Commonwealth of Massachusetts
Office of the State Auditor
Suzanne M. Bump
Making government work better

Official Audit Report – Issued February 25, 2015

An Examination of State Policies and Practices Regarding Medicaid Coverage for Inmate Inpatient Healthcare Costs

For the period January 1, 2011 through December 31, 2012

Commonwealth of Massachusetts
Office of the State Auditor
Suzanne M. Bump
Making government work better

February 25, 2015

Ms. Marylou Sudders, Secretary
Executive Office of Health and Human Services
One Ashburton Place, 11th Floor
Boston, MA 02108

Dear Ms. Sudders:

I am pleased to provide this performance audit of state policies and procedures regarding Medicaid eligibility of inmates and potential federal reimbursement for inmate inpatient healthcare costs. This report details the audit objectives, scope, methodology, findings, and recommendations for the audit period, January 1, 2011 through December 31, 2012. My audit staff discussed the contents of this report with management of the agencies involved, and their comments are reflected in this report.

I would also like to express my appreciation to MassHealth for the cooperation and assistance provided to my staff during the audit.

Sincerely,

Suzanne M. Bump
Auditor of the Commonwealth

TABLE OF CONTENTS

LIST OF ABBREVIATIONS

CMR	Code of Massachusetts Regulations
CMS	Centers for Medicare & Medicaid Services
DOC	Department of Correction
DPH	Department of Public Health
FFP	federal financial participation
HOC	house of correction
LSH	Lemuel Shattuck Hospital
MCI	Massachusetts Correctional Institution
MMARS	Massachusetts Management Accounting and Reporting System
OSA	Office of the State Auditor
UMMS	University of Massachusetts Medical School

EXECUTIVE SUMMARY

Under Chapter 118E of the Massachusetts General Laws, the Executive Office of Health and Human Services, through the Division of Medical Assistance, administers the state's Medicaid program, known as MassHealth. MassHealth provides access to healthcare services to approximately 1.4 million eligible low- and moderate-income children, families, seniors, and people with disabilities annually. In fiscal year 2013, MassHealth paid more than $10.8 billion to healthcare providers, of which approximately 50% was funded by the Commonwealth. Medicaid expenditures represent approximately 33% of the Commonwealth's total annual budget.

The Office of the State Auditor has conducted an audit of the state policies and practices regarding Medicaid eligibility of inmates and potential federal reimbursement for inmate inpatient healthcare costs for the period January 1, 2011 through December 31, 2012. The objective of our audit was to determine whether the Commonwealth had effectively reduced inmate inpatient healthcare costs by requiring hospitals and other medical service providers to bill MassHealth for eligible inmate inpatient healthcare services.

The federal government does not reimburse states for inmate healthcare costs under the Medicaid program. However, an exception is allowed if inmates are eligible for MassHealth and leave a correctional facility to become inpatients in a medical facility. Currently, the Massachusetts Department of Public Health (DPH) receives federal reimbursement for certain inmate healthcare services provided at its public-health hospital Lemuel Shattuck Hospital (LSH). MassHealth, however, does not have a process to obtain federal reimbursement (known as federal financial participation, or FFP) for inpatient healthcare costs of Medicaid-eligible inmates. For this reason, Outside Section 227 of Chapter 165 of the Acts of 2014 (Appendix B) requires MassHealth to develop a plan to seek FFP for eligible inmate inpatient healthcare costs. MassHealth must have effective controls—including program regulations, administrative and operating policies and procedures that are consistent with state and federal requirements, and monitoring activities—to ensure that the Commonwealth does not lose the opportunity to receive FFP for these costs. Because MassHealth lacked these controls, Massachusetts

did not receive FFP totaling as much as $11,644,611[1] for inmate inpatient healthcare costs during the audit period.

Below is a summary of our finding and our recommendations, with links to each page listed.

Finding 1 **Page 7**	MassHealth did not seek available federal reimbursement, which could have totaled as much as $11,644,611, for inmate inpatient medical costs.
Recommendations **Page 12**	MassHealth should take the following actions: 1. Collaborate with the Department of Correction (DOC) and county houses of correction (HOCs) to establish processes to (1) determine Medicaid eligibility of inmates, (2) enroll eligible inmates in MassHealth but suspend their benefits until they are admitted as inpatients in medical facilities, (3) re-suspend inmate benefits after the inmates are discharged from the medical facility, and (4) reactivate inmate benefits upon release from the correctional facility. 2. Once the aforementioned processes have been established, issue a Provider Bulletin notifying all MassHealth-participating medical facilities that certain inmates are Medicaid-eligible and that inpatient services provided to these inmates should be billed through MassHealth and not to DOC and county HOCs. This will allow the Commonwealth to obtain FFP for eligible inmate inpatient healthcare costs. 3. Consider the effect of any new processes on LSH's operations, including budgetary and programmatic effects, since DPH already has a process to obtain FFP for DOC inmates treated at LSH (see Appendix A). 4. Comply with Outside Section 227 of Chapter 165 of the Acts of 2014 (Appendix B), including submitting a plan to the Legislature detailing MassHealth's efforts to develop and implement a process to obtain FFP for eligible inmate inpatient healthcare and reporting the financial impact on the Commonwealth.

1. During calendar years 2011 and 2012, DOC and county houses of correction paid hospitals a total of $23,289,221 for inmate inpatient healthcare services, of which $11,644,610.50 (50%) could have been reimbursable to the Commonwealth through FFP.

OVERVIEW OF AUDITED ENTITY

Under Chapter 118E of the Massachusetts General Laws, the Executive Office of Health and Human Services, through the Division of Medical Assistance, administers the state's Medicaid program, known as MassHealth. Medicaid is a joint federal and state program created by Congress in 1965 as Title XIX of the Social Security Act. At the federal level, the Centers for Medicare & Medicaid Services (CMS), within the U.S. Department of Health and Human Services, administer the Medicare program and work with state governments to administer their Medicaid programs. States have considerable flexibility in designing and operating their Medicaid programs, but must comply with applicable federal requirements. Such programs may include covered medical services provided to eligible inmates who are hospitalized for inpatient services.

As a general rule, the federal government does not reimburse states for medical care provided to inmates under the Medicaid program. However, Section 1905 of Title XIX of the Social Security Act allows an exception for any eligible inmate who is an inpatient in a medical facility. In a December 12, 1997 letter to state Medicaid directors, CMS confirmed that federal financial participation (FFP) is available for inmate inpatient medical services:

> *An exception to the prohibition of FFP is permitted when an inmate becomes a patient in a medical institution. This occurs when the inmate is admitted as an inpatient in a hospital, nursing facility, juvenile psychiatric facility, or intermediate care facility. Accordingly, FFP is available for any Medicaid covered services provided to an "inmate" while an inpatient in these facilities provided the services are included under a State's Medicaid plan and the "inmate" is Medicaid-eligible.*

Further, 130 Code of Massachusetts Regulations (CMR) 503.002(H) and 130 CMR 517.002(H) both allow inmates of penal institutions to receive MassHealth benefits when they become inpatients in a medical facility:

> *Inmates of penal institutions may not receive MassHealth benefits except under one of the following conditions, if they are otherwise eligible for MassHealth:*
>
> *(1) they are inpatients in a medical facility; or*
>
> *(2) they are living outside of the penal institution, are on parole, probation, or home release, and are not returning to the institution for overnight stays.*

Massachusetts also requires the Department of Public Health to seek FFP for care provided to inmates of the Department of Correction and of county houses of correction[2] who are treated at public-health hospitals, including Lemuel Shattuck Hospital. Specifically, Section 4590-0915 of the Massachusetts budget appropriation for fiscal years 2012 and 2013 states,

> *Notwithstanding any general or special law to the contrary, the department shall seek to obtain federal financial participation for care provided to inmates of the department of correction and of county correctional facilities who are treated at the public health hospitals.*

The federal government reimburses the Commonwealth 50% of every dollar spent on eligible Medicaid services. Outside Section 227 of Chapter 165 of the Acts of 2014 (Appendix B) directs MassHealth to develop a plan to seek FFP for eligible inmate inpatient healthcare costs.

2. Massachusetts maintains 14 houses of correction at the county level, each under the supervision of a county sheriff.

AUDIT OBJECTIVES, SCOPE, AND METHODOLOGY

In accordance with Chapter 11, Section 12, of the Massachusetts General Laws, the Office of the State Auditor (OSA) has conducted a performance audit of state policies and procedures regarding Medicaid eligibility of inmates and potential federal reimbursement for inmate inpatient healthcare costs for the period January 1, 2011 through December 31, 2012.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Below is a list of our audit objectives, indicating each question we intended our audit to answer; the conclusion we reached regarding each objective; and, if applicable, where each objective is discussed in the audit findings.

Objective	Conclusion
1. Did the Commonwealth effectively reduce inmate healthcare costs by requiring hospitals and other medical service providers to bill MassHealth for eligible inmate inpatient health services?	**No; see Finding 1**
2. Did the Commonwealth seek federal financial participation (FFP) for care provided to the following?	
a. inmates of the Department of Correction (DOC) who were treated at Lemuel Shattuck Hospital (LSH)	**Yes**
b. inmates of county houses of correction (HOCs) who were treated at LSH	**No; see Finding 1**

We reviewed applicable state and federal laws, rules, and regulations and interviewed officials from MassHealth, DOC, the 14 county HOCs, the University of Massachusetts Medical School (UMMS) Commonwealth Medicine,[3] and LSH.[4] We also reviewed federal and state audit reports regarding available FFP for inmate inpatient healthcare costs. In addition, we conducted fieldwork at the 14 county

3. UMMS Commonwealth Medicine had a contract with DOC to provide medical care, billing, and processing services during the audit period. The Massachusetts Partnership for Correctional Healthcare became DOC's healthcare vendor on July 1, 2013.
4. LSH provides inpatient and outpatient medical services for inmates of DOC and HOCs.

HOCs, UMMS, and LSH. Our fieldwork consisted of reviewing policies and procedures for (1) medical intake of newly incarcerated persons and (2) payments for inmate inpatient healthcare. We obtained schedules of payments made by these facilities for inmate inpatient healthcare. Subsequently, we audited these schedules by testing a non-statistical judgmental sample of payments:[5] we reviewed related invoices and compared them to payment data in the Massachusetts Management Accounting and Reporting System (MMARS).

To assess the reliability of the data provided by county HOCs,[6] UMMS Commonwealth Medicine, and LSH, we performed testing at each of those entities, as follows:

- We compared the schedules of inmate inpatient data provided by these entities to copies of original source documents.
- We compared the schedules of inmate inpatient data to MMARS data or inmate tracking logs[7] to ensure that the entities reported a complete list of all inmate inpatient claims during the audit period.
- We analyzed the schedules for obvious errors in accuracy and completeness.
- We conducted interviews with officials at related correctional facilities and third-party administrators to ensure that they understood the regulatory definition of an inmate inpatient stay and to confirm their understanding of our data requests.
- We resolved any data discrepancies with appropriate officials.

Based on our current audit work and OSA's data reliability assessment of MMARS[8] information technology controls, we have determined that the data obtained were sufficiently reliable for the purposes of this report.

5. The sample size at these facilities ranged from 7 payments to 50 payments, depending on the number of inmate hospitalizations during the audit period.
6. Certain county HOCs contracted with third-party medical administrators to provide various services, including inmate medical care and billing services. We obtained detailed information on inmate inpatient care from these third-party administrators.
7. Certain county HOCs maintain inmate tracking logs, which identify instances when inmates are transported outside the facility, including trips to medical facilities for inpatient care. These logs were used when payments for inmate inpatient care were processed through third-party administrators instead of through MMARS.
8. In 2014, OSA performed a data reliability assessment of MMARS. As part of this assessment, we tested general information technology controls for system design and effectiveness. Our audit tested for (1) accessibility of programs and data and (2) system change management policies and procedures for applications, configurations, jobs, and infrastructure.

DETAILED AUDIT FINDINGS WITH AUDITEE'S RESPONSE

1. The Commonwealth could have saved as much as $11,644,611 by seeking federal financial participation for eligible inmate inpatient medical costs.

MassHealth did not seek available federal reimbursement for inmate inpatient medical costs, and consequently the Commonwealth lost the opportunity to save as much as $11,644,611 for these medical expenses during the audit period. According to Section 1905 of Title XIX of the Social Security Act and guidance from the Centers for Medicare & Medicaid Services (CMS), federal financial participation (FFP) is available for medical services provided to inmates who become inpatients in a medical facility. FFP is paid by the federal government to reimburse states for a portion of eligible healthcare expenditures, including inmate inpatient healthcare costs. Massachusetts is currently eligible to receive a 50%[9] federal reimbursement of these medical expenditures.

The table below illustrates FFP the Commonwealth could have received during the audit period (January 1, 2011 through December 31, 2012) for inmates incarcerated at county houses of correction (HOCs) and treated at Lemuel Shattuck Hospital (LSH) or non-state hospitals.

County HOC	Amount Paid to LSH for Inpatient Care*	Amount Paid to Non-State Hospitals for Inpatient Care	Total Cost of Inpatient Healthcare	Total Potential FFP (50%) Reimbursement Lost to the Commonwealth
Barnstable County	$ 110,666.00	$ 114,952.00	$ 225,618.00	$ 112,809.00
Berkshire County	–	187,835.00	187,835.00	93,917.50
Bristol County	590,385.00	543,283.00	1,133,668.00	566,834.00
Dukes County	205.00	–	205.00	102.50
Essex County	553,027.00	2,324,400.00	2,877,427.00	1,438,713.50
Franklin County	–	88,319.00	88,319.00	44,159.50
Hampden County	3,361.00	666,256.00	669,617.00	334,808.50
Hampshire County	–	83,770.00	83,770.00	41,885.00
Middlesex County	1,148,271.00	960,485.00**	2,108,756.00	1,054,378.00
Nantucket County	–	–	–	–

9. Massachusetts received approval from CMS to expand its Medicaid coverage to include non-disabled childless adults under a Section 1115 demonstration waiver. This new class of members includes inmates who meet applicable income and residency eligibility requirements. Since receiving CMS approval, Massachusetts has been eligible to receive FFP at a 50% reimbursement rate for qualified inmate inpatient healthcare costs. With the passage of the Patient Protection and Affordable Care Act of 2010, states that did not previously elect to expand Medicaid coverage for non-disabled childless adults may now expand coverage to include this group and be eligible to receive 100% FFP for up to five years.

County HOC	Amount Paid to LSH for Inpatient Care*	Amount Paid to Non-State Hospitals for Inpatient Care	Total Cost of Inpatient Healthcare	Total Potential FFP (50%) Reimbursement Lost to the Commonwealth
Norfolk County	739,716.00	337,934.00	1,077,650.00	538,825.00
Plymouth County	1,412,864.00	539,094.00	1,951,958.00	975,979.00
Suffolk County	2,056,945.00	1,501,156.00	3,558,101.00	1,779,050.50
Worcester County	375,415.00	798,614.00	1,174,029.00	587,014.50
Total	$ 6,990,855.00	$ 8,146,098.00	$ 15,136,953	$ 7,568,476.50

* These amounts are based on total medical payments of $8,738,569 made by county HOCs to LSH. LSH estimates that approximately 80% ($6,990,855) of the payments represent inmate inpatient hospital charges.

** This amount is an estimate of the inmate inpatient hospital charges incurred by the Middlesex County HOC during the audit period.

MassHealth lost the opportunity to obtain approximately $7,568,477 in FFP for eligible HOC inmate inpatient healthcare costs.

Similarly, the table below illustrates the FFP the Commonwealth could have received during the audit period (January 1, 2011 through December 31, 2012) for inmates incarcerated at Department of Correction (DOC) facilities and treated at non-state hospitals.

State DOC Facility*	Total Amount Paid to Non-State Hospitals**	Total Potential FFP (50%) Reimbursement Lost to the Commonwealth
Bay State Correctional Center	$ 76,067.00	$ 38,033.50
Bridgewater State Hospital	593,026.00	296,513.00
Boston and Brooke House Pre-Release Centers†	52,498.00	26,249.00
Massachusetts Alcohol and Substance Abuse Center	204,461.00	102,230.50
Massachusetts Treatment Center	674,905.00	337,452.50
Massachusetts Correctional Institution (MCI)–Cedar Junction	186,311.00	93,155.50
MCI–Concord	364,859.00	182,429.50
MCI–Framingham	623,470.00	311,735.00
MCI–Norfolk	1,405,540.00	702,770.00
MCI–Plymouth	38,806.00	19,403.00

State DOC Facility*	Total Amount Paid to Non-State Hospitals**	Total Potential FFP (50%) Reimbursement Lost to the Commonwealth
MCI–Shirley	1,582,777.00	791,388.50
North Center Correctional Institution–Gardner	534,550.00	267,275.00
Northeastern Correctional Center	34,699.00	17,349.50
Old Colony Correctional Center	496,398.00	248,199.00
Pondville Correctional Center	434,121.00	217,060.50
South Middlesex Correctional Center	67,531.00	33,765.50
Souza-Baranowski Correctional Center	782,249.00	391,124.50
Total	$8,152,268.00	$4,076,134.00

* Medical payments for an inmate's inpatient stays are reflected in the last facility where the inmate was located before release.

** These amounts were provided by DOC's third-party contract administrator for inmate healthcare services, the University of Massachusetts Medical School Commonwealth Medicine.

† The total amount for Boston Pre-Release Center also includes inmate inpatient stays aggregated from the Brooke House facility.

MassHealth lost the opportunity to obtain $4,076,134 in FFP for eligible DOC inmate inpatient healthcare costs.

It should be noted that some inmates in DOC custody also received inpatient care at LSH during the audit period. However, we did not include the cost of this care as a potential lost reimbursement to the Commonwealth, since the Department of Public Health (DPH) had captured this cost and received FFP.

Authoritative Guidance

Section 4590-0915 of the Massachusetts fiscal year 2013 budget appropriation provides funding for public-health hospitals to treat incarcerated persons. This section requires DPH to seek FFP for expenditures related to inmates who become inpatients in a public-health hospital:

> *Notwithstanding any general or special law to the contrary, the department shall seek to obtain federal financial participation for care provided to inmates of the department of correction and of county correctional facilities who are treated at the public health hospitals.*

FFP is available for inmates according to Section 1905(a)(29)(A) of the Social Security Act, which states that Medicaid funding is available to inmates of public institutions (e.g., jail) who are patients in medical facilities, although it is not available to other inmates. In 1997, CMS issued a letter to clarify this section of the Social Security Act. This letter states that for inmates, FFP is only allowed if an inmate becomes an

inpatient in a medical facility. Similarly, CMS issued a second letter in 1998 to clarify that FFP is not available to an inmate of a public institution (e.g., jail) but is available for a Medicaid-eligible inmate if s/he is in a medical facility:

> *Medical Institution*
>
> *Section 1905(a)(A) provides an exception to the prohibition of the FFP for inmates of public institutions. If an inmate is a patient in a medical institution, FFP may be available for the individual's medical care and services. In order for a person to be a patient in a medical institution for purposes of this policy, the person must be admitted as an inpatient in a hospital, nursing facility, institution for mental disease, or intermediate care facility, and must be expected to remain in the facility for a period of 24 hours or longer. When an inmate is an inpatient in such a facility, FFP is available for Medicaid covered services provided to the individual, even though the person is still considered to be an inmate. (The statement of FFP availability presumes that the individual meets all other factors pertinent to Medicaid eligibility and coverage.)*

Further, 42 Code of Federal Regulations 435.1010 defines inpatient status for the determination of FFP for inmates:

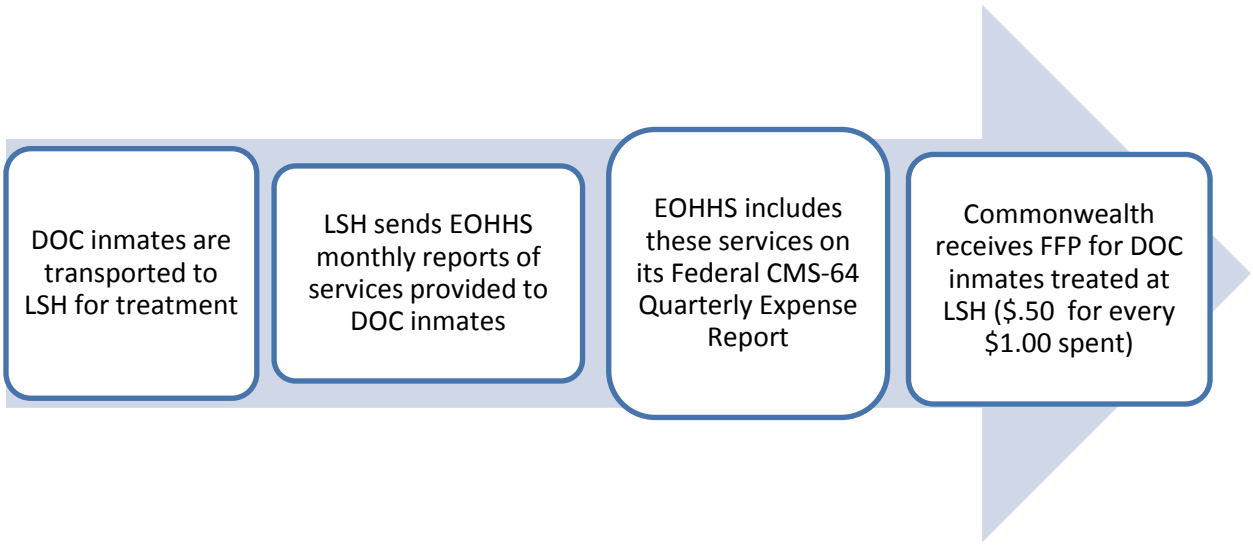
> ***Inpatient*** *means a patient who has been admitted to a medical institution as an inpatient on recommendation of a physician or dentist and who—*
>
> *(1) Receives room, board and professional services in the institution for a 24 hour period or longer, or*
>
> *(2) Is expected by the institution to receive room, board and professional services in the institution for a 24 hour period or longer even though it later develops that the patient dies, is discharged or is transferred to another facility and does not actually stay in the institution for 24 hours.*

In addition, 130 Code of Massachusetts Regulations (CMR) 503.002(H) and 130 CMR 517.002(H) both allow inmates of penal institutions to receive MassHealth benefits when they become inpatients in a medical facility:

> *Inmates of penal institutions may not receive MassHealth benefits except under one of the following conditions, if they are otherwise eligible for MassHealth:*
>
> *(1) they are inpatients in a medical facility; or*
>
> *(2) they are living outside of the penal institution, are on parole, probation, or home release, and are not returning to the institution for overnight stays.*

Current Practices

Currently, MassHealth does not have policies and procedures to obtain FFP for eligible inmate inpatient healthcare services provided by non-public hospitals and other medical service providers. In contrast, the Executive Office of Health and Human Services and the Office of Medicaid, in accordance with state budgetary requirements,[10] have developed a process to obtain FFP for DOC inmates treated at LSH, a state public-health hospital. During the audit period, this resulted in the Commonwealth receiving $4,115,269 in federal reimbursements.[11] The process for obtaining FFP for DOC inmates treated at LSH is detailed below.



During our audit, DOC and county HOC officials identified issues and concerns regarding inmate hospitalizations:

- Inmate hospitalization costs have significantly exceeded county HOC budgets for inmate healthcare, requiring these HOCs, at times, to reallocate money from other budgetary line items. For example, the Middlesex County HOC paid $183,235 to hospitalize one inmate at Tufts Medical Center for nine days in May 2012, creating budgetary concerns on the HOC's part.
- Because of the complexity of medical billing, county HOCs have had to outsource it or hire additional personnel with medical-billing expertise. This has significantly increased administrative costs for inmate healthcare.
- MassHealth has been unwilling to collaborate with DOC and county HOCs to enroll hospitalized inmates. In fact, MassHealth's policy is to terminate Medicaid coverage for inmates.

10. This refers to Section 4590-0915 of the Massachusetts budget appropriation for both fiscal year 2012 and fiscal year 2013.
11. According to MassHealth officials, MassHealth's Section 1115 demonstration waiver from CMS allows it to obtain FFP for both inpatient and outpatient services provided by designated state health programs, including LSH.

Reasons for Not Obtaining FFP for Inmate Inpatient Healthcare

MassHealth has not collaborated with DOC and county HOCs to establish processes for determining Medicaid eligibility of inmates in order to obtain FFP for inmate inpatient medical costs.

Our analysis indicates that MassHealth could save the Commonwealth millions each year by developing a process to seek FFP.

Recommendations

MassHealth should take the following actions:

1. Collaborate with DOC and county HOCs to establish processes to (1) determine Medicaid eligibility of inmates, (2) enroll eligible inmates in MassHealth but suspend their benefits until they are admitted as inpatients in medical facilities, (3) re-suspend inmate benefits after the inmates are discharged from the medical facility, and (4) reactivate inmate benefits upon release from the correctional facility.

2. Once the aforementioned processes have been established, issue a Provider Bulletin[12] notifying all MassHealth-participating medical facilities that certain inmates are Medicaid-eligible and that inpatient services provided to these inmates should be billed through MassHealth and not to DOC and county HOCs. This will allow the Commonwealth to obtain FFP for eligible inmate inpatient healthcare costs.

3. Consider the effect of any new processes on LSH's operations, including budgetary and programmatic effects, since DPH already has a process to obtain FFP for DOC inmates treated at LSH (see Appendix A).

4. Comply with Outside Section 227 of Chapter 165 of the Acts of 2014 (Appendix B), including submitting a plan to the Legislature detailing MassHealth's efforts to develop and implement a process to obtain FFP for eligible inmate inpatient healthcare and reporting the financial impact on the Commonwealth.

Auditees' Responses

Department of Correction

- *It is important to reinforce the message to all parties that the DOC is very interested and willing to collaborate with MassHealth and the counties to establish a process to retain FFP and promote positive fiscal responsibility for the Commonwealth.*

- *Since the DOC receives several county transfers, and vice versa, it will be important for MassHealth to consider a system where the DOC is able to share eligibility information with the counties to prevent lapses in coverage, improve continuity of care and ensure costs are allocated to the appropriate correctional system. This will be important for the DOC's county step-down inmates as well.*

12. MassHealth issues Provider Bulletins to clarify program regulations and provide operational guidance to its medical service providers.

- *DPH has already established a process to retain FFP for inmates who were admitted to Lemuel Shattuck Hospital (LSH), resulting in $4,115,269 in FFP reimbursements. The DOC will have to secure additional resources to enroll and facilitate eligibility determinations for inmates at intake and during incarceration to preserve MassHealth for all inmates at outside hospitals.*

- *The enrollment or disenrollment of an inmate in MassHealth by electronic means, will bring the agency (DOC) within the purview of [the federal Health Insurance Portability and Accountability Act, or HIPAA], and will require that the DOC become fully HIPAA compliant. Achieving and maintaining HIPAA compliance is a lengthy process that will incur significant initial and ongoing costs to the agency. The DOC will need to make substantial changes to its records policies and practices, as well as amendments to existing health services contracts, and will need to hire HIPAA privacy officers.*

- *The DOC will need to know what changes will be necessitated to its contract with [DOC's healthcare vendor], given that the per diem rates were negotiated under the assumption that [the vendor] would fully bear the cost of outside hospitalization. . . .*

- *LSH may be negatively impacted if FFP reimbursements replace current level funding by the DOC's medical/mental health vendor. . . . If LSH is required to pursue FFP and it results in a negative fiscal impact, LSH will reduce services—or close. The DOC should conduct a thorough cost benefit analysis regarding FFP reimbursements. The review should consider the overall impact to security, medical costs at different hospitals, overtime, etc. The review should discern if it is more cost effective to have LSH manage our patient population in a secured setting which reduces risk and officer OT costs, etc.? Or, is it more beneficial to have reimbursements from FFP which will reduce our medical contract costs but increase our security costs and possibly overtime?*

- *Of note, several other state DOC's are doing this quite successfully. Mississippi, Louisiana and Kansas, actually created the roadmap on how to do this. There may be upwards of 15 or 16 states that are doing this successfully.*

The report represents that MassHealth has not engaged the DOC in securing FFP for medical services we provide to our inmate population. It also represents LSH's concerns regarding implementation of MassHealth for inmates who are inpatients. It will be important to reiterate that the DOC is willing to work collaboratively with MassHealth and the counties to develop a seamless process for assessing an inmate's Medicaid eligibility, enrolling inmates as members of MassHealth and communicating with all parties to ensure services are covered as appropriate.

MassHealth

MassHealth is in the process of implementing the recommendations put forth by the State Auditor's Office (SAO) in its report "An Examination of the Policies and [Practices] Regarding Medical Coverage for Inmate Inpatient Healthcare Costs." These recommendations align with those of Section 227 of Chapter 165 of the Acts of 2014 (Section 227), which require that the Office of Medicaid ("MassHealth") suspend MassHealth benefits for inmates of penal institutions and reactivate benefits if the

individual is admitted for an inpatient hospitalization or upon release from incarceration, subject to all required federal approvals.

Section 227 further requires the Medicaid Director to submit a plan to implement this section to the House and Senate Chairs of the Committees on Ways and Means and the Chairs of the Joint Committee on Health Care Financing. With input from the DOC, Sheriffs, the Executive Office for Administration and Finance (A&F) and other partners, MassHealth has developed a plan to implement Section 227 and the recommendations of the SAO.

The Executive Office of Health and Human Services (EOHHS) believes implementing this plan will help to strengthen continuity of care for MassHealth-eligible individuals involved in the criminal justice system and has the potential to contribute to reducing recidivism and improving long-term health outcomes for these individuals. While MassHealth has long had processes in place to work with the Department of Correction (DOC) and county correctional facilities to assist with enrollment of eligible inmates in subsidized health coverage as part of the pre-release process, pursuing a "suspension" approach rather than requiring inmates to reapply will help to further streamline the process to ensure that eligible individuals have health care coverage available upon release.

In addition, this approach will provide an opportunity to increase federal revenue received by the Commonwealth by allowing EOHHS to claim federal Medicaid matching dollars for inpatient care provided to Medicaid-eligible inmates during their incarceration, to the extent allowed under federal rules.

MassHealth will implement the SAO's recommendations through the following steps:

1. *Make changes to MassHealth's eligibility and claims payment systems to:*

    a. *Allow inmates to qualify for Medicaid coverage if they meet all other eligibility requirements; the current Health Insurance Exchange (HIX) system is programmed to disqualify any applicant who indicates that he or she is incarcerated at the time of application;*

    b. *Create a new eligibility category in the eligibility system specifically for incarcerated individuals in a suspended status;*

    c. *Create a set of rules in MassHealth's claims payment system to ensure that MassHealth does not pay for services for inmates that are prohibited under federal rules and that inmates are not enrolled in MassHealth managed care programs.*

2. *Implement processes, in collaboration with DOC and the Sheriffs, by which inmates who are already enrolled in MassHealth at the time of their incarceration are identified in a timely manner and placed into a suspended status, and by which inmates' full eligibility is reactivated at the time of their release.*

3. *Implement processes, in collaboration with DOC and the Sheriffs, by which inmates who are not enrolled in MassHealth at the time of incarceration have the opportunity to go through the application process and, if eligible, be enrolled in MassHealth in a suspended status.*

4. *Determine the appropriate mechanisms for paying providers that provide qualifying inpatient services to inmates, defining the methodologies for federal claiming for these services, and obtaining federal approval for these methodologies, if needed.*

5. *Work with A&F, DOC, and the Sheriffs to assess the full fiscal impact of implementing Section 227 and ensure that this impact is appropriately reflected in the Commonwealth's budget.*

6. *Disseminate information and conduct outreach to internal and external stakeholders about the upcoming changes in MassHealth policy and processes in order to maximize enrollment for eligible inmates and educate health care providers that treat inmates.*

To support the implementation plan, MassHealth and the [Massachusetts Sheriffs' Association] have jointly submitted a letter requesting technical assistance from the National Institute of Corrections (NIC), an agency within the U.S. Department of Justice that provides training, technical assistance, information services, and policy and program development assistance to federal, state, and local corrections agencies. NIC has experience working with other states on the design of processes for enrolling Medicaid-eligible inmates and implementation of a suspended eligibility status policy.

Federal Approvals

Once EOHHS/MassHealth determine the most appropriate methodologies for claiming federal financial participation (FFP), it may be necessary to secure federal approval for these methodologies before FFP can be claimed. For example, the Centers for Medicare and Medicaid Services (CMS) may have to approve a new Certified Public Expenditure methodology to claim for expenditures incurred by the DOC for inpatient care provided to inmates.

Lemuel Shattuck Hospital

In the fall of 2014, MassHealth was able to secure, as part of the renewal of its 1115 Demonstration Waiver, federal matching funds for health care services provided to inmates at the Department of Public Health's Lemuel Shattuck Hospital. This approval ensures that the Commonwealth will be able to obtain federal revenue for health care costs related to certain inmates during state fiscal years 2015 through 2017. MassHealth recognizes that Lemuel Shattuck Hospital is an integral part of providing health care to inmates of both state and county correctional facilities and will ensure that Lemuel Shattuck Hospital is strongly considered as we develop and enhance processes to maximize federal financial participation for inmates' health care costs. . . .

MassHealth looks forward to working with the Sheriffs and DOC to implement these recommendations to ensure the Commonwealth is both receiving all potentially available FFP and strengthening continuity of care for MassHealth-eligible individuals involved in the criminal justice system.

Auditor's Reply

We commend the DOC and MassHealth for their willingness to collaborate with each other and with county HOCs to create a new process to obtain FFP for eligible inmate inpatient costs.

DOC shared several obstacles to implementing this new process (e.g., data sharing, HIPAA requirements, contract renegotiations). These are valid concerns, and overcoming them will require DOC to collaborate effectively with all stakeholders. MassHealth described its detailed action plan for implementing Outside Section 227 of Chapter 165 of the Acts of 2014. MassHealth's plan addresses all of our recommendations and should help ensure that the Commonwealth obtains FFP for all eligible inmate inpatient healthcare costs.

We agree with DOC and MassHealth that special attention must be given to LSH because it provides a unique healthcare model (staffing, funding, medical services, and security) for the Commonwealth's prison population. As suggested by DOC, a thorough cost-benefit analysis should be performed to compare LSH's current healthcare model to an FFP-based model. The goal is to ensure that LSH continues to provide healthcare for prisoners in the most efficient and cost-effective manner.

APPENDIX A

Lemuel Shattuck Hospital Memorandum to the Office of the State Auditor

Paul D. Romary
Chief Executive Officer

THE COMMONWEALTH OF MASSACHUSETTS
EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES
DEPARTMENT OF PUBLIC HEALTH
LEMUEL SHATTUCK HOSPITAL

Inmate Medicaid Eligibility: Potential Impacts on Correctional Health at Shattuck Hospital

Paul Romary, CEO and Mike Donovan, CFO
August 4, 2014

Issue Summary

MassHealth and the Commonwealth's 15 correctional systems are currently assessing how to qualify incarcerated and jailed individuals for Medicaid in order to shift their hospitalization costs from state funding to the federal government. This initiative was lent urgency by the December 14, 2014 implementation deadline set by the Legislature in section 227 of the FY15 state budget. Depending on how this "inmate Medicaid" initiative is structured and new federal reimbursement is captured, the Lemuel Shattuck Hospital (LSH) stands to be held harmless from its effects or face budget cuts that will force curtailment of specialized services to correctional systems. This memo details the potential impacts of this change on the hospital's clinical role in correctional health.

Background

Prior to enactment of the Affordable Care Act (ACA), detainees awaiting trial and incarcerated inmates were excluded from Medicaid, which historically had been limited to children, pregnant women, very low-income parents, people with disabilities and the elderly. The ACA expanded Medicaid to include childless single adults that earn up to 138% of the federal poverty level, which is about $15,800 for an individual. By virtue of their limited or non-existent income, most inmates and detainees qualify for Medicaid under this expansion. Some states, such as Colorado and Minnesota, implemented this expansion with waivers before it officially took effect nationwide last January. Consistent with restrictions in the Medicaid enabling statute, Title XIX, inmates that are not U.S. citizens or in the country under color of law do not qualify for Medicaid.

As an incentive for the states to buy in, the ACA established enhanced federal funding of expansion coverage. Historically, Massachusetts has recovered only 50% of its Medicaid costs (known as "federal financial participation" or FFP) from the federal government. Enhanced FFP for inmate Medicaid promises to shift the most expensive portion of their care – hospitalization -- to federal funding.

Not all health care benefits are covered by this expansion. Inmate Medicaid will only cover the cost of hospitalizations lasting 24 hours or more and not outpatient services or the cost of health services delivered behind prison walls. The ACA does, however, permit non-adjudicated individuals awaiting trial to be enrolled in private insurance plans purchased through state health insurance exchanges, which would be of particular benefit to county correctional systems in Massachusetts.

Many advocates, especially corrections officials, note that maintaining Medicaid coverage behind the walls will ensure that inmates and detainees maintain continuous insurance coverage upon their release. Because they have disproportionately higher rates of chronic disease, including mental illness and addictive disorders, continuous coverage will provide more ready access to care that

LEMUEL SHATTUCK HOSPITAL • 170 MORTON ST., JAMAICA PLAIN, MASSACHUSETTS 02130-3782 • 617-971-3201

should lead to more effective management of their conditions, reduce the public health risks that result from infectious conditions like hepatitis C and HIV/AIDS and potentially lead to lower recidivism rates treatment and medication regimens deter the illegal or risky behavior that often results in renewed incarceration.

Background of LSH Correctional Service Arrangements and Payment Agreements
Inmate Medicaid poses fiscal challenges for LSH because three of its five funding sources derive from correctional reimbursement, which cover over 12% of its $74M annual budget. (See table below for a history of these accounts.) To the extent this initiative generates amounts that are comparable to current correctional payments, it will be budget neutral and LSH will be able to sustain its inmate care services. If, however, the hospital cannot retain these Medicaid payments or they fall short of budgetary needs, LSH would be faced with cutting services that primarily benefit state and county correctional systems, as described in more detail below.

Since the mid-1970's, LSH has offered a wide range of health care services to the Department of Correction (DOC) and the 14 county correctional systems. The Hospital's delivery of care is closely coordinated with the 24/7 security provided by the DOC correctional officers stationed at LSH. Available services include inpatient care on a secure 29 bed ward, a small intensive care unit for high acuity, palliative care for end-ofer-life inmates, 25 outpatient specialties, including surgery, prison-site clinics, a secure outpatient waiting area, telemedicine and a full range of diagnostic imaging.

Inmates and detainees are referred to LSH based on the clinical, security and management criteria used by the correctional system where they are incarcerated or detained. Once diagnosed or treated at LSH, the hospital expedites their discharge back to their referring facility as soon as their clinical needs can be met behind the walls. LSH generates invoices for all billable services that enable each correctional system to monitor utilization and track the cost of doing business with LSH. On average, 75% of the charges that LSH bills to correctional systems is for inpatient care, although this percentage is about 70% for MPCH patients that tend to use more outpatient services, and 80% for county patients that tend to use more inpatient care. The county Sheriffs also gain the correctional officer labor savings during hospitalization at LSH since DOC usually provides the security staffing. On average, $7M out of $9.2M in total correctional payments that LSH receives is for hospitalization which reimbursed just under 9,000 days of inpatient care in FY14. This is the portion of the LSH budget that is at immediate risk if inmate Medicaid does not support LSH operating costs, with the possibility that more revenue and volume is at risk if service cuts snowball into reduced use of the hospital, especially by the county correctional systems.

Three types of service and reimbursement contracts or agreements govern relationships between LSH and its correctional partners. For services provided to state inmates, LSH has a contract with the managed care vendor, Massachusetts Partnership for Correctional Health (MPCH), which manages care on behalf of DOC's 10,500 inmates at 17 sites. In FY15, MPCH will reimburse LSH a fixed, or "capitated", amount of $5.05M to cover comprehensive inpatient, outpatient, prison-site and telemedicine services. Of this amount, $4.55M is paid to a retained revenue account, 4590-0917. The remaining $500K is used to purchase high cost medical equipment that the LSH state appropriation does not support. Items, such as the $320K cardiac telemetry system that was recently replaced are bought by MPCH for LSH to own and maintain according to a prioritized equipment list developed by LSH.

For the county correctional systems, two types of agreements are used, both of which offer the Sheriffs' departments a discount from the hospital's typical charges. Most of the eastern Mass. Sheriff's make fee-for-service payments to LSH that are credited to a state chargeback account

(4590-0903), which generates $3.4M to $4.0M annually depending on utilization. The account is capped at $3.8M in the FY15 budget. For Bristol and Essex counties, their managed care vendors reimburse LSH for services by making fee-for-service payments to a retained revenue account (4590-0913), which takes in between $500K and $900K annually and is capped at $508K in FY15.

In contrast with the correctional payments that LSH retains, all other revenue generated by the hospital is credited to the General Fund, including Medicaid FFP and the reimbursement generated by Medicaid managed care organizations, Medicare, commercial insurers and self-pay patients. In FY14, these third party payments to the General Fund exceeded $32M.

Potential Impacts on LSH Clinical Services

As noted previously, the fiscal effects of inmate Medicaid could be budget-neutral or lead to service cuts at LSH. If state law is changed to permit LSH to retain these payments, the initiative would not be budget neutral if these payments did not reach levels comparable to the amounts currently generated by correctional health systems. If these payment do not meet LSH budgetary requirements, the hospital would face hard choices over which clinical services are no longer sustainable. Correctional health has been a major line of business for LSH since 1976. Its diversity of clinical needs and its critical financial contributions to the budget have enabled the hospital to justify supporting a broader range of services, which in turn has also benefited non-correctional patients at LSH. But correctional health is not the hospital's sole stakeholder, and the higher costs of caring for inmates and detainees cannot be justified if they negatively affect these other patient populations. It will be impossible to justify the continued operation of more costly correctional health services if inmate Medicaid reimbursement falls short of LSH revenue targets.

Alternative Models for Inmate Medicaid

There are two diametrically different approaches to implementing inmate Medicaid; one is budget neutral and the other that would create fiscal uncertainty.

The budget neutral approach would retain the status quo for state budgeting of each correctional system's health services and have each system remain responsible for paying providers for their utilization. The enhanced FFP that the ACA makes available would be generated by MassHealth using the same mechanisms that are now used to claim FFP for eligible services provided by DPH, DMH, DDS and other publicly funded/operated services to Medicaid beneficiaries. The General Fund, and not providers, would therefore be credited with inmate Medicaid FFP.

This approach offers several benefits. Providers would not face any disruption of current arrangements for service delivery or payments. They would not be burdened with determining much less have to chase Medicaid eligibility determinations. This approach also upholds the prudent management principle that comes with having correctional systems retain responsibility for managing hospital utilization, and provide the preventative services that avoid the need for costly hospitalization.

An alternative approach that poses far more risk to LSH would shift the fiscal burden to providers that would bill MassHealth for inmate hospitalization just as they not seek reimbursement for traditional Medicaid populations. It relieves correctional systems of having to budget part of the payment burden, with the exception of inmates that do not qualify for MassHealth. It should also result in cuts to correctional system budgets based on the amount of their appropriations that shift to MassHealth.

Among the downsides of this approach for LSH is its inability to retain Medicaid payments and FFP, but more importantly, the inability to make up revenue losses if Medicaid payments fall short of

budgetary needs. Because hospital budgeting is constrained by statutory accounting rules, and does not allow for accrual budgeting, this possibility is likely at the end of the fiscal year when MassHealth sometimes manages the payment cycle in response to cashflow issues. Payment delays also occur as a result of the time lag created by the claims adjudication process. This possibility is especially likely when inmate Medicaid eligibility determinations are not accurate or timely, and the system rejects claims that need to be re-billed to Medicaid or to the correctional system. Finally, this outcome is likely if any of the correctional systems, especially at the county level, choose to move their utilization away from LSH to other hospitals, especially for short-term stays where the added cost of providing security with their own officers outweighs the cost advantage of shifting the hospitalization bill to the federal government.

Medicaid Eligibility Verification – Risks to MassHealth and Providers

Another risk of this second approach is the challenge that providers will face with verifying inmate Medicaid eligibility in order to be assured of payment. Verification relies on correctional systems to meet MassHealth data requirements on a consistent, accurate and timely basis. This is no simple task since most correctional systems lack the staff for this role, and many factors complicate the reliability and accessibility of inmate eligibility data. Prior to incarceration, many inmates live on society's margins, may be homeless, suffer from mental illness and may resist cooperating with authorities for information requests. Inmate identities can be counfounded by aliases and the lack of readily available documentation, such as birth certificates. Inmates often move within and between correctional systems, making it difficult to track their whereabouts and complicating the accuracy of their current eligibility. They can be released unpredictably by a court while in detention or civilly committed, which can take weeks to reconcile with the eligibility system. All of these and other factors can leave hospital billing departments with the puzzle of chasing eligibility in order to obtain payment. Finally, Massachusetts lacks a unified and comprehensive inmate management system that tracks inmates across its disconnected state and county systems. To the extent that verification errors result in payment delays or lost revenue, LSH and other providers will incur transactional costs that will prove frustrating to the success of inmate Medicaid.

Other Questions / Issues / Concerns

Other issues also require attention in order to ensure a seamless and orderly transition to inmate Medicaid.

1. MassHealth requires legal and system modifications that enable Medicaid benefits to be suspended while an inmate is behind the walls until a hospital admission is required or the inmate is released to the community.

2. The ACA does not permit Medicaid to reimburse the costs of care delivered behind prison walls. The inpatient unit (8North) at LSH is listed as an official prison site by the DOC website. It operates under the direction of a superintendent and functions much like a prison within the hospital. This long-term partnership between DOC and DPH is estimated to save over $10M annually in DOC security costs, compared with hospitalizing inmates in private sector hospital beds. DOC also provides free security to inmates from the county systems, saving Sheriffs' departments over $1,000 a day in security costs. What change is required to reclassify or relabel 8 North as a hospital unit, instead of a prison ward?

3. DOC/HOC contracts for vendor-managed health care services will need modifications to address expectations for inmate Medicaid billing, payment and clinical planning for re-entry. Modifications may also be needed to vendor compensation arrangements due to the availability of inmate Medicaid

4. Current and future health care vendor contracts may also address expectations for accessing parental insurance or for inmates under age 27 or spousal insurance while awaiting trial. Future correctional health vendor contracts should also address expectations for enrolling inmates in Medicaid or insurance through the state health insurance exchange.

Summary

While the affordability and clinical benefits of treating inmates at LSH have been cost-effective and viable for several decades, the newfound availability of Medicaid coverage for inmate hospitalization changes the underlying assumptions and financial basis for this model. To date, reliance on correctional retained revenue to fund the LSH operating budget has relieved budgetary pressure on the other DPH hospitals which share the same appropriation account. The higher cost of sustaining correctional health services at LSH has been achieved because of the flexibility afforded by the status quo budgetary model. With the advent of inmate Medicaid, these advantages may be reduced if the hospital's budget is negatively impacted, and its commitment to maintaining high quality inmate care is undermined.

LSH Funding Sources	FY 11	FY 12	FY13	FY14	% of Total FY14 Funding
DPH Consolidated Hosp. Account - 4590-0915	$60.9M	$60.8M	$62.7M	$64.0M	87.9%
DOC Vendor (Ret Rev) 4590-0917*	$4.1M	$4.0M	$4.2M	$4.4M	6.02%
HOC (Chargeback) 4590-0903	$3.8M	$3.7M	$3.8M	$3.6M	5.21%
HOC Mgd Care (Ret Rev) 4590-0913	$0.5M	$0.5M	$0.5M	$0.5M	.69%
State Agency (Chargeback) 4590-0901	$0.08M	$0.07M	$0.03M	$0.03M	.04%
Total	$69.9M	$69.3M	$71.4M	$72.M	100%

* DOC Vendor also purchases $500K in medical equipment annually to support correctional health services at the hospital which is not reflected in these retained revenue amounts.

APPENDIX B

Outside Section 227 of Chapter 165 of the Acts of 2014

(a) Notwithstanding any general or special law to the contrary, the office of Medicaid shall suspend MassHealth benefits for inmates of penal institutions, including those awaiting trial and during incarceration, as defined in 130 CMR 501.001. MassHealth benefits shall be reactivated or provided to an inmate if: (i) an inmate is otherwise eligible for MassHealth; and (ii) is admitted as an inpatient, as defined in 42 [Code of Federal Regulations] 435.1010, to a hospital or other eligible institution. If an inmate, upon incarceration, is determined to be eligible for MassHealth but is currently not a member of MassHealth, the office of Medicaid shall enroll the inmate in MassHealth and immediately suspend benefits until the inmate is eligible to receive MassHealth benefits. An inmate's MassHealth benefits shall be immediately reactivated upon release from incarceration. The office of Medicaid shall implement this section subject to all required federal approvals.

(b) The director of Medicaid shall submit a plan to implement this section to the house and senate chairs of the committees on ways and means and the chairs of the joint committee on health care financing not later than December 31, 2014. The implementation plan shall include, but not be limited to: (i) progress and status updates of any state plan amendment or other necessary federal approval; (ii) details on collaboration with the department of correction and sheriffs; and (iii) a proposed timeline for full implementation of this section.

(c) Not later than March 1 of each year, up to and including March 1, 2017, the office of Medicaid shall provide a status report to the clerks of the house of representatives and the senate who shall forward the report to the house and senate chairs of the committees on ways and means. The report shall identify: (i) the number of inmates enrolled in MassHealth prior to incarceration and the number of inmates enrolled in MassHealth while incarcerated and whether the inmate is in a house of correction or state prison; (ii) the number of inmates that had their MassHealth benefits reactivated; (iii) the period of time that each inmate received benefits through their reactivated MassHealth benefits; and (iv) the cost to MassHealth for those benefits and any federal financial participation received.