets that are spending more to address these issues at the detriment of other needs."

Currently, TennCare is terminated upon a prisoner's incarceration in state and local jails, meaning taxpayers are required to pay the bill if he or she is transported to a medical facility for treatment. The new law allows the state and local government to seek reimbursement under Medicaid with the federal

government picking up a majority of the costs for Medicaid-eligible inmates who are awaiting trial, but remain incarcerated because they cannot make bail, as well as those who are admitted to inpatient healthcare facilities for more than 24 hours. It also authorizes local governments to piggy-back on state contracts to manage pharmacy benefits, with the savings being remitted back to them.

"State prisons and county jails are an ever-expanding cost that governments across Tennessee are struggling to manage," added Mayor Frank. "This new law allows us to tap into federal funds which are available to help with these constitutionally mandated needs, to give our local taxpayers relief."

Bell said about a dozen states are already receiving reimbursements under these scenarios, and a dozen more are considering similar measures. Similar legislation approved in North Carolina saved taxpayers in that state over $100 million in healthcare costs for prisoners.

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Reference: *Senate Bill 2023 by Bell, McNally, Bowling, Massy, Yager / Status: Public Chapter 926*

Question: Why do we need this legislation?

Answer: State prisons and county jails are an ever-expanding cost that government is struggling to manage and threatens to take an ever increasing portion of their budgets. A significant portion of these costs can be attributed to inmates' health care, which state and local governments are constitutionally mandated to provide. Drug addiction, particularly related to opiates and methamphetamine and the rising number of female and elderly inmates are causing health care costs to rise at a disproportionate rate. sets out a framework and a legal basis for counties to reduce medical expenses for inmates who receive medical care outside of a jail. This bill allows state and local government to seek reimbursement under Medicaid – with the federal government picking up a majority of the costs – for Medicaid-eligible inmates. About a dozen states are already receiving reimbursements under these scenarios, and a dozen more are considering similar measures.

Question: Does this bill expand TennCare enrollment?

Answer: This bill only affects individuals who were already enrolled in TennCare before they were jailed. Because of their incarceration, the federal government dismissed them from the managed care program, leaving state and local governments to pick up 100 percent of the costs during their time in jails.

Question: Will this bill make it more difficult for others to receive TennCare benefits?

Answer: No, exactly the opposite. This bill would save state and local governments' money by allowing them to seek reimbursement from the federal government for medical services provided to inmates – expenses for which state and local governments now pay 100 percent. The bill would provide significant savings that could be dedicated to other citizens' needs, whether that is health care or education.

MEMORANDUM

TO: **Bill Nolan**

FROM: **Michael Nolan**

SUBJECT: **Jail Overcrowding Solutions Summit**

The referenced Summit produced several promising areas for potential savings to county jails. Actual release of inmates was considered a last resort so other solutions were examined. The areas which promised potential savings to the counties with minimum financial impact on the State were:

1. Disability Benefits
2. State buying power used for the benefit of the counties.
3. Reducing transportation expenses.
4. Training of officers to recognize mental health impairments
5. Redefining when counties are reimbursed for housing state prisoners.

Disability Benefits

In Tennessee, Federal Disability Benefits of inmates are terminated upon incarceration. The county jail becomes responsible for the medical needs of the inmates. However, other states such as Florida and Colorado have initiated procedures which allow inmates to retain such benefits. The legislative changes in these states should be examined and modified as necessary to allow Tennessee inmates to retain the same benefits.

Buying Power

The costs of providing pharmaceutical needs of inmates could be reduced if the counties were allowed to purchase drugs under the same terms of the States contracts with pharmaceutical companies.

Transportation

One example which was discussed at the Summit involved the transportation of an inmate from Morristown to Memphis to obtain necessary evaluation and treatment. The possible use of contracts with regional mental health providers should be explored to reduce such transportation expense.

Training

Training of officers to recognize mentally impaired individuals could result in better placement prior to incarceration. All of the participants believe that more training is necessary.

Reimbursement

Several incidents were discussed involving the timing of reimbursements to counties. Inmates become state prisoners upon conviction. However, counties were not being reimbursed for time spent in county jails while the inmates were awaiting sentencing. This issue is one that needs to be examined. The structure of court proceedings may prevent changes in the actual time spent awaiting sentencing. However, changes in when reimbursements begin may be possible.

These five issues seem to have the best chance of actually getting some legislative attention. Ellen Abbott may have some significant input as to which issues should be more vigorously pursued. The handling of the Disability Benefit issue alone may result in accessing millions in Federal funds.

Medicaid for prisoners: States missing out on millions

by Christine Vestal, Pew/Stateline Staff Writer

Only a dozen states have taken advantage of a long-standing option to stick the federal government with at least half the cost of hospitalizations and nursing home stays of state prison inmates.

The other states have left tens of millions of federal dollars on the table, either because they didn't know about a federal rule dating to 1997 or they were unable to write the laws and administrative processes to take advantage of it.

States and localities have a constitutional obligation to provide adequate health care to prisoners, and they must pay for it out of their own budgets. However, a 1997 ruling says that care provided to inmates beyond the walls of the prison qualifies for Medicaid reimbursement if the prisoner is Medicaid eligible. The federal government then pays 50 percent to 84 percent of Medicaid costs.

Ever since that ruling, it has made fiscal sense to get inmates who needed outside medical attention enrolled in Medicaid, said Aaron Edwards, a legislative analyst in California who helped get the state's program started, "but in 2014 it really becomes a no-brainer."

That's when the major elements of the Affordable Care Act take effect, and most prison inmates will be eligible for Medicaid if they need health services outside of prison. The number of inmates in state prisons as of 2011 was nearly 1.6 million, according to the U.S. Justice Department. An additional 745,000 were in local jails, a population that would also qualify for Medicaid benefits if they required outside medical care.

Right now, in most states, only prisoners who are pregnant, disabled or aged are eligible for Medicaid coverage when they need outside medical attention.

But most states and localities don't bother to seek Medicaid reimbursement for that limited class of prisoners, an omission that deprives them of millions of dollars in potential federal reimbursement. It's not the inmates themselves but rather the states and localities that are the beneficiaries of the federal Medicaid reimbursement.

So far, only Arkansas, California, Colorado, Delaware, Louisiana, Michigan, Mississippi, Nebraska, North Carolina, Oklahoma, Pennsylvania, Washington and some scattered local governments are tapping Medicaid to pay for inpatient medical and nursing home care. A few more states are looking into it, including Georgia, Massachusetts, Minnesota, New Mexico, New York and Virginia.

In states that are using Medicaid to help pay for hospital stays, the most common type of medical care that qualifies is hospitalization for childbirth, nursing home care for elderly inmates and surgery and other treatments for cancer, liver disease and other illnesses. Arkansas uses Medicaid exclusively to cover hospitalization of pregnant inmates.

How it works

Under early interpretations of the 1965 law that created Medicaid, anyone entering a state prison lost Medicaid eligibility. The same went for people who were in local jails, juvenile lock-ups and state mental institutions. The reasoning was that states and local governments had historically taken responsibility for inmate health care so the federal-state Medicaid plan was not needed.

But an exception to that general rule opened up in 1997 when the U.S. Department of Health and Human Services wrote to regional Medicaid directors saying inmates who leave state or local facilities for at least 24 hours to receive treatment in local hospitals or nursing facilities could get their bills paid by Medicaid, if they were otherwise eligible. In addition to the incarcerated, those on probation or parole or under house arrest could participate.

But few prisoners were eligible since most states extend Medicaid benefits only to infants and children under five, pregnant women, people with disabilities and the frail elderly.

That changes in January when 22 states expand Medicaid eligibility to all poor adults in accordance with the Affordable Care Act. Most prison and jail inmates in those states would immediately become Medicaid eligible. (The only likely exceptions are undocumented immigrants and people who for whatever reason do not have a Social Security number.)

Since most inmates would be considered newly eligible for Medicaid, the federal government would pay 100 percent of all costs from 2014 to 2017. After that, states would be responsible for a small share of the costs, increasing to10 percent by 2020. In addition, state health insurance exchanges — scheduled to go live this October — will make it easier for corrections departments to sign inmates up for the program.

Big dividends

In states that are already using Medicaid to pay for outside inmate care, federal payments have added up quickly.

North Carolina, for example, started the reimbursement process in 2011. In May, the state reported that federal payments came to $10 million in the first year, a 4 percent chunk out of the state's $259 million prison health care bill.

Of the 1,449 inmates admitted to North Carolina hospitals in the fiscal year that ends July 1, almost half were eligible for Medicaid.

This year, the state expects much higher federal payments because the program is running more smoothly, said Larry Huggins, who supervises the corrections department's Medicaid program. But North Carolina won't see a big leap in federal payments in 2014, because Gov. Pat McCrory, a Republican, has said the state will not expand its Medicaid rolls under the new health care law.

In California, which is expanding Medicaid, federal Medicaid dollars for state inmates in the current fiscal year will reach $31 million. Edwards, the legislative analyst, said the legislature's

conservative prediction is that federal payments for fiscal year 2014, which includes only six months under the 2014 expansion rules, will reach $52 million, about 3 percent of the state's $1.6 billion prison health care bill. In 2015, federal reimbursements are projected to total $69 million.

California prisons house about 130,000 inmates. Its state mental hospitals hold another 5,500 patients who mostly come from state prisons and jails and would be eligible for similar Medicaid reimbursements. But the Department of State Hospitals has not made the effort to set up the agreements with other agencies that would make reimbursements possible. The same goes for most county jails in the state.

Delay and misinformation

"It's enormously complicated if you haven't started yet"

— Donna Strugar-Fritsch, Health Management Associates

Why have so few states and localities taken advantage of the opportunity to collect millions in federal money to defray correctional health care costs? Like everything else connected with Medicaid, the rules are complicated and implementing the program requires cooperation among at least three separate agencies: corrections, Medicaid and local social services.

Another problem is that inmates don't necessarily want to cooperate with prison personnel once they explain they are trying to defray some of their costs by drawing on federal funds.

In California, for example, most inmates who were asked to sign a Medicaid enrollment form gave a "screw you" response to corrections officials, Edwards said. As a result, California passed a law allowing prison personnel to fill out and sign Medicaid enrollment forms on behalf of inmates, but only for services received while incarcerated.

Another reason is that state corrections agencies didn't find out about the ruling right away. The announcement first went from Washington to federal regional Medicaid officials who interpreted the ruling before sending it to Medicaid agencies in the states. Medicaid agencies then further analyzed the ruling before alerting the corrections agencies. Some corrections departments never got the memo.

Delaware, Louisiana and Oklahoma were the first states to use Medicaid for inmate hospitalization. As word of mouth traveled, a few more states enacted the needed laws and administrative procedures.

"There's been a lot of misinformation out there," said Donna Strugar-Fritsch, a consultant with Health Management Associates who works with states to help them take advantage of the program. "It's enormously complicated if you haven't started yet," she warned.

As a result, most states likely will not be prepared to take advantage of it for the 2014 expansion, Strugar-Fritsch said. But once states understand how much federal money they're leaving on the

table, most will do what it takes to set up the needed systems, she predicted. "By 2015, it will be just silly if they don't."

Stateline is a nonpartisan, nonprofit news service of the Pew Charitable Trusts that provides daily reporting and analysis on trends in state policy.