CAPPS
CITIZENS ALLIANCE ON PRISONS & PUBLIC SPENDING

CAPPS Testimony Regarding H.B. 4101-02

House Appropriations Committee, December 6, 2017

Good morning. I am the Policy Director at the Citizens Alliance on Prisons and Public Spending (CAPPS), a criminal justice research and advocacy organization based in Lansing. I appreciate the opportunity to provide testimony today in support of H.B. 4101 and 4102,[1] which offer the best available solution to the problem of "medically frail" prisoners in the Michigan Department of Corrections (MDOC). I strongly encourage the Legislature to pass this legislation, which will save taxpayers millions, allow MDOC to focus on its core functions instead of elder care, and provide a more appropriate environment than prison for medically frail prisoners, who pose no meaningful threat to public safety.

The Problem

About 850 prisoners in MDOC custody are "medically frail"[2]—that is, are mentally or physically incapacitated and unable to perform basic tasks of daily living without assistance.

MDOC is unable to transfer these individuals to an outside facility for nursing or palliative care unless they are parole eligible,[3] and the vast majority of them are not, so MDOC is responsible for providing them nursing and end-of-life care. Further, because Medicaid does not cover the cost of medical care for prisoners,[4] MDOC must bear 100% of the cost of these prisoners' care, notwithstanding the very high costs of doing so (3-5 times greater than average[5]).

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[1] CAPPS does not support H.B. 4103, as existing law is sufficient to protect the public from the possibility that an individual on medical parole violates the terms of their release, or is assisted in doing so.

[2] *Testimony of MDOC Legislative Liaison Kyle Kaminski*, House Appropriations Subcommittee on Corrections (Oct. 18, 2017).

[3] *See* MCL 791.265(2) ("A prisoner who is … committed to the jurisdiction of the department shall be confined in a secure correctional facility for the duration of his or her minimum sentence …").

[4] Section 1905(a)(29)(A) of the Act prohibits Medicaid federal financial participation (FFP) for "any such payments with respect to care or services for any individual who is an inmate of a public institution (*except as a patient in a medical institution*)" (emphasis added).

[5] *Testimony of MDOC Legislative Liaison Kyle Kaminski*, House Appropriations Subcommittee on Corrections (Oct. 18, 2017).

The Solution

H.B. 4101 & 4102 propose needed reforms to the current system by authorizing a medical parole for medically frail prisoners based on the input of MDOC, an independent medical professional, and the parole board.

This response to the problem of medically frail prisoners in MDOC is necessary, and superior to alternative proposals, for several reasons.

1. Best Chance to Shift Costs to Medicaid.

MDOC currently pays essentially all of the costs of care for medically frail prisoners. Other states, such as Connecticut, have successfully shifted the costs of care to Medicaid and generated significant savings to taxpayers in doing so. Shifting costs to Medicaid has been a key goal of this legislation from the start, and it is tailored to maximize the chances that the Center for Medicare and Medicaid Services (CMS) will approve funding for the care of individuals granted a medical parole under this program.

By way of background, the Social Security Act prohibits Medicaid from making "any such payments with respect to care or services for any individual who is an inmate of a public institution (except as a patient in a medical institution)."[6] In attempting to flesh out the distinction between an "inmate" and a "patient" the Medicaid regulations and guidance look to whether the individual is treated by the facility where they live as if they are in custody or not. For example, in a 2016 letter to State Health Officials, Medicaid Director Vikki Wachino explained that a key factor in determining whether a person is an "inmate" under CMS regulations is whether they are treated as if they are in custody: "Regardless of the label attached to any particular custody status, an important consideration of whether an individual is an "inmate" is his or her legal ability to exercise personal freedom."[7]

Consistent with this, Connecticut was previously denied Medicaid funding for nursing home care provided to medically frail prisoners when (1) the home primarily housed prisoners (as opposed to parolees), (2) the residents were automatically returned to custody if they no longer met the criteria for release, and (3) some residents were confined to secure units for reasons unrelated to their treatment.[8] Notably, after Connecticut began issuing medical paroles to prisoners at the facility in question it did eventually receive CMS approval.

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[6] *See* section 1905(a)(29)(A) of the Act.
[7] *See* Vikki Wachino, *Centers for Medicare & Medicaid Services,* SHO # 16-007 (April 28, 2016), available at https://www.medicaid.gov/federal-policy-guidance/downloads/sho16007.pdf.
[8] David Drury, "Feds: No Medicaid Reimbursement For Prisoners At Rocky Hill Nursing Home," *Hartford Courant* (Sept. 5, 2015) available at http://www.courant.com/community/rocky-hill/hc-rocky-hill-nursing-home-0905-20150904-story.html.

H.B. 4101 and 4102 address all of these concerns. First, providing a medical parole to medically frail prisoners before placing them in an outside facility forecloses the issue of whether the facility primarily houses prisoners. Second, unlike the rejected Connecticut plan, this legislation does not provide for an automatic return to custody if certain conditions of release are not met. Rather, it (1) gives the parole board discretion as to the appropriate response, and (2) directs the board to consider the medical needs of the prisoner in determining what placement is appropriate. In light of CMS guidance, both factors are likely to support a determination that individuals on medical parole are "patients" rather than "inmates."

2. Lets MDOC Focus on Offender Success.

MDOC does not want to be in the nursing care business and supports these bills, which let MDOC focus on its core functions. Having a mechanism to send medically frail prisoners outside of MDOC will allow MDOC to reduce its investment in health care functions, and should free up resources to invest in the success of offenders that are not medically frail (more than 95% of whom will be released) in areas such as in-prison programming, vocational training, and reentry support services.

This legislation dispenses with the requirement of a mandatory return (which was in Connecticut proposals that were denied by in CMS, and is in alternative proposals here in Michigan). Doing so allows MDOC to shift resources because it does not need to reserve space for the possibility of individuals returned to custody, and is not necessarily on the hook for the care of individuals that are paroled, even if later they no longer comply with the medical conditions of release. It also increases the likelihood that CMS will approve Medicaid funding for the care of medically frail prisoners.

3. Puts Nursing Care in the Hands of Medical Professionals.

As noted above, MDOC does not want to be in the business of providing care to medically frail prisoners. They have done so to date because they had to, and they have expended significant resources to provide an adequate level of care to medically frail prisoners in a corrections setting—through the Duane Waters facility, and by creating units for medically frail prisoners outside of the general population.

Notwithstanding MDOC's efforts, the care of medically frail prisoners is better placed in the hands of medical professionals in settings designed to meet the medical needs of medically frail prisoners. Prisons are not designed to serve this purpose, and I am confident that MDOC would not disagree that outside nursing care is a more appropriate setting for medically frail prisoners than prison.

Again, by dispensing with the requirement of a mandatory return, this legislation allows MDOC to shift resources and makes it more likely CMS will approve Medicaid funding for the care of medically frail prisoners.

4. The Parole Board is in the Best Position to Decide Who is Medically Frail.

I am aware of other proposals to address the issue of medically frail prisoners that do not put decisionmaking authority in the hands of the parole board. However, I am convinced that the parole board is the appropriate place for this authority to reside, and putting it elsewhere (e.g. with the sentencing court) is likely to undermine the purposes of this legislation. This is the case for several reasons:

1. The parole board is the institution that is normally responsible for evaluating a prisoner's fitness for release, and routinely makes similar determinations regarding prisoners' health and threat to the community.

2. The parole board is better-situated than a court to make the determination of whether a prisoner should receive a medical parole. The parole board has a close working relationship with MDOC administration and has easy access to the prisoner health information and relevant MDOC personnel necessary to decide whether a medical parole is appropriate. In contrast, a court has not had contact with the defendant since sentencing, knows nothing of their institutional conduct or current health conditions, and is subject to influence by parties motivated by factors unrelated to whether a medical parole is appropriate.

3. Requiring MDOC to file a petition with a court to medically release a prisoner—as some alternative proposals recommend—would place unnecessary burdens on the medical release process that would lead to much slower releases and significantly fewer releases overall. Putting this decision in the hands of the parole board, in contrast, would expedite the process and focus it on the right issues from a policy standpoint.

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Thank you for the opportunity to testify today. Please do not hesitate to contact me if you have questions.

Sincerely,

/s/

John S. Cooper