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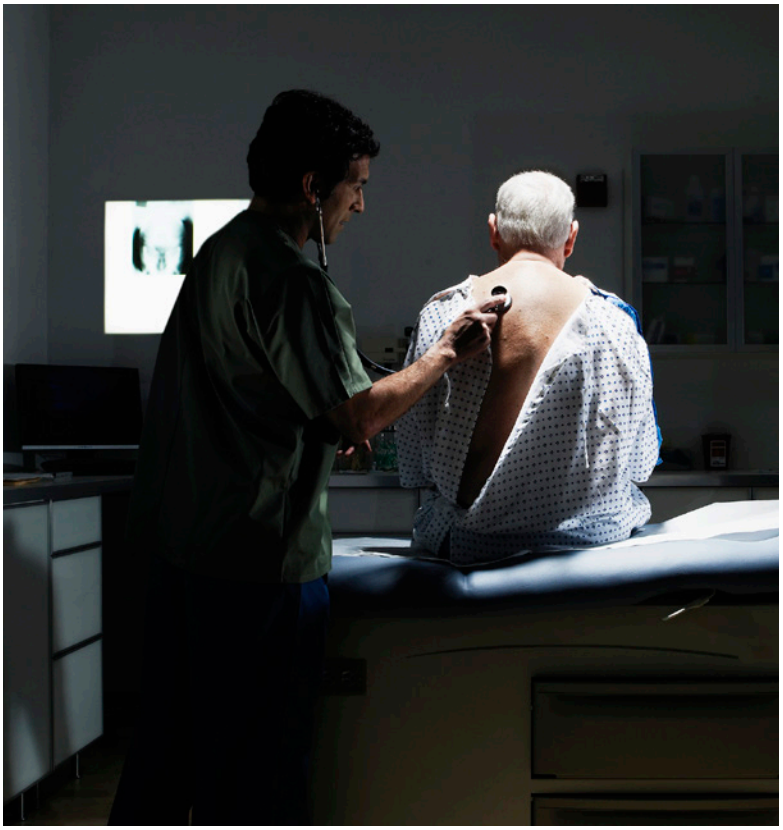

Managing Prison Health Care Spending

OCTOBER 2013

The State Health Care Spending Project, an initiative of The Pew Charitable Trusts and the John D. and Catherine T. MacArthur Foundation, helps policymakers better understand how much money states spend on health care, how and why that amount has changed over time, and which policies are containing costs while maintaining or improving health outcomes.

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HEALTH CARE CHALLENGES IN THE STATES

This report is part of a series that explores promising state efforts to manage health care costs across a range of spending areas.

To find other reports in this series, please visit www.pewstates.org/healthcarespending.

Overview

Nationwide, spending on both health care and corrections is putting serious pressure on state budgets. Medicaid—the largest component of states' health care spending—has been the fastest-growing part of state expenditures over the past two decades, with corrections coming in just behind it.[1]

Despite increasing interest among policymakers and taxpayers in improving outcomes and controlling costs in health care and corrections, the intersection of these two areas—health care for prison inmates—has garnered comparatively little attention. To better understand spending for inmate health services, researchers from The Pew Charitable Trusts analyzed cost data from the 44 states included in a study by the federal Bureau of Justice Statistics, or BJS.

Pew found that prison health care spending in these 44 states totaled $6.5 billion in 2008, out of $36.8 billion in overall institutional correctional expenditures.[2] Most states' correctional health care spending increased substantially from fiscal 2001 to 2008, the years included in the BJS report:

- Spending increased in 42 of the 44 states, with median growth of 52 percent.[3] In a dozen states, prison health expenditures grew 90 percent or more. Only Texas and Illinois experienced inflation-adjusted decreases in this spending area.[4]
- Per-inmate health care spending rose in 35 of the 44 states, with 32 percent median growth.
- In 39 of the states, prison health care costs claimed a larger share of their total institutional corrections budgets, increasing, on average, from 10 percent in fiscal 2001 to 15 percent in fiscal 2008. Maine, Nevada, North Dakota, Oklahoma, and West Virginia were the only exceptions.[5]

This significant growth reflects, in part, the rise in prison populations nationally. From 2001 to 2008, the number of sentenced prisoners in correctional institutions increased by 15 percent, from 1,344,512 to 1,540,100.[6] This rise was part of a multi-decade trend; the number of Americans in prison nearly tripled from 1987 to 2007.[7] The dramatic increase was driven in part by tougher sentencing

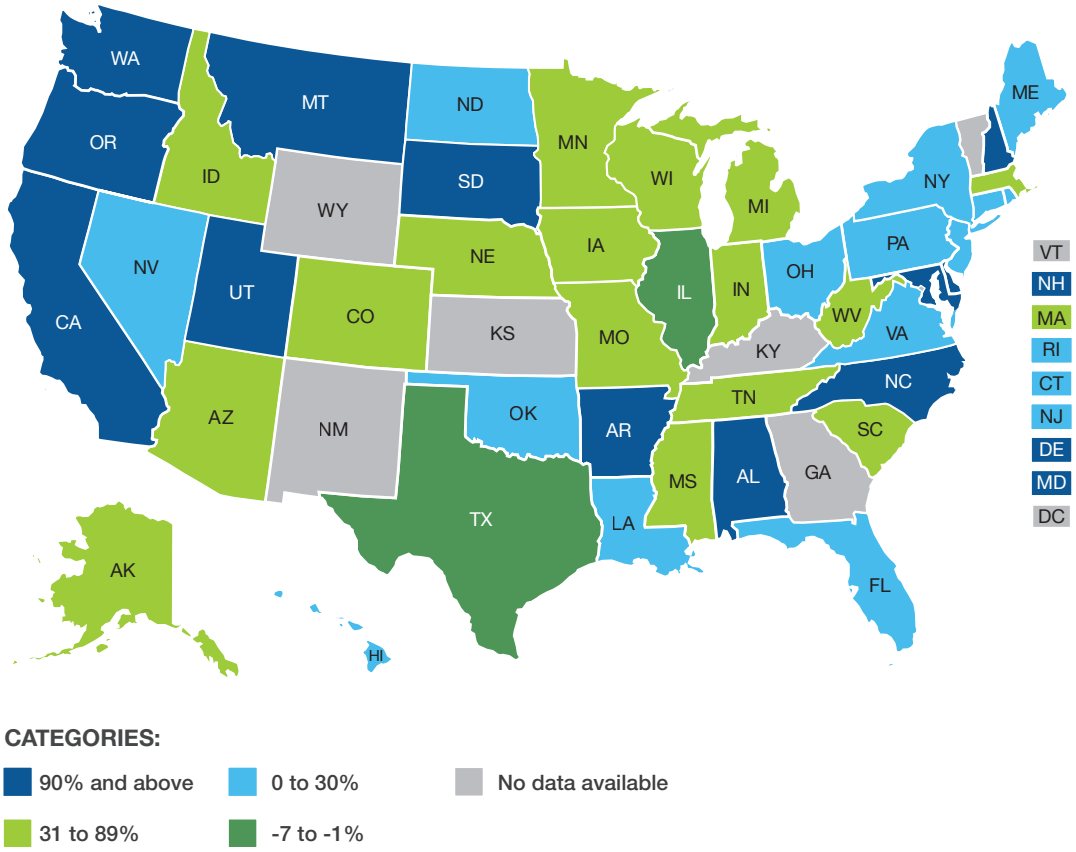
laws and more restrictive probation and parole policies that have put more people in prison and held them there longer.[8] This trend, however, has recently begun to reverse in about half of the states as sentencing and corrections reforms have spurred reductions in prison populations.

The sheer number of state prisoners does not explain all of the increased

FIGURE 1:

Spending on Inmate Health Care Rose in 42 of the 44 States, With Median Growth of 52 Percent Over 7 Years

Correctional health care spending change by state, 2001–08



CATEGORIES:

- 90% and above
- 31 to 89%
- 0 to 30%
- -7 to -1%
- No data available

Note: All spending figures are in 2008 dollars. Nominal fiscal 2001 data provided to Pew by the Bureau of Justice Statistics were converted to 2008 dollars using the Implicit Price Deflator for state and local government consumption expenditures and gross investment included in the Bureau of Economic Analysis' National Income and Product Accounts.

Source: U.S. Department of Justice, Bureau of Justice Statistics

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spending. Higher per-inmate expenses and the expanding slice of corrections budgets devoted to health care suggest that other factors are also pushing costs up, including:

- Aging inmate populations.
- Prevalence of infectious and chronic diseases, mental illness, and substance abuse among inmates, many of whom enter prison with these problems.
- Challenges inherent in delivering health care in prisons, such as distance from hospitals and other providers.

Inmates' health, the public's safety, and taxpayers' total corrections bill are all affected by how states manage prison health care services. Effectively treating inmates' physical and mental ailments, including substance abuse, improves their well-being and can reduce the likelihood that they will commit new crimes or violate probation once released.

In addition to examining spending data, Pew researchers interviewed correctional health care experts across the country to identify innovative strategies to deliver health care to inmates, protect public safety, and control costs.

This report examines Pew's findings on state prison health care spending and explores the factors driving costs higher. It also illustrates a variety of promising approaches that states are taking to address these challenges by examining four strategies that were frequently cited during the expert interviews: the use of telehealth technology, improved management of health services contractors, Medicaid financing, and medical or geriatric parole. These examples offer important lessons as policymakers seek the best ways to make their correctional health care systems effective and affordable.

IMPRISONMENT RATES DECLINE IN MORE THAN HALF THE STATES

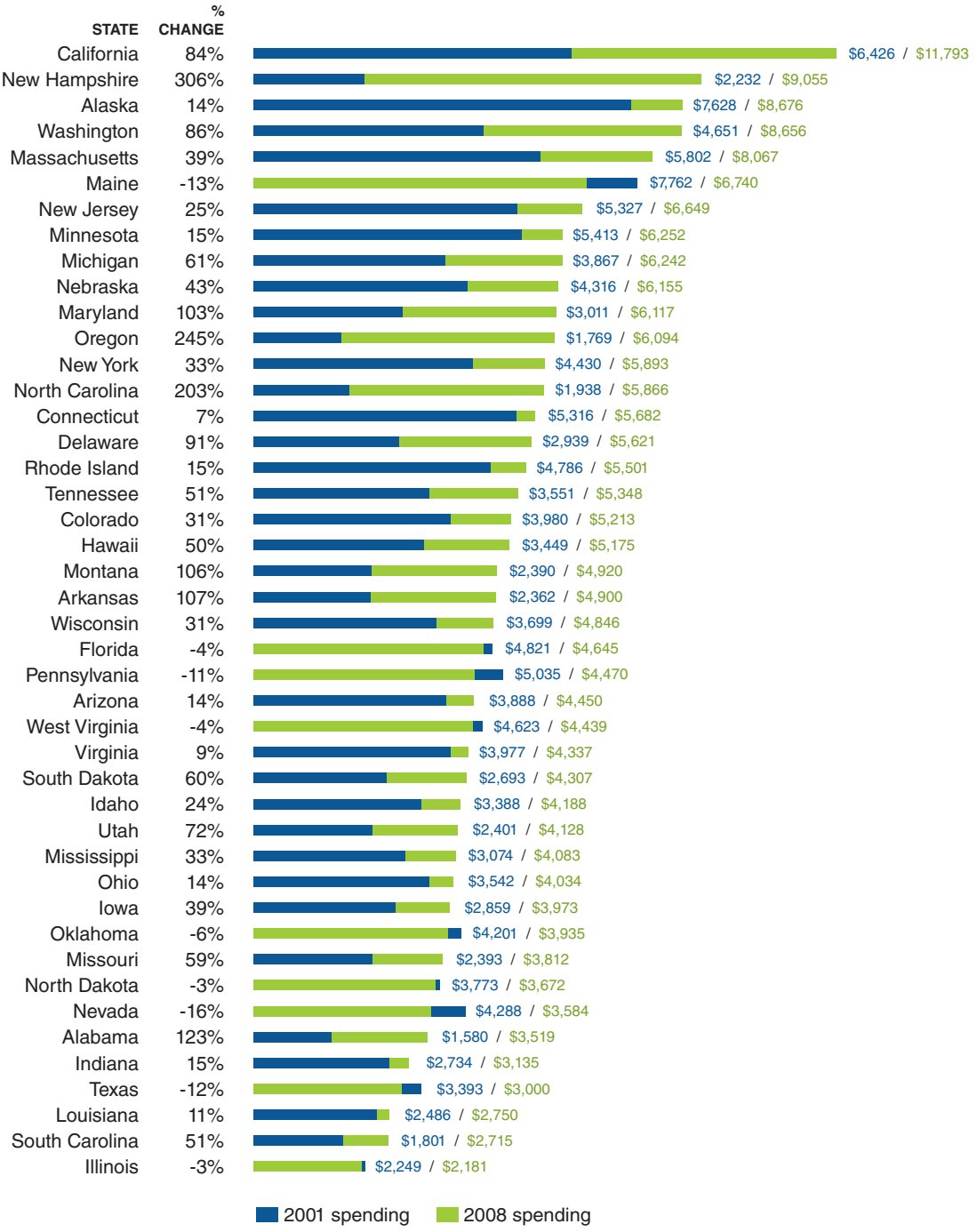
The BJS announced in July 2013 that the number of offenders in state prisons declined for the third straight year in 2012, falling by 2.1 percent.* This downward trend follows four decades of steady growth in state prison populations, which led many states in recent years to analyze and reform their corrections and sentencing policies.

* E. Ann Carson and Daniela Golinelli, "Prisoners in 2012—Advance Counts," Bureau of Justice Statistics, July 2013, http://www.bjs.gov/content/pub/pdf/p12ac.pdf

FIGURE 2:

Per-Inmate Health Care Spending Rose in 35 of the 44 States, With Median Growth of 32 Percent Over 7 Years

Correctional per-inmate health care spending change by state, 2001 and 2008 (2008 dollars)



Notes: No data available for states not listed. All spending figures are in 2008 dollars. Nominal fiscal 2001 data provided to Pew by the Bureau of Justice Statistics were converted to 2008 dollars using the Implicit Price Deflator for state and local government consumption expenditures and gross investment included in the Bureau of Economic Analysis' National Income and Product Accounts.

Source: U.S. Department of Justice, Bureau of Justice Statistics

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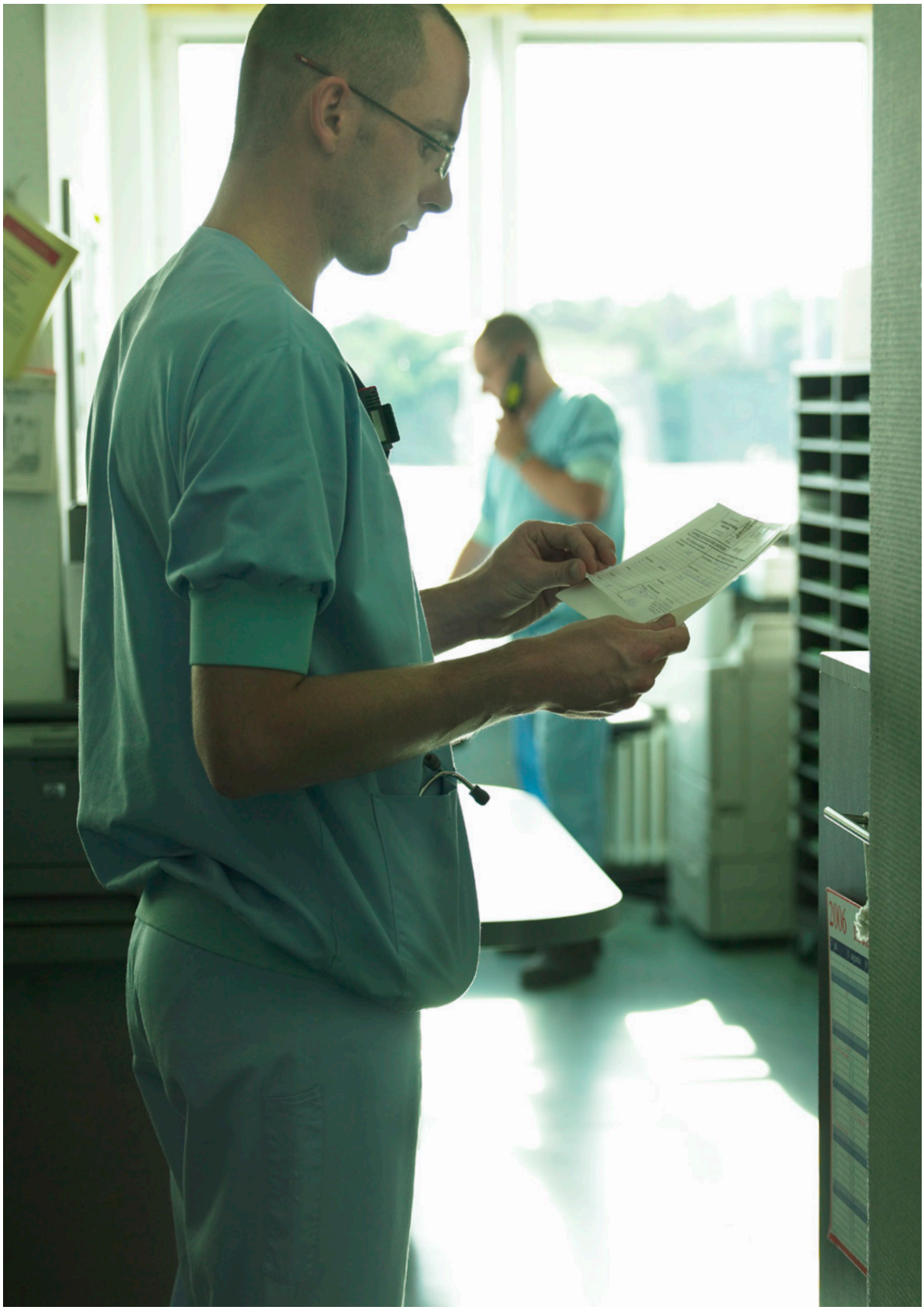


The challenge for states

States differ considerably in how they provide health care to prisoners. Some hire medical practitioners, others contract with private companies or university medical staffs, and many use a hybrid approach.[9] Whichever model is used, many institutions, including those that are accredited by the National Commission on Correctional Health Care, have requirements for timely intake screening, comprehensive exams, and periodic health-maintenance and chronic-illness management consultations.

Inmates who become ill typically submit "sick call" slips that are collected at an appointed time each day. These requests are triaged by the medical staff to determine whether the inmate requires a nurse, doctor, or outside specialist. In emergency situations, offenders usually make their requests through correctional officers, who consult with the on-site medical staff to assess the severity of symptoms and determine a course of treatment. Inmates requiring surgery or dialysis or who exhibit complicated symptoms typically are treated at outside hospitals or transferred to special correctional medical facilities. Large prisons may have infirmaries on their grounds that are capable of handling some of these cases.[10]

Despite these variations, several factors characteristic of most state corrections systems can hinder the delivery of health care and drive up costs.

Location, staffing, and inmate transportation

Some prisons are located in remote places, far from population centers where most medical professionals tend to work. States may have to provide higher-than-average compensation to attract and retain medical staff and may incur considerable overtime and temporary-worker costs if their recruitment efforts fall short. When offenders must travel to see specialists or stay overnight in hospitals, related expenses add up quickly. The Legislative Analyst's Office in California reported that medically related guarding and transportation costs for one inmate can exceed $2,000 per day.[11]

A LEGAL STANDARD FOR CARE

States are legally required to ensure that cost-containment strategies preserve health care quality for offenders in prison. In the landmark 1976 Estelle v. Gamble decision, the U.S. Supreme Court affirmed that prisoners have a constitutional right to adequate medical attention and concluded that the Eighth Amendment is violated when corrections officials display "deliberate indifference" to an inmate's medical needs.† The high court's 1988 decision in West v. Atkins and subsequent lawsuits established that this standard also applies to private medical contractors. Over time, other litigation has influenced standards and practices at the state level. In some instances, court decisions require states to expand or improve medical services, upgrade facilities, or increase staff.

† William J. Rold, "Thirty Years After Estelle v. Gamble: A Legal Retrospective," Journal of Correctional Health Care 14:1 (January 2008): 11–20.

Prevalence of mental illness and disease

Inmates have a higher incidence of mental illness and chronic and infectious diseases, such as AIDS and hepatitis C, than the general population.[12] These conditions, many of which exist prior to incarceration, are costly to treat and place a significant burden on state correctional budgets, which assume the entire cost of care.

Estimates of the prevalence of hepatitis C in prisons vary across the country, indicating regional differences in high-risk behaviors such as intravenous drug use. A weighted average derived from a survey of state correctional department medical directors, conducted in 2011 and 2012, placed the national rate of hepatitis C among inmates at 17.4 percent in 2006.[13] By way of comparison, roughly 1 percent of all U.S. residents have chronic hepatitis C infection. More conservative research estimates the prevalence of hepatitis C among prisoners at seven times that of people outside prison walls.[14]

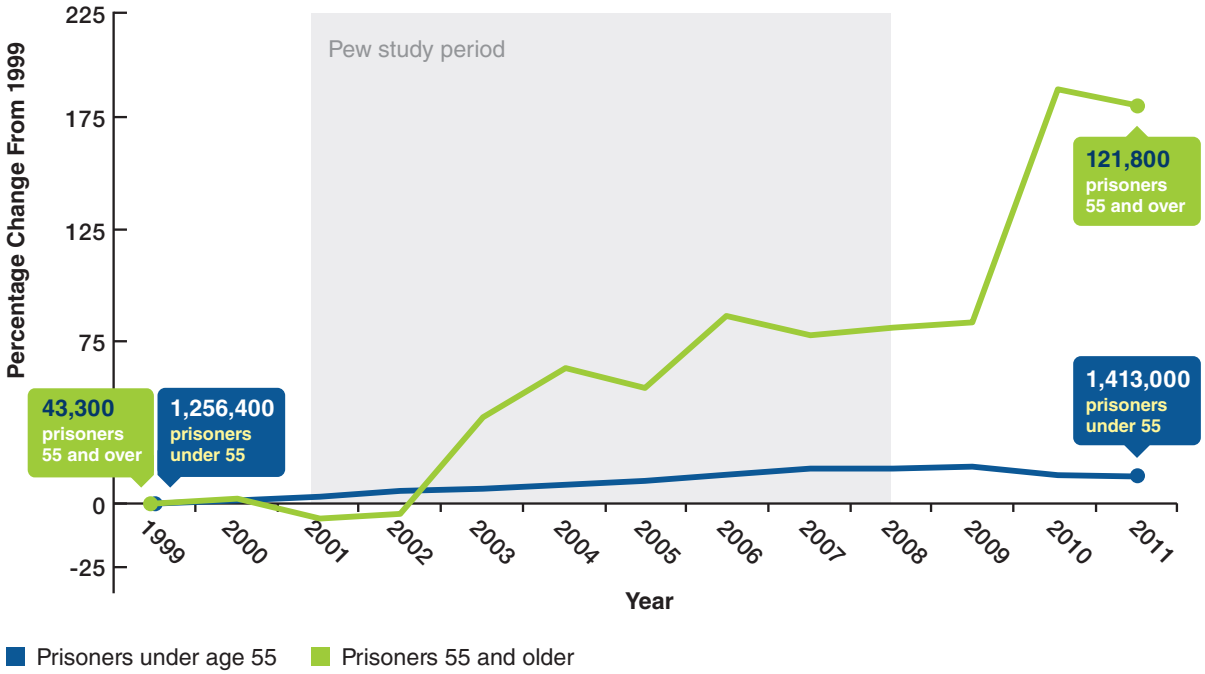
Older inmates, greater expense

A newer development pushing up correctional health care costs is a dramatic increase in inmates who, partly because of lengthy prison sentences, have grown old behind bars and tend to require more health care than younger inmates. From 2001 to 2008, the number of state and federal prisoners age 55 or older increased 94 percent, from 40,200 to 77,800. During the same period, the number younger than 55 grew more slowly: up 12 percent, from 1.3 million to 1.46 million.[15] This trend continued in succeeding years.[16]

FIGURE 3:

Nationwide, the Number of Prisoners Age 55 and Older Rose Sharply Over the Past Decade

Percentage change in sentenced prison populations by age group, state and federal, 1999-11



Note: The Bureau of Justice Statistics estimates the age distribution of prisoners using data from the Federal Justice Statistics Program and statistics that states voluntarily submit to the National Corrections Reporting Program. State participation has varied, which can cause year-to-year fluctuations in the Bureau's estimates but does not affect long-term trend comparisons. Between 2009 and 2010, the number of states submitting data increased substantially.

Source: U.S. Department of Justice, Bureau of Justice Statistics
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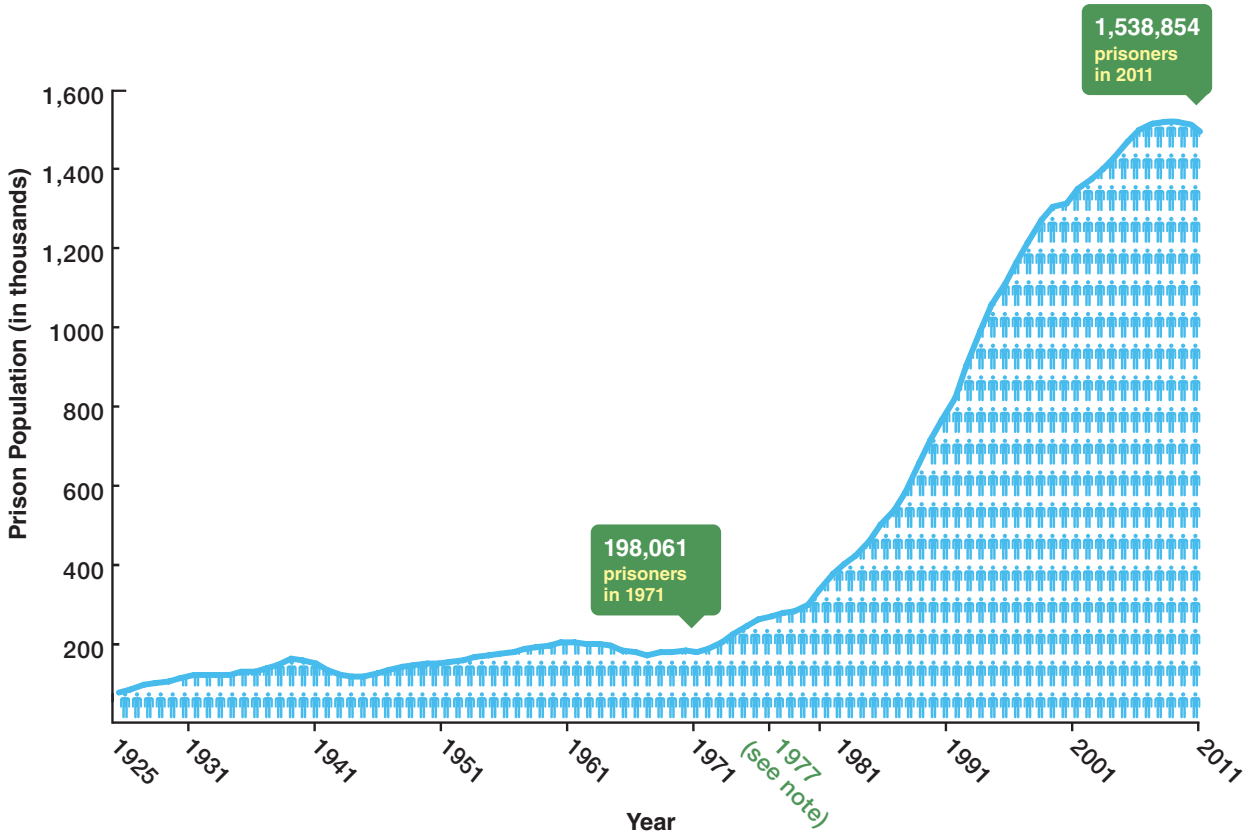
The graying of American prisons stems largely from the use of longer sentences as a public safety strategy over the past two decades. From 1984 to 2008, the number of state and federal prisoners serving life sentences more than quadrupled to 140,610, or 1 in 11 prisoners. Nearly a third of these inmates were ineligible for parole. The proportion of prisoners with life sentences has continued to rise, reaching 1 in 9 by 2012.[17] Many of today's older inmates were convicted of serious, violent felonies in their younger years.

A second factor in the aging incarcerated population is increasing admissions of older offenders to prison. From 2001 to 2008, new commitments of inmates age 55 and older increased by 55 percent, from 5,750 individuals to 8,914,

FIGURE 4:

The National Prison Population Skyrocketed 677 Percent From 1971 to 2011

U.S. prison population growth, sentenced state and federal inmates, 1925-11



Note: Annual figures prior to 1977 reflect the total number of sentenced prisoners in custody. Beginning in 1977, all figures reflect the jurisdictional population as reported in the Bureau of Justice Statistics' "Prisoners" series.

Sources: Sourcebook of Criminal Justice Statistics, University at Albany; U.S. Department of Justice, Bureau of Justice Statistics
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compared with an 8 percent increase among all age groups, from 294,147 to 316,475.[18]

Like senior citizens outside prison walls, elderly inmates are more susceptible to chronic medical and mental conditions, including dementia, impaired mobility, and loss of hearing and vision. In prisons, these ailments necessitate increased staffing levels, more officer training, and special housing—all creating additional expense. Medical experts say inmates typically experience the effects of age sooner than people outside prison because of issues such as substance abuse,

inadequate preventive and primary care prior to incarceration, and stress linked to the isolation and sometimes-violent environment of prison life.[19]

Together, these factors have a substantial impact on prison budgets. The annual cost of incarcerating prisoners age 55 and older with chronic and terminal illnesses is, on average, two to three times that of the expense for all other inmates, particularly younger ones:[20]

- **Virginia's** geriatric inmates, defined by the state as age 50 and older, incurred an average of $5,372 each in off-site medical expenses in fiscal 2010, compared with only $795 per inmate under 50.[21]
- A report by the **Michigan** Senate Fiscal Agency found that the $11,000 annual cost of medical care for an average inmate age 55 to 59 in 2009 was more than four times that of an offender age 20 to 24.[22]
- In **Georgia**, medical care for each prisoner age 65 and older—a more elderly cohort—costs the state an average of $8,565 per year, compared with $961 for those under 65.[23]

State responses to growing costs

These cost drivers, as well as the overall size of prison populations, are straining state budgets. In response, corrections officials are pursuing ways to rein in costs without sacrificing either the quality of care or public safety. The experts interviewed by Pew said these approaches include use of telehealth technologies, outsourcing of prison health care, enrollment of prisoners in Medicaid, and paroling of elderly and/or ill inmates.

Telehealth

Many states are using electronic communications and information technology to provide or support clinical care, a strategy that has been shown to produce savings and improve care for inmates. In 2010, 26 of 44 states surveyed by the American Correctional Association were using telehealth in some fashion to deliver medical services to inmates.[24]

Videoconferencing between an off-site doctor and an incarcerated offender is a common application of telehealth in correctional settings. Exam cameras, monitors, and electronic stethoscopes allow doctors to capture vital signs and treat patients remotely while nurses or physician assistants at the correctional facilities operate equipment and provide support. Telehealth is expanding into psychiatry, radiology, cardiology, neurology, and even emergency care. In Colorado, for example, most psychiatric consultations are done via telehealth.[25] In Texas, many prisoners complaining of chest pain are now connected to monitors and evaluated by an off-site clinician to determine whether a hospital visit is needed. In the past, the typical response to such symptoms was an immediate trip to a hospital.[26]

For correctional facilities, the technology's greatest cost-cutting benefit lies in bridging the distances between prisons and medical professionals. By allowing inmates to consult with primary care physicians and specialists without leaving prison grounds, telehealth eliminates transportation and guarding expenses, can reduce the time needed to determine a diagnosis and begin treatment, and avoids any public safety risks associated with taking inmates out of prison. In Georgia, where corrections spending totaled $1.5 billion in fiscal year 2011, telehealth saved about $9 million—approximately $500 per telehealth

encounter—in corrections officer pay and transportation costs in fiscal year 2012.[27] In California, the savings are roughly four times that amount per encounter, according to the state's nonpartisan Legislative Analyst's Office.[28]

A 1999 report sponsored by the National Institute of Justice found cost savings associated with a telehealth pilot project in four federal prisons.[29] The study also described how telehealth contributed to better care for inmates by expanding the types of medical specialists available and reducing the time between referrals and initial consultations from an average of 99 days to 23 days.

Delivering better, cheaper care with telehealth in Texas

Texas, with its vast open spaces, has employed telehealth for years. A recent estimate by the University of Texas Medical Branch, which provides care for a large proportion of the state's inmates, suggests that telehealth saved Texas $780 million from 1994 to 2008.[30]

In the early 1990s, the state's prisons were grappling with a shortage of doctors and escalating health care costs, driven in part by a growing number of inmates with chronic health problems and the need to transport them long distances for care. Many inmates were not properly evaluated before being transferred for hospitalization, leading to unnecessary admissions. In 1994, the university contracted to provide care for most inmates and began investing in telehealth. Texas Tech University, which serves the balance of the state's inmates, also makes extensive use of the technology.[31] During fiscal 2012 alone, Texas recorded 83,738 telehealth encounters, mostly in psychiatry and primary care.[32]

"Telehealth has greatly improved access to quality care for our offenders, because we are no longer dependent on providers in remote areas to see patients," says Dr. Owen Murray, vice president of offender care services for the University of Texas Medical Branch. "[It] allows us to … get patients treated before they reach the point where they need emergency care. It's about the timely delivery of services."[33] The university has established a standard

> "Telehealth is allowing us to get patients seen, meet our contractual standards, and do it all at a lower cost than if we had to move them out of prison to an off-site provider or bring that provider to them."
>
> —Stephen Smock, University of Texas Medical Branch's associate vice president, Correctional Outpatient Services*

* The Pew Charitable Trusts interview with Stephen Smock, associate vice president, Correctional Outpatient Services, University of Texas Medical Branch, December 2, 2012.

that an inmate referred by a physician for further treatment should be examined within 10 days. In fiscal 2012, this benchmark was met 97 percent of the time.[34]

Texas officials estimate that telehealth, combined with the use of electronic medical records, preferred drug lists, and close adherence to disease-management guidelines, led to several positive outcomes from 1994 to 2003. Together, these practices helped lower average blood sugar rates for inmates with diabetes by 18 percent, improved blood pressure readings for those with hypertension, and contributed to an 84 percent reduction in AIDS-related deaths.[35]

TELEHEALTH IN CONTRACTS

States that partner with private companies to deliver inmate health care can require those vendors to employ telehealth. In Michigan, for example, a contract completed in 2009 mandated the expansion of telehealth, and today all of the state's correctional facilities have telemedicine capabilities.*

* Steve Angelotti and Sara Wycoff, "Michigan's Prison Health Care: Costs in Context," Michigan Senate Fiscal Agency, November 2010, http://www.senate.michigan.gov/sfa/Publications/Issues/PrisonHealthCareCosts/PrisonHealthCareCosts.pdf

Expanding telehealth in California

A robust telehealth program is now under development in California following a gradual expansion of high-speed network infrastructure in the states' prisons and the creation of a system to schedule and track inmate medical appointments.[36]

Inadequate access to a high-speed Internet connection is a common barrier to the use of telehealth in prisons. Another is startup capital costs. Institutions must purchase telehealth carts, or T-carts, which are stocked with audiovisual and diagnostic equipment used to transmit information outside the prison. One estimate pegs the cost of these carts at $30,000 to $45,000 per institution.[37]

California has made such investments over the past decade, contributing to an increase in the number of telehealth encounters from about 9,000 in fiscal 2005 to about 23,000 in fiscal 2011, a period when the inmate population actually fell 12 percent. The California Legislative Analyst's Office estimates that expanding telehealth could save up to $15 million annually by reducing inmate transportation and guarding costs and potentially facilitating lower contract costs with outside physicians.[38]

Advances in outsourcing care

Many states have looked to outside partners, such as public university medical centers or for-profit companies, to provide all or part of their prison medical, dental, and mental health care at lower costs. Beyond deciding whether to outsource services, policymakers and corrections officials need to consider how they will ensure that contractors meet state goals for quality and cost. Some states have gained more control over spending on outsourced correctional health care through capitated contracts, under which providers agree to deliver services at a fixed reimbursement rate.[39] Others have also attached performance standards and tracking systems to their outsourcing contracts so that the timeliness and effectiveness of prisoners' treatment is continuously monitored and improved.

University partnerships in New Jersey and Connecticut

University Correctional Health Care, or UCHC, was established in 2005 through an interagency agreement between the New Jersey Department of Corrections and the University of Medicine and Dentistry of New Jersey (since absorbed by Rutgers, the State University of New Jersey). Initially the agreement was limited to mental health and sex offender treatment, but it was expanded in 2008 to include all medical and dental health care for 24,000 inmates held in 13 adult correctional facilities, as well as juvenile offenders and parolees.

Cost savings—which are recouped by the state, not held as profit by Rutgers—have been significant. In 2008, correctional health expenditures were $10 million below the budgeted amount, and overall costs remained mostly flat thereafter, according to Jeff Dickert, vice president of UCHC at Rutgers.[40]

Successful cost-containment initiatives have included the use of a peer review process to determine the medical necessity of specialist referrals, and reductions in emergency room visits by handling more of patients' care in prison infirmaries. By using evidence-based treatment guidelines and formulary controls, among other efforts, UCHC has succeeded in reducing prescription drug costs to a six-year low.[41]

Evidence shows that UCHC's approach to care contributed to positive health outcomes for inmates. In 2012, for example, blood pressure readings were within normal limits for 89 percent of New Jersey inmates previously diagnosed with hypertension, far higher than the share of hypertensive U.S. adults outside of prisons who have their blood pressure under control.[42] Eighty-five percent of HIV-infected inmates who received treatment for at least six months had undetectable viral loads (the level of active HIV in their blood). In comparison, only 77 percent of adult HIV patients

nationwide had a suppressed viral load in 2010.[43] In addition, the requirements of two prisoner rights lawsuits have been satisfied, and the state reports a 42 percent reduction in inmate medical complaints from 2007 levels. In 2013, the New Jersey Hospital Association honored UCHC with its Excellence in Quality Improvement award.[44]

Connecticut officials report similarly positive results from a partnership between the state's Department of Correction and the University of Connecticut Health Center. In 1997, the university's Correctional Managed Health Care Division, or CMHC, assumed responsibility for all medical, mental health, pharmacy, and dental services within the state's combined system of prisons and local jails.

Citing cost-containment strategies similar to those used in New Jersey, Connecticut has consistently kept costs under budget, saving the state $28 million from fiscal 2009 to 2013, according to Dr. Robert Trestman, CMHC executive director.[45] CMHC has also succeeded in keeping down blood pressure levels of hypertensive inmates.

Both Trestman and Dickert see an intrinsic benefit to these interagency agreements. "Universities are always looking to do things better, so while we have a contract with the Department of Corrections, every day is a new day, and we are constantly looking for creative ways to maximize quality of care and be good stewards of taxpayer dollars," says Dickert. "These partnerships make sense. Both parties work for the state, and neither is driven by profit."[46]

"With academic institutions, there is a mission at the core of what we do," Trestman notes. "And we are also embedded in the community, which gives us a better sense of what's important in terms of continuity of care" when inmates are released.

Capitated contracts in California

In 2011, California hired Health Net Federal Services to maintain a statewide network of outside specialists for its 33 prisons, eliminating the state's burden of managing hundreds of individual contracts. The move saved an estimated $24 million annually in succeeding years.[47] "Prior to Health Net, we couldn't close contracts, we couldn't keep up, and we used a lot of hospitals and providers despite having no contract at all," says J. Clark Kelso, California's prison health care receiver. "Now we have one-stop shopping for specialists and hospital care, and the savings have been tremendous."[48] Shortly before the contract went out to bid, California armed itself with a fiscal advantage: The Legislature imposed statutory caps on the amount the corrections system could pay providers and hospitals, ranging from 110 percent to 130 percent of Medicare rates. These limits

were designed to strike a balance between controlling expenditures and attracting willing providers. Texas passed a similar law in 2011 to help contain costs.[49]

Tracking performance in Kansas

Critics of privatization express concern that for-profit companies put their interest in cutting costs ahead of providing high-quality medical care. To help preserve the quality of care for inmates served by health care contractors, Kansas specifies and monitors performance measures and imposes penalties on providers when standards are not met. If an inmate fails to receive a physical exam within seven days of admission to prison, for example, the provider must pay a $100 fine.

"The key is oversight, and our data collection system allows me to track which inmate did not receive a physical exam, and if not, why not," says Viola Riggin, director of health care services for the Kansas prison system. "We also monitor various quality indicators to ensure that patients with chronic diseases such as cancer or diabetes are receiving timely care."[50]

Riggin adds that requiring contractors to meet clear benchmarks has improved inmates' satisfaction with their care, as evidenced by a dramatic decline in grievances and lawsuits. Overall, she said, outsourcing accompanied by strong oversight has helped control costs in Kansas, where state officials expected to reduce per-inmate health care spending by 11 percent between fiscal 2012 and 2013.

Medicaid financing

To date, just a handful of states have pursued Medicaid financing for eligible prisoners' health care services. Still, the results of these efforts hold lessons for all states, especially those that elect to expand their Medicaid programs under the Affordable Care Act, or ACA.

The relatively rare use of Medicaid to finance prison health care is due in part to state and federal policies governing the jointly funded program, which limit both the number of eligible inmates and the types of care covered. These factors have restrained the potential savings states could realize through this strategy. Currently, federal law requires states to cover only certain populations, such as low-income children and low-income pregnant women, through their Medicaid programs. Inmates who fall into one of these categories are eligible for Medicaid, and if they are enrolled in the program, states can seek federal matching funds to pay for some health care services that these prisoners receive. Most inmates, though, are nondisabled adults without dependent children, a group generally not eligible for Medicaid.[51]

In states that expand their Medicaid programs under the ACA in 2014, however, coverage will be available to

low-income childless adults, making more prisoners eligible. These states also will receive an enhanced federal reimbursement rate for newly enrolled inmates' care.

The ACA will not remove a second long-standing constraint on Medicaid financing of prisoners' health care. In 2014, as now, the federal government will offer coverage only for inpatient health services delivered beyond prison walls, such as when an offender is hospitalized. Care provided within a prison will not qualify for reimbursement. So states could expect Medicaid to cover a relatively infrequent albeit expensive portion of prisoners' health care.

Medicaid financing achieves savings for states

Though few in number, the states that have initiated Medicaid financing for inmates' health care have quickly achieved savings for two reasons: (1) Federal reimbursements cover at least 50 percent of inmates' inpatient hospitalization costs,[52] and (2) Medicaid typically pays the lowest rates of any payer in a state because of its negotiating power. Therefore, this approach represents both an important new funding source and a cost-containment strategy.

- **Mississippi's** program, launched in 2009, saves about $6 million annually through federal reimbursements for the cost of eligible inmates' care, according to the state Department of Corrections.[53]
- **Louisiana** saved a total of $2.6 million in fiscal years 2009 and 2010.[54]
- **New York** reported initial federal Medicaid reimbursements of $4.5 million as of December 2012. The state's comptroller estimates that as much as $20 million could be saved annually—a projection that does not account for New York's 2014 ACA Medicaid expansion or enhanced match rate, which would increase the annual savings beyond the comptroller's estimate.[55]

Programs such as these, as well as future efforts as part of the Medicaid expansion, are possible under a federal rule adopted in 1997 allowing states to seek federal Medicaid reimbursement for inpatient care provided to eligible inmates outside prison walls. Medicaid-enrolled offenders must be admitted for more than 24 hours to an inpatient facility such as a hospital, nursing home, or psychiatric center for the state to receive a federal match. This typically occurs only when inmates need specialty or emergency care that the prison cannot provide.

Because of these restrictions and the current limitations on prisoners' Medicaid eligibility, most states have elected not to pursue this savings strategy.

Affordable Care Act expands inmate eligibility

As of September 30, 2013, 25 states had opted to participate in the Medicaid expansion, authorized under the ACA, beginning in 2014.[56] These states will cover Americans under age 65 whose income is less than 138 percent of the federal poverty level. Virtually all inmates are below that threshold, making them eligible for Medicaid under the new rules in expansion states. Moreover, the federal government will initially reimburse 100 percent of the cost of covered services for all newly eligible enrollees, including inmates, with the federal matching rate gradually decreasing to 90 percent by 2020.

The recent experience of California, which in fiscal 2011 spent more than $8 billion on prisons and other corrections costs, gives a sense of the savings that states could realize under the expanded eligibility.[57] California received permission from federal authorities in 2010 to phase in coverage for non-pregnant adults who make less than 133 percent of the federal poverty level—a group that includes nearly 75 percent of inmates in the state—before the 2014 expansion.[58] Legislators directed the Department of Corrections and Rehabilitation to begin enrolling eligible prisoners and claiming federal reimbursements for covered services, which, though narrow in scope, cost the state roughly $100 million a year. From April 2011 to December 2012, the state was reimbursed $5 million. If its Medicaid eligibility is expanded in 2014, California stands to save nearly $70 million annually, according to its Legislative Analyst's Office.[59]

Other states also project significant savings on correctional health care from expanding their Medicaid eligibility. In New Hampshire, where Governor Maggie Hassan, a Democrat, described the ACA's Medicaid expansion as "a good deal," a study commissioned by the state's Department of Health and Human Services estimated that the state Corrections Department would save nearly $22 million from 2014 to 2020 as a result of expanded Medicaid coverage for inpatient care.[60]

A study estimating the fiscal and economic effects of expanding Ohio's Medicaid eligibility found that the state correctional system would save $273 million from fiscal 2014 to 2022.[61] Governor John Kasich, a Republican, has voiced his support for expanding the program in accordance with the reform law.[62]

In Michigan—where Governor Rick Snyder, a Republican, characterized the expansion of his state's Medicaid program as "an opportunity for savings"—the state stands to save roughly $250 million on inpatient hospital services delivered to prisoners during the first 10 years of implementation, according to the Center for Healthcare Research & Transformation at the University of Michigan.[63]

PROTECTING THE PUBLIC BY PREVENTING GAPS IN HEALTH COVERAGE

Research demonstrates that effective health care, particularly treatment for substance abuse and certain mental health conditions, such as cognitive-behavioral treatment, can reduce the likelihood that offenders will return to prison for new crimes or parole violations.* But states have frequently struggled to ensure that eligible individuals are enrolled in health care programs when they exit prison or while under community supervision.

One major reason is that most states terminate a Medicaid enrollee's coverage upon incarceration, making it necessary for the offender to re-enroll later—a potentially difficult process to navigate when behind bars or making the transition back to the community. To help alleviate this problem, federal officials indicated that instead states may suspend inmates' coverage and reinstate it when they are discharged from prison. Further, beginning in 2014, many offenders will qualify for Medicaid in states that participate in the ACA expansion, improving their access to care after release.

Oklahoma illustrates how states can further promote health coverage among eligible ex-offenders. A program started in 2007 helps inmates with severe mental illness apply for federal disability and Medicaid benefits during their final months in prison. The effort produced impressive results: After a year, the share of inmates with severe mental illness who were enrolled in Medicaid on their day of release had increased by 28 percentage points.†

States that expand their Medicaid programs may also consider using suspension as opposed to termination for their incoming prisoners, more of whom will be eligible and enrolled in Medicaid after January 2014. This may also facilitate the use of Medicaid to pay for inmates' inpatient care during incarceration.

* Steve Aos, Marna Miller, and Elizabeth Drake, "Evidence-Based Adult Corrections Programs: What Works and What Does Not," Washington State Institute for Public Policy, 2006, http://www.wsipp.wa.gov/rptfiles/06-01-1201.pdf; Elizabeth Maier, Peter Wicklund, and Max Schlueter, "Evidence-Based Initiatives to Reduce Recidivism," Vermont Center for Justice Research, December 2011, http://66.147.244.94/~vcjrorg/reports/reportscrimjust/reports/ebiredrecid_files/DOCRR%20LitRev%20Report.pdf; Fred Osher et al., "Adults With Behavioral Health Needs Under Correctional Supervision: A Shared Framework for Reducing Recidivism and Promoting Recovery," Council of State Governments Justice Center, 2012, http://www.asca.net/system/assets/attachments/4908/9.27.12_Behavioral_Framework_v6_full.pdf?1348755628; David Mancuso and Barbara E.M. Felver, "Providing Chemical Dependency Treatment to Low-Income Adults Results in Significant Public Safety Benefits," Washington State Department of Social and Health Services Research and Data Analysis Division, February 2009, http://www.dshs.wa.gov/pdf/ms/rda/research/11/140.pdf; Melissa Ford Shah, et al., "The Persistent Benefits of Providing Chemical Dependency Treatment to Low-Income Adults," Washington State Department of Social and Health Services Research and Data Analysis Division, November 2009, http://www.dshs.wa.gov//pdf/ms/rda/research/4/79.pdf.

† U.S. Department of Health and Human Services, "Establishing and Maintaining Medicaid Eligibility upon Release from Public Institutions," 2010, http://store.samhsa.gov/shin/content/SMA10-4545/SMA10-4545.pdf.

Medical or geriatric parole

With America's incarcerated population growing older, sicker, and more expensive to care for, states are beginning to adopt or expand laws and policies allowing medical or geriatric parole for elderly inmates and those who are terminally ill or incapacitated. Typically, they contain strict eligibility criteria that exclude certain types of offenders: sex offenders, for instance, or those serving life terms with no possibility of parole. Many allow the release only of inmates who are unable to perform basic activities of daily living, such as feeding and bathing themselves.[64] Eligible inmates must be deemed to pose little or no threat to public safety.[65]

Because of the high cost of incarcerating older prisoners with chronic and terminal illnesses, medical or geriatric parole policies can achieve notable savings, even if the state retains financial responsibility for those individuals' health care costs outside prison.[66]

Reductions in guarding and transportation expenses, especially for inmates receiving care in community settings, yield much of the savings. In 2011, for example, California identified 25 "permanently medically incapacitated" inmates being treated at outside hospitals who were recommended for medical parole because they no longer posed a public safety threat. The state estimated that, should they remain incarcerated, it would spend more than $50 million on those inmates that year, including as much as $21 million for correctional officers' salaries, benefits, and overtime.[67] Medical parole can also reduce expenses associated with building special protective housing for disabled and frail inmates.[68]

Lower risk of recidivism

Evidence suggests that release of elderly prisoners, particularly those with debilitating illnesses, poses far less public safety risk than release of younger inmates. A BJS study that followed 272,111 offenders for three years after their release in 1994 found that those who were age 45 or older when released were roughly half as likely to return with a new sentence as those ages 18 to 24.[69]

State-specific recidivism data indicate similar trends:

- In **Wisconsin**, the rate of inmates age 60 or older released in 2005 who went back to prison within two years was less than half that of offenders ages 17 to 25.[70]
- **Florida's** Department of Corrections found similar results for prisoners age 65 and older released from 2003 to 2010, and the trend held for the full seven years the state tracked them.[71]
- Among **New York** inmates ages 50 to 64 released from 1985 to 2008, less than 7 percent returned to prison on new convictions, and for older inmates, the figure was 4 percent.[72]

FEDERAL SUPPORT FOR COMPASSIONATE RELEASE

At the federal level, the Justice Department's independent inspector general concluded in an April 2013 report that "an effectively managed compassionate release program would result in cost savings for the [Federal Bureau of Prisons], as well as assist the BOP in managing its continually growing inmate population and the resulting capacity challenges it is facing. We further found that such a program would likely have a relatively low rate of recidivism."*

U.S. Attorney General Eric H. Holder Jr. echoed these sentiments in August 2013 when he announced new Justice Department policies that, among other things, would expand the use of compassionate release for elderly inmates who did not commit violent crimes, have served significant portions of their sentences, and are judged to pose little threat to public safety.† Careful consideration of eligible inmates' applications for release, he said, is the "fair" and "smart" thing to do.

* U.S. Department of Justice, "The Federal Bureau of Prisons' Compassionate Release Program," April 2013, http://www.justice.gov/oig/reports/2013/e1306.pdf.

† U.S. Department of Justice, "Attorney General Eric Holder Delivers Remarks at the Annual Meeting of the American Bar Association's House of Delegates," August 2013, http://www.justice.gov/iso/opa/ag/speeches/2013/ag-speech-130812.html.
gov/sfa/Publications/Issues/PrisonHealthCareCosts/PrisonHealthCareCosts.pdf

Challenges of medical or geriatric parole

By late 2009, 15 states and the District of Columbia had geriatric release provisions in place, and 39 states had medical parole statutes for inmates with terminal or debilitating conditions.[73] But in practice, states have released relatively few people. Narrow eligibility criteria, complicated applications, lengthy review processes, challenges in assessing medical suitability, and a shortage of nursing home spaces for such offenders are key barriers. Another significant obstacle is opposition among policymakers and citizens to the concept of medical or geriatric parole, because many older and infirm prisoners were convicted of violent crimes or sentenced under habitual-offender laws.

Recent events in Wisconsin illustrate these political sensitivities. The state instituted medical and geriatric parole in 2001, allowing inmates to petition a sentencing court for early release because of age or medical condition. In 2009, the law was amended to broaden the category of eligible inmates and streamline the procedure for sentence modification. The original law's exclusion of elderly inmates serving life sentences was eliminated, and release was no longer limited to inmates with terminal illnesses. Instead, prisoners were required to demonstrate the existence of an "extraordinary health condition," such as advanced age, infirmity, or a disability.[74] The law also moved decision-making from the sentencing court, made

up of elected judges, to an administrative panel with a chairperson nominated by the governor and confirmed by the state senate for a two-year term.

Fifty-five inmates petitioned for early release in the months after the amendment's passage, and eight were granted parole.[75] But opposition began building before implementation, driven largely by lawmakers and residents who considered the expanded eligibility to be dangerous policy. In 2011, the state Legislature repealed most of the 2009 changes to the law.

Recent state reforms

Despite political and other barriers, a number of states recently expanded geriatric and medical parole programs as part of ongoing efforts to reduce rising correctional health care costs:

- In 2011, **Louisiana** policymakers expanded parole eligibility for elderly prisoners. Nonviolent inmates who are at least 60 years old, have served more than 10 years, and have been designated as low-risk by the state's Department of Public Safety and Corrections, among other requirements, may apply for parole consideration.[76] Burl Cain, the Louisiana State Penitentiary warden, was among the law's supporters. "I'd rather have predators in those beds instead of dying old men," Cain said as the bill was moving through the state Legislature.[77]
- **Ohio** also passed geriatric parole legislation in 2011 as part of a larger package of criminal justice reforms projected to save the state $46.3 million over three years and reduce the prison population by more than 7 percent.[78] A measure in the package that permits the Ohio Department of Rehabilitation and Correction to petition for judicial release of certain inmates who have served 80 percent of their sentences (among other requirements) was expected to account for a sizable portion of the savings.[79]

  But events that followed the law's adoption suggest that change will be difficult. The law required the department to review the cases of all parole-eligible inmates age 65 or older who had participated in at least one parole hearing and justify in a report to the Legislature why these inmates had not been released. The review identified 347 eligible inmates, none of whom were recommended for an immediate early-release hearing.[80] Explanations included the seriousness of inmates' original offenses, subsequent crimes committed while on parole previously, and significant community opposition.
- **New York** expanded the eligibility requirements of its medical parole policy in 2009 to include any inmate who is judged not to be a threat to

society, is chronically or terminally ill, is physically or cognitively incapacitated, and has served at least half of his or her sentence. Those convicted of first-degree murder are ineligible. The state expected the expansion to save $2 million annually.[81]

- **California** sought in 2010 to build on its rarely used compassionate release program for terminally ill inmates by adopting a new law allowing medical parole for incapacitated prisoners. But amid concerns that released prisoners could harm public safety, eligibility was restricted to inmates who require 24-hour nursing. "Everybody is worried that someone is going to wake up from a coma and do something terrible," says Kelso, the prison health care receiver and a strong advocate of the law. "You need to go slow, be patient, and be very careful about who is in the pipeline." [82]

  As of October 2012, California had granted medical parole to 47 inmates under the revised law, reducing correctional health care spending more than $20 million, primarily by reducing associated guarding and transportation expenses. Released parolees were in comas, had extensive brain damage or severe Alzheimer's disease, or were in the final stages of another chronic disease. Eighteen of the original 47 had died by October 2012.[83]

- In 2012, **Connecticut** took a major step toward expanding its medical parole and compassionate release program. Legislators voted to give the correction commissioner discretion to release severely debilitated inmates from custody for palliative and end-of-life care. But simply granting that authority did not solve a problem that Connecticut shared with many other states: a shortage of facilities to house and care for ill or incapacitated offenders upon parole. The state had long struggled to find private nursing homes willing to take offenders who had reached the end of their sentences and had no families to care for them, or were cleared for compassionate release or medical parole.[84]

  To resolve the problem, corrections officials contracted with a private company that bought a 95-bed nursing home to house released offenders and mentally ill patients from the community who were under state care. Moving eligible prisoners to this facility reduces custody expenses for the state, which also expects to receive federal matching funds for Medicaid-enrolled parolees.[85] The plan also eliminates the need to construct a multimillion-dollar correctional nursing home.[86] Nearby residents, however, tried unsuccessfully to prevent the converted facility from opening.[87]

A STANDARDIZED FRAMEWORK FOR MEDICAL AND GERIATRIC PAROLE

A group of researchers, led by two geriatrics specialists at the University of California, San Francisco, have proposed the creation of national guidelines for medical and geriatric parole by an independent panel of palliative medicine, geriatrics, and correctional health care experts.* The group's recommendations were inspired by two primary criticisms of most states' medical and geriatric parole policies:

1. First, the group considers the medical eligibility criteria in most states to be clinically flawed, in part because they frequently require physicians to predict limited life expectancy and functional decline. Such requirements exclude prisoners with severe but not near-death illnesses (such as dementia) who are incapable of causing harm, participating in rehabilitation, or experiencing punishment.
2. Second, the researchers criticize what they consider to be overly onerous procedural hurdles in many states that could prevent inmates with cognitive incapacities or illiteracy from being able to apply. In other cases, they argue, the process may be too lengthy to evaluate and release a terminally ill inmate before death.

To address these concerns, the group advocates the categorization of medical eligibility into three groups: (1) terminally ill prisoners with predictably poor prognoses (e.g., Lou Gehrig's disease, rapidly progressing cancer); (2) prisoners with dementia; and (3) prisoners with nonterminal illnesses who have profound functional and/or cognitive impairments (e.g., advanced liver disease, severe heart failure).

The guidelines would also call for assignment of an advocate to represent incapacitated prisoners; fast-track evaluation of rapidly dying prisoners; and a clear application procedure that is widely publicized to inmates. To ease anxiety about released offenders regaining their health and endangering public safety, the researchers recommend that states adopt formal recall mechanisms for prisoners whose conditions improve substantially after release. Twenty-nine national experts in the areas of prison health care, geriatrics, and palliative medicine endorsed these proposed guidelines in 2012.†

* Brie A. Williams, Rebecca L. Sudore, Robert Greifinger, and R. Sean Morrison, "Balancing Punishment and Compassion for Seriously Ill Prisoners," *Annals of Internal Medicine* 155:2 (July 2011): 122-126.

† Brie A. Williams et al., "Aging in Correctional Custody: Setting a Policy Agenda for Older Prisoner Health Care," *American Journal of Public Health* 102:8 (August 2012): 1475-1481.

Conclusion

Health care and corrections spending will continue to pose a fiscal challenge to state lawmakers in the years ahead. Addressing the intersection of these spending areas—health care services provided to prison inmates—will be particularly important.

This report demonstrates that four strategies—telehealth, outsourcing care, Medicaid financing for eligible inmates, and medical or geriatric parole—offer states promising opportunities to save taxpayer dollars and maintain or improve the quality of inmate care while protecting public safety.

State Correctional Health Care Expenditures

Fiscal 2001 and 2008 (2008 dollars)

	2001 health care spending		
	Total (in thousands)	Per inmate	Share of institutional correctional spending
Alabama	$39,090	$1,580	13%
Alaska	$23,136	$7,628	11%
Arizona	$102,183	$3,888	13%
Arkansas	$27,137	$2,362	10%
California	$981,238	$6,426	16%
Colorado	$59,259	$3,980	10%
Connecticut	$93,066	$5,316	13%
Delaware	$20,106	$2,939	8%
Florida	$329,785	$4,821	15%
Hawaii	$13,331	$3,449	7%
Idaho	$13,289	$3,388	7%
Illinois	$99,746	$2,249	7%
Indiana	$51,213	$2,734	7%
Iowa	$22,763	$2,859	7%
Louisiana	$41,589	$2,486	9%
Maine	$12,916	$7,762	14%
Maryland	$71,087	$3,011	10%
Massachusetts	$59,193	$5,802	8%
Michigan	$187,159	$3,867	9%
Minnesota	$34,674	$5,413	12%
Mississippi	$35,339	$3,074	12%
Missouri	$68,382	$2,393	10%
Montana	$4,082	$2,390	5%
Nebraska	$16,897	$4,316	13%
Nevada	$40,242	$4,288	15%
New Hampshire	$5,399	$2,232	6%
New Jersey	$124,831	$5,327	11%
New York	$299,280	$4,430	10%
North Carolina	$62,050	$1,938	6%
North Dakota	$3,939	$3,773	10%
Ohio	$152,126	$3,542	10%
Oklahoma	$63,275	$4,201	22%
Oregon	$19,370	$1,769	4%
Pennsylvania	$186,991	$5,035	10%
Rhode Island	$16,099	$4,786	8%
South Carolina	$39,111	$1,801	7%
South Dakota	$7,443	$2,693	14%
Tennessee	$48,955	$3,551	11%
Texas	$448,320	$3,393	12%
Utah	$9,954	$2,401	4%
Virginia	$118,930	$3,977	10%
Washington	$70,822	$4,651	10%
West Virginia	$15,731	$4,623	10%
Wisconsin	$64,126	$3,699	7%

Sources: (1) Correctional health care expenditures: Tracey Kyckelhahn, "State Corrections Expenditures, FY 1982-2010," Bureau of Justice Statistics, December 2012, http://www.bjs.gov/index.cfm?ty=pbdetail&iid=4556; (2) Total institutional correctional expenditures: Bureau of Justice Statistics, Justice Expenditure and Employment Extracts.

Note: Nominal data for fiscal 2001 were converted to 2008 dollars using the State and Local Consumption Expenditures and Gross Investment price index included in the Bureau of Economic Analysis' National Income and Product Accounts. The Bureau of Justice Statistics did not report data for Georgia, Kansas, Kentucky, New Mexico, Vermont, and Wyoming.

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State Correctional Health Care Expenditures

Fiscal 2001 and 2008 (2008 dollars), *continued*

	2008 health care spending		
	Total (in thousands)	Per inmate	Share of institutional correctional spending
Alabama	$88,886	$3,519	22%
Alaska	$30,775	$8,676	15%
Arizona	$138,335	$4,450	16%
Arkansas	$64,365	$4,900	21%
California	$1,981,919	$11,793	27%
Colorado	$93,509	$5,213	16%
Connecticut	$107,824	$5,682	15%
Delaware	$39,033	$5,621	18%
Florida	$421,381	$4,645	20%
Hawaii	$17,322	$5,175	9%
Idaho	$20,602	$4,188	10%
Illinois	$99,180	$2,181	9%
Indiana	$74,454	$3,135	12%
Iowa	$34,654	$3,973	13%
Louisiana	$49,298	$2,750	10%
Maine	$13,797	$6,740	14%
Maryland	$140,421	$6,117	13%
Massachusetts	$90,146	$8,067	10%
Michigan	$304,210	$6,242	19%
Minnesota	$52,632	$6,252	18%
Mississippi	$50,624	$4,083	17%
Missouri	$114,896	$3,812	18%
Montana	$7,862	$4,920	6%
Nebraska	$27,512	$6,155	30%
Nevada	$42,629	$3,584	14%
New Hampshire	$25,843	$9,055	33%
New Jersey	$147,564	$6,649	14%
New York	$354,749	$5,893	13%
North Carolina	$233,123	$5,866	21%
North Dakota	$5,063	$3,672	8%
Ohio	$196,664	$4,034	17%
Oklahoma	$70,698	$3,935	16%
Oregon	$82,523	$6,094	18%
Pennsylvania	$214,197	$4,470	13%
Rhode Island	$20,570	$5,501	12%
South Carolina	$64,266	$2,715	14%
South Dakota	$14,373	$4,307	15%
Tennessee	$76,076	$5,348	16%
Texas	$417,649	$3,000	13%
Utah	$21,183	$4,128	11%
Virginia	$134,668	$4,337	15%
Washington	$141,308	$8,656	16%
West Virginia	$21,735	$4,439	10%
Wisconsin	$107,755	$4,846	14%

Sources: (1) Correctional health care expenditures: Tracey Kyckelhahn, "State Corrections Expenditures, FY 1982-2010," Bureau of Justice Statistics, December 2012, http://www.bjs.gov/index.cfm?ty=pbdetail&iid=4556; (2) Total institutional correctional expenditures: Bureau of Justice Statistics, Justice Expenditure and Employment Extracts.

Note: Nominal data for fiscal 2001 were converted to 2008 dollars using the State and Local Consumption Expenditures and Gross Investment price index included in the Bureau of Economic Analysis' National Income and Product Accounts. The Bureau of Justice Statistics did not report data for Georgia, Kansas, Kentucky, New Mexico, Vermont, and Wyoming.

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State Correctional Health Care Expenditures

Fiscal 2001 and 2008 (2008 dollars), *continued*

	Real change in spending, 2001-08		
	Total	Per inmate	Share of institutional correctional spending
Alabama	127%	123%	69%
Alaska	33%	14%	30%
Arizona	35%	14%	19%
Arkansas	137%	107%	110%
California	102%	84%	67%
Colorado	58%	31%	61%
Connecticut	16%	7%	21%
Delaware	94%	91%	130%
Florida	28%	-4%	36%
Hawaii	30%	50%	14%
Idaho	55%	24%	45%
Illinois	-1%	-3%	43%
Indiana	45%	15%	73%
Iowa	52%	39%	69%
Louisiana	19%	11%	21%
Maine	7%	-13%	-1%
Maryland	98%	103%	36%
Massachusetts	52%	39%	25%
Michigan	63%	61%	112%
Minnesota	52%	15%	58%
Mississippi	43%	33%	44%
Missouri	68%	59%	84%
Montana	93%	106%	27%
Nebraska	63%	43%	135%
Nevada	6%	-16%	-9%
New Hampshire	379%	306%	446%
New Jersey	18%	25%	21%
New York	19%	33%	28%
North Carolina	276%	203%	256%
North Dakota	29%	-3%	-13%
Ohio	29%	14%	73%
Oklahoma	12%	-6%	-31%
Oregon	326%	245%	298%
Pennsylvania	15%	-11%	38%
Rhode Island	28%	15%	47%
South Carolina	64%	51%	112%
South Dakota	93%	60%	9%
Tennessee	55%	51%	36%
Texas	-7%	-12%	11%
Utah	113%	72%	165%
Virginia	13%	9%	57%
Washington	100%	86%	60%
West Virginia	38%	-4%	-5%
Wisconsin	68%	31%	88%

Sources: (1) Correctional health care expenditures: Tracey Kyckelhahn, "State Corrections Expenditures, FY 1982-2010," Bureau of Justice Statistics, December 2012, http://www.bjs.gov/index.cfm?ty=pbdetail&iid=4556; (2) Total institutional correctional expenditures: Bureau of Justice Statistics, Justice Expenditure and Employment Extracts.

Note: Nominal data for fiscal 2001 were converted to 2008 dollars using the State and Local Consumption Expenditures and Gross Investment price index included in the Bureau of Economic Analysis' National Income and Product Accounts. The Bureau of Justice Statistics did not report data for Georgia, Kansas, Kentucky, New Mexico, Vermont, and Wyoming.

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Appendix B: Sources interviewed

The following experts in the field of correctional health care were interviewed for this report.

Daniel Bannish
Director of Behavioral Health
Connecticut Department of Correction

Dr. Ricki Barnett
Chief Medical Officer
California Correctional Health Care Services

Jamey Boudreaux
Executive Director, Louisiana-Mississippi Hospice and Palliative Care Organization

Tina Chiu
Director of Technical Assistance
Vera Institute of Justice

Karen Creighton
Associate Director
California Correctional Health Care Services

Jeff Dickert
Vice President, University Correctional Health Care
Rutgers, The State University of New Jersey

Aaron Edwards
Fiscal and Policy Analyst
California Legislative Analyst's Office

Edward Harrison
President, National Commission on Correctional Health Care

Joyce Hayhoe
Legislative Director
California Correctional Health Care Services

J. Clark Kelso
Receiver
California Correctional Health Care Services

Darby Kernan
Policy Consultant
California Senate President Pro Tempore Darrell Steinberg

Nanette Larson
Director, Health Services Unit
Minnesota Department of Corrections

Marc Levin
Director, Center for Effective Justice
Texas Public Policy Foundation

Lannette Linthicum
Director, Health Services Division
Texas Department of Criminal Justice

Mark Looney
Public Protection Unit
New York State Division of the Budget

Carol McAdoo
Coordinating Consultant, National Hospice and Palliative Care Organization

Owen Murray
Vice President, Offender Health Services
Correctional Managed Care, University of Texas Medical Branch

Dan O'Connor
Analyst, Michigan State Senate Fiscal Agency

Linda J. Redford
Director, Geriatric Education Center and Rural Interdisciplinary Training Program
University of Kansas Medical Center

Viola Riggin
Director of Healthcare Services
Kansas Department of Corrections

Joan Shoemaker
Deputy Director of Prisons
Colorado Department of Corrections

Stephen Smock
Associate Vice President, Outpatient Division
Correctional Managed Care, University of Texas Medical Branch

Donna Strugar-Fritsch
Principal
Health Management Associates

Robert L. Trestman
Executive Director, Correctional Managed Health Care
University of Connecticut

Jonathan Turley
Executive Director, Project for Older Prisoners
Professor, George Washington University Law School

Anthony Williams
Associate Vice President, Inpatient Division, Correctional Managed Care, University of Texas Medical Branch

Jack Williams
Deputy Director, Office of Health Services
Georgia Department of Corrections

April Zamora
Director, Texas Correctional Office on Offenders with Medical or Mental Impairments
Texas Department of Criminal Justice

Stephanie Zepeda
Director, Pharmacy Services
Correctional Managed Care, University of Texas Medical Branch

These individuals provided additional information to Pew's researchers via email.

Matthew Buettgens
Mathematician, Health Policy Center
Urban Institute

Jessica Bullard
Parole Manager
Connecticut Board of Pardon and Paroles

Scott Clodfelter
Senior Attorney, Florida Senate Committee on Criminal Justice

Will Counihan
Team Lead, Data Analysis
Texas Comptroller of Public Accounts

Steve Van Dine
Research Chief
Ohio Department of Rehabilitation and Corrections

Stan Dorn
Senior Fellow
Urban Institute

Josh Fangmeier
Health Policy Analyst
Center for Healthcare Research & Transformation

Linda Foglia
Assistant Public Information Officer
New York State Department of Corrections and Community Supervision

Brian Garnett
Spokesman, Connecticut Department of Correction

Kate Gurnett
Deputy Press Secretary
New York State Office of the State Comptroller

John Holahan
Institute Fellow, Health Policy Center
Urban Institute

Alison Lawrence
Policy Specialist, Criminal Justice Program
National Conference of State Legislatures

Cristina Rodda
Director, Office of Public Affairs
New Mexico Corrections Department

Drew Soderborg
Fiscal and Policy Analyst
California Legislative Analyst's Office

Endnotes

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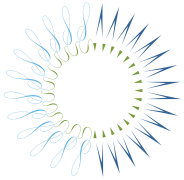

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