

# **Medicaid Coverage For Inmates And Reentering Populations In North Carolina**

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## EXECUTIVE SUMMARY

### I. Policy Question (p.1)

What was the process by which the North Carolina Department of Correction (DOC)<sup>1</sup> was able to implement the state's new Inmate Medicaid Enrollment (IME)<sup>2</sup> program, and what are the implications of Medicaid expansion in 2014 for DOC and reentering populations of formerly incarcerated prisoners?

### II. Background (pp. 2-7)

#### *Health of Inmates*

American prison and jail inmates are less physically and mentally healthy than the general public. Prison and jail inmates are five times more likely to have AIDS and eight to ten times more likely to have HIV Infection. Forty two percent of state prison inmates suffer from at least one chronic medical condition (NCCH 2002; Wilper, et al 2009).

Inmates are also likelier to have substance abuse problems in conjunction with other diseases, including mental disorders, HIV/AIDS, hepatitis B and C, cardiovascular disease and cirrhosis of the liver (Davis and Pacchiana 2004; Mallik-Kane and Visser 2008).

#### *The Provision and Cost of Inmate Health Care*

In 1976 the U.S. Supreme Court ruled that the government is constitutionally obligated by the eighth amendment to provide adequate health care to prison or jail inmates for the duration of their incarceration (*Estelle v. Gamble* 1976). In the decades since this ruling, states prison systems have seen their financial burdens grow partly due to rising health care costs. By 2010, North Carolina's DOC spent more than \$100 million on medical services, \$44.9 million of which was for care provided by hospitals and other medical contract providers (Wood, 2010).

#### *Medicaid and Inmates*

Medicaid is a means-tested, joint federal-state program that provides health care coverage to low-income Americans based on specific categorical and financial requirements. Under current Medicaid eligibility criteria, most inmates are not Medicaid eligible and a

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<sup>1</sup> In January 2012 the North Carolina Department of Correction merged with other state departments to become part of a new Department of Public Safety. As such, DOC is now formally the Division of Adult Correction. However, for the purposes of this report I maintain the use of the former DOC acronym.

<sup>2</sup> The term "Inmate Medicaid Enrollment Program," or IME is of my own creation. To my knowledge DOC does not have a specific name for this program, but for the purposes of this project I thought it prudent to establish a consistent term to refer to the program- hence, IME.

2010 audit estimated that only 646 out of North Carolina's 40,379 inmates may be enrolled in Medicaid (Wood 2010).

Medicaid rules preclude federal financial participation (FFP) for inmates of government institutions who are committed against their will, namely prison or jail inmates. However, in 1997 the Centers for Medicare and Medicaid Services (CMS) issued a rule clarification explaining that an inmate is FFP eligible for treatment or services they receive at an institution that is open to the public- including hospitals- if they remain in that institution for longer than 24 hours (Streimer 1997). The underlying principal for this provision is that once located and receiving treatment in a public medical institution for more than one day, a person is no longer considered an "inmate" by CMS and is eligible once again for FFP (Strugar-Fritsch 2012).

In the early 2000's, North Carolina's Division of Medical Assistance (DMA) inquired with the Region IV CMS office into this issue but was informed that this CMS office did not interpret the rules to include inmates under FFP (Wilson 2011).

#### *Medicaid Expansion under Health Care Reform*

In March 2010 President Obama signed two health care reform laws collectively known as the Patient Protection and Affordable Care Act (PPACA). As part of this reform, Medicaid coverage in the states will mandatorily expand to cover all individuals under the age of 65 whose income falls below 133% of the federal poverty line (Stone, et al 2010). As part of this expansion the federal government will cover between 90-100% of Medicaid expenses for newly eligible enrollees by 2020 (Stone, et al 2010).

Presently, North Carolina's Department of Health and Human Services (DHHS)- the department under which DMA operates- is responsible for \$.35 for every \$1.00 spent on Medicaid (Wood 2010). However, once Medicaid expands DHHS will only be responsible for up to 10% of the costs for new enrollees, and the federal government will fund the remaining 90%.

There is no indication that the provision allowing for a change in inmate status once treated in a public institution for longer than 24 hours would change under PPACA (Strugar-Fritsch 2012).

### **III. North Carolina's Inmate Medicaid Enrollment Program (pp. 7-18)**

#### **IME Conception**

The implementation of North Carolina's Inmate Medicaid Enrollment (IME) program is a model for other states to emulate. It is also illustrative of the harsh realities states face in today's economy as well as their aspirations for creative, cost-saving innovations in government programs. Though other state departments of corrections began utilizing Medicaid for inmates prior to North Carolina, many of those states relied on consultation by health management firms to achieve what a handful of North Carolinian agency staff members accomplished in less than one year (Shoemaker 2012). The speed, efficiency and relative ease with which the people at NC DOC and DMA were able to conceive, create and implement this initiative is impressive and commendable.

I identify five key events or components that were essential in creating this new program:

1. The motivation for change created by the recession budget crises
2. The objective and timely release of reports from the State Auditor's office, highlighting the problems of inmate medical care costs and proposing Medicaid enrollment as a possible solution
3. The legislative leadership and directives coming from the Governor's office and the General Assembly, which combined to remove any doubt that DOC and DMA would work together to enact this program
4. Preliminary cost-savings measures that DOC took prior to IME, including hiring staff members with expertise in medical cost containment strategies
5. The drafting and signing of a Memorandum of Agreement between the two agencies, which created an introductory period when the staff from DOC and DMA could establish a strong working relationship as well as an operating structure for the program

#### **IME Execution**

The IME program's execution and daily operation is based primarily on a new cross-referencing data system that was created by the information and technology departments within DOC and DMA. This system allows DOC to check daily lists of inmates against Medicaid enrollee and eligibility records. When DOC finds a "hit," or a dual match on both systems, they initiate the process of re-enrollment for the inmate (presuming that their eligibility has either expired or was terminated at the county level upon their initial arrest and conviction). DMA then processes the applications for Medicaid eligibility through the inmates' county departments of social services (Keller and Cansler 2010).

The Medicaid reimbursement process includes several steps. Whenever inmates receive treatment at medical institutions, the billing office for that institution sends the final bill to DOC for payment. Under the new IME program, all of these bills are now cross-referenced with the list of Medicaid enrolled inmates. If the care was administered to an inmate who is eligible and enrolled, DOC returns the bill to the institution with an explanation that they must seek reimbursement from Medicaid. At this point, the hospital begins its negotiations with DHHS and CMS to receive the payments at the Medicaid reimbursement rates (Yates 2011).

As indicated in the MOA, DHHS (via DMA) agrees to act as a payer proxy for DOC in paying the current state Medicaid portion of the reimbursement, which is approximately 30% with the remaining reimbursement covered by the federal government. DHHS then submits quarterly invoices to DOC for the inmate Medicaid payments it issued and DOC reimburses DHHS for these funds (Yates 2011; Keller and Cansler 2010; Rogers, Smith and Keller 2010).

### **IME Challenges**

The IME program is noteworthy for its relative smooth operation after only fourteen months in operation. However, both Ms. Yates and Mr. Wilson admit that there have been obstacles throughout the implementation process that require solutions (Yates 2011; Wilson 2011).

#### *Medicaid Termination*

The first problem that Ms. Yates and Mr. Wilson identified was that of Medicaid terminations taking place at the county level. DMA's official policy is that an individual's Medicaid benefits should be suspended upon their arrest. In practice many North Carolina county systems are terminating these benefits, making the Medicaid eligibility identification process more difficult for DOC and DMA (Wilson 2011; Yates 2011).

#### *Estimating Savings*

Another key challenge comes in quantifying the savings realized through the IME program. Calculating potential or realized savings depends on many assumptions that are inconsistent year-to-year, including: how many inmates are or will be eligible; the likelihood that they will require medical attention outside prison property; and the nature, length and expense of that care (Vincoli 2012).

### *Payers of Last Resort*

Early on in the creation of the IME program, DOC received a warning from the state Attorney General's office that utilizing Medicaid as a payer for inmate care may violate the "payer of last resort" clause in Medicaid rules. The CMS Region IV office in Atlanta gave their consent to the program and did not indicate similar concerns, but administrators at DOC are unsure if they are, in fact, violating this rule.

Other state corrections departments have protected themselves from possible liability by inquiring into whether or not the inmate in question has family members or support networks who can reasonably afford the hospital care that would otherwise be billed to Medicaid. In most cases there are no viable third parties, protecting the states if they need to defend themselves against future CMS inquiries (Strugar-Fritsch 2012).

### *Hospital Contracts*

All hospitals are required to treat any person- inmate or civilian- who enters an Emergency Room. For scheduled procedures, however, it is up to the hospital's discretion if they will or will not treat an inmate. In most cases, DOC negotiates and signs contracts with hospitals for inmate care reimbursement rates.

DOC attempted to strengthen its leveraging power in these negotiations by lobbying for the inclusion of a requirement that all state licensed hospitals must treat non-emergency inmates. Unfortunately, this provision was removed from the 2010 budget bill at the very final stage in the process (Vincoli 2012; Lancaster and Rogers 2011).

DOC has taken two large steps towards reducing its dependency on expensive hospital contracts: constructing the new Central Prison Hospital Complex; and seeking out a single, private health contractor to provide all medical services for DOC. It is unclear to what extent these projects will affect IME, but they undoubtedly indicate DOC's prioritization of solving the contracting issue to address health care costs.

## **IV. Implications for the Future (pp. 18-23)**

### **Medicaid Expansion**

Medicaid's expanded eligibility in 2014 will likely include the vast majority of the inmate population in North Carolina, perhaps as high as 90% (Yates 2011). Federal reimbursement rates for these newly enrolled inmates will concurrently increase to 100% for the first two years after expansion (through December 2016), and slowly decline over subsequent years to a minimum of 90% by 2020 (Wood 2010).

## **Potential Cost-Savings**

Based on average hospital cost and inmate population growth rates in recent years, I project possible cost-savings associated with IME under Medicaid expansion beginning in 2014. These figures are estimates based on various assumptions and scenarios, including different percentages of the prison population that may become Medicaid eligible in 2014. Based on my calculations, DOC could save between \$139 million and \$530 million between 2014-2020. It is also possible that these are low estimates given the higher numbers initially attached to the Auditor's preliminary estimations.

## **Public Health Impacts**

IME may also have important impacts on public health. DOC reentry planning procedures already include inmate counseling and preparation for accessing public assistance programs, including Medicaid (Yates 2011). Under the recently passed Justice Reinvestment Act, all released felons will receive post-release supervision, including 14,000 released prisoners who previously would not have received any supervision (Holbrook 2011).

These programs may ensure greater continuity of care for reentering prisoners once Medicaid is expanded in 2014. If individuals leaving prison are enrolled in Medicaid either prior to or during their transition period and receive closer post-release supervision, they may be likelier to utilize their health care coverage and seek out mental health, substance abuse and medical treatment.

## **V. Conclusions and Recommendations (pp. 23-25)**

North Carolina's Inmate Medical Enrollment Program is a model other states may wish to emulate in their own pursuit of cost-savings and innovative solutions to rising incarceration and medical costs. In particular, the cooperation between DOC and DMA on an administrative and personnel level indicate that complicated inter-agency programs can be successfully implemented quickly and efficiently.

To build on the success of the IME program's implementation and expand its positive impacts, I recommend DOC take the following actions:

- 1) DOC and DMA should educate and train county managers in the process of Medicaid utilization for enrolled inmates. While it may not be feasible to expect all 100 of North Carolina's counties to implement their own IME program for jail

inmates, even a handful of densely populated or high incarceration counties stand to reap financial and public health benefits if they follow the state model.

- 2) DOC should work with county social service agencies to create and implement their own IME program, whereby arrested individuals are immediately cross-referenced against Medicaid records for possible matches. In particular, NC DOC should model the Colorado Department of Correction's jail enrollment program. DOC may consider working first with the most populated counties and those with the highest incarceration rates, as they will likely be most motivated and have the greatest staff and infrastructural resources to enact their own successful IME programs.
- 3) To protect the state from any legal repercussions, DOC should add an additional information search related to inmates' family participation or ability to pay for medical care. At the very least, DOC should ensure access to contact information for inmates' families so that those requiring hospital care are screened for any other possible payers of last resort.
- 4) Finally, in the event Medicaid expansion does move forward, DOC should implement a health care training process for all probation and post-release supervision officers as well as other reentry programs to maximize the potential for improved public health and reduced recidivism.

With public confidence in government historically low it is all the more important and valid to analyze and credit IME for its smooth implementation as well as its outcomes. As the country faces a slow and halting economic recovery, state governments may look to the North Carolina Inmate Medicaid Enrollment Program as an example for how government can quickly respond to economic crises and create new programs that may reduce spending and result in long term community benefits.

## **I. INTRODUCTION AND POLICY QUESTION**

As part of the Patient Protection and Affordable Care Act (PPACA), Medicaid will expand in 2014 to extend eligibility for health care coverage to millions more Americans. Included among these will be those prison inmates and ex-offenders who are currently ineligible for Medicaid coverage. Corrections systems are constitutionally mandated to provide adequate health care to all prison and jail inmates for the duration of their incarceration. The expenses associated with providing this care are a leading cost driver for most state correctional systems. As states continue to battle large budget deficits, elected officials and agency leadership are increasingly motivated to reduce high prison costs. North Carolina is no exception, and in 2010 the General Assembly issued a directive compelling the state Department of Correction (DOC) to identify and implement new cost-saving measures.

The result was the implementation of a new Inmate Medicaid Enrollment (IME) program that became operational in February 2011. According to internal estimations, this new program was projected to save DOC \$14 million by the end of the 2011-2012 fiscal year. IME also represents a uniquely successful cross-collaboration between two large state agencies with no prior working relationship- DOC and the State Department of Medical Assistance (DMA). As more states consider similar inmate Medicaid utilization programs, North Carolina has established itself as a leader that is well poised to take advantage of Medicaid expansion and its increased federal reimbursements scheduled for 2014.

In this project I analyze the process by which these North Carolina state agencies created and implemented IME, while also examining the implications of Medicaid expansion for DOC's costs, inmate populations and reentering prisoners. The following paper offers background information on prisoner health care and medical costs; Medicaid as it currently relates to inmates and as its projected change in 2014; and the public health dynamics of prisoner health and reentry. The second section offers an analysis of IME in North Carolina, from its conception to its current operation.

The third section offers projections for IME once Medicaid expansion is implemented and the possible implications for the future. Finally, I offer conclusions based on my analysis and five specific recommendations for how North Carolina can best maximize the potential benefits of IME, whether or not Medicaid expansion progresses.

## II. BACKGROUND

### *The Health of Prisoners*

The poor health of American prison and jail inmates, both during and after their incarceration is well-documented. Prisoners suffer from higher rates of mental illness, substance abuse problems and chronic health conditions (Mallik-Kane and Visser 2008; Maruschak and Beck 1997; Wilper, et al 2009; National Commission on Correctional Health 2002; Freudenberg 2001). Formerly incarcerated individuals face an adjusted risk of death that is 3.5 times higher than other state residents (Binswanger, et al 2007). Essentially, inmates are both more ill while incarcerated and more likely to suffer from poor health upon their release.

In 2002, the National Commission on Correctional Health presented a comprehensive analysis of the health conditions of American's inmates to Congress. The findings were stark. Compared to the general U.S. population, prison and jail inmates were five times more likely to have AIDS, eight to ten times more likely to have HIV, nine to ten times more likely to have hepatitis C, and four to seven times more likely to have tuberculosis (NCCH 2002; Jacobi 2005). In 1997 at least 200,000 individuals who were either incarcerated or released from prison were infected with STDs such as syphilis, gonorrhea and chlamydia (NCCH 2002). In the prior year, 35% of all U.S. tuberculosis cases were found in released prisoners (Jacobi 2005).

Inmates also suffer from mental health and substance abuse disorders at higher rates than the general public, including schizophrenia or psychotic disorders, major depression, bipolar disorder and post-traumatic stress disorder (NCCH 2002; Miller 2007). A 2004 survey found that 38.5% of federal inmates, 42.8% of state inmates and 38.7% of jail inmates suffered from at least one chronic medical condition (Wilper, et al 2009).

By one estimate, 700,000 mentally ill individuals are admitted into U.S. jails every year and studies indicate higher rates of mental illness than among the general public (Freudenberg 2001). The Bureau of Justice Statistics (BJS) estimates that one in four of all male and female state prison inmates suffer from alcohol dependence, and that 83% of male state prison inmates reported using drugs within one month of their arrest (Davis and Pacchiana 2004).

Mandatory minimum sentences and three-strike laws have also increased sentences for many inmates, resulting in older and aging prison populations with greater health needs and risks (Kinsella 2004). These older inmates often suffer from more chronic diseases like hypertension, cancer and diabetes, which require a great deal more treatment and

cost (Kinsella 2004). Overall, America's inmates represent a particularly ill population of individuals suffering from a host of complicated and comorbid mental and physical ailments.

### ***The Provision and Cost of Inmate Health Care***

For most of American history neither prison administrators nor the general public were particularly concerned with the provision of inmate health care. In 1970, the American Medical Association surveyed jails across the country and found that 65% of jails were only able to provide first aid while 28% reported they had no physician regularly available for sick inmates (Anno 2001). In 1976 the U.S. Supreme Court took action to reverse these conditions, ruling that the government is constitutionally obligated by the eighth amendment to provide adequate health care to prison or jail inmates for the duration of their incarceration (*Estelle v. Gamble* 1976).

This landmark decision codified federal and state responsibilities regarding inmate health care and distinguished inmates as the only Americans who are constitutionally mandated to receive health care (Kinsella 2004). The Supreme Court's ruling also significantly increased state correctional systems' financial responsibilities and burdens. Between 1998-2001 state prison healthcare expenses rose by 10% annually, and cost upwards of \$12 per inmate per day (Kinsella 2004).

Prisoner's poorer health and higher risk lifestyles are two primary cost drivers for inmate health care. In 1997 it cost \$475 million total just to treat prisoners infected with syphilis, chlamydia and gonorrhea (Kinsella 2004). Aging prisoners and their increased medical needs also drive costs, and some estimates calculate that a prisoner aged 50 years or older may cost as much as \$70,000 per year to house in a prison or jail (Kinsella 2004).

In 2010, North Carolina's DOC spent more than \$100 million on medical services with average inmate health care costs up 9.7% from the previous year (Wood 2010; Division of Prisons Health Services Expense Report 2010). Of these expenses, \$44.9 million was for contracted medical and rehabilitative services that DOC's medical facilities and staff were unable to provide themselves (Wood 2010).

According to former DOC Deputy Secretary Frank Rogers, it would be prohibitively expensive and wasteful for DOC to fully duplicate the facilities and resources available at public and private hospitals, leading them to seek medical care from outside providers (Rogers 2011). However, in order for DOC to bring its inmates to these providers and hospitals, there must be a contract agreement in place establishing the prices DOC will

pay for services rendered (Vincoli 2011). Under current law, hospitals and providers are only required to admit emergency care inmates, meaning they need not enter into a contract with DOC to treat non-emergency inmates. Thus, the prices that are negotiated are often to DOC's disadvantage (Vincoli 2011; Rogers 2011).

These costs were partly responsible for a conclusion drawn by State Auditor Beth Wood, whose office issued a report finding that DOC "does not have internal controls in place to ensure medical costs are minimized...[and] should implement procedures designed to contain costs of inmate medical care." (Wood 2010) The report included a cross-comparison with other states' departments of corrections, and found that one effective cost containment strategy was the use of Medicaid enrollment and billing for eligible inmates to help cover hospital and other inpatient services (Wood 2010).

### ***Medicaid and Inmates***

Medicaid is a means-tested, joint federal-state program that provides health care coverage to people based on categorical and financial eligibilities (Stone, et al 2010). There are over 50 different classes, or "pathways" to Medicaid eligibility, but primarily only low-income children, custodial parents, and disabled and elderly adults are covered. Thus, low-income adults who are non-custodial, non-disabled or are of working age are ineligible (Stone, et al 2010).

Of the 1.6 million people who were incarcerated in the United States by 2009, 93% were male with an average age of 39 years old (West and Sabol 2010). By 2011, 93% of North Carolina's 40,379 inmates were male, with an average age of 36 years old (North Carolina Department of Correction Prisons Statistics Card 2011; Monahan 2011). Additionally, a 2010 audit of North Carolina's Department of Correction found that at least 646 inmates were eligible for Medicaid coverage (Wood 2010).

Medicaid rules prohibit federal reimbursement for inmates of a public institution who are held against their will, i.e. prison inmates (Allen 2010). However, there is an exception to this preclusion that reinterprets a person's status as an inmate depending on where they receive medical care after a certain time threshold. According to the Centers for Medicare & Medicaid Services (CMS), individuals are no longer considered inmates when they receive medical care in a facility that is open to the public, such as nursing or hospital centers, for more than 24 hours (Strugar-Fritsch 2012). Essentially, if a prison inmate spends more than one day at a non-prison medical facility and they are enrolled in Medicaid, their care will be eligible for federal financial participation (FFP) or federal reimbursement of their care (Streimer 1997).

Strangely, this allowance for some inmate coverage went unknown and unutilized in state departments of corrections for more than thirty years following Medicaid's 1965 enactment. In 1997, CMS Director Robert A. Streimer issued a memo to all regional CMS offices entitled "Clarification of Medicaid Coverage Policy for Inmates of a Public Institution." In this document, Mr. Streimer wrote that "Section 1905(a)(A) of the Social Security Act specifically excludes Federal Financial Participation (FFP) for medical care provided to inmates of a public institution, except when the inmate is a patient in a medical institution" (Streimer 1997).

He goes on to explain that inmates do not lose their Medicaid eligibility while incarcerated, rather that the federal government will not reimburse for the care they receive while in prison facilities. This partly relates to the practice of Medicaid termination for individuals who are arrested or convicted of crimes. While CMS recommends that states suspend, rather terminate Medicaid benefits for incarcerated individuals, more than 90% of states and counties- including in North Carolina- terminate an individual's enrollment eligibility upon their arrest or conviction (Wakeman, et al 2009; Morrissey, et al 2006).

Mr. Streimer's 1997 letter also distinguishes between public and medical institutions, explaining, "a facility is a public institution when it is under the responsibility of a governmental unit, or over which a governmental unit exercises administrative control." (Streimer 1997). The difference between these two types of institutions became important in 2009 when the Colorado State Department of Health Care Policy and Financing (DHCPF) denied Medicaid payment for care that Denver county jail inmates received from the Correctional Care Medical Facility within the Denver Health Medical Center. This unit was specifically created within a larger public hospital to serve county inmates, and was a closed and guarded unit (Allen 2010). In their denial, DHCPF claimed the closed nature of the ward restricted it from FFP and thus the care administered within was not Medicaid eligible. CO DOC appealed the state's denial and received confirmation from CMS in 2010 that according to Medicaid rules, even this closed and guarded unit qualified as a "medical institution," and as such any care administered to patients (i.e., inmates) therein was eligible for FFP (Allen 2010).

The situation in Colorado illustrates the confusion around the issue of when and if inmate medical care qualifies for Medicaid reimbursement. Following Mr. Streimer's 1997 letter, the CMS Region IV office in Atlanta issued its own clarification reiterating Mr. Streimer's definition of when FFP applied to inmates of public institutions (Britton 1998). In fact, this letter was almost an exact transmittal of the previous clarification, and was issued as an official notice. In theory, these two documents and their subsequent circulation would establish uniform clarity on the issue of inmate Medicaid eligibility.

However, only four years later a new CMS Director, Mr. Dennis Smith, issued his own letter to all CMS regional administrators stating, “Section 1905(a) of the Social Security Act and the regulations at 42 CFR 435.1008 and 435.1009...prohibit (FFP) for services provided to inmates of public institutions” (Smith 2002).

These back and forth letters and clarifications are part of a general confusion that surrounds the issue of Medicaid and inmates. This lack of clarity was certainly true at the agency staff level in North Carolina as well. In the late 1990’s, Andy Wilson- a Medicaid specialist for the North Carolina Division of Medical Assistance- attended a nationwide conference where colleagues from Indiana and Illinois indicated their state agencies were receiving FFP for inmate hospital services. However, when Mr. Wilson contacted the regional CMS office in Atlanta, they informed him that this was not their interpretation of Medicaid rules and they would not consider inmates eligible for FFP (Wilson 2012).

According to Mr. Wilson, CMS is usually not as disparate in their interpretations of rules as they initially were regarding inmates. However, Donna Strugar-Fritsch of Health Management Agencies said it is common to have conflicting interpretations of Medicaid law between regional offices (Strugar-Fritsch 2012). Both Mr. Wilson and Ms. Strugar-Fritsch acknowledged, however, that these discrepancies have decreased in recent years, particularly around the issue of Medicaid FFP for inmates.

However, the 1998 CMS Region IV transmittal letter had either not been adequately circulated to North Carolina’s DMA or it went unrecognized by agency staff. By the early 2000’s, Mr. Wilson and his colleagues believed FFP was not available to inmates at any point during their incarceration, and began to look into ways of preventing their termination from Medicaid upon entry into a corrections or jail facility. Ultimately, DMA established that upon entering prison, a Medicaid recipient would continue receiving coverage from DMA for inpatient (non-prison) medical services through the period of his or her eligibility- but only until their Medicaid enrollment came up for renewal, at which point it would be allowed to expire (Wilson 2011). Though this policy was established in 2002, it was never fully implemented and went unrealized in North Carolina (Wilson 2012).

### ***Medicaid Expansion under Health Care Reform***

In March 2010 President Obama signed two health care reform laws collectively known as the Patient Protection and Affordable Care Act (PPACA). As part of this reform, Medicaid coverage in the states will mandatorily expand to cover all individuals under the age of 65 whose income falls below 133% of the federal poverty line (Stone, et al

2010). A major part of this expansion includes a new financing arrangement, whereby the federal government will cover 100% of Medicaid expenses for newly eligible enrollees through 2016 and eventually decrease coverage to 90% by 2020 (Stone, et al 2010). Currently the state of North Carolina covers \$.35 for every \$1.00 spent on Medicaid, meaning that this expansion and the new cost-sharing agreement will lower the state's financial Medicaid responsibilities significantly (Wood 2010).

Similar to current Medicaid rules, under PPACA inmates would be ineligible for FFP while incarcerated. However, there is nothing in PPACA to indicate that the redefinition of an inmate upon their admittance into a public, medical facility for more than 24 hours would change (Strugar-Fristch 2012). As such, Medicaid's expansion under PPACA will likely include FFP for those inmates who receive care outside of prison facilities for more than one day. Investigators who have looked into this issue in Auditor Wood's office believe there is the chance that Congress or CMS will try to change this provision if and when more states begin to utilize Medicaid coverage for inmates (Barnette 2012). Until that happens, enrolled inmates will continue to qualify for FFP.

### **III. NORTH CAROLINA'S INMATE MEDICAID ENROLLMENT PROGRAM**

#### **IME Conception**

The implementation of North Carolina's Inmate Medicaid Enrollment program is a model for other states to emulate. It is also illustrative of the harsh realities states face in today's economy as well as their aspirations for creative, cost-saving innovations in government programs. Though other state departments of corrections began utilizing Medicaid for inmates prior to North Carolina, many of those states relied on consultation by health management firms to achieve what a handful of North Carolinian agency staff members accomplished in less than one year (Shoemaker 2012). The speed, efficiency and relative ease with which the people at NC DOC and DMA were able to conceive, create and implement this initiative is impressive and commendable.

The following sections analyze the instrumental factors and events that facilitated the implementation of IME in North Carolina, with lessons learned that may prove relevant and helpful to other states considering their own IME program.

#### *Recession Budget Crisis*

The expense of inmate medical care is an issue that has worried DOC administrators and fiscal analysts for a long time (Poteat 2011). What, then, motivated the necessary leadership and key players to join together to identify and initiate a creative, new

program to solve the problem? Unsurprisingly, the state budget crisis resulting from the “Great Recession” was the watershed event that aligned a broad cross section of individuals and agencies around the common goal of utilizing Medicaid for inmates (Wood 2012; Lancaster 2011; Poteat 2011).

In the wake of the national economic crash, North Carolina’s budget deficit reached \$3.5 billion by FY 2009-2010- creating immense challenges for Governor Perdue and other leaders struggling to identify cost-savings measures within the budget. With an annual budget of \$1.3 billion, the Department of Correction represented both the need for new, less expensive programs as well as an immense opportunity for reforms. DOC’s leadership and staff were already struggling with the department’s ballooning budget needs. Medical costs have long been a fiscal burden for DOC, and often times the department was forced to use roll-over salaries and other budget tricks to make up shortfalls caused by the expense in providing inmate medical care (Poteat 2011).

Jennie Lancaster, Chief Operating Officer at DOC was a longtime advocate for reforming criminal justice policies in favor of reduced recidivism to establish long-term cost-savings (Lancaster 2011). She also encouraged previous administrations and other state agencies to work with DOC to reduce the rising costs of providing prisoners with adequate health care (Lancaster 2011; Wood 2012). However, with a strong economy there was little motivation to effectively examine the current systems. By 2009, however, historic budget shortfalls inspired Governor Perdue and General Assembly members from both sides of the aisle to work collaboratively towards reducing agency spending.

In periods of plenty, states have the luxury of maintaining a costly, growing corrections system. But in lean times there is new motivation to change course and pursue new modes of operation. It is possible that the average hospital cost growth rates and an ever-increasing inmate population would have inspired state legislators and agency leaders to move toward new, innovative programs like IME in time. However, the Great Recession and the economic shockwaves that followed undoubtedly created the motivation for change that drove much of IME’s implementation.

Other states grappling with similar rising health care and corrections costs in the wake of budget shortfalls will likely have similar motivation among its legislative and agency leadership to reduce spending wherever possible. However, motivation for change and innovation in corrections health programs may decrease as the national economy begins to improve and states inch towards improved fiscal outcomes. The North Carolina model proves that improved government collaboration and innovative program development are especially possible during economic crises.

## *State Auditor Reports*

The General Assembly and the Governor's search for ways to reduce government spending was directed towards corrections health care spending in part by a series of investigations and reports issued by State Auditor Beth A. Wood and her staff.

In February 2010, Auditor Wood's office issued a Fiscal Control Audit of the Department of Correction. In the published report, Auditor Wood wrote that "there were no special circumstances that caused us to conduct the audit," but that it was part of a periodic examination into the financial activities of state agencies and institutions (Wood 2010). The audit examined each division and department within DOC, and assessed the spending numbers and habits between July 1 and December 31, 2008.

The results indicated "deficiencies in internal control," particularly relating to inmate medical costs (Wood 2010). According to the report, annual inmate medical service costs were \$100 million and rising, largely due to the contractual services DOC sought from hospitals and other medical. Department staff informed the auditors that while they attempted to control costs, ultimately the terms of contracts with non-DOC facilities were dictated by the hospitals and service providers, with little leverage for DOC to keep prices low.

DOC's lack of control over these contractual prices resulted in dramatic overpayments for services that would cost significantly less if billed through Medicare or Medicaid. DOC's reimbursement rates ranged from 198% to 879% higher than those of Medicare or Medicaid (Wood 2010). These overpayments were partly responsible for the \$44.9 million DOC spent on contractual medical services in the examined audit year (Wood 2010).

The following August, the Auditor's office issued a follow-up performance audit titled "Inmate Medicaid Eligibility." Unlike the previous report, this document specifically addressed medical cost containment and suggested that DOC "could save about \$11.5 million a year by requiring hospitals and other medical service providers to bill Medicaid for eligible inmate inpatient hospital and professional services" (Wood 2010).

This change was the basis for the Auditor's recommendation that North Carolina's DOC take advantage of the exception to the restricted FFP for eligible inmates when they receive off-prison medical services. In North Carolina, the federal government pays 66% of all Medicaid costs for enrollees (Wood 2010). The report estimated that there were 646 inmates who were Medicaid eligible whose inpatient health care costs would

have been dramatically reduced had DOC utilized Medicaid and the federal government's two-thirds reimbursement rates (Wood 2010).

However, at the time the audit was released in August 2010 there were no systems in place within DOC to verify which inmates were enrolled prior to their conviction, or would be eligible for Medicaid coverage. A major recommendation within the report was to enact a system that enables DOC to enroll eligible inmates and take advantage of Medicaid benefits when applicable. According to Ms. Lancaster, these reports were instrumental in bringing the issue and possibilities in reformed corrections medical spending to the forefront of larger debates around how to cut corrections costs (Lancaster 2011).

Ultimately, the reports that Auditor Wood and her staff issued provided objective, clear information about the problems in corrections health care spending as well as potentials for reform and their corresponding savings. This kind of non-partisan and well-researched report armed DOC administrators with hard facts about the problem, while providing political cover to elected leaders advocating for change. It is unlikely that a report issued directly from DOC or a partisan advocate would have received the same kind of universal attention and support from legislators whose leadership was crucial to IME's successful implementation.

#### *Legislative Leadership & Directives*

The General Assembly and the Governor's office both made it clear that DOC and DMA were to work together to achieve cost savings. The cohesive and clear buy-in from elected leadership sent the message of "when," rather than "if" IME would go into effect, which made it more imperative for DOC and DMA that they establish a positive and successful working relationship (Wilson 2011).

Four months after the publication of the Auditor's initial report, the General Assembly included a series of directives for DOC within the 2009-2010 Operations and Capital Appropriations bill. Section 19.6 (a-f) of Session Law 2010-31 instructed DOC to contain costs through a series of measures, including renegotiating more favorable rates with contracted hospital facilities and making use of prison medical facilities as much as possible (General Assembly 2010).

Section 19.6(c) of SL 2010-31 specifically addressed the Auditor's recommendation that Medicaid be utilized for eligible inmates:

"The Department of Correction shall consult with the Division of Medical Assistance in the Department of Health and Human Services to develop protocols for prisoners who

would be eligible for Medicaid if they were not incarcerated to access Medicaid while in custody or under extended limits of confinement. The Department shall seek reimbursement from Medicaid for those health care costs incurred by the Department in those instances when an inmate's Medicaid eligibility has been temporarily reinstated due to a hospitalization.”

The directive also instructed DOC to study additional cost containment measures and to report back to the General Assembly on its progress no later than March 1, 2011.

Governor Perdue’s office was simultaneously working to institute new methods of reducing costs across the state. Upon taking office, the Governor began to pursue new cooperative partnerships in an effort to move away from “silo” mentalities that often prevented agencies from working together (Brown 2012). Though her support for the General Assembly’s directives was not publicly stated, the Governor made it clear to the agency leadership and staff that she was eager for DOC and DMA to utilize Medicaid for inmates (Wilson 2011; Lancaster 2011).

With clear direction from both the General Assembly and the Governor’s office, DOC now had the freedom to pursue new methods for reducing its medical costs as well as the pressure to implement a whole new program in less than one year.

The political buy-in and unity around a single goal and plan enabled agency staff to work effectively towards achieving IME in a limited time frame. The solid leadership and pressure from both the General Assembly and the Governor distinguished the IME program from other policy exercises that might just as easily be ignored or delayed. It may be rare to have elected officials from separate bodies and political parties unified behind a policy initiative like IME, but this unified and clear leadership ensured this new program’s efficient implementation.

#### *Preliminary Cost-Savings Measures*

DOC took preliminary cost savings measures shortly after the General Assembly issued its directive. One their first actions was to hire new staff with expertise in health care spending who were able to provide leadership within DOC towards cost savings. The other preliminary steps DOC took signaled to interested parties- including the Governor and the General Assembly- that DOC was committed to achieving cost-savings for their department and the whole state.

The Health Services Division within DOC predates the latest budget crises and General Assembly directives, but it was only in recent years that agency leadership began to hire Health Services staff who would specifically address medical cost containment (Poteat

2011; Lancaster 2011). Two new staff members highlight DOC's commitment to better understanding and controlling its medical costs and spending: Terri Catlett and Joe Vincoli. Ms. Catlett was hired in 2010 to administer over a new department within Health Services specifically aimed at medical cost containment. Mr. Vincoli, who was hired in November 2010, works as a Special Assistant to Ms. Catlett, bringing his experience as the former Associate Director at DMA for Provider and Recipient Services (Vincoli 2011).

These additional staff members equipped DOC with health care spending experts and resources that readied the Department for the instructions and directives issued by Governor Perdue and the General Assembly. As such, by March 2011 DOC was able to report back to the General Assembly that it had made headway in reducing costs. One achievement was the successful transition to a new reimbursement program, whereby DOC now pays contracted and non-contracted medical providers a standardized reimbursement rate not to exceed 70% of the amount charged based on the usual and customary rates (UCR), or twice Medicaid reimbursement rates (Vincoli 2011; Vincoli 2012).

Other states looking to reduce corrections spending should recognize the importance of hiring staff with expertise in health care spending. Mr. Vincoli and Ms. Catlett's expertise and leadership helped DOC realize immediate savings through other, non-IME solutions while also signaling the priority DOC placed on these endeavors.

### *Inter-Agency Agreement*

The inter-agency agreement that became IME's official Memorandum of Agreement (MOA) was important for three reasons: it established ground rules for the program and how it would operate; it gave both agencies time to adjust to their new working relationship; and it created a window of time to construct the necessary technological infrastructure and systems.

Prior to 2010, there was no working relationship or history between DOC and DMA. When the General Assembly issued its directive instructing the two agencies to collaborate, it was unclear to what extent each would be able to adapt and work with the other in the strict time frame dictated by the directive.

Each agency appointed specific staff to work on this project, with Andy Wilson representing DMA and Laura Yates, Director of the Division of Prisons' Social Work Program representing DOC. Joe Vincoli and additional staff from both agencies

provided support as needed, but the primary leadership came from Ms. Yates and Mr. Wilson throughout the nine-month creation period.

The first and, in many ways most arduous process was the drafting and signing of the MOA (Wilson 2012). It was important that the document adequately represented and protected each agency's interests while also establishing the basic framework and division of responsibility for the actual program.

There were two key concerns for DHHS and DMA. The first was establishing which agency would be responsible for financing the state's financial responsibility for any Medicaid payments made for inmate care. While the Auditor's report had estimated only several hundred inmates might be eligible to enroll in Medicaid, DHHS was not willing to take on the financial burden of these additional enrollees (Vincoli and Yates 2011; Wilson 2011).

Fortunately, DOC did not contest this point given that the 33% of costs that constituted the state's Medicaid reimbursement would assuredly be lower than the contracted rates DOC would otherwise pay. The MOA outlines the process by which DHHS submits quarterly invoices to DOC for all Medicaid payments made on behalf of inmates (Keller and Cansler 2010). Further, the MOA explicitly states that the entire agreement between DHHS and DOC "is subject to and conditional upon the receipt of available state funds from DOC...and the availability of federal matching funds" (Keller and Cansler 2010). Essentially, if FPP ceased to apply for inmate Medicaid coverage, the MOA would be void and the program would dissolve.

The second concern for DHHS and DMA surrounded complying with health record privacy requirements in the Health Insurance Privacy and Portability Act (HIPPA). In order for DMA to release or share individuals' personal Medicaid information with DOC, DMA would have to demonstrate that the release of this information would result in some kind of improvement to the Medicaid program overall (Wilson 2012). The agencies overcame this issue by working to identify 2,000 cases of Medicaid fraud perpetrated by inmates who had handed off their Medicaid cards to family members or friends' for illegal use while they were incarcerated (Yates 2011; Wilson 2011). Identifying these fraud cases resulted in cost-savings for DMA that justified a reasonable "improvement" for Medicaid. This helped assuage DMA's HIPAA concerns and allowed the agency to feel comfortable sharing inmates' private, personal information with DOC.

The MOA also included a detailed description of the process by which each agency would collaborate to identify and enroll Medicaid eligible inmates, as well as how the

reimbursement program would work. On October 11, 2010 DOC Secretary Alvin W. Keller and DHHS Secretary Lanier M. Cansler each signed the MOA.

According to Andy Wilson, the process of drafting the MOA was slow but relatively painless, and the greatest point of contention between the various parties was whether it was a Memorandum of Understanding or Agreement (Wilson 2012). When asked why they felt the process moved with such ease and geniality, both Mr. Wilson and Ms. Yates paid compliments to the other and indicated that their personalities and work styles seemed to mesh well with little conflict (Wilson 2011; Yates 2011).

Further, they each indicated that the clear directives from the Governor, the General Assembly and their own agencies' leadership about the imperative nature and timing of implementing IME ensured that everyone involved was on the same page and working towards a mutual goal.

Drafting and signing an inter-agency MOA is a key process in helping a new program like IME to grow and function. The time and effort that went into drafting the MOA allowed each agency to learn about the other while staff members established a positive, amicable working relationship. There was also time for the IT personnel to create the systems needed to cross-reference between agencies. It is impossible to know if and when individuals will collaborate well, but starting with a relatively low-stakes process like creating a MOA may help resolve early conflicts that might otherwise have slow down implementation further along in the process.

### **IME Execution**

The first step towards the program's creation was the design and construction of a new data system to cross-reference DMA lists of Medicaid enrollees and eligibility against daily intake forms from DOC prisons. The bulk of this program was written and designed between July and September 2010, even as the MOA negotiations were ongoing (Wilson 2011). The decision to move forward with the programming before finalizing the agreement was dictated by DOC's impending deadline to report to the Governor and the General Assembly in March 2011 (Yates 2011). Ultimately, the decision to move forward with the creation of the data system enabled the fast implementation of the IME program once the MOA was signed.

The program operates in a fairly straight forward manner. Every day, DMA's data on Medicaid eligible individuals are cross-referenced against DOC's admissions data (Yates, 2011). When DOC finds a "hit," or a dual match on both systems, they initiate the process of re-enrollment for the inmate (presuming that their eligibility has either expired

or was terminated at the county level upon their arrest or conviction). DMA then processes the applications for Medicaid eligibility received from DOC through the inmates' county departments of social services (Keller and Cansler 2010).

The Medicaid reimbursement process includes several steps. Whenever inmates receive treatment at medical institutions (such as hospitals or nursing facilities), the billing office for that institution sends the final bill to DOC for payment. Under the new IME program, all of these bills are now cross-referenced with the list of Medicaid enrolled inmates. If there is a match, i.e. if the care was administered to an inmate who is Medicaid enrolled, DOC returns the bill to the institution with an explanation that they should seek reimbursement from Medicaid. At this point, the hospital begins its negotiations with DMA and CMS to receive the necessary payments (Yates 2011).

DMA agrees to act as a payer proxy for DOC in paying the current state Medicaid portion of the reimbursement- approximately 33%- with the federal government, via CMS covering the remaining reimbursement. DMA then submits quarterly invoices to DOC for the inmate Medicaid payments it issued and DOC reimburses DMA for these funds (Yates 2011; Keller and Cansler 2010; Rogers, Smith and Keller 2010).

### **IME Challenges**

The IME program became operational in February 2011. Fourteen months later it is still working smoothly, a noteworthy feat for any new program. However, both Ms. Yates and Mr. Wilson admit that there have been obstacles throughout the implementation process that required both agencies' attention and collaborative problem-solving skills (Yates 2011; Wilson 2011). Further, there are long-standing issues surrounding inmate health costs that persist despite IME and will continue to test the program. The following sections examine each of these challenges.

#### *Medicaid Termination*

The first problem that Ms. Yates and Mr. Wilson identified was that of Medicaid terminations at the county level. CMS recommends that Medicaid benefits be suspended when an enrollee is convicted of a crime. Despite this recommendation, more than 90% of states do, in fact, terminate a person's Medicaid enrollment upon arrest (Wakeman, et al 2009; Morrissey, et al 2006).

In North Carolina, DMA's official policy follows CMS' recommendation, yet in the process of implementing IME it became clear that many county social service departments and jails were terminating individuals' Medicaid enrollment upon their arrest

or conviction. These terminations have made it more difficult for DOC to identify eligible inmates. DMA and DOC are currently collaborating on ways to better inform county departments of social services and county jails about the importance of suspending rather than terminating a convict's Medicaid status (Yates 2011).

### *Estimating Savings*

Another key challenge DOC has had throughout the implementation process is the estimation of savings realized through the IME program. The Auditor's report from August 2010 estimated annual cost savings of \$11.5 million upon the implementation of any inmate Medicaid utilization program, and as of October 2011 DOC estimated it was on track to saving \$14 million (Yates 2011). However, according to Mr. Vincoli, it is difficult to estimate future potential savings due to the reliance on assumptions about changing factors in the life and health of inmates (Vincoli 2012).

In order to calculate savings, one would have to assume how many inmates would be eligible; the likelihood of their requiring medical attention in medical (non-prison) institutions; and the nature, length and expense of that care. Even the way hospitals bill for Medicaid complicates DOC's efforts to estimate savings, given that DOC does not typically see the final bill that is sent to DMA before receiving an inter-agency fund transfer request for the portion of the reimbursement DMA paid (Vincoli 2012).

These shifting factors make it difficult for DOC to fully evaluate the cost-savings they have already achieved under the IME program. The costs of IME can also only be roughly assumed, given the increased staffing that has taken place to support DOC and DMA's efforts and the cost of new technology and data systems. The State Auditor's office is in the midst of conducting a follow-up investigation and with findings in a forthcoming audit (Wood 2012). This report may prove to be an important document in assessing the costs and benefits associated with IME in its totality.

### *Payers of Last Resort*

Another concern came from a member of the staff of the state Attorney General, who proposed that DOC was potentially violating a key provision in Medicaid law that states people may only enroll in Medicaid if that program is the "payer of last resort," or if there are no other options by which that person may afford the care they require (Vincoli 2011). If this presumption is correct, DOC would in fact be a viable third party who could cover inmates and thus negate Medicaid as a "last resort" altogether.

To address these concerns, DOC contacted the regional CMS office in Atlanta and received their official support for the plan to utilize Medicaid for eligible inmates with the expectation of normal federal reimbursement rates (Yates 2011; Vincoli 2011). Ms. Strugar-Fritsch has addressed this concern with other states by recommending that inquiries be made into whether or not the inmate in question has family members or support networks who can reasonably afford the hospital care that would otherwise be billed to Medicaid. In most cases the result is that there are no viable third parties, and so the other states' departments of corrections are protected if they need to defend themselves against CMS inquiries (Strugar-Fritsch 2012)

### *Hospital Contracts*

Negotiating contracts with hospital providers is a long-standing challenge for DOC, and to many it is the single greatest culprit behind DOC's high medical costs (Poteat 2011; Rogers 2011). Throughout DOC's history, the standard practice has been that the inmates in most need of serious medical attention were sent to the Central Prison campus located in Raleigh. Unfortunately, this also placed those inmates in North Carolina's Research Triangle area with high quality and high cost hospitals, including UNC Chapel Hill and WakeMed. As such, the facilities required by DOC to treat inmates in greatest need of expensive medical attention are also those that negotiate the most expensive contracts and demand higher reimbursement rates (Lancaster and Rogers 2011; Vincoli 2011).

Any hospital is required to treat a person, inmate or civilian who enters an Emergency Room, but for scheduled procedures it is up to the hospital's discretion if they will or will not treat an inmate. In many cases, DOC negotiates contracts with hospitals for inmate-specific reimbursement rates. In some areas of the state these contracts can be favorable for DOC, typically when a hospital is under-used or in lower demand by the surrounding area (Poteat 2011). However, DOC's negotiating power with the high-demand hospitals around the Central and Women's Prison in Raleigh is extremely weak and the Department has typically signed fiscally unfavorable contracts to secure access to these facilities (Rogers 2011).

In an effort to strengthen DOC's leverage, the Department lobbied for the inclusion of a provision in the 2010 budget bill, requiring that all hospitals must agree to enter into contracts with DOC to treat non-emergency inmates in exchange for state licensure. This new rule would have allowed DOC to better negotiate lower rates with hospitals that might otherwise threaten to walk away unless they receive exponentially higher rates. The provision was included in both the House and Senate version of the bill, but the Hospital Administrator's lobby successfully had it removed at the very end of the budget

process (Vincoli 2012; Lancaster and Rogers 2011). In fact, WakeMed announced last year that it will no longer treat inmates of any kind, leaving DOC with even more limited options in the Triangle area (Poteat 2011; Vincoli 2011; Rogers 2011).

To counteract its problems securing favorable hospital contracts and save costs overall, DOC began the process of building a new, central prison hospital in downtown Raleigh nearly a decade ago. Governor Perdue supported these efforts as a State Senator, and in October 2011 the new \$155 million medical hospital at Central Prison opened for operations (Brown 2012). In addition to upgrading the existing (and outdated) Central infirmary, DOC estimates that the new hospital will ultimately save \$40 million per year, primarily by avoiding costly hospital contracts with nearby hospitals (Broome 2011).

DOC has also sought to resolve its contract problem by issuing a request for proposals (RFP), seeking to sign a contract with a provider under a seven-year \$1.5 billion contract that will streamline health services (deBruyn 2011). DOC retracted its RFP in March 2012 when contractors informed them that certain conditions in the proposed contract were “completely unattainable,” but as of April 2012 DOC indicated it would issue a revised RFP for a private health contractor (deBruyn 2012).

It is unclear to what extent the new Central Prison Hospital or a single, private health contractor will affect IME. However, both of these large and expensive projects are projected to save DOC many millions of dollars in the long-term, and their prioritization indicate that DOC is perhaps more concerned with finding a solution to its problems with hospital contracts than any other cost-saving measure, including IME.

#### **IV. IMPLICATIONS FOR THE FUTURE**

##### **Medicaid Expansion**

The Auditor’s report estimated that by 2010 only 646 inmates were eligible for Medicaid coverage, but the expanded eligibility coming in 2014 will likely include the vast majority of inmates, perhaps as high as 90% of prison and jail populations (Yates 2011). Furthermore, federal reimbursement rates will increase from 66% to 100% for all newly enrolled Medicaid recipients the first two years after expansion- through December 2016- and slowly decrease over subsequent years to a minimum of 90% (Wood 2010). This means that as more inmates become eligible, the State’s reimbursement burdens for those individuals will dramatically decrease.

Some have speculated that the change in Medicaid under the health reform law will “close the loophole” of allowing inmate reimbursements, in which case only pre-trial jail detainees will be eligible before they are convicted (Blair, et al 2011). However, health care reform analysts believe the new law does not change the definition of when a person is or is not considered an inmate by Medicaid’s standards, and that 2014 will indeed allow for an exponentially larger population of prisoners to enroll (Strugar-Fritsch 2012).

Ms. Strugar-Fritsch of Health Management Associates recently explained that a separate division of CMS issued its own clarification of inmate definitions that contradicted those issued by CMS in 1997. Several advocates around this issue have written to CMS to oppose any redirection and are as yet awaiting further explanation or a final answer on whether the policy will change. According to Ms. Strugar-Fritsch, this seems more likely than health care reform to potentially limit state departments of corrections from utilizing Medicaid for inmates (Strugar-Fritsch 2012).

These doubts about the future of inmate Medicaid reimbursement make it difficult for North Carolina to definitively commit to scaling its IME program up with more staff and resources in preparation of enrolling more prisoners. Additionally, some at DOC are concerned that it will be harder to obtain favorable contracts with difficult and discriminating hospitals if 90% or more of the inmates treated there will only be worth the Medicaid reimbursement rates, which are already twice as low as what DOC is willing to pay for inmate care (Rogers 2011). Finally, DOC’s announcement that it was seeking a private contractor to administer all health care provision throughout the system could very well disqualify any inmates from receiving FFP for non-prison institutional care.

### ***Potential Cost-Savings***

Figures 1 through 4 illustrate projections for DOC’s potential cost savings across several scenarios between 2014 and 2020. Each table estimates hospital cost and prison population growth rates based on my own calculations of average rates of increase across these areas over the recent years. Figures 2 through 4 estimate cost-savings associated with IME should DOC decide to enroll all eligible inmates, and based on my own variant estimations of percentages of the prison population that may be eligible for Medicaid upon expansion. For example, figure 2 assumes that only 25% of inmates will be newly eligible in 2014, while figure 3 estimates 50% and figure 4 estimates 90%. Further, figures 2, 3 and 4 all take into account that the state and federal reimbursement changes will only apply to those inmates who are *newly* enrolled in 2014, thus they all subtract the estimated savings that came from IME prior to Medicaid expansion.

**Figure 1: Projected Cost-Savings under IME, 2011-2013**

Year	Hospital Costs*	Total Prison Population**	Hospital Costs per Inmate	Medicaid Eligible Inmates***	Medicaid Eligible Costs	State vs. Federal Reimbursement percentages	Expected DOC Expenditures	Expected Federal Expenditures	Total DOC Savings
2011	\$44,900,000	40,379	\$1,112	646	\$718,329	33% (S) vs. 66% (F)	\$237,049	\$474,097	<b>\$481,280</b>
2012	\$50,288,000	41,994	\$1,197	672	\$804,528	33% (S) vs. 66% (F)	\$265,494	\$530,989	<b>\$539,034</b>
2013	\$56,322,560	43,674	\$1,290	699	\$901,072	33% (S) vs. 66% (F)	\$297,354	\$594,707	<b>\$603,718</b>
<i>*assumes annual hospital cost growth rate of 12% based on 5 year average from previous DOC hospital costs</i>								<b>TOTAL</b>	<b>\$1,624,032</b>
<i>**assumes annual population growth rate of 4% based on 25 year average growth rate</i>									
<i>***assumes same annual growth rate of 4% for number of eligible inmates pre-Medicaid expansion</i>									

**Figure 2: Projected Cost-Savings under IME, 2014-2020 with Low Estimates of Inmate Eligibility (25% inmate population eligibility)**

Year	Hospital Costs*	Total Prison Population**	Hospital Costs per Inmate	Medicaid Eligible Inmates	Medicaid Eligible Costs	State vs. Federal reimbursement percentages	Expected DOC Expenditures	Expected Federal Expenditures on	Total DOC Savings
2014	\$63,081,267	45,421	\$1,389	10,656	\$14,799,932	0% (S) vs. 100% (F)	\$297,354	\$14,502,578	<b>\$14,502,578</b>
2015	\$70,651,019	47,238	\$1,496	11,110	\$16,617,725	0% (S) vs. 100% (F)	\$297,354	\$16,320,371	<b>\$16,320,371</b>
2016	\$79,129,142	49,127	\$1,611	11,583	\$18,656,869	0% (S) vs. 100% (F)	\$297,354	\$18,359,515	<b>\$18,359,515</b>
2017	\$88,624,639	51,092	\$1,735	12,074	\$20,944,172	6% (S) vs. 94% (F)	\$1,554,004	\$19,390,168	<b>\$19,390,168</b>
2018	\$99,259,595	53,136	\$1,868	12,585	\$23,509,682	7% (S) vs. 93% (F)	\$1,943,031	\$21,566,650	<b>\$21,566,650</b>
2019	\$111,170,747	55,261	\$2,012	13,116	\$26,387,068	10% (S) vs. 90% (F)	\$2,936,060	\$23,451,008	<b>\$23,451,008</b>
2020	\$124,511,236	57,472	\$2,166	13,669	\$29,614,066	10% (S) vs. 90% (F)	\$3,258,760	\$26,355,306	<b>\$26,355,306</b>
<i>*assumes annual hospital cost growth rate of 12% based on 5 year average from previous DOC hospital costs</i>								<b>TOTAL</b>	<b>\$139,945,597</b>
<i>**assumes annual population growth rate of 4% based on 25 year average growth rate</i>									

**Figure 3: Projected Cost-Savings under IME, 2014-2020 with Medium Estimates of Inmate Eligibility (50% inmate population eligibility)**

Year	Hospital Costs *	Total Prison Population **	Hospital Costs per Inmate	Medicaid Eligible Inmates	Medicaid Eligible Costs	State vs. Federal reimbursement percentages	Expected DOC Expenditures	Expected Federal Expenditures	Total DOC Savings
2014	\$63,081,267	45,421	\$1,389	22,012	\$30,570,249	0% (S) vs. 100% (F)	\$297,354	\$30,272,895	\$30,272,895
2015	\$70,651,019	47,238	\$1,496	22,920	\$34,280,480	0% (S) vs. 100% (F)	\$297,354	\$33,983,126	\$33,983,126
2016	\$79,129,142	49,127	\$1,611	23,865	\$38,439,154	0% (S) vs. 100% (F)	\$297,354	\$38,141,800	\$38,141,800
2017	\$88,624,639	51,092	\$1,735	24,847	\$43,100,332	6% (S) vs. 94% (F)	\$2,883,374	\$40,216,958	\$40,216,958
2018	\$99,259,595	53,136	\$1,868	25,869	\$48,324,580	7% (S) vs. 93% (F)	\$3,680,074	\$44,644,506	\$44,644,506
2019	\$111,170,747	55,261	\$2,012	26,932	\$54,179,755	10% (S) vs. 90% (F)	\$5,715,329	\$48,464,426	\$48,464,426
2020	\$124,511,236	57,472	\$2,166	28,037	\$60,741,875	10% (S) vs. 90% (F)	\$6,371,541	\$54,370,334	\$54,370,334
<i>*assumes annual hospital cost growth rate of 12% based on 5 year average from previous DOC hospital costs</i>								<b>TOTAL</b>	<b>\$290,094,046</b>
<i>**assumes annual population growth rate of 4% based on 25 year average growth rate</i>									

**Figure 4: Projected Cost-Savings under IME, 2014-2020 with High Estimates of Inmate Eligibility (90% inmate population eligibility)**

Year	Hospital Costs *	Total Prison Population **	Hospital Costs per Inmate	Medicaid Eligible Inmates	Medicaid Eligible Costs	State vs. Federal reimbursement percentages	Expected DOC Expenditures	Expected Federal Expenditures	Total DOC Savings
2014	\$63,081,267	45,421	\$1,389	40,180	\$55,802,756	0% (S) vs. 100% (F)	\$297,354	\$55,505,402	\$55,505,402
2015	\$70,651,019	47,238	\$1,496	41,815	\$62,540,887	0% (S) vs. 100% (F)	\$297,354	\$62,243,534	\$62,243,534
2016	\$79,129,142	49,127	\$1,611	43,516	\$70,090,811	0% (S) vs. 100% (F)	\$297,354	\$69,793,457	\$69,793,457
2017	\$88,624,639	51,092	\$1,735	45,284	\$78,550,187	6% (S) vs. 94% (F)	\$5,010,365	\$73,539,822	\$73,539,822
2018	\$99,259,595	53,136	\$1,868	47,124	\$88,028,419	7% (S) vs. 93% (F)	\$6,459,343	\$81,569,076	\$81,569,076
2019	\$111,170,747	55,261	\$2,012	49,037	\$98,648,054	10% (S) vs. 90% (F)	\$10,162,159	\$88,485,895	\$88,485,895
2020	\$124,511,236	57,472	\$2,166	51,026	\$110,546,370	10% (S) vs. 90% (F)	\$11,351,991	\$99,194,379	\$99,194,379
<i>*assumes annual hospital cost growth rate of 12% based on 5 year average from previous DOC hospital costs</i>								<b>TOTAL</b>	<b>\$530,331,564</b>
<i>**assumes annual population growth rate of 4% based on 25 year average growth rate</i>									

While these are reasonable estimates of possible savings, I concede they are based on several assumptions that are hard to predict and subject to change. Further, my calculations may underestimate the calculations given the Auditor's estimate that with even 646 Medicaid enrolled inmates DOC could save \$11.5 million (Wood 2010). This would equal just over \$178,000 in savings for each enrolled inmate. Based on these estimates, if even 25% of DOC's 2014 prison population enrolls in Medicaid, their hospital costs- and subsequent DOC savings- would total over \$2 billion in 2014 alone.

The forthcoming Auditor's follow-up report as to IME's savings to date will no doubt further illuminate the potential for future fiscal benefits. However, the above figures illustrate that even under a variety of scenarios including some with conservative estimates as to prison population enrollment, there is great possibility for DOC to save hundreds of millions of dollars through the IME program.

### ***Public Health Impacts***

There are also serious potential impacts of IME on public health if Medicaid expansion goes through and more inmates are enrolled in the program. The poor health of prisoners has profound impacts on the health of their home communities, particularly given that there are particularly high concentrations of incarcerated individuals in specific, non-white urban neighborhoods (Freudenberg 2001). Approximately 650,000 inmates are released and 9 million people cycle through jails ever year (McDonnell, et al 2011). The poor health of prisoners during and after their incarceration leads to higher risk of exposure to diseases for the communities to which they return.

DOC reentry planning procedures already include counseling inmates about the public assistance programs for which they are eligible, including Medicaid (Yates 2011). Another important development is the passage of the Justice Reinvestment Act in June 2011. A key reform made under this new legislation is increased probationary supervision for more reentering inmates, including the extension of probation supervision for all released felons, including 14,000 released prisoners who previously would not have received any post-release supervision (Holbrook 2011). At the same time, probation officer caseloads will be lowered to allow for more nuanced and careful monitoring of ex-offenders (Holbrook 2011).

These changes may ensure greater continuity of care for reentering prisoners once Medicaid is expanded in 2014. If individuals leaving prison are enrolled prior to their reentry- whether through IME or as part of their reentry counseling procedure- and receive closer post-release supervision, they may stand a better chance of utilizing health care coverage to obtain mental health, substance abuse and medical care. Megan Brown,

the Governor's primary reentry policy analyst expressed optimism that the changes in probationary supervision will have these and other positive ripple effects for reentering prisoners and their home communities (Brown 2012).

## **V. CONCLUSIONS AND RECOMMENDATIONS**

North Carolina's IME program is a national model that other states may study and emulate as they consider how they might utilize Medicaid to reduce inmate health care costs. Though the future of Medicaid expansion remains in doubt, North Carolina is well positioned to maximize IME whether or not more inmates become eligible. Further, DOC has three years before 2014 during which it can improve and expand IME to make sure that the program will generate the most benefits throughout the state.

At first glance, one might imagine the single most beneficial expansion of IME would come from enrolling as many inmates as possible, up to the highest possible percentage if Medicaid expansion moves forward. However, it is impossible to know if IME will survive or even continue to work effectively given DOC's ongoing struggles to negotiate favorable reimbursement rates with hospitals, as well as the role that the new Central Prison Hospital complex and a possible health contractor may play in DOC's medical services division. Instead, I recommend that DOC take the following steps to expand IME beyond the state level to the counties where the program may have immediate impacts:

### **1. Educate County Managers**

DOC and DMA should educate and train county managers in the process of Medicaid utilization for enrolled inmates. While this effort may not directly affect the state budget or costs, should Medicaid expansion preclude convicted inmates from receiving FFP, pre-trial jail detainees may be the only population of enrollees still eligible. It is highly unlikely that DHHS will volunteer to remain in its current role as the initial source of state Medicaid reimbursement, but it is possible that the agency may be willing to work with county departments of social service to establish a similar contract and model as its current MOA with DOC. Adjustments in hospital costs to the 33% state Medicaid reimbursement responsibility would likely have similar financial benefits for county jail systems and budgets as it has for DOC.

While I cannot speculate as to whether or not all 100 of North Carolina's counties will be able to coordinate their own IME programs with the same efficiency or success as DOC, it is possible that the most populated counties or those with higher

incarceration rates may be especially motivated to move forward with similar programs.

## **2. Automatic Enrollment at the County Jail Level**

Simultaneously, DOC and DMA should work with county social service agencies to identify and enroll Medicaid eligible inmates and detainees upon their admission into the county jail system. A model program to emulate might be Colorado's, where the CO DOC successfully established a county-level automatic Medicaid enrollment program ten years ago (Shoemaker 2012). This automation could help reduce some of DOC and DMA's current responsibilities and help streamline the information for those inmates who are Medicaid eligible.

## **3. Verify Payers of Last Resort**

DOC and DMA should also work towards verifying whether an IME inmates' family can financially participate or cover medical care. This may be as simple as collecting the contact information for an inmates' family members or support networks so that DOC may inquire as needed into whether or not there are reasonable payers of last resort beyond Medicaid when necessary. Further, DOC should consider whether it is feasible for the IME staff members to add the step of establishing whether or not a Medicaid enrolled inmate has others who can pay for their hospital medical care to the IME process. By demonstrating that there are no other payers of last resort, DOC should effectively insulate itself from any challenges from CMS.

## **4. Medicaid Training for Reentry Professionals**

Finally, if Medicaid expansion moves forward, DOC should begin working with reentry programs and personnel to ensure that eligible reentering prisoners maintain continuity of care upon their release. This process should involve educating all probation and post-release supervision officers about Medicaid enrollment and programs to connect with the released prisoners they supervise. Further, DOC and DMA may consider a similar education campaign for reentry programs throughout the state. Organizations like the Durham County Criminal Justice Resource Center and the Treatment Alternatives for Safer Communities (TASC) North Carolina reentry councils could be instructed on the implications and possibilities for Medicaid expansion, and may be able to add health care coverage and access to the programs and services they offer their clients.

The potential for improved public health from greater ex-offender continuity of care is only possible if reentering prisoners are aware of the services available to them and are able to access them. If Medicaid expansion proceeds and reentering prisoners remain un-enrolled or uneducated as to how they can seek health care coverage and services, North Carolina will lose the opportunity to improve public health. Implementing even a cursory training and education program for reentry professionals and programs will help achieve greater long-term benefits for the state.

North Carolina's Inmate Medicaid Enrollment program was conceived in the wake of an historic economic crisis, created by an inter-agency collaboration and implemented under the steady hands of thoughtful, hard-working DOC and DMA staff members. Ultimately, the success or failure of IME may be judged solely on the costs or savings it generates, and I imagine the Auditor's forthcoming report will primarily address these aspects of the program. What is missed in such a cost-benefit analysis, however, is the other success story- that of the process behind developing the theory of IME into an operational government program.

With public confidence in government historically low, it is all the more important and valid to analyze IME for its smooth implementation as well as its outcomes. The country faces a slow and halting economic recovery and other state governments should look to the North Carolina Inmate Medicaid Enrollment Program as an example for how government can quickly respond to economic crises and think outside the box to create new programs that may reduce spending and result in long term community benefits.

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