Washington State Department of Social and Health Services

Transforming Lives

REPORT TO THE LEGISLATURE

Caring for Individuals under Department of Corrections Jurisdiction in Skilled Nursing Facilities

Enacted by Budget Proviso in ESSB 5693(204) (54) in the 2022 Legislature

June 30, 2023

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1 Executive summary

This report was prepared by the Washington State Department of Social and Health Services (DSHS) Aging and Long-Term Support Administration (ALTSA) in collaboration with the Department of Corrections (DOC) and the Health Care Authority (HCA). It was prepared in accordance with the budget proviso in ESSB 5693 (204) (54), from the 2022 legislative session.

The report includes:

- A review of the clinical parameters identified within DOC records indicative of needs for medical treatments/therapies or assistance with mobility or cognitive deficits.
- Profiles of the medical conditions, behavioral health, and long-term care needs of individuals under DOC jurisdiction who would likely benefit from long-term services and supports in a Skilled Nursing Facility setting.
- An analysis of the cost of serving these individuals in a variety of nursing and long-term care settings as examples of potential facility costs.
- Actual costs that were incurred to stand up a new medical and rehabilitation facility that DSHS established in response to emergent needs created by the COVID-19 pandemic.
- Details on the operating costs of current DOC facilities.
- Other options, including extraordinary medical placement and partial confinement programs, that could play a significant role in obtaining appropriate services for those incarcerated individuals in need of such services.
- An assessment of Medicaid funding eligibility for individuals under DOC jurisdiction who would be eligible for such services and the facilities that would potentially provide these services.

This report describes the limitations of Medicaid funding for individuals currently under DOC jurisdiction based on assessment by the agencies listed above and the Office of the Attorney General. There are individuals under DOC jurisdiction who may be functionally eligible for the state's Medicaid-funded long-term services and supports program. However, the custody status of the individuals and the resident rights requirements of Skilled Nursing Facilities (SNFs) may limit the use of Medicaid funding. Federal funding would only be available under conditions where the individual is no longer fully incarcerated, and has a certain degree of freedom facilitated either by complete release from DOC jurisdiction or participation in a partial confinement program administered by DOC.

Statute changes could be made to allow new opportunities for SNF-eligible incarcerated individuals to have other levels of confinement. The legislature has already written into statute DOC's Extraordinary Medical Placement program and other successful partial confinement arrangements.

The report concludes the service expansion options available include: 1) Significantly expanding the healthcare capabilities of existing DOC facilities; 2) Establishing a facility that can address combined healthcare and security needs; and/or 3) Pursuing legislative support for expanded opportunities for partial confinement so that individuals can be served in community facilities available to the general public.

2 Purpose

The purpose of this report is to meet the requirements of Engrossed Substitute Senate Bill 5693, Section (204) (54), from the 2022 legislative session. The bill requires DSHS, in collaboration with DOC and HCA, to submit a final report to the Governor and the relevant fiscal and policy committees of the Washington State Legislature by June 30, 2023. The final report shall:

(a) Assess the relevant characteristics and needs of the potential patient population

(b) Assess the feasibility, daily operating costs, staffing needs, and other relevant factors of potential locations or contractors, including the Maple Lane Corrections Center, for placement of long-term care individuals under the jurisdiction of DOC for a potential nursing home facility to be licensed by the department.

(c) A cost-benefit analysis of placing individuals under the jurisdiction of DOC in potential facilities identified in subsection (b) of this subsection, including the possibility or absence of federal funding for operations. DOC must provide daily operating costs of prisons where these individuals may be coming from, the fiscal year 2021 daily costs per incarcerated individual assigned to the Sage living unit, and the costs associated with electronic home monitoring costs per individual. This analysis shall consider both state-run and privately contracted options

(d) Assess the ability of potential facilities identified in subsection (b) of this subsection to better meet clients' medical and personal needs

(e) Assess the ability to provide Medicaid-funded services to meet the healthcare needs of these individuals

3 Relevant Characteristics of the Potential Patient Population

Data Constraints

It is difficult to accurately assess the long-term services and supports eligibility of individuals under DOC jurisdiction for treatment in a SNF. While DOC is in the process of procuring an electronic health records (EHR) system, DOC does not currently maintain an electronic database of individuals' medical conditions and long-term care needs. The data required to perform an assessment is maintained in paper records held at each individual facility. To perform such assessments would require a manual, case-by-case review of individuals at several locations across the state, which is both time consuming and labor intensive.

In the process of preparing the preliminary report, DOC used available administrative data to identify a group of 117 individuals who are potentially functionally eligible for placement in a SNF. The data does not contain the medical and functional information necessary to fully confirm eligibility for SNF admission. A full functional assessment would be needed to assess the individuals more accurately.

Data on Potential Patients

Below is a breakdown of the demographics, medical conditions, and long-term care needs of the individuals in DOC custody who have been identified as potentially eligible for care in a SNF. It should be noted that incarcerated individuals are well documented to have "accelerated aging", exhibiting physiological characteristics of people in the community who are, on average, 10 years older (Machi, Viola, and Sun 2012[1]). Individuals incarcerated in jail and prison have a higher burden of most chronic medical conditions than the general population (Binswanger, Krueger, and Steiner 2009[2]). Although this report focuses on SNF eligible individuals, there is a much greater need than indicated to have an appropriate unit for patients who are aging with complex healthcare needs that may not meet SNF level of care requirements. As of March 2023, 1,165 incarcerated persons, or 8.7 percent of the total prison population in Washington, were over the age of 60 and 2,802 incarcerated persons, or 21 percent of the total prison population, were serving a sentence of life or life without the possibility of parole. In the coming years, a growing portion of DOC's prison population will be in need of long-term care services as they continue to age in place.

The data for this report was gathered on June 13, 2022, during development of the preliminary report required as part of this budget proviso and was included within the preliminary report. This data has not been updated because there has not been a significant change to the population targeted for this effort. DSHS staff did contact the relevant DOC facilities to procure more recent data, but the current data available did not indicate any significant changes from the data available in June 2022. This review identified a total of 117 individuals whose clinical characteristics indicate the need for medical treatments/therapies or assistance with mobility, cognitive deficits, or other Activities of Daily Living (ADLs). Of these 117 individuals:

- Twenty-three were identified as most likely to meet SNF criteria. They ranged in age from 33 to 87 years old, with an average age of 61.4 years. Twenty-two of them (95.7%) are male, and one (4.3%) is female.
- Ninety-four individuals were identified as potentially eligible. They ranged in age from 23 to 87 years old, with an average age of 61.2 years. Ninety-three (98.9%) of this group are male, and one (1.06%) is female.

[1] Maschi T, Viola D, Sun F. The high cost of the international aging prisoner crisis: well-being as the common denominator for action. *Gerontologist*. 2013 August, 543-54.

[2] Binswanger IA, Krueger PM, Steiner JF. Prevalence of chronic medical conditions among jail and prison inmates in the USA compared with the general population. *Journal of Epidemiology & Community Health* 2009, 912-919.

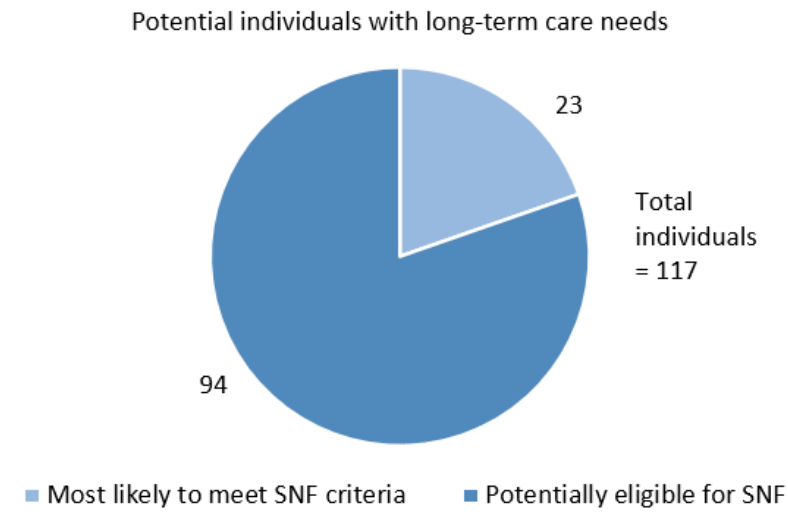

Figure 1: Potentially eligible individuals by eligibility classification.

Table 1 below, represents a breakdown of the 117 potentially eligible individuals by DOC facility and eligibility classification (see Appendix for facility abbreviations). Four DOC facilities had no individuals identified as likely or potentially eligible and are therefore not listed in the table.

Facility	Total Population	Distinct # of Patients in Parameter(s)			% of Total Population
		Most Likely	More Info Needed	Total	
AHCC	1,842	1	11	12	0.7%
CBCC	376	0	1	1	0.3%
CRCC	1,854	7	20	27	1.5%
MCC	1,488	5	20	25	1.7%
SCCC	1,747	4	19	23	1.3%
WCC	1,671	0	4	4	0.2%
WCCW	536	1	1	2	0.4%
WSP	1,908	5	18	23	1.2%
Total	**12,187**	**23**	**94**	**117**	**1.0%**

Table 1: Potentially eligible individuals by DOC facility and eligibility classification.

Table 2 shows the number of individuals per specialized need as determined from DOC data. Eighty-two (70.1%) of these individuals fall into more than one of these categories. Twenty-eight (23.3%) fall into four or more.

Condition	# of Patients with Condition	% of Total Sample
Special transportation needs such as a wheelchair van.*	61	52.1%

Condition	# of Patients with Condition	% of Total Sample
Organic system disease requiring frequent monitoring and on-site medical care with moderate mobility restrictions	59	50.4%
Organic system disease requiring frequent monitoring and on-site medical care with disability, including hearing and significant sight impairment	45	38.5%
Disability, including hearing and significant sight impairment, with moderate mobility restrictions	42	35.9%
Significant health services which may require assistance with ADLs	19	16.2%
Age 75+	18	15.4%
Significant mobility restrictions	8	6.8%
Dementia or other debilitating neurological condition	8	6.8%

Table 2: Potentially eligible individuals by specialized need.

*Note: Transportation in and of itself is not a qualifier for long-term care. LTC transportation is limited to accessing groceries, medical appointments, and community integration where assistance with ADLs is delivered.

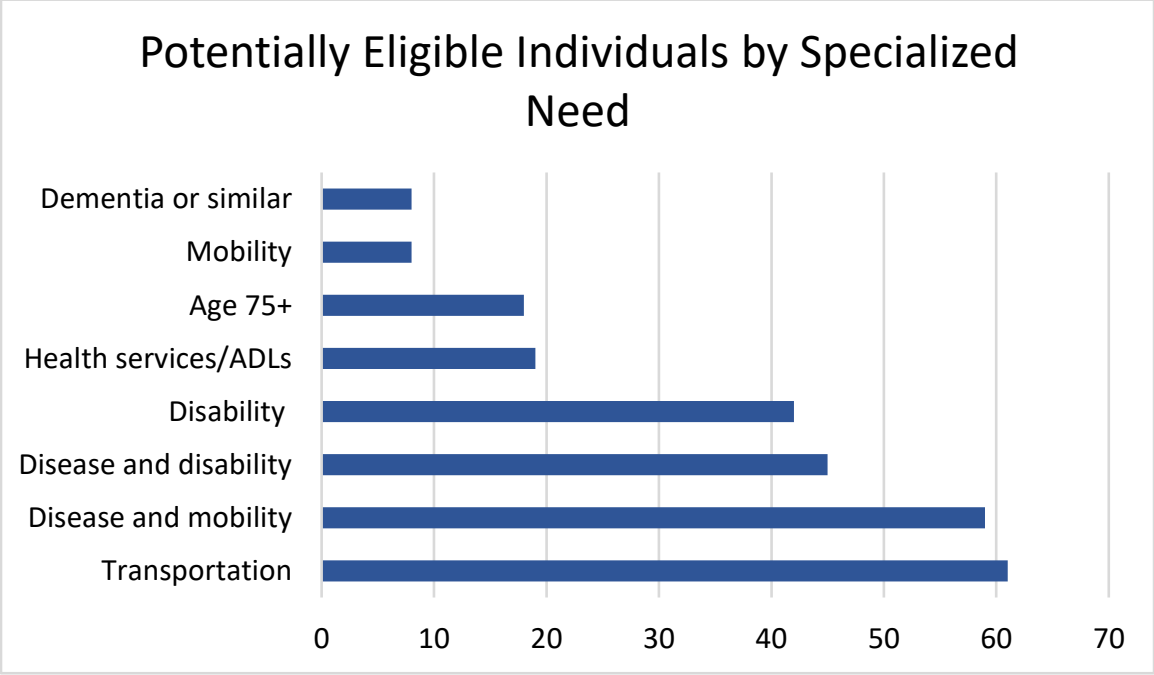

Figure 2: Potentially eligible individuals by specialized need.

To determine SNF functional eligibility, the clinical complexity of potential participants must be considered relevant to the diagnosis and the extent to which they require assistance with their ADLs or daily Skilled Nursing tasks. For this reason, it is difficult to determine eligibility by examining the

diagnosis alone. Considerations include treatments and frequency of need, wound care/skin issues (pressure ulcers, stasis ulcers, wound care, repositioning program), incontinence care, bowel program, catheter care, and issues with swallowing. Individuals with bariatric needs sometimes receive significant assistance with transfers, and individuals with decreased levels of cognition due to dementia or other conditions may need assistance with eating, toileting, mobility, and exit-seeking behaviors.

Detailed data was obtained and examined for 15 individuals from the group identified as most likely to qualify for SNF care. These individuals display a variety of chronic conditions of a physical, cognitive, and/or psychiatric nature. Their ages range from 44 to 81 years old, with an average age of 66.8 years. Of these, nine (60%) require regular assistance with ADLs, 10 (67%) have mobility issues, eight (53%) have neurocognitive conditions. All have chronic conditions that require regular medical care and/or assistance with ADLs.

Example Scenarios

Two individuals, profiled below, were chosen as prime examples of clearly eligible individuals who could benefit from SNF services and supports: Client A and Client B, both 70-year-old males.

Client A suffers from type 1 diabetes, paraplegia, chronic hepatitis C, cirrhosis, neurogenic bowel, heart disease, and end-stage renal disease. He has a suprapubic catheter that requires monthly changing and cleaning around the site, routine labs, fluid restriction, blood sugar checks, insulin injections, and dialysis three times per week. He requires extensive assistance with nearly all ADLs. He eats independently, but often requires encouragement. He has no balance and cannot sit up on his own, requiring regular Hoyer lift transfers with a limited ability to propel a wheelchair. He wears incontinence briefs that need changing every two hours, and it takes staff 90 minutes to shower him.

Client B suffers from type 2 diabetes, chronic hepatitis C, severe dementia, and is blind in one eye. He requires blood glucose checks twice per day and insulin injections once per day (if levels remain within normal limits). He requires assistance with all ADLs, including eating and walking (he is very unsteady with a walker and often uses a wheelchair). He frequently wanders in a confused state, sometimes attempting to exit the medical facility. He is not aware of what day it is, experiences sundowning and bladder incontinence, and is resistant to care.

Many other individuals represented in the sample also require complex medical care and accommodations that can place a significant strain on DOC facilities, staff, and other resources. This represents health and safety risks both for these potential clients and for other individuals and staff.

4 Relevant Factors of Potential Locations or Contractors

Estimating operating costs, staffing needs and other relevant factors of facilities offering nursing and long-term care needs is highly dependent upon the needs of the individuals being served, whether any specialized services are warranted and whether the facility is new construction or is an existing building in need of significant renovation. There are unknown factors that could significantly affect aspects of facility operation. For example:

- Facility size, patient needs, specialized staffing needs.

- State requirements for security based on involvement with the correctional system and Center for Medicare and Medicaid Services (CMS) rules and regulations.
- The costs of leasing or purchasing a building in which to run such a facility could vary greatly depending on location, size, condition, etc.
- The cost of maintenance, repair, and capital improvements associated with such a facility will vary depending on numerous factors including size, location, current condition, and any specific operational requirements.

With that in mind, the approach taken in this report is to provide information about several currently-operating facilities that might mirror some of the operational characteristics of a facility that would serve incarcerated individuals with long-term care needs and security needs.

We identified six facilities that are currently operating with various levels of care and security:

The Transitional Care Center of Seattle (TCCS) is a SNF established by DSHS during the COVID-19 pandemic and currently operated by a contractor. DSHS purchased the building for $13.5 million and subsequently invested an additional $9.96 million in capital improvements. TCCS was included in this assessment to provide an example of approximate costs for the establishment of a new nursing facility. This facility is Medicaid and Medicare certified.

60 West is a nursing facility in Rocky Hill, Connecticut operated by a contractor and specializing in treating previously incarcerated individuals. This facility has received certification from the Centers for Medicare and Medicaid Services and receives Medicaid funding. It was included in this assessment due to its focus on justice-involved individuals, but it is important to note that all clients at this facility have been released from custody and are no longer under the jurisdiction of a governmental entity.

Enhanced Services Facilities (ESFs) are licensed long-term care facilities for individuals with complex behavioral, medical, chemical dependency, and/or mental health needs. ESFs use high staffing ratios to offer effective services to their residents. ESFs are not secure facilities. They offer behavioral supports, personal care services and nursing. These facilities are Medicaid funded.

Western State Hospital and the **Special Commitment Center** are secure facilities operated by DSHS. They were included in this assessment as examples of facilities that provide medical care while also securely confining their patients. These facilities provide psychiatric care, so operating costs might differ from a facility specializing in Skilled Nursing and long-term care services. Also, specific security needs might differ from a potential DOC facility, which may also affect operating costs. These facilities are not Medicaid and Medicare certified. As is discussed throughout the report, the Centers for Medicare and Medicaid Services do not allow for delayed egress in long-term care facilities except in very limited circumstances, such as when caring exclusively for patients with dementia. It is likely that a facility where a patient would need to be secured would not be able to access Medicaid funding.

The Maple Lane facility was not included in this assessment as it is no longer a DOC facility, but rather an inpatient behavioral health treatment center operated by the DSHS Behavioral Health Administration.

The daily cost per patient in each of these facilities is displayed in the tables below, which also includes notes on the nature of each facility. We have also included the average daily private pay rate for nursing facilities statewide. We separated these facilities into two tables. Table 3 lists facilities with no security. Table 4 lists two secured facilities.

Facilities without security

Facility Name	Description	Cost per Patient per Day	Medical Care/Security Level	Notes
Transitional Care Center of Seattle (TCCS)	Medicaid and Medicare certified Skilled Nursing Facility providing short-term care and rehab to patients transitioning out of acute care hospitals. Nursing Facility operations are provided by EmpRes Healthcare.	$537-$930	Medical care only, no security	The population of this nursing facility is to support dual eligible recipients with exceptional care needs from Acute Hospital settings. Examples include individuals with bariatric care needs, behavior support needs and/or extensive skilled nursing needs. The daily nursing home Medicaid rate consists of two pieces, the Medicaid base rate and an add on rate for exceptional care needs. This combined direct care payment is subject to annual settlement. Does not include building purchase of $13.5 million and improvement costs of $ 7,557,578 (2021 and 2022 costs plus $2.4 million in 2023).
60 West	Private, Medicaid and Medicare certified, Skilled Nursing center operated by SecureCare Options in Rocky Hill, CT.	$400-$440	Medical care only, no security	Provides Skilled Nursing, specialty clinical programming and long-term care to residents. Residents are difficult to place in “regular” SNF due to behavioral issues or justice involvement.
Average Private Pay	WA nursing facilities. No Medicaid funding.	$354.47	Medical care only, no security	Average private pay rate charged in 2021

Facility Name	Description	Cost per Patient per Day	Medical Care/Security Level	Notes
Enhanced Services Facilities	Medicaid-contracted long-term care residential facilities for individuals with complex behavioral, medical, chemical dependency, and/or mental health needs.	$445	Medical care only, no security	Provides behavioral supports, personal care, and nursing services at a level of intensity not generally provided in other licensed long-term care settings. Residents access medical, mental health and substance use treatment on an outpatient basis in the community.

Table 3: Daily costs per patient per day in facilities with no security.

Facilities with security

These are two facilities that serve as examples of state-operated facilities that provide a level of security required because of the patient/resident's involvement with the justice system and some level of medical care. They are included here to demonstrate the potential cost of a facility that would serve higher custody patients, discussed further in section 6.

Facility Name	Description	Cost per Patient per Day	Medical Care/Security Level	Notes
Western State Hospital	Inpatient psychiatric hospital located in Lakewood, WA.	$1356.57	Secure facility, limited medical care	Eight hundred-bed facility providing evaluation and inpatient treatment for people with serious or long-term mental illness.
Special Commitment Center	Facility on McNeil Island that provides specialized treatment for civilly committed individuals who have completed their prison sentence.	$809.01	Secure facility, limited medical care	Total confinement facility for individuals with specialized behavioral health needs.

Table 4: Daily costs per patient per day for facilities with security.

Note: the costs represented in the two tables above reflect the daily operating costs per patient in facilities that have already been established. The cost of establishing a new facility of this type can vary widely and can be affected by numerous factors. The only recent experience DSHS has had with this process is the establishment of the TCCS, as noted above.

Additional Considerations for Feasibility

Siting of facilities that serve individuals with behavioral health needs, substance abuse disorders, or those who are, or have been, involved in the criminal justice system is rarely done without significant barriers put in place by local jurisdictions in response to concerns from the community. DSHS also experiences difficulty siting facilities serving those in need of mental health treatment, whether or not the prospective patients have been involved with the criminal justice system.

As an example, DOC sites reentry centers and, in that process, contracts with a third-party technical consultant to assist DOC with the various concerns from local jurisdictions related to zoning, code enforcement, and specific physical plant requirements brought forward by each jurisdiction. This consultant also provides a facilitator for each Local Advisory Committee community meeting to allow DOC to be an equal participant in the process, rather than be perceived as "running the show." This has been somewhat effective at maintaining equity during discussions, especially when challenging or difficult questions about the program or process are raised during a meeting.

DOC strives to create and sustain positive partnerships with local jurisdictions but does see projects discontinued and moratoriums on future development of centers put in place following considerable resistance from elected city officials. This results in lack of local service options for those reentering our communities in need of support to continue their successful reentry process. DSHS also encounters difficulties in siting community-based facilities that serve individuals with mental health needs who may or may not have criminal justice history. A potential fix to this issue could be legislation that puts siting requirements clearly and transparently in state statute.

5 Cost-benefit Analysis of Placing Individuals under DOC Jurisdiction in Potential Facilities

The fiscal year 2021 daily costs per incarcerated individual assigned to the Sage living unit and the average statewide cost of incarceration

Prison costs are comprised of two types of costs, known as "fixed" costs and "variable" costs Variable costs change as the number of incarcerated individuals in prison change. Variable costs are comprised of the utilities, supplies, pharmaceuticals, offsite medical services, and food consumed by each incarcerated individual in an institution. Fixed costs do not vary with each incarcerated individual but only increase or decrease as many incarcerated individuals enter or leave the prison system since they are driven by a unit model. Incarcerated individuals are housed in units that range from fewer than 100 incarcerated individuals to more than 250 incarcerated individuals. Staffing is largely dependent on how many units are open, with staffing models for each unit determined by size and layout of the unit, custody level of incarcerated individuals in the unit, and services at the unit level versus provided centrally at the facility level. The average daily cost per incarcerated individual in Washington prisons is $174.32 per day (FY22) and this is a combination of fixed and variable costs.

The Sage unit at Coyote Ridge Correctional Center houses inmates with diagnoses of dementia, hypertension, diabetes and other issues. DOC does not have electronic health records or pharmaceutical technology to track and report medical costs per incarcerated individual. Due to these limitations, DOC

cannot identify the cost of healthcare incurred by an individual incarcerated person. Incarcerated individuals receiving high levels of care or who have several significant health issues can be identified, but the actual cost of care cannot be determined. As a result, the requested cost for incarcerated individuals housed in the Sage unit is not available. DOC is currently in the process of procuring a vendor for the development of an EHR system to serve the incarcerated population in Washington that will track service encounters and costs efficiently.

The average statewide cost of incarceration including healthcare and institution costs is $174.32 per individual per day for FY22. The data available does not isolate the true costs of providing care to incarcerated individuals with long-term care needs, and DOC assumes their costs are higher. DOC's funding model supports general healthcare positions to care for the incarcerated population. The model does not provide funding for specialists such as palliative care clinical staff or any other specialty type truly needed to care for this population in need of long-term services and supports.

There are unknown costs associated with meeting the security needs of potential clients who are still under DOC jurisdiction. Security considerations may impact the way clients experience long-term care and may interfere with the ability to secure federal funding. The consensus is that federal funding would only be available under conditions in which the individual in question is no longer fully incarcerated, and has a certain degree of freedom facilitated either by complete release from DOC jurisdiction or participation in a partial confinement program administered by the DOC. The details and costs of such partial confinement programs are discussed below.

Extraordinary Medical Placement Program

RCW 9.94A.728 provides the authority for the Extraordinary Medical Placement (EMP) program which has been operating in Washington state since 2009. The program allows for incarcerated individuals to complete their prison time in home confinement on electronic home monitoring if they meet certain qualifications, including "physical incapacitation." Public safety must be ensured with any release, and the incarcerated individual must have an appropriate placement in the community. Candidates for EMP are identified through a referral process which can come from community or internal sources including self-referral. Individuals served through the EMP program may be eligible for Medicaid-funded services if they are assessed as functionally and financially eligible.

Individuals who are sentenced to life imprisonment without the possibility of release or meet the legal requirements as a persistent offender under RCW 9.94A.570 are not currently eligible for the extraordinary medical placement program or other partial confinement options under RCW 9.94A.728 or graduated reentry under RCW 9.94A.733. Therefore, we did not focus on this subpopulation for this report. If these populations were intended to be part of the population that utilizes this facility, the Department of Corrections would need new legal authority.

DSHS/ALTSA administers programs and supports for individuals who qualify for Medicaid long-term care services. ALTSA currently works with DOC to support low-income incarcerated individuals who need long-term services and supports when they are released from custody. The two agencies have a working agreement regarding individuals who participate in the EMP program and other incarcerated individuals who have barriers to finding settings in the community. ALTSA has tracked transitions into the EMP program since the program's inception in 2009. Under DOC's authority per RCW 9.94A.728,

any individual participating in the EMP program may be returned to prison for any reason and this has been allowable within DSHS-operated facilities since this law was established. DOC prepares a yearly report to the legislature regarding EMP placements following RCW 72.09.620 reporting requirements. Most individuals receiving services through the EMP program reside in adult family homes in Washington, although there is currently one individual living in an SNF, and one in a private home.

The RCW governing this program severely restricts DOC's ability to release on EMP, and some individuals die prior to placement. Due to a lack of providers willing to serve this population, it can take several months to find a viable community alternative for individuals with long-term care needs who are being released from DOC custody (in some cases 6 months or more). Eight individuals in 2019 and 12 individuals in 2020 died while waiting for EMP transitions.

The 2023 legislature passed Substitute Senate Bill 5101 which increases eligibility for the EMP program so that an incarcerated individual may be authorized for an EMP if:

- The individual has been assessed by two physicians and is determined to be either:
  - Affected by a permanent or degenerative medical condition to such a degree that the individual does not presently, and likely will not in the future, pose a threat to public safety; or
  - In ill health and is expected to die within six months and does not presently, and likely will not in the future, pose a threat to public safety;
- The incarcerated individual has been assessed as low risk to the community at the time of release; and
- Granting the EMP is expected to result in cost savings to the state.

Implementation of this legislation will expand the EMP program eligibility and caseloads. The individuals on EMP may be candidates for placement in a long-term care facility that is the focus of this report.

Electronic Home Monitoring Costs

Electronic Home Monitoring (EHM) is used as an alternative to confinement, allowing a person to serve a sentence while remaining in their own home and maintaining a connection to the community. There are several different types of EHM products used by DOC, depending on the partial confinement program in which the individual is assigned. For the purposes of this report, DOC would suggest using GPS EHM which simply requires an individual to wear a tracking item (usually a bracelet). GPS enables 24/7 monitoring of an individual as it relates to their location, with geographic boundaries or "geo fences" set up so that if the person travels outside of the set boundary, an assigned DOC staff person is notified.

DOC staffing at a Long-term Care Facility Serving Low-Risk Individuals

As an additional security measure, DOC could place a Community Corrections Specialist (CCS) physically on site at a long-term care facility serving low-risk individuals. The cost of one CCS FTE would be approximately $106,427. Depending on the number of incarcerated individuals served at the facility, a ratio of incarcerated individuals to CCS staff could be developed. DOC has never had a serious incident occur with anyone in the EMP program wearing an EHM, so they do not believe this

extra security measure is necessary but have added it to this report as an additional security option. This would affect eligibility for Medicaid funding as discussed in section seven of this report.

Cost-benefit analysis

DOC is unable to conclusively identify the cost of treatment within their medical facilities and the Sage unit. Across DOC facilities, the average statewide cost of incarceration including healthcare and institution costs is $174.32 per individual per day for FY22.

Facility/Program	Cost per individual per day	Notes
Sage Unit	Unknown	The average statewide cost of incarceration is $174.32 per day.
Electronic Home Monitoring	$9.50 plus monitoring cost	Monitoring costs would include 2 Community Corrections Specialists ($212,854)
Extraordinary Medical Placement	Varies based on the assessed daily rate	Each EMP placement cost varies based on the individual's assessed level of need and the setting to which the individual is transitioned.

Table 5: Cost estimates for existing DOC facilities/programs

DOC facilities are not healthcare facilities and are neither equipped nor funded to provide the skilled level of care required by those in need of long-term services and supports. There are two primary determinants of the daily operating costs of facilities that would be better equipped to meet the needs of individuals under DOC jurisdiction: 1) the level of care and specific services required to care for these individuals, and 2) the level of security needed to comply with legal requirements and preserve safety for clients, staff, and the community at large. As each of these factors increases in complexity, we assume costs will increase. It is important to note that depending on the intent and function of the security provided, the ability to draw down Medicaid match may be impacted.

6 Ability of potential facilities to meet potential clients' needs

As noted above, any potential solution involves a careful balance between an individual's long-term care needs and their security requirements. A dedicated long-term care facility in the community could easily meet the long-term care needs of these individuals, but currently only a DOC facility could meet the security needs of incarcerated individuals whose custody requirements are such that they cannot be released as part of a partial confinement program. There are two populations of inmates to consider when evaluating potential facilities: partially confined and fully confined.

The first population comprises individuals whose sentences could be reduced to some type of partial confinement. Once released from a condition of full confinement in a DOC facility, these individuals could be served in a long-term care facility in the community and, depending on their financial resources and their level of functional need, could qualify for Medicaid-funded care. DOC would remain responsible for the administration of the partial confinement program in which the individual is

participating. The long-term care facility would not be responsible for enforcing any security measures that would apply to the individual.

The second population comprises those individuals who would not be eligible for partial confinement due to the severity of their sentences or their necessary security and custody levels. These individuals would not be eligible for care in a community long-term care facility and must be housed in a facility with security measures like those in operating prisons or an embedded facility within an operating prison. As discussed in section seven of this report, a facility of this nature would not be eligible for federal Medicaid funding. While there are no existing facilities such as this in Washington state, there is a possibility of creating one that would meet the legal and medical requirements for caring for individuals under the jurisdiction of DOC.

Table 6 compares the differing populations of inmates and potential solutions for meeting their long-term care needs, including the two distinct possibilities for a long-term care facility that could serve incarcerated individuals who are not eligible for participation in a partial confinement program.

Population	Potential Facility Type	Requirements
Eligible for EMP today	Home and community setting or SNF	No legislative action needed. Authority is established. Medicaid funds are used to serve this population.
Eligible for partial confinement category that does not exist today	A SNF or other type of long-term care facility in the community	Would require legislative action to create a partial confinement category. Once released, these individuals could be served in an SNF in the community. Medicaid funds could be used to serve this population as long as the home and community-based settings with any allowable restrictions were followed.
Not eligible for partial confinement	Expanded medical facilities and staffing to care for these individuals within existing DOC facilities	Would require remodeling/upgrading current DOC medical facilities and the addition of appropriately trained staff (physicians, nursed, CNAs, etc.). Medicaid funds could not be used as the residents are still incarcerated.
Not eligible for partial confinement	Purchase or lease of a facility in the community that would meet both the security and long-term care needs of the residents	Would require the purchase or lease of a building and appropriate remodeling to provide sufficient security as well as the staff and equipment needed for long-term care supports and services. Medicaid funds could not be used as the residents are still incarcerated.

Table 6: Potential facility types and requirements for populations with different security needs.

Security and custody levels of potential participants

One of the most significant considerations when discussing potential programs of this nature is the level of security required to support a safe environment for clients, staff, and the community. DOC provided

security and custody information relating to the 117 incarcerated individuals identified as potentially eligible for placement in a long-term care facility.

Custody classification is the management tool used to assign incarcerated individuals to the least restrictive custody designation possible while providing for the safety of personnel, the community, and the individuals themselves. Incarcerated individuals are placed in custody levels from least restrictive Minimum Custody to most restrictive Maximum Custody. Each level has different restrictions. Incarcerated individuals in Maximum Custody will require more security—such as handcuffs—during movement and less time out of their cell for hygiene and yard time. Minimum Security individuals have less supervision, more freedom of movement, and more program opportunities.

The Sage unit at CRCC houses only Minimum Custody individuals or individuals who can have an override to this classification. Individuals at higher custody levels do not have an opportunity to access this type of unit in DOC facilities. With the prison population aging, many individuals who may require long-term care have sentences that do not qualify for a lower custody level or placement in the community. Although it is a small number of individuals, DOC does not have the infrastructure to appropriately manage the level of care needs for this population as it ages.

Table 7 shows a breakdown of the security and custody level of the 117 individuals identified as potentially eligible for SNF services.

Security and Custody Level	Distinct # of Patients	% of Total Sample
Security Level 5 - Maximum Custody	1	0.9%
Security Level 4 - Close Custody	7	6.0%
Security Level 3 - Medium Custody	15	12.8%
Security Level 2 - Minimum Custody	94	80.3%

Table 7: Potentially eligible individuals by security and custody level.

Table 8 shows a breakdown of the 23 individuals identified as most likely eligible by security and custody level.

Security and Custody Level	Distinct # of Patients	% of Total Sample
Security Level 5 - Maximum Custody	0	0.0%
Security Level 4 - Close Custody	1	4.3%
Security Level 3 - Medium Custody	1	34.8%
Security Level 2 - Minimum Custody	21	56.5%

Table 8: Most likely eligible individuals by security and custody level.

Three individuals who are potentially eligible are listed as having active mental health symptoms that cause serious impairment in functioning in one or more areas and may pose a safety risk for themselves or others. They may also require more intensive treatment such as that provided in a residential

treatment unit. Additionally, 16 individuals who are potentially eligible are also listed as having current active mental health symptoms with moderate severity and with some noted problems with daily functioning. Conditions such as these may warrant safety and security considerations beyond those represented by custody level and must be addressed on an individual basis.

Many other individuals represented in the sample also require complex medical care and accommodations that can place a significant strain on DOC facilities, staff, and other resources. This represents health and safety risks both for these individuals and for other individuals and staff. Most cells are not ADA-accessible, and most individuals must walk a distance for daily meals, medical needs, medication pill lines, programming, and recreation. This is challenging for individuals with mobility restrictions or cognitive limitations. Prison life is based on following rules, and individuals with an underlying condition that limits the ability to understand rules and directions can impact the safety of the individual as well as the safety and security of the facility. For example, an individual with advanced dementia was recently removed from the general population after starting a fire in a microwave oven as he could not remember how to use it.

Each person being considered for transition into a facility in the community would need to be evaluated for the setting being considered. In the final design of any potential setting, both the physical structure of the facility and staffing arrangement would need to be appropriate to meet the needs of those served. Without a full assessment of each individual, it is difficult to assess the individual care needs of the current population. DSHS and DOC would need to establish a shared tool to assess for transition that identifies qualifications for transition based on the needs of the individual and best fit with the facility.

DSHS stresses that existing long-term care facilities lack the infrastructure, security, training, staff, and knowledge to serve individuals with high security needs. Trying to serve these individuals could create unsafe conditions and introduce risk to residents, staff, and the community at large. Implementing confinement controls for these individuals outside of existing DOC facilities could be inconsistent with federal Medicaid guidance for an SNF.

We conclude that addressing the long-term care needs of individuals who represent a high or medium security risk is a complex and challenging problem without an obvious solution. Under existing rules, long-term care facilities cannot provide the necessary security for such individuals, and current prison facilities cannot provide for their long-term care needs. For individuals eligible for partial confinement programs, access to long-term care services in the community can provide for their needs. There may be a subset of individuals, not currently eligible for EMP or partial confinement programming under DOC, that is low-risk and could be served in a long-term care facility setting.

7 Ability to provide Medicaid-funded services

In considering the potential availability of Medicaid funding, we must examine the question of eligibility from two perspectives: individual and institutional.

From an individual perspective, federal law prohibits states from using federal Medicaid matching funds for healthcare services provided to adult and juvenile inmates of public institutions. The Centers for Medicare and Medicaid Services (CMS) defines a public institution as “an institution that is the responsibility of a governmental unit or over which a governmental unit exercises administrative

control." While in the custody of a public institution, the institution is required to provide medical care to an "inmate."

Whether a person is eligible to receive Medicaid-funded care depends on whether they meet the Medicaid definition of an inmate, what exactly an individual's custody and release conditions are, the level of involvement DOC would have in their release and care, and the ability of long-term care Medicaid providers furnishing their care to otherwise meet federal Medicaid requirements while providing that care. To obtain Medicaid Federal Financial Participation (FFP), individuals involved with the justice system could not have any conditions of confinement that would cause them to meet Medicaid's definition of an inmate or otherwise interfere with their ability to enjoy—or a facility's ability to comply with—Medicaid resident rights laws. DOC has been successful in the past in creating programs that allow for this.

CMS considers an individual of any age to be an inmate if the individual is in custody and held involuntarily through the operation of law enforcement authorities in a public institution. To be considered not an inmate for the purposes of Medicaid, the individual must have "freedom of movement." By federal and state rules, individuals living and receiving care in nursing facilities have the right to free access to the community and to community activities—such as social, religious, and other group activities—and the right to discharge planning for movement into the community. Individuals receiving services through Medicaid are also entitled to free choice between qualified providers. Section 1902(a) (23) provides that any individual eligible for medical assistance (including medications) may obtain such assistance from any institution, agency, community pharmacy, or person qualified to perform the service or services required that undertakes to provide them such services.

The federal rule for Medicaid Apple Health does not prohibit having an individual open/active on Apple Health while residing in a correctional facility, but it does prohibit the Health Care Authority (HCA) from receiving federal matching funds while the individual is incarcerated. Under current policy, an incarcerated individual can retain their Apple Health *eligibility* indefinitely, however, their *scope of coverage* will change. When an individual is incarcerated, per federal Medicaid law, HCA suspends full scope coverage and limits it to inpatient hospitalization only. While incarcerated, the agency also suspends any payments to managed care organizations, behavioral health organizations, and any other Medicaid-related service authorizations. This means that all healthcare services an incarcerated individual residing in a correctional facility needs, absent hospitalization for a period of 24 hours or more, are currently paid for with state funds.

According to Substitute Senate Bill 6430,

> Individuals who are on parole, probation, or have been released to the community pending trial, including under pre-trial supervision, are not considered inmates. Federal funding for Apple Health (Medicaid) is available for services provided to these individuals.

This leaves two populations of individuals currently in DOC care and custody that are eligible for Medicaid: 1) those on the Extraordinary Medical Placement program (described above); or 2) those under partial confinement by DOC. The partial confinement population consists of three options: Community Parenting Alternative (CPA), Graduated Reentry (GRE) and Work/Training Release and is currently not the target population for this work in terms of sentencing lengths. The target population in

that regard are those with longer-term sentences and with health and long-term care needs that are outside the capacity, infrastructure, and specialty for DOC to provide. Additional statutory authority would be needed under Chapter 9.94A RCW to add a partial confinement sentencing type that would include longer-term sentences and would be eligible for long-term services and supports in a long-term care facility, potentially with eligibility for Medicaid funding.

HCA presents this table on their website, which illustrates when a justice-involved individual can be eligible for Medicaid. The table includes the following description of the DOC Work/Training Release program and affirms that such individuals are eligible for Medicaid.

> **Supervised Community Residential facility/Halfway House/DOC Re-entry Centers (work release)**
> The justice involved individual is housed in state or local corrections-related supervised community residential facility which allows for '*freedom of movement'* to: 1) work outside the facility in employment opportunities available to individuals who are not under justice system supervision, 2) use community resources at will (libraries, grocery stores, recreation, etc.) and 3) seek health care treatment in the broader community to the same or similar extent as other Medicaid enrollees. The residential facility may be public or privately operated. These facilities may have "house rules" where for example residents may be required to report during certain times and sign in and out. Similarly, they may be restricted from traveling to or frequenting locations associated with criminal activity. The majority of state operated (DOC) work release programs use this model. Please refer to the list of approved work release facilities.

If the statutory authority to add a partial confinement type for longer-term sentences could be obtained, a similar facility could house long-term care clients.

From an institutional perspective, CMS Conditions of Participation clearly prohibit institutions receiving Medicaid funding from serving clients who are confined in any way, as they cannot be restricted for any reason other than directly related to their medical condition as determined by a physician. These facilities are also unable to enforce any kind of restrictions on visitation or contact between the clients they serve and any other person. The following are examples of facility restrictions that would result in enforcement action or termination from participation in Medicaid FFP:

- The facility makes a determination as to which visitors a resident may or may not see. The resident has the right to choose his or her own visitors.
- The facility requires or implements a DOC or law enforcement restriction that the individual must reside in a locked unit in the SNF or NF for reasons that are not derived directly and exclusively from the resident's assessment(s) as conducted by the facility's medical professionals.
- The facility does not allow a resident to possess a personal telephone and/or denies a resident the right to conduct telephone conversations in private.
- The facility has a requirement that a resident must wear an item (e.g., a color-coded bracelet) that indicates to staff that they are justice involved.

From a DOC Conditions of Confinement perspective, individuals served under EMP and partial confinement (as described above) choose to leave the prison facility and, in doing so, sign an agreement

that they will adhere to all safety and security rules defined by DOC based on their specific conditions of confinement. DOC may return the individual to prison for any reason, including not adhering to these conditions. In these instances, the responsibility for imposing confinement restrictions on a resident does not fall on facility staff, but rather on DOC.

Additionally, the US Department of Health and Human Services recently issued guidance that encourages states to apply for an 1115 waiver that would allow incarcerated individuals access to Medicaid services up to 90 days prior to their earned release date from prison. In addition to increased health and well-being and saving lives, the demonstration aims to accomplish several other essential goals, including improving coordination and communication between correctional systems, Medicaid systems, managed care plans, and community-based providers, as well as increasing investments in health care and related services. HCA is applying for this 1115 waiver to serve incarcerated individuals in Washington state. Although this is not the population that is the focus of this report, which is concerned with individuals without an impending release date, it is an example of positive movement by the federal government to increase access to Medicaid-funded services for those that are incarcerated.

An institution would also be ineligible for Medicaid funding if it exclusively serves inmates and was established for that purpose. CMS addresses this issue directly in SHO #16-007:

> Q27: Can hospitals or nursing homes that exclusively serve inmates qualify for FFP?
> A27: No. Hospitals, nursing facilities, or other medical institutions operated primarily or exclusively to serve inmates are considered correctional institutions and FFP would not be available for services. Nursing facilities and all medical institutions under this exception to the general exclusion must be operated as medical institutions generally available to the public, organized primarily for the provision of medical care, meet federal requirements discussed in A21, and meet the additional requirements of the definition of a medical institution at 42 CFR 435.1010.

To summarize, Medicaid FFP is available to facilities in the community that are available to the public and have no enhanced security protocols. Medicaid FFP is not available to facilities that are located within—or are themselves—secure facilities.

8 Conclusion

Based on the information presented in this report, we can conclude that many individuals incarcerated in DOC facilities could meet functional eligibility requirements for services provided through a long-term care facility such as nursing homes. These individuals with high needs currently represent a strain on the medical staff and facilities of DOC institutions, which are not equipped nor funded to provide the services that these incarcerated individuals require.

Long-term care facilities are not currently equipped to handle individuals who have high custody requirements. Attempting to transition these individuals into these facilities represents safety risks to other clients, staff, the community, and the individuals themselves.

However, we believe that there is a population that is both low risk to the community, and in need of long-term services and supports that would benefit from services in a more equipped, appropriate long-

term care setting. This population is not currently served under the existing EMP program and could be a starting place in terms of how we, as a state, tackle the issue of incarcerated individuals who are aging and in need of long-term care.

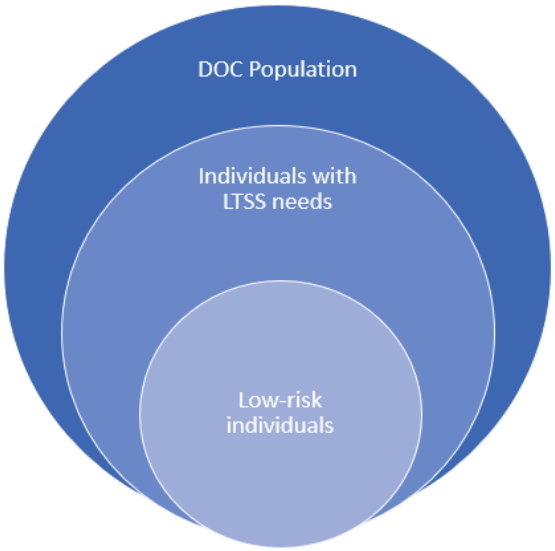

Figure 4: DOC population subsets.

It is also important to note that there is a need in the state for additional long-term care beds for individuals releasing from DOC custody who have served their full sentence and reached their earned release date. Often, DOC serves this population in need of long-term services and supports past their earned release date in prison facilities because they have no established reasonable and safe release plan. A facility that serves a combination of incarcerated and released justice-involved individuals might solve multiple issues within the current system.

For those in full custody of DOC, if the state cannot secure the ability to consider partial release as it has with other partial confinement programs, Medicaid funds will simply not be allowed to be used as these individuals are in the custody of public institutions, and those institutions are responsible for all their medical care, including any long-term care needs.

Providing the legislature is able to create partial confinement opportunities for long-term care-eligible incarcerated individuals, Medicaid funds can be secured for a program involving serving these low-risk individuals in a facility that specializes in offering Skilled Nursing services, therapies, treatments, and assistance with ADLs.

Federal law requires that all SNFs be certified by CMS, and as a result, they must adhere to federal rules and regulations regardless of payment source. Serving individuals in full DOC custody would require the creation of a separate licensing type or a waiver from current federal statutes. It would also require a specialized staffing model or partnership with DOC to meet custody requirements.

It is the opinion of both DSHS and DOC that the care provided for potential long-term care clients currently residing in DOC facilities is neither specialized nor sufficient. Some of these individuals have a constellation of medical and behavioral issues that are not necessarily appropriate for long-term care

supports and services either. For those individuals identified as likely to meet the functional assessment for long-term services and supports, there is currently no partial confinement program available that would allow them to be served in a community long-term care facility. The EMP program is currently the only available option to serve these individuals and it is unclear how much SB 5101 will expand this program for individuals within DOC care and custody.

Considering the relevant opportunities and restrictions, there are three courses of action available to the state to address the needs of the relevant population under DOC jurisdiction: 1) Expand the medical facilities and resources inside one or more existing DOC facilities to accommodate incarcerated individuals with long-term care needs; 2) Use state funds to build or lease and contract out or operate a new facility that could address the needs of that population; or 3) Pursue a scenario in which potential clients have limited levels of confinement and receive services from a facility available to the general public that would be eligible for Medicaid FFP.

DSHS, DOC, and HCA understand that this is a complex issue with complicating factors that include funding and federal rule limitations and current state law limitations related to confinement levels. Current aging physical plant characteristics of our state prison facilities would require expensive upgrades. Provider liability and reluctance to accept justice-involved patients, and concerns by local communities and jurisdictions would make it difficult to site a facility for this population. We believe that all individuals regardless of race, ethnicity, gender, sexual orientation, age, ability, capacity, socio-economic background, or criminal history deserve to receive healthcare that is compassionate and person-centered in meeting their unique needs, goals, and preferences. We are committed to continuing this important work of finding solutions to providing appropriate healthcare, including long-term services and supports, to incarcerated individuals in need in DOC's care and custody.

9 Appendix

Abbreviations	Facility Name	Location
AHCC	Airway Heights Corrections Center	Airway Heights, WA
CBCC	Clallam Bay Corrections Center	Clallam Bay, WA
CCCC*	Cedar Creek Corrections Center	Littlerock, WA
CRCC	Coyote Ridge Corrections Center	Connell, WA
LCC*	Larch Corrections Center	Yacolt, WA
MCC	Monroe Correctional Complex	Monroe, WA
MCCCW*	Mission Creek Corrections Center for Women	Belfair, WA
OCC*	Olympic Corrections Center	Forks, WA
SCCC	Stafford Creek Corrections Center	Aberdeen, WA
WCC	Washington Corrections Center	Shelton, WA
WCCW	Washington Corrections Center for Women	Gig Harbor, WA
WSP	Washington State Penitentiary	Walla Walla, WA

*Omitted from Table 1 above. Zero patients identified as potentially eligible for SNF services.