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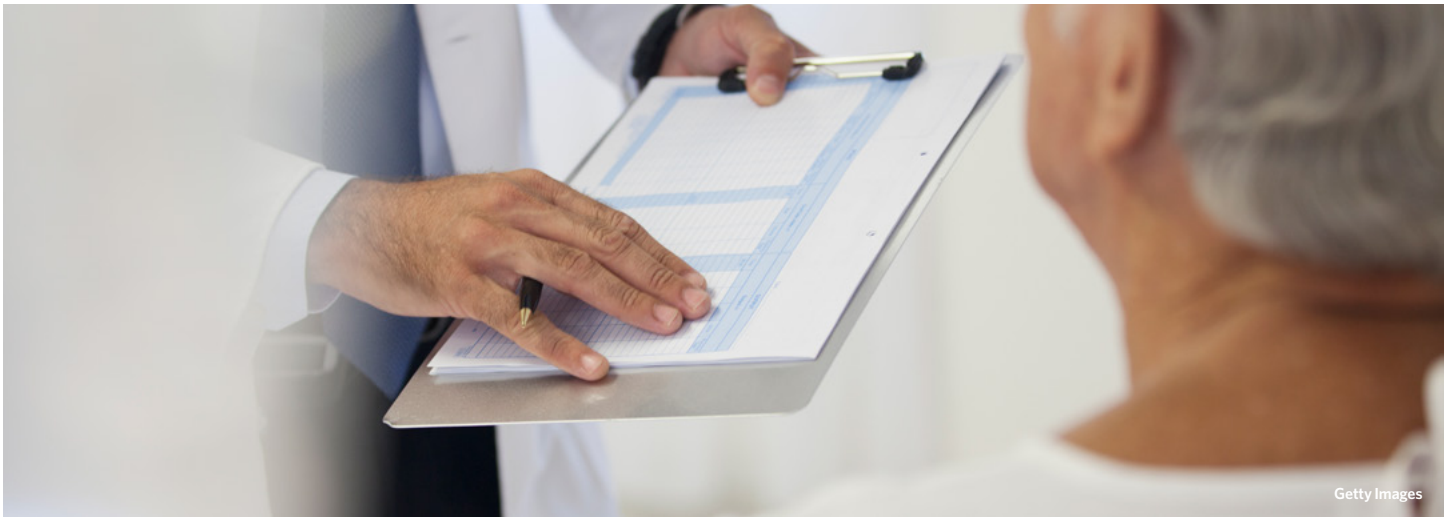

How and When Medicaid Covers People Under Correctional Supervision

New federal guidelines clarify and revise long-standing policies

Overview

The Centers for Medicare & Medicaid Services (CMS), a unit of the U.S. Department of Health & Human Services (HHS), released new guidance in April 2016 on how states and localities may facilitate access to Medicaid coverage for individuals before, during, and after a correctional institution stay.[1] In announcing these guidelines, HHS noted that Medicaid "connects individuals to the care they need once they are in the community and can help lower health care costs, hospitalizations and emergency department visits, as well as decrease mortality and recidivism for justice-involved individuals,"[2] people under community supervision (e.g., parole) or incarcerated in prisons or jails. This population has disproportionately high rates of physical and behavioral health illnesses.

The guidelines reiterate and elaborate on long-standing policies pertaining to Medicaid coverage of inmates and remove some restrictions on covering certain individuals after release. This analysis, building on **previous research** conducted by The Pew Charitable Trusts,[3] explains CMS' latest communication, its practical impact for state and local policymaking, and how some jurisdictions have navigated this terrain.

History of Medicaid coverage for the incarcerated

Jurisdictions have never been precluded by inmates' incarceration status from enrolling them in Medicaid, the joint federal-state health care program for vulnerable populations. CMS has long held that individuals who meet states' Medicaid eligibility criteria "may be enrolled in the program before, during, and after the

time in which they are held" in jail or prison.[4] However, most inmates could not enroll because, as nondisabled adults without dependent children, they did not meet many states' categorical eligibility criteria despite their low income.

The Affordable Care Act (ACA) created an opportunity, beginning in January 2014, for states to change this situation by providing additional federal money to those that elect to expand their eligibility criteria for Medicaid coverage to all individuals under age 65 who earn up to 138 percent of the federal poverty level ($16,394 for a single adult in 2016).[5] This expansion removes a key barrier that frequently prevented states and localities from enrolling inmates—or keeping them enrolled during incarceration with suspended coverage—and seeking federal Medicaid reimbursement for certain services provided to inmates. Thirty-one states and the District of Columbia had expanded their criteria in accordance with the ACA as of May 2016.[6]

New guidelines clarify and amend prior rules

In its communication to state officials, CMS repeated long-standing federal policy: Incarceration does not make one ineligible for Medicaid. Echoing previous guidance, the agency declared that, for eligible applicants, "the state must enroll or renew the enrollment of the individual effective before, during, and after the period of time spent in the correctional facility." It also reiterated, however, that the nature of Medicaid coverage—that is, the services for which the program may pay—varies depending on whether a person involved with the criminal justice system meets the agency's definition of an inmate, with significant limitations applying to such individuals. In contrast, benefits were newly extended to residents of state or local community residential facilities under correctional supervision (e.g., those in a halfway house).

Limited coverage of inmates

To be considered an inmate, a person must be in the lawful custody of a state or locality and held involuntarily in a correctional facility. States may not provide Medicaid coverage for health care services delivered to these individuals, with one exception: for care delivered outside the institution, such as at a hospital or nursing home, when the person has been admitted for 24 hours or more. Under these circumstances, states can obtain federal reimbursement that covers at least 50 percent—and much more, if the person is newly Medicaid-eligible—of prisoners' off-site inpatient costs, as long as they are eligible and enrolled in the program.

In the new guidance, CMS clarified that, in instances where an inmate is eligible but not enrolled at the time that covered inpatient services are delivered, states may secure retroactive Medicaid coverage and therefore federal reimbursement so long as the person applies for the program within three months of receiving treatment. For example, if an inmate is hospitalized from March 1 to 4, federal assistance may be sought if the inmate was Medicaid-eligible at the time of the hospital stay and submits an application for enrollment—often with assistance from public officials—to the state Medicaid agency by June 30.

States that expand their Medicaid eligibility under the ACA will generally realize the largest savings from this option because most inmates, as nondisabled adults without dependent children, are eligible for Medicaid coverage only under the expansion. Moreover, payments for these newly eligible individuals will trigger the enhanced federal match of at least 90 percent.

States have begun to report realized and projected savings. For example, Arkansas, Colorado, Kentucky, and Michigan detail combined fiscal years 2014 and 2015 savings of $2.8 million, $10 million, $16.4 million, and $19 million, respectively.[7]

Medicaid Eligibility During Out-of-State Incarceration

Correctional departments sometimes transfer inmates involuntarily to institutions in other states. In these instances, for the purposes of Medicaid eligibility, the inmate retains residency in the home state. That is, covered inpatient services provided to Medicaid-eligible inmates would be billed to the home state's Medicaid program, with its corresponding federal reimbursement.

When people commit crimes and are incarcerated outside their home state, they are considered residents of that state for the purposes of Medicaid eligibility and enrollment. Such enrollees may apply for Medicaid enrollment in a second state—for example, their home state prior to release—before benefits are terminated in the first state. But the new coverage cannot be activated before termination.

Suspending inmate coverage

CMS has long encouraged states not to terminate coverage for enrolled inmates during their time in correctional facilities, but rather to temporarily suspend it until release or until enrollees receive off-site inpatient care. Suspension allows coverage of all Medicaid services to resume seamlessly upon re-entry to the community, a time of particularly high mortality.[8] Suspension also helps ensure that states do not seek federal reimbursement for non-inpatient health care services provided to enrolled inmates.

As of May 2016, 31 states and the District of Columbia had policies to suspend coverage, at least temporarily. Fifteen suspended coverage for a specific time period, such as the first 30 days or the first year of incarceration. Time-limited policies are especially applicable to those in local jails, which house inmates awaiting trial and those convicted of misdemeanors who are serving sentences of less than one year. An additional 16 states and the District suspend coverage for the full duration of time spent in correctional facilities. Nineteen states terminate coverage. Colorado, Delaware, Hawaii, Nevada, New Hampshire, North Dakota, and Pennsylvania were the only states with a termination policy that had adopted the ACA expansion by May 2016.[9] (Colorado and Hawaii passed laws changing their policies from termination to suspension but had not yet begun implementation.)

Once again urging states to make use of suspension—and to promptly lift suspensions as soon as appropriate—CMS noted in its latest guidance that during the time in which a Medicaid-enrolled individual is an inmate, the state may either suspend the person's eligibility (i.e., make him or her ineligible for all Medicaid-covered treatment pending enrollment reactivation) or leave enrollment unaltered and instead ensure that claims are not approved for excluded services. One way this can be done systematically is by establishing "edits" in state Medicaid claims processing systems. Edits are automated safeguards that states use throughout their Medicaid program to prevent improper payments.

Substantial federal support is available to assist states with upgrading Medicaid eligibility and enrollment technology if their systems hinder or prevent them from suspending eligibility or coverage for incarcerated

individuals. CMS will cover 90 percent of the costs of the design, development, and installation of new or improved claims processing and information retrieval systems, and 75 percent of ongoing maintenance and operation costs of such systems, so long as the modifications meet certain standards and conditions.[10] The enhanced funding—previously set at 50 percent—became available in April 2011 with an initial expiration of Dec. 31, 2015, but CMS later made the additional money permanently accessible.[11]

Coordinating with contractors

CMS advises states and localities to make careful arrangements in two key ways with contracted partners to ensure that care and payments for Medicaid-eligible inmates are handled appropriately.

First, states that utilize managed care organizations (MCOs) to provide Medicaid benefits in return for a set per-member, per-month payment should either exclude individuals in correctional facilities from managed care plans and provide covered services on a fee-for-service basis, or disenroll them during incarceration to ensure that payments are not made on their behalf. The latter approach requires timely reporting among state and local correctional departments, Medicaid agencies, and Medicaid managed care plans. Contracts should also establish a process for recoupment of whole or partial payments, depending on the time of month an enrollee becomes an inmate.

The inmate MCO payment restriction could present a challenge for release planning. CMS notes that "states can encourage or require their Medicaid managed care entities to work with state and local correctional agencies to connect such individuals to needed health services upon release." However, if states are precluded from paying MCOs before Medicaid-eligible inmates return to their communities—on the first of the month of release, for example—plan officials may not be compensated for engaging in discharge planning activities (e.g., establishing treatment plans, scheduling appointments) that can help smooth transitions. There may also be a gap in post-release coverage, potentially weakening care continuity during this highly vulnerable period.

States may overcome this obstacle by retroactively reimbursing an MCO for pre-release discharge planning activities by incorporating those costs into payments made after an individual has returned to the community and Medicaid coverage is reactivated. However, this still leaves the possibility of discontinuity in coverage if, for example, an inmate is released midmonth and payments (and coverage) are not initiated until the following month. This problem can be prevented by making partial-month payments prorated to release dates.

Second, states and localities that contract with vendors to deliver health care to inmates should, according to CMS, be mindful of who bears responsibility for the costs of inpatient services under their agreements. If the vendor is required to pay—costs it would presumably pass along to the state or locality by incorporating them into negotiated contract payments—federal Medicaid assistance may not be sought for those who are enrolled. Alternatively, if the jurisdiction retains liability for such treatment, Medicaid may be billed. One exception is when an agreement caps a vendor's responsibility for inpatient costs and the total cost of covered services exceeds the ceiling. In that instance, states may receive federal matching funds for the difference between what the vendor pays and the amount for which Medicaid may pay, so long as the patient is Medicaid-eligible and the community provider participates in the program. For example, if a vendor is responsible for the cost of hospitalizations up to $15,000 and a total bill comes to $20,000—all of which falls under the Medicaid-allowable rate—the state may receive federal reimbursement for a portion of the $5,000 it must pay.

Jails vs. Prisons

Jails are facilities that house inmates awaiting trial and those convicted of misdemeanors who are serving sentences of less than one year. In most states, they are run by counties or cities. Prisons are state or federal facilities that incarcerate convicted inmates serving sentences of more than one year. From June 2013 to June 2014, jails held approximately 11.4 million inmates.[12] State prisons housed 1.4 million on a typical day in 2014.[13] For the purposes of this analysis, no distinction is made between inmates of jails and prisons because Medicaid policies apply identically to both. However, owing to the much shorter nature of jail stays (frequently mere hours or days), the less predictable timing of bookings and releases, and the sheer volume of individuals cycling through, state and local officials face different challenges as they design programs to enroll inmates in Medicaid.

Covering individuals under community supervision

Persons involved with the criminal justice system who are not defined as inmates—comprising 69 percent of the correctional population nationally[14]—may receive Medicaid benefits if they meet the state's eligibility criteria required of all residents. Historically, this has applied only to those arrested but released pending trial, as well as probationers, parolees, and individuals under home confinement.[15] Probationers are typically low-level offenders who remain in the community under the supervision of a probation officer, whereas parolees are people who have spent time incarcerated and are released to complete the remainder of their sentence under community supervision.

The latest guidance reverses previous policy that prohibited the coverage of services for Medicaid-eligible persons residing in state or local community residential facilities under correctional supervision (e.g., halfway houses). To help ease the transition from incarceration to the community, some inmates are temporarily placed in such facilities that provide a safe, structured environment where individuals can stay while they acquire job training or employment, permanent housing, and other critical elements of re-entry.

Benefits may now be provided to these residents so long as the facility affords them freedom of movement and association. Specifically, residents must be permitted to work outside the facility at a job available to those not under correctional supervision; free to use community resources (e.g., library, grocery store) at will; and free to access health care treatment like other nearby Medicaid enrollees do. The new rules do allow for some limitations. For example, the residence may be closed or locked during certain hours, and residents may be required to report to staff at various times and sign in and out of the building. Individuals may also be restricted from traveling to high-crime locations.

Federal officials estimate that this action will extend access to benefits for up to 96,000 individuals annually in the 31 states plus the District of Columbia that had adopted the ACA's Medicaid expansion as of the release of the guidance.[16]

Enrolling inmates before release

Because of the extensive and, in some cases, communicable health conditions of many inmates, state and local officials recognize that facilitating seamless access to health care upon re-entry into society can improve the individuals' prospects for successful reintegration and benefit the public's health and safety. People frequently enter jail or prison with a substance use disorder[17] and/or a mental illness[18] and have high rates of chronic medical conditions[19] (such as hypertension and diabetes) and infectious diseases (such as HIV[20] and hepatitis C[21]).

Health insurance is a key ingredient of access to quality care for all Americans, including those involved with the justice system. But many of those released—nearly 80 percent, according to some estimates—have historically returned to their communities uninsured because they were initially without access to employer-sponsored insurance, unable to afford insurance in the individual market, or did not qualify for safety net health programs such as Medicaid.[22] This increased the likelihood that they would face challenges accessing quality care.

With many more inmates qualifying in states that have expanded their Medicaid programs, several jurisdictions have begun putting programs in place to enroll those soon to be released.[23] For example, the Ohio Department of Rehabilitation and Correction partners with the state's Medicaid agency to enroll inmates and facilitate their selection of a Medicaid managed care plan 90 days before their release. Corrections officials believe that Medicaid coverage will help departing inmates more successfully access appropriate medical, mental health, and substance use disorder services, which they view as having the potential to reduce recidivism.[24]

Indiana enacted a law in July 2015 requiring its Department of Correction to help enroll individuals before releasing them from custody. Intake facilities screen every new inmate for enrollment and relay the information of active enrollees to a Medicaid processing unit within the department, which works with the state Family and Social Services Administration to then suspend coverage. The processing unit also coordinates the reactivation of suspended coverage and works with inmates to complete new applications 60 days before their departure. As of May 2016, 12,071 inmates had been covered upon release.[25]

In Illinois, the Cook County Health and Hospitals System works with a local social services agency to screen detainees entering the Chicago-area jail for eligibility. As of June 2015, more than 12,000 had been enrolled.[26] Speaking of the coverage expansion for individuals passing through his jail, Cook County Sheriff Thomas Dart said, "I have the highest level of confidence that this will either keep them from coming back, or extend out the period of time before they come back."[27]

Importantly, states need not expand their Medicaid programs in accordance with the ACA to make coverage available to inmates who are released. Wisconsin, for example, has not adopted the ACA's Medicaid expansion but provides coverage to nondisabled, childless adults whose incomes do not exceed 100 percent of the federal poverty level.[28] With assistance from corrections staff, the state allows soon-to-be-released inmates to apply for benefits over the phone at the end of the month before their release.[29] Coverage goes into effect on the first day of the month in which inmates are released.

State and local enrollment programs are spreading coverage to more people. For example, researchers at Johns Hopkins University found that the uninsured rate for adults in the community with a substance use disorder and with prior-year involvement with the criminal justice system (i.e., having been arrested and booked or on probation or parole in the previous 12 months) fell from a consistent 38 percent from 2004-13 to 28 percent in 2014, the first year of the ACA Medicaid expansion. The change was mainly due to increased Medicaid enrollment.[30]

CMS urged these places to continue their efforts and others to follow their examples, stating, "We strongly encourage correctional institutions and other state, local, or tribal agencies to take an active role in preparing inmates for release by assisting or facilitating the application process prior to release." Richard Frank, HHS assistant secretary for planning and evaluation, said health coverage after release is "critical to our goal of reducing recidivism and promoting the public health."[31] The director of national drug control policy, Michael Botticelli, drew an even finer point: Immediate Medicaid coverage upon release "can mean the difference between ... life and death."[32]

Sharing medical records with community providers

Like anyone switching doctors, the continuity of care provided to individuals in jail or prison can be improved during intake and after release by the transfer of medical records between correctional health systems and community providers. Records sharing—whether paper-based or through electronic means—can save time and money by conveying critical patient information, such as medical history, diagnoses, current medications, and laboratory test results, and improves the likelihood that successful treatment plans are continued without delay or disruption. CMS affirmed its support for records transfers in its latest guidance, noting that various federal funding sources are available to support these activities.

Since February 2016, CMS has made 90 percent match funding available to states for costs associated with establishing and promoting the electronic exchange of health information between certain community-based Medicaid providers and providers in correctional settings.[33] This means, for example, that federal money could be available to support administrative actions required for prison or jail officials to access a community health information exchange (HIE) and to add new data. Correctional health providers in Camden, New Jersey, and Delaware query information from a community HIE and a statewide one, respectively.[34] In Lexington, Kentucky, electronic information can be accessed, modified, and updated by providers inside and outside correctional facilities.

Correctional health providers themselves may receive up to $63,750 in incentive payments—and assign them to their employer, if appropriate—for using electronic health records if the providers meet certain criteria.[35] Two key ones are that at least 30 percent of their patients are Medicaid-enrolled and that the records system is certified by the Office of the National Coordinator for Health Information Technology, a unit of HHS. Providers serving patients in correctional settings face steep obstacles to qualify, but some in King County, Washington, and New York City have done so.[36] Providers have until the end of 2016 to begin participating.

Both of these funding streams were created by the Health Information Technology for Economic and Clinical Health (HITECH) Act, which was enacted as part of the American Recovery and Reinvestment Act of 2009.

Covering inmates released to nursing homes

Many states are grappling with an increasing number of older inmates among their prison populations. From 1999 to 2014, the number of state and federal prisoners age 55 or older increased 250 percent. This compares to a growth rate of only 8 percent among inmates younger than 55. In 1999, inmates age 55 and above—a common definition of older prisoners—represented just 3 percent of the total population. By 2014, that share had grown to 10 percent.[37]

Like senior citizens outside prison walls, older inmates are more likely than younger ones to experience dementia, impaired mobility, and loss of hearing and vision, among other conditions. They are also especially susceptible to costly chronic medical conditions such as hypertension, arthritis, or diabetes.[38]

These ailments create additional health and nonhealth expenses for prisons, where they can necessitate enhanced staffing levels and training, as well as structural accessibility adaptions, such as special housing and wheelchair ramps. The National Institute of Corrections pegged the annual cost of incarcerating prisoners 55 and older with chronic and terminal illnesses at, on average, two to three times that of the expense for all other inmates.[39] More recently, other researchers have found that the cost differential may be wider.[40]

One policy response has been to relocate prisoners to community nursing homes using medical or geriatric parole policies that allow for the release of certain older, terminally ill, or incapacitated inmates. For example, Connecticut contracted with a privately owned and operated skilled nursing facility to assist with caring for parolees and patients moving out of the state mental health hospital.[41] Similarly, Michigan lawmakers are considering legislation that would allow, under certain conditions, for inmates determined to be "medically frail" to be moved to community medical facilities, including a nursing home or hospice.[42] Separate analyses of the bill by the Michigan House and Senate fiscal agencies assumed that Medicaid would help pay for the health care costs of parolees, assistance that could contribute to total estimated savings of between $1.2 million and $3 million annually over the long run.[43]

CMS outlined restrictions in its April 2016 guidance regarding when Medicaid may reimburse covered health care costs for parolees who are moved to hospitals or nursing facilities. Specifically, it indicated that, among other requirements, such individuals must be placed in medical institutions that are generally available to the public and not operated primarily or exclusively to care for those involved with the criminal justice system. In a May 3, 2016, letter to staff who survey providers (e.g., nursing homes) for compliance with Medicaid and Medicare participation requirements, federal officials clarified that correctional terms of supervision may conflict with CMS requirements if they affect the care and services or violate a resident's rights.[44] For example, for such care to be eligible for Medicaid coverage, residents must be free from physical restraint imposed solely for the purposes of discipline or convenience. They must also be free to choose visitors, live in an unlocked unit unless otherwise necessary for medical reasons, and conduct private telephone conversations.

CMS has reportedly twice denied Connecticut federal matching funds, having determined that its contracted facility does not meet all necessary requirements.[45] "Some of these inmates live in a secure unit with no medical justification to support this placement," wrote William Roberson, associate regional administrator, in the denial issuance.[46]

Conclusion

While states and localities have never been prohibited from enrolling offenders in Medicaid, as long as they met other criteria, the Affordable Care Act created an opportunity for policymakers to make this coverage more widely available with additional federal support. Aside from contributing to care continuity as individuals transition in and out of incarceration, this also increases states' chances of receiving federal assistance for off-site inpatient care costs covered by Medicaid. CMS' April 2016 communication clarifies when and how jurisdictions may make use of these options, and it expands the population to which Medicaid coverage applies by making certain residents of supervised community residential facilities newly covered.

Federal, state, and local policymakers increasingly argue that providing coverage contributes to improved care continuity among released inmates, especially when paired with additional actions such as connecting them with community health providers and case management. These actions, in turn, help preserve the benefits of care delivered during a jail or prison stay, and reduce reliance on expensive, uncoordinated emergency department care. Moreover, because of the chronic and, in some cases, communicable diseases of many inmates, more officials are recognizing that facilitating seamless access to health care upon re-entry into society improves individuals' prospects for successful reintegration and benefits the public's health and safety.

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