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Collaborative Approaches to Public Safety

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Medicaid and Financing Health Care for Individuals Involved with the Criminal Justice System

People in prisons and jails often have complex and costly health care needs, and states and local governments currently pay almost the entirety of these individuals' health care costs. In addition, it is estimated that as many as 70[1] to 90[2] percent of the approximately 10 million[3] individuals released from prison or jail each year are uninsured. Lack of health insurance is associated with increased morbidity and mortality,[4] and the high rate of uninsurance among individuals involved with the criminal justice system is compounded by rates of mental illness, substance use disorders, infectious disease, and chronic health conditions that are as much as seven times higher than rates in the general population.[5]

When an individual returns to the community after incarceration, disruptions in the continuity of medical care have been shown to increase rates of reincarceration and lead to poorer and more costly health outcomes.[6] Research shows that the first few weeks after release from incarceration are the most critical in terms of connecting people to treatment. Reentry into the community is a vulnerable time, marked by difficulties adjusting, increased drug use, and a 12-fold increase in the risk of death in the first two weeks after release.[7] For many, the failure to provide a link to healthcare coverage and services upon release results in needless, potentially months-long gaps in their access to health care. If they access care at all, these individuals often rely upon hospital emergency room services, shifting much of the cost burden to hospitals and state, county, and city agencies.[8]

This failure to link individuals involved with the criminal justice system to health coverage and services upon release from incarceration is especially costly to state and local governments. Total state and local spending on uncompensated health care for the uninsured reached $17.2 billion in 2008.[9] Individuals involved with the criminal justice system, who make up as much as one-third of the uninsured population in the United States, can be expected to account for a significant portion of this spending.[10] Furthermore, elevated recidivism rates, which are associated with a lack of access to health care for individuals with mental illnesses or substance use disorders, contribute to the burden of state and local corrections spending.[11]

The appropriate use of federal Medicaid dollars to help pay for health care provided to this population can save states and localities money, in addition to minimizing health and public safety concerns associated with reentry following incarceration. However, opportunities to maximize and maintain Medicaid enrollment for eligible individuals in this population, and especially to make use of Medicaid to finance certain types of care provided to those who are incarcerated, have been largely underutilized by states.

Historically, adults who do not have dependent children or do not meet disability criteria have not been eligible for Medicaid, which has limited the extent to which the program has funded services for people involved with the criminal justice system. Under the Affordable Care Act (ACA), a significant portion of the justice-involved population will gain eligibility for Medicaid coverage for the first time. Some will qualify for federally subsidized health insurance plans offered through the state health

insurance marketplaces, but the majority will be newly eligible for Medicaid under the law's expansion of the Medicaid program. States that make full use of opportunities to enroll eligible individuals in their criminal justice systems in Medicaid and appropriately leverage the program to finance eligible care can realize considerable cost savings by diverting more individuals to treatment—which is significantly less costly than incarceration—and by reducing reliance on state-funded health care services for the uninsured.

There are also opportunities to achieve budget savings for certain health care services provided to those who are incarcerated. Although the Medicaid "inmate exclusion"—which refers to language in the Social Security Act barring the use of federal Medicaid funding to pay for health care services for "inmates of a public institution"[12]—limits the ability of states and localities to draw on Medicaid funding for inmate health care, certain exceptions to this provision can generate important cost savings. Medicaid payment for services provided in correctional settings is restricted by the inmate exclusion, but federal law does grant states the authority to use Medicaid to finance inpatient health care services for incarcerated individuals when provided by a licensed medical facility in the community, i.e., one that is not under the authority of the corrections agency. Only a few states have yet opted to take advantage of this opportunity. However, with the expansion of Medicaid under the ACA, an opportunity exists for states to better leverage Medicaid to help finance inmates' inpatient medical care.

This paper will provide an overview of federal Medicaid law related to people involved with the criminal justice system; discuss policy options available to improve continuity of coverage while ensuring federal funds are spent appropriately; provide state examples of best practices; and give recommendations for state and local governments.

Federal Medicaid Rules on Coverage of Criminal Justice Populations

A significant portion of states' criminal justice populations, including prison and jail populations, are eligible for Medicaid, and the numbers will increase significantly in 2014 in those states participating in the Medicaid expansion authorized by the ACA. Although federal law restricts the use of Medicaid to finance health care provided to beneficiaries while they are incarcerated, the ability to finance qualifying inpatient medical care is an important exception. In addition, Medicaid can serve as a valuable source of coverage for health care services for individuals who are mandated to treatment, on probation or parole, or who are returning to the community following incarceration. States that effectively utilize Medicaid to finance care provided to eligible justice-involved individuals can realize significant cost savings. Furthermore, criminal justice systems that identify and enroll eligible individuals in Medicaid at all points of justice system involvement, including in jails and prisons, can greatly improve access to needed health services for this population.

While there is a Constitutional requirement under the Eighth Amendment to provide health care services to individuals who are incarcerated, federal law prohibits states from using federal Medicaid funds to pay for care provided to incarcerated individuals in most circumstances, even if they are eligible and enrolled in the program.[17] Specifically, section 1905 of the Social Security Act prohibits "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)."[18] This provision, known as the inmate exclusion provision, pertains to all individuals involuntarily confined in state or federal prisons, jails, detention facilities, or other penal facilities.

The inmate exclusion provision applies only to the availability of federal financial participation, i.e. it does not restrict the ability of states to utilize state dollars to pay for inmate health care services. In practice, the exclusion results in most health care provided in jails and prisons being financed by the state or local corrections agency, rather than by the state Medicaid program. However, the inmate exclusion provision does not change whether an individual is *eligible* for Medicaid and does not require termination of Medicaid enrollment during incarceration.[19] In fact, under federal Medicaid law, an individual incarcerated in a public institution may remain enrolled in Medicaid if the appropriate eligibility criteria are met. States have been encouraged by CMS to suspend rather than terminate an individual's Medicaid enrollment during incarceration, allowing

Medicaid

Jointly financed and administered by states and the federal government, Medicaid is the primary source of health care coverage for more than 50 million low-income parents, children, and pregnant women. Beginning in 2014, millions of additional individuals, including many low-income, childless adults will gain eligibility for coverage for the first time as a result of the passage of the ACA. State participation in the expansion of Medicaid eligibility is optional, and eligibility criteria will continue to vary by state.

Each state has a distinct Medicaid program that operates within broad guidelines defined by federal law.[13] States document the design of their Medicaid programs and outline the benefits that are available to Medicaid beneficiaries and the amount, duration, and scope of those benefits in their State Plans, which are submitted to and reviewed by the federal Centers for Medicare and Medicaid Services (CMS).[14] While there is considerable variation in Medicaid programs and benefits among states, and sometimes even among various categories of enrollees within a state, the comprehensiveness of Medicaid coverage generally compares favorably with commercial health insurance. Through a combination of low overhead costs and below average provider reimbursement rates, Medicaid is also typically more cost-effective than other sources of health care coverage.[15] This is particularly true in comparison with health care spending by corrections systems, which typically do not have the same negotiating power and cannot obtain similarly favorable rates for health care services.

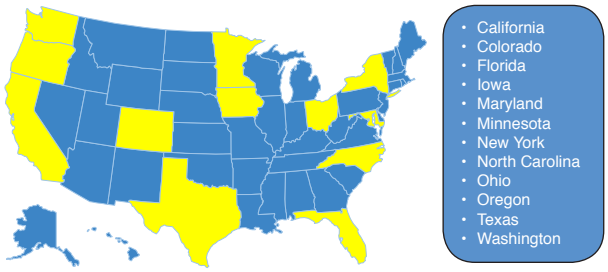
The costs of the Medicaid program are shared by states and the federal government. The federal share varies by state based on the state's average personal income compared to the national average. For most services, the federal government pays a state between a floor of 50 percent and about 74 percent of service costs, leaving the state responsible for the remainder. For newly eligible enrollees under the ACA, the federal share will be at least 90 percent from 2014 forward. This federal share of Medicaid costs is called the Federal Medical Assistance Percentage, or FMAP. In addition, the state's costs for administering the Medicaid program are generally matched dollar for dollar by the federal government, with some administrative activities matched at a higher rate.[16]

Medicaid to be billed for certain, limited types of health care services that are permitted to be reimbursed during incarceration. An additional benefit of suspension is that individuals can more easily access Medicaid services following release, which can be critical to a successful transition during the reentry process.

However, states and localities often misinterpret the exclusion to require the termination of Medicaid enrollment, and some states' information technology systems are simply unable to accommodate a suspension of Medicaid enrollment. As a result, the vast majority of states currently forgo the opportunity to utilize Medicaid as a funding source for inpatient healthcare services. By enabling the suspension of enrollment in Medicaid, states can make more effective use of Medicaid and ensure that it is leveraged appropriately both during incarceration and upon release to link people to appropriate services.

States Suspending Medicaid

Suspension of Medicaid Benefits upon Incarceration: At least 12 states have laws or administrative policies to suspend Medicaid enrollment of inmates.



Allowable Uses of Medicaid for Incarcerated Persons

The inmate exclusion provision expressly allows the use of federal Medicaid funding to finance care provided to an eligible incarcerated individual when that individual is "a patient in a medical institution."[20] The Department of Health and Human Services has clarified that this allows federal funds to be used when the incarcerated individual is admitted as an inpatient in a hospital, nursing facility, juvenile psychiatric facility, or intermediate care facility for at least 24 hours.[21] Because community-based inpatient care can represent a sizeable portion of the

cost of care provided to individuals in prisons and jails, there is the potential for considerable cost savings to a state that is able to effectively use Medicaid funding to finance some of these services. For example, North Carolina has reported that it saved $10 million in the first year of billing Medicaid for eligible inpatient services, while California saved about $31 million by doing so in FY 2013.[22]

To qualify for federal financial participation, the individual must be admitted for at least 24 hours and the facility must be community-based and separate from the corrections system.[24] Once the individual has been admitted in the appropriate inpatient setting for at least 24 hours, all medically necessary Medicaid covered services provided to that individual while admitted can be billed by the provider to Medicaid. At least 14 states—Arkansas, California, Colorado, Delaware, Louisiana, Michigan, Mississippi, Nebraska, New York,[25] North Carolina,[26] Oklahoma, Pennsylvania, Vermont,[27] and Washington—currently bill Medicaid for at least some eligible inpatient health services provided to incarcerated individuals, and additional states are exploring this option.[28]

The potential savings available to state budgets are spurring efforts by additional states to bill Medicaid for allowable inpatient medical services, as well as to expand the scope of this practice in states already doing so in a limited fashion. For example, in a study of prison expenditures on health care services in New York between April 2008 and March 2010, it was found that the New York Department of Corrections and Community Supervision contracted with community-based healthcare providers for certain emergency, inpatient, and outpatient services for its incarcerated population, at a cost of approximately $230 million. Approximately $89 million of this money, or 38 percent of the costs for community-based care over the two-year period, was for inpatient services that were potentially reimbursable by Medicaid. To date, New York has implemented policies to seek federal Medicaid reimbursement retroactively for its jail population in limited instances, and it is currently making policy changes to allow the state to draw on federal funds in all allowable circumstances.[29] New York's efforts, as well as recent efforts to bill Medicaid for inmate inpatient care in North Carolina and Colorado, are discussed in more detail later in this report.

While underutilized, this opportunity to use Medicaid to finance inpatient care for individuals in prisons and jails has long existed. However, the ACA's Medicaid expansion and enhanced federal funding will likely make this practice much more attractive to states that choose to expand their Medicaid program beginning in 2014. The resulting increase in the number of eligible inmates and the higher federal matching rate in those states will likely incentivize the implementation of policy changes to make use of federal Medicaid funding for their incarcerated populations' inpatient medical care.

Understanding Medicaid Enrollment, Suspension, and Termination

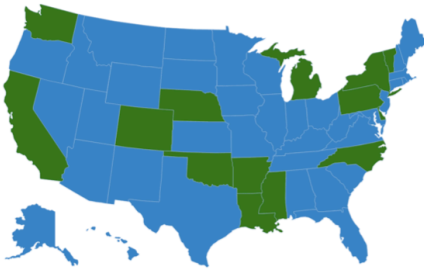
Medicaid termination—This term refers to the removal of an individual from the Medicaid rolls as a result of incarceration, without regard to whether or not an individual remains eligible for the program. If terminated, an individual would need to submit a new application for the Medicaid program. Depending upon the type of application, a new eligibility determination may take as long as 45 to 90 days under federal guidelines.[23]

Medicaid suspension—This option allows an incarcerated individual to remain on the Medicaid rolls in a suspended status, which reflects that the individual continues to meet eligibility criteria but that health care services (apart from qualifying inpatient medical care) cannot be financed using federal Medicaid dollars.

Medicaid redetermination—Federal policy requires that an individual's eligibility for Medicaid be redetermined at least every 12 months. Federal rules also state that for those who are eligible based on Modified Adjusted Gross Income (MAGI) criteria, eligibility may not be redetermined more frequently than every 12 months.

States Billing for Inpatient Care

Billing Medicaid for Inmate Inpatient Care: At least 14 states bill Medicaid for at least some eligible inmate inpatient care.



- Arkansas
- California
- Colorado
- Delaware
- Louisiana
- Michigan
- Mississippi
- Nebraska
- New York
- North Carolina
- Oklahoma
- Pennsylvania
- Vermont
- Washington

The ACA's Medicaid Expansion: Opportunities to Increase Health Coverage for Individuals Involved with the Criminal Justice System

In the vast majority of states, Medicaid eligibility guidelines have excluded childless adults from coverage, regardless of their income or poverty level. A few states have used waivers and other mechanisms to extend coverage to this population, but most states have limited Medicaid eligibility to those who meet categorical eligibility criteria, such as low-income pregnant women, individuals disabled by medical conditions, children, and parents of dependent children. As a result, low-income, childless adults make up a substantial portion of the uninsured in this country. Recognizing the high proportion of uninsured individuals in this population, Congress significantly expanded Medicaid coverage under the ACA to include adults at or below 133 percent of the federal poverty level (FPL), or $15,282 annual income for an individual and $25,975 for a family of three, at a projected cost to the federal government of about $434 billion through 2019.[30]

Under the ACA, up to 15.1 million previously uninsured, low-income adults ages 19 to 64 may become Medicaid eligible,[31] and the expansion will have important implications for the criminal justice system. Estimates indicate that approximately 35 percent of people gaining Medicaid eligibility under the ACA will have a history of criminal justice system involvement.[32] Furthermore, there are approximately 4.5 million adults in the United States that are currently eligible for Medicaid but are not enrolled, who may have more opportunities to be enrolled into coverage when the major provisions of ACA take effect on January 1, 2014.[33]

Increased Federal Funding for the Newly Medicaid Eligible Population

States that expand Medicaid eligibility as outlined under the ACA will receive a significantly increased FMAP to do so, meaning that the reimbursement available from the federal Medicaid program will be significantly enhanced. In fact, federal reimbursement for health care services for all newly eligible adults who gain coverage under the ACA (known as the "expansion population") will equal 100 percent for the years 2014-2016, and reimbursement will continue to be significantly increased after full federal funding expires. Beginning in 2017, states will receive 95 percent FMAP for the expansion population, and the rate will be reduced slightly each year through 2020, at which point it will remain permanently at 90 percent.[34]

A number of "expansion states" used waivers to expand Medicaid to childless adults making at least 100 percent FPL prior to the passage of the ACA. These states will have few or no individuals who qualify as "newly eligible" under the law, but new federal matching provisions aimed specifically at these states will still provide an opportunity for significant savings on health care expenditures. These expansion states will begin receiving enhanced FMAP for those individuals that were eligible on March 23, 2010 and would otherwise have been newly eligible under the ACA.[35] The expansion state FMAP will vary by state, but will be at least 75 percent in 2014 and will gradually increase annually until all states receive a permanent 90 percent FMAP for this population by 2020.[36]

As a result of the expansion of Medicaid to childless adults and higher income parents and the greatly enhanced funding available from the federal government for this newly eligible population, states that implement policies to maximize and maintain enrollment for their justice-involved populations will see the potential for even more considerable cost savings than these opportunities have presented in the past. For example, Kentucky currently covers the full cost of providing health care for its incarcerated population, but the Governor's FY 2013 budget estimated a $4

million savings could be realized for the state in FY 2013-2014 as a result of the ACA's expansion of Medicaid eligibility to state inmates with income levels up to 133 percent FPL.[37]

Opportunities to Maximize Medicaid Enrollment

The major provisions of the ACA, including the major coverage expansion provisions and the enhanced FMAP for newly-Medicaid eligible adults, take effect in January 2014. In preparation for the enormous changes coming to the health care system, federal, state, and local governments have been redesigning eligibility systems, defining Medicaid benefits packages for the expansion population, developing enrollment strategies, and implementing countless other policy and practice reforms. As states consider how they can maximize the Medicaid program to enhance access to health care services for individuals while reducing state and local spending, it may be helpful to review states' existing efforts to leverage the Medicaid program to provide health care to individuals involved with the criminal justice system.

State Approaches to Utilizing Medicaid for Healthcare Services for People Involved with the Criminal Justice System

This section details examples of best practices and ongoing systems changes to bill Medicaid for allowable services provided to incarcerated populations in three states: North Carolina, New York, and Colorado. These states were chosen for more in-depth analysis of their Medicaid policies due to their recent and ongoing efforts to implement effective practices related to Medicaid eligibility and enrollment for their incarcerated populations. Each of the states profiled has chosen to implement a different set of policy options to maximize Medicaid coverage for this population, and they are at varying stages of implementation. Policy and programmatic issues explored include the use of Medicaid funds to bill for inpatient medical care for jail and prison inmates and suspension versus termination of Medicaid status upon incarceration.

Of the three states, only North Carolina has adopted and widely implemented policies to bill Medicaid for community-based, inpatient medical care provided to those who are incarcerated. It also requires suspension of enrollment under an August 2008 directive to county directors of social services,[44] however, it appears that in practice, many counties may not be following this directive,[45] potentially limiting the impact of recent policy changes by the state to bill Medicaid for eligible services provided to its incarcerated population. New York suspends Medicaid enrollment when an eligible individual is incarcerated, bills Medicaid retroactively for inpatient care in some circumstances, and is currently undertaking policy and practice changes to make full use of Medicaid for both its prison and jail populations. Finally, Colorado passed legislation to suspend, rather than terminate Medicaid enrollment for its incarcerated population in 2008, and this legislation is still in the process of being implemented.

North Carolina

North Carolina has recently implemented policies to make use of Medicaid for eligible services provided to Medicaid-enrolled individuals incarcerated in the state's jails and prisons. A state law was passed in 2010 requiring the Departments of Corrections and Health and Human Services to develop protocols for utilizing Medicaid to pay for care provided to those in the state that would be receiving Medicaid if not for their incarceration.[46] Since February 2011, under the State Plan, North Carolina has been requiring hospitals and other inpatient providers to bill Medicaid for services provided to Medicaid-enrolled incarcerated individuals. By requiring these community-based health care providers to bill Medicaid directly for services provided to incarcerated individuals—as these providers do for all Medicaid beneficiaries they serve—the corrections system can avoid certain administrative burdens and can generate greater efficiencies and reduced costs.

A report in 2010 by North Carolina's State Auditor found that during the two-year period from 2008 to 2009, the state Department of Corrections paid about $159.8 million for health care, about $26.5 million of which was for inpatient medical care that was provided to likely Medicaid-eligible incarcerated individuals. The report

Special benefits considerations for the Medicaid expansion population

All newly-eligible Medicaid beneficiaries will be enrolled in an "alternative benefits plan" (also known as a "benchmark plan"), which may be based on certain private health insurance plans or be any coverage approved by the Secretary of HHS, including a state's traditional coverage under the State Plan.[38] In addition, coverage must include the ACA's ten categories of Essential Health Benefits (EHBs).[39] Among the mandatory EHB coverage categories for Medicaid alternative benefit plans is coverage of services for mental health and substance use disorders, which must be covered at parity with medical/surgical benefits.[40] The inclusion of substance use disorder treatment services as an EHB to be provided at parity is especially significant, as there has been wide variation in coverage of substance use disorder services across state Medicaid programs, if these services have been covered at all.[41] Given that the justice-involved population is estimated to make up a significant proportion of the newly eligible and taking into account the higher than average prevalence of substance use and mental health disorders in this population, the requirement that plans covering the expansion population include these benefits represents a significant opportunity to improve access to mental health and substance use disorder services.

These protections are important to ensure that newly eligible adults, including those with involvement in the criminal justice system, receive adequate coverage. However, states will continue to have significant discretion in outlining the services covered within these mandatory benefit categories, and some states may use the flexibility available to them to offer the expansion population a package of benefits that is potentially less robust that what Medicaid traditionally covers. To protect the coverage of vulnerable populations, the ACA specifies that certain categories of individuals, including the "medically frail," are exempt from mandatory enrollment in the alternative benefit plan.[42] Those who qualify as medically frail include individuals with a wide range of disabilities and limitations, including individuals with chronic substance use disorders and adults with serious mental illness.[43] These individuals will want to evaluate both the alternative benefit plan and traditional Medicaid to determine which set of benefits best meets their needs.

estimated that by using Medicaid to pay for hospital and other inpatient care for its eligible prison and jail population, North Carolina could have realized a two-year savings of $23 million. According to the auditor, this approximately 87-percent savings on inpatient care for Medicaid-eligible individuals would have resulted both from the ability to bill Medicaid for eligible services thereby drawing down federal funding, as well as from the lower provider rates negotiated by Medicaid as compared to the prices paid by the Department of Corrections.[47]

The State Auditor's report also noted that the Medicaid expansion under the ACA would result in considerable additional savings for the state, should it choose to participate in the Medicaid expansion. While the report did not attempt to quantify the potential savings to the state under the ACA, if North Carolina expands Medicaid eligibility to nearly everyone in the state at or below 133 percent FPL, state spending on health care services for justice-involved individuals would fall significantly.[48]

New York

New York is one of the few states that suspends Medicaid enrollment when someone is incarcerated, and it is the only state to suspend Medicaid indefinitely, rather than only until a new eligibility determination is required.[49] It is also one of only a handful of states to have provided Medicaid coverage to childless adults up to 100 percent FPL prior to the passage of the ACA in 2010. These policies put New York in a unique position to utilize Medicaid to pay for care provided to its incarcerated population; however the state is just recently beginning to undertake an effort to maximize Medicaid enrollment and reimbursement policies for care provided to people involved with the criminal justice system.

New York removed restrictions in state law that prohibited claiming federal Medicaid funds for care provided to incarcerated individuals beginning in 2001, and it started suspending rather than terminating Medicaid enrollment for incarcerated individuals in 2008.[50] However, state practices have resulted in the receipt of just a portion of potentially available federal Medicaid funds for qualifying services provided to incarcerated individuals. Under current New York policy, reimbursement from the federal government is only sought for services provided to individuals incarcerated in local jails. Moreover, reimbursement for care provided to individuals in local jails is only sought in limited situations compared to the broader range of eligible situations that federal law permits.[51] As a result, the state is only receiving a small portion of the federal reimbursement that might be available.

Still, to date, local governments in New York have received more than $4.5 million in reimbursement from the federal government for inpatient medical services provided to Medicaid eligible inmates.[52] To claim this reimbursement, the state submits claims to the federal government on behalf of the local jurisdiction for the amount that would have been billed by the inpatient treatment facility. The local jurisdiction then receives reimbursement for the federal share of the Medicaid costs. The local jurisdiction remains responsible for what the state's share of costs would have been, as well as any difference between Medicaid rates and the rate paid by the jail for those inpatient services.[53]

New York's approach is more administratively complicated than approaches in which states require the treating medical facility to bill Medicaid directly, and it fails to capture available federal funds that could be used to reimburse providers for allowable inpatient medical services provided to state prisoners. New York is working to change its policy to allow the state to access federal Medicaid funds for care provided to its incarcerated population in all allowable circumstances, i.e., for inmates of both jails and prisons, as well as to require health care providers to bill Medicaid directly rather than submitting for retroactive reimbursement.[54] According to a December 2012 report by the Office of the State Comptroller, New York could save $20 million annually if it used Medicaid to finance allowable inpatient services provided to all eligible incarcerated individuals.[55]

New York's practice of suspending Medicaid enrollment indefinitely when an individual is incarcerated, which relies on a state law providing that time incarcerated shall not count toward the required redetermination period,[56] as well as its status as a Medicaid expansion state, makes it strongly positioned to access federal Medicaid funding for its incarcerated population and may potentially make it a model for other states to follow.

Colorado

In 2008, the Colorado state legislature passed a law to require that "persons who are eligible for Medicaid just prior to their confinement in a jail, juvenile commitment facility, Department of Corrections facility, or Department of Human Services facility shall have their Medicaid benefits suspended, rather than terminated, during the period of their confinement."[57] This legislation is in the process of being implemented, and in the years since the passage of the state law a detailed correspondence between the state and the federal Department of Health and Human Services has developed that may be useful for other states considering similar policy changes (see appendix).[58] For example, the correspondence clarifies that:

- As long as the individual continues to be eligible for Medicaid and is residing as an inpatient in a medical facility, federal policy and regulations do not place a time limit on federal Medicaid funding availability for those individuals under the exception to the inmate exclusion provision;[59]
- If the correctional authority limits an individual's ability to leave a correctional facility on a permanent basis, such as a requirement that the individual return to the facility at night, that would be considered incarceration under the federal standard;[60]
- The state would not have to amend its Medicaid State Plan in order to establish suspension of Medicaid for incarcerated individuals, and would therefore not need approval from the federal Centers for Medicare & Medicaid Services (CMS) to institute the change.[61]

The Colorado Department of Health Care Policy and Financing continues to communicate with CMS

and other states as it moves forward to implement Medicaid suspension policies for those in its prison and jail system. Colorado's ongoing clarifications on the appropriate use of federal Medicaid funds to finance inpatient medical care for eligible, incarcerated individuals have been critical to the state's efforts to utilize Medicaid funding and can serve as a valuable source of information for other states.

Opportunities and Recommendations for State Policymakers

While opportunities to make more effective use of Medicaid have always been available, with the passage of the Affordable Care Act and the expansion of Medicaid, states have an important opportunity to reevaluate whether their use of Medicaid to finance care for eligible, justice-involved populations is making efficient use of state and federal resources. Below are recommendations for states to consider implementing in order to better meet the health needs of incarcerated and reentering individuals.

1. Discontinue automatic Medicaid terminations

The federal government has repeatedly encouraged states to ensure that incarcerated individuals eligible for Medicaid are returned to the Medicaid rolls upon release, so that coverage is immediately available.[62] However, just a few states have implemented this recommendation. It appears that only New York suspends Medicaid enrollment indefinitely, allowing individuals who are incarcerated for longer periods or those who are incarcerated during their annual redetermination date to remain enrolled. Other states, including California,[63] Florida,[64] Iowa,[65] Maryland, Minnesota, North Carolina,[66] Ohio,[67] Oregon,[68] Texas, and Washington, do not automatically terminate Medicaid but suspend it for a certain period of time, typically until the enrollee's scheduled eligibility redetermination period.[69] Additional states have policies in place to enroll eligible individuals in Medicaid as part of discharge planning.[70] States that suspend Medicaid can more easily ensure that enrollment is reinstated when incarcerated individuals are released and that formerly incarcerated individuals can immediately access health care without gaps in coverage. An indefinite suspension approach as exemplified by New York would likely enable states to make the most effective use of federal funding, as there would be no lapses in Medicaid enrollment for incarcerated individuals that continue to meet eligibility criteria. Policy options include:

- End the automatic termination of Medicaid for individuals when they are incarcerated by indefinitely suspending Medicaid enrollment and facilitating reactivation when needed.

  or

- Suspend Medicaid up to the enrollee's annual eligibility redetermination date, minimizing disruptions in Medicaid enrollment for those incarcerated for short periods of time. Combined with discharge planning that includes Medicaid eligibility screenings, states could use this more limited approach to reenroll eligible individuals when they are released. However, this limited approach may continue to result in disruptions in enrollment that would likely make it more difficult for states to draw down available federal funding for care provided to incarcerated individuals.
- Upgrade claims systems and other computer systems to track suspended enrollment. States are currently upgrading their Medicaid systems to prepare for the implementation of the ACA, with enhanced federal funding for certain administrative activities.[71] This may provide states that have previously chosen not to implement Medicaid suspension policies due to difficulties upgrading eligibility and claims systems with an opportunity to revisit their disenrollment policies.
- Regardless of Medicaid suspension or termination policies, ensure that all individuals released from incarceration who are eligible for Medicaid are enrolled and eligible to receive health care services upon release.

2. Make effective use of federal Medicaid funding for inpatient services

Federal officials have repeatedly informed states that the Medicaid inmate exclusion provision does not apply to inpatient medical services provided in certain facilities under federal law. States that have designed their Medicaid eligibility and enrollment systems in a way

that makes use of federal funding for these services, or studied potential savings associated with doing so, have shown that considerable reductions in state and local spending can be achieved by using federal funding to help finance these services. In addition, these analyses have also frequently demonstrated that additional savings can be captured as a result of the more favorable provider rates negotiated by Medicaid, as compared with the rates paid by the local or state corrections agency. As many more incarcerated individuals become Medicaid eligible in 2014 at the enhanced federal matching rate, states prepared to use Medicaid to finance inpatient care will see substantial savings.

- States should ensure that processes are in place to determine an inmate's Medicaid eligibility and enrollment status at entry into the criminal justice system.
- States should implement policies to require community-based hospitals, nursing homes, juvenile psychiatric facilities, and intermediate care facilities to bill Medicaid for eligible inpatient services provided to incarcerated individuals.

3. Screen individuals involved with the criminal justice system for Medicaid eligibility at every opportunity

While much of the discussion in this report focuses on untapped opportunities to leverage Medicaid for incarcerated populations, states can ensure greater access to health coverage and services and achieve efficiencies in state and local spending by ensuring that all individuals involved in the criminal justice system are screened for Medicaid eligibility. The ACA requires the use of a single, streamlined application to evaluate eligibility for both Medicaid and federally subsidized health coverage offered by the health insurance Marketplace, meaning that the submission of a single application will be sufficient to ensure that an individual's eligibility for enrollment in either type of health care coverage is considered. In addition, the Medicaid alternative benefits package required by the ACA, including coverage of mental health and substance use disorder services, provides new opportunities to expand appropriate diversion to treatment and to ensure access to necessary health care services upon release for people involved with the criminal justice system. As discussed earlier, opportunities to utilize Medicaid to fund health care services for incarcerated individuals are limited by the inmate exclusion, but are still quite financially significant. To ensure that these opportunities are fully captured, states should screen individuals involved with the criminal justice system for Medicaid eligibility at every opportunity, including during incarceration. Contrary to common perceptions among individuals charged with reentry planning, there is no federal prohibition against screening individuals for Medicaid eligibility during incarceration. In fact, federal law requires that Medicaid applicants be allowed to have individuals accompany, assist, and represent them in the application or eligibility redetermination processes if they choose.[72] HHS has clarified that "corrections department employees and others working on behalf of incarcerated individuals are not precluded from serving as an authorized representative of incarcerated individuals for purposes of submitting an application on such individual's behalf."[73] States could implement policies to screen everyone for Medicaid eligibility in all of their prisons and jails, and immediately suspend coverage when an incarcerated individual is found eligible.

Administrative costs incurred by states for staffing, training, and performing Medicaid eligibility determinations are split evenly by the states and the federal government, and a federal administrative matching rate of 90 percent is temporarily available to states for the costs of upgrading eligibility and enrollment systems to prepare for the coverage expansions under the ACA.[74] By maximizing enrollment of its incarcerated population, a state could also maximize the use of available federal Medicaid funds and ensure that all eligible individuals leaving prisons and jails are enrolled in Medicaid and able to access services. HHS has made clear that corrections department employees and others working on behalf of individuals incarcerated in prisons and jails may serve as authorized representatives for the purposes of submitting an application for Medicaid coverage, and that these administrative activities are likely eligible for federal matching funds.

To ensure that the state budget efficiencies and expanded Medicaid coverage are achieved:

- States should implement policies to screen all individuals in their prisons and jails for Medicaid eligibility, and suspend enrollment for those found eligible. By maximizing their incarcerated populations' Medicaid coverage, states can make full use of Medicaid to finance inpatient health care for this population and ensure that all eligible individuals being released from prison or jail have Medicaid coverage.
- States should develop strategies to screen and enroll Medicaid-eligible individuals at all points of justice-system involvement and maximize the use of federal administrative matching funds to support enrollment staff and processes. A large percentage of those who are on probation, parole, or at other points in the criminal justice system may be eligible for Medicaid, and states should work to ensure that those who are eligible are enrolled and able to access needed health services.
- Given the significant overlap in justice-involved and Medicaid-eligible populations, criminal justice and Medicaid agencies should work closely to identify and address enrollment challenges and coverage issues unique to the criminal justice population.

4. Ensure that Medicaid coverage for the newly eligible offers an adequate scope of services

Finally, increased enrollment in Medicaid will be of limited value in enhancing coverage and access to health care services for people involved with the criminal justice system who are living in the community, if the Medicaid alternative benefit plans covering the newly eligible population do not include an adequate scope of services. The high rates of chronic and communicable disease in the justice-involved population point to a compelling need for access to comprehensive coverage, especially with regard to mental health and substance use disorder services. While the ACA requires that coverage for all ten categories of essential health benefits be included in these plans, including the provision of mental health and substance use disorder coverage at parity, it does not address scope of services. To ensure that individuals can access necessary health care services:

- Criminal justice and Medicaid agencies should work as a team to ensure that the scope of services included in the state's Medicaid alternative benefit plan are adequate to meet the needs of the justice-involved population. Essential services include, but are not necessarily limited to: integrated treatment for co-occurring mental and addictive disorders, cognitive behavioral interventions to address factors associated with illegal activity, and intensive case management.

Conclusion

The Affordable Care Act has provided a new focus on enrolling those who are eligible for health care coverage but who remain uninsured, as well as those who will gain coverage for the first time under the law. These system changes are ongoing and will take years to fully implement, however criminal justice systems, health departments, and state and local officials can now identify and review existing and new opportunities to utilize Medicaid to meet the health needs of people involved with the criminal justice system.

The expansion of Medicaid under the ACA provides an opportunity for states to review their health coverage policies for their criminal justice populations. HHS has made clear that states can and should ensure that Medicaid enrollment is suspended while an eligible individual is incarcerated and that they should implement policies to immediately return an eligible individual to the Medicaid rolls at release. In addition, federal law gives states flexibility to use Medicaid for certain inpatient medical services provided to their Medicaid eligible incarcerated populations. This flexibility is underutilized and states that suspend, rather than terminate, and reinstate Medicaid eligibility when an incarcerated individual receives community-based inpatient care could see considerable cost-savings.

Many more people who are involved with the criminal justice system will soon be eligible for Medicaid at an enhanced federal match, and states have an unprecedented opportunity to improve health outcomes, maintain continuity of care, and reduce their health care costs for the criminal justice population by implementing policies to maximize Medicaid coverage and reimbursements. To effectively meet these challenges, policymakers from criminal justice and Medicaid agencies should regularly communicate and partner to improve relevant systems, processes, and policies affecting their Medicaid-eligible criminal justice population.

Resources

The following resources may be helpful to state officials working to implement changes in Medicaid eligibility and enrollment policies for criminal justice populations.

Implications of The Affordable Care Act on People Involved with the Criminal Justice System (2013)
A brief providing an overview of the implications of the ACA for adults involved with the criminal justice system, as well as information about how professionals in the criminal justice field can help this population access the services now available to them.

County Jails and the Affordable Care Act: Enrolling Eligible Individuals in Health Coverage (March 2012)
A report by the National Association of Counties detailing issues and challenges local jails and human services agencies may face determining eligibility and enrolling those in county jails into health coverage gained under the Affordable Care Act.

How Will the Medicaid Expansion for Adults Impact Eligibility and Coverage? (July 2012)
An issue brief prepared by the Kaiser Family Foundation that provides an overview of Medicaid eligibility for adults and implications of the ACA for adult Medicaid coverage.

Frequently Asked Questions: Implications of the Federal Health Legislation on Justice-Involved Populations (2011)
A set of FAQs from the Council of State Governments Justice Center detailing the impact of health coverage and other provisions in the ACA for those in criminal justice system.

Medicaid Expansion and the Local Criminal Justice System (2011)
An article published in American Jails describing the implications of the Medicaid expansion for local correctional systems.

Facilitating Medicaid Enrollment for People with Serious Mental Illnesses Leaving Jail or Prison: Key Questions for Policymakers Committed to Improving Health and Safety (2011)
A brief providing elected officials and corrections and mental health directors with guidance related to enrolling eligible individuals with serious mental illness in Medicaid and other programs.

Establishing and Maintaining Medicaid Eligibility upon Release from Public Institutions (2010)
A report by the Substance Abuse and Mental Health Services Administration discussing opportunities and challenges for increasing Medicaid coverage among those being released from correctional institutions and other public institutions.

Policy Basics: Introduction to Medicaid (2008)
A short report by the Center on Budget and Policy Priorities providing an overview of Medicaid eligibility, benefits, and financing.

Endnotes

[1] Kamala Mallik-Kane and Christy A. Visher, *Health and Prisoner Reentry: How Physical, Mental, and Substance Abuse Conditions Shape the Process of Reintegration* (Washington: Urban Institute, 2008).
[2] Emily Wang, et al., "Discharge Planning and Continuity of Health Care: Findings from the San Francisco County Jail," *American Journal of Public Health* 98, no. 12 (2008): 2182-2184.
[3] E. Ann Carson and William J. Sabol, *Prisoners in 2011* (Washington: Bureau of Justice Statistics, U.S. Department of Justice, 2012); Todd D. Minton, *Jail Inmates at Midyear 2011—Statistical Tables* (Washington: Bureau of Justice Statistics, U.S. Department of Justice, 2012).
[4] Min Rex Cheung, "Lack of Health Insurance Increases All Cause and All Cancer Mortality in Adults: An Analysis of National Health and Nutrition Examination Survey (NHANES III) Data," *Asian Pacific Journal of Cancer Prevention* 14, no. 4 (2013): 2259-2263.
[5] National Institute of Corrections, "Solicitation for a Cooperative Agreement—Evaluating Early Access to Medicaid as a Reentry Strategy," *Federal Register* 76, no. 129 (2011): 39438-39443.
[6] Mary Sheu, et al., "Continuity of Medical Care and Risk of Incarceration in HIV-Positive and High-Risk HIV-Negative Women," *Journal of Women's Health* 11 no. 8 (2002): 743-750; Carol E. Adair, et al, "Continuity of Care and Health Outcomes Among Persons with Severe Mental Illness," *Psychiatric Services* 56, no. 9 (2005): 1061-1069; Richard R. Van Dorn, et al., "Effects of Outpatient Treatment on Risk of Arrest of Adults with Serious Mental Illness and Associated Costs," *Psychiatric Services* 64, no. 9 (2013): 856-862; Faye S. Taxman, "Reducing Recidivism through a Seamless System of Care," (paper presented at Office of National Drug Control Policy Treatment and Criminal Justice System Conference, February 20, 1998), available at ncjrs.gov/ondcppubs/treat/consensus/taxman.pdf.
[7] Ingrid A. Binswanger, et al., "Release from Prison—A High Risk of Death for Former Inmates," *New England Journal of Medicine* 356, no. 2 (2007): 157–165.
[8] Nicholas Freudenberg, et al., "Comparison of Health and Social Characteristics of People Leaving New York City Jails by Age, Gender, and Race/Ethnicity: Implications for Public Health Interventions," *Public Health Reports* 122, no. 6 (2007):733-743; Emily Wang, Yongfei Wang, and Harlan Krumholz, *A High Risk of Hospitalization Following Release from Correctional Facilities in Medicare Beneficiaries: A Retrospective Matched Cohort Study, 2002 to 2010, JAMA Internal Medicine* 173, no. 17 (2013): 1621-1628.
[9] Allison Hamblin, et al., "Medicaid and Criminal Justice: The Need for Cross-System Collaboration Post Health Care Reform" (Oakland: Community Oriented Correctional Health Services, January 2011).
[10] Jack Hadley, et al., "Covering the Uninsured in 2008: Current Costs, Sources of Payment, and Incremental Costs," *Health Affairs* 27, no 5 (2008): 399-415.

[11] Pew Center on the States, *State of Recidivism: The Revolving Door of America's Prisons* (Washington: Pew Center on the States, The Charitable Trusts, 2011).
[12] §1905, Social Security Act.
[13] The Supreme Court Decision on the constitutionality of the ACA effectively rendered states' participation in the law's Medicaid expansion optional, rather than mandatory. As of July 2013, 28 states were reported to be moving toward expansion. See "Beyond the Pledges: Where the States Stand on Medicaid," available at advisory.com/Daily-Briefing/Resources/Primers/MedicaidMap.
[14] For a general overview of the Medicaid program, see Kaiser Family Foundation, *Medicaid Resource Book, 2003*, available at kff.org/medicaid/2236-index.cfm.
[15] Families USA, "Cutting Medicaid Ineffective and Harmful," (Washington: Families USA, September 2012), available at familiesusa2.org/assets/pdfs/medicaid/Cutting-Medicaid-Ineffective-and-Harmful.pdf.
[16] For more information, see: Kaiser Family Foundation, "Medicaid Financing: An Overview of the Federal Medicaid Matching Rate (FMAP)" (Washington: Kaiser Family Foundation, September 2012), available at kff.org/health-reform/issue-brief/medicaid-financing-an-overview-of-the-federal.
[17] *Estelle v. Gamble*, 429 U.S. 97 (1976).
[18] §1905(a)(A), Social Security Act.
[19] Robert A. Streimer to All Associate Regional Administrators, Division for Medicaid State Operations, "Clarification of Medicaid coverage Policy for Inmates of a Public Institution" (Washington: Health Care Financing Administration, U.S. Department of Health and Human Services, December 12, 1997).
[20] §1905(a)(A), Social Security Act.
[21] Streimer, "Clarification of Medicaid Coverage Policy for Inmates of a Public Institution."
[22] Christine Vestal, "States Missing Out on Millions in Medicaid for Prisoners," *Stateline: The Daily News Service of the Pew Charitable Trusts*, June 25, 2013, available at pewstates.org/projects/stateline/headlines/states-missing-out-on-millions-in-medicaid-for-prisoners-85899485969.
[23] U.S. Code of Federal Regulations, Title 42, Public Health, Section 435.911 [42 CFR 435.911] states that Medicaid eligibility determinations may not exceed 90 days for Medicaid applications made on the basis of disability and 45 days for all other applications.
[24] Richard C. Allen to Joan Henneberry (Washington: Centers for Medicare & Medicaid Services, U.S. Department of Health and Human Services, August 16, 2010), available at colorado.gov/cs/Satellite/HCPF/HCPF/1247146939485.
[25] New York State Office of the State Comptroller, *Payments for Inmate Health Care Services: Department of Corrections and Community Supervision* (Albany: Division of State Government Accountability, December 2012), available at osc.state.ny.us/audits/allaudits/093013/10s41.pdf.
[26] Beth A. Wood, *Performance Audit: Department of Correction Inmate Medicaid Eligibility, August 2010* (Raleigh: Office of the State Auditor, State of North Carolina, August 2010), available at ncauditor.net/EPSWeb/Reports/Performance/PER-2010-7260.pdf.
[27] "Correction: Pew Report on Medicaid and Inmate Health Care Was Inaccurate; Aug 16 Story Updated," *Vermont Digger*, August 29, 2013, available at vtdigger.org/2013/08/29/correction-pew-report-on-medicaid-and-inmate-health-care-was-inaccurate-aug-16-story-updated.
[28] Vestal, "States Missing Out on Millions in Medicaid for Prisoners."
[29] New York State Office of the State Comptroller, *Payments for Inmate Health Care Services: Department of Corrections and Community Supervision.*
[30] U.S. Congressional Budget Office, *H.R. 4872, Reconciliation Act of 2010 (Final Health Care Legislation)* (Washington: U.S. Congressional Budget Office, March 20, 2010), available at cbo.gov/publication/21351.
[31] Genevieve M. Kenney, et al., "Opting in to the Medicaid Expansion under the ACA: Who are the Uninsured Adults Who Could Gain Health Insurance Coverage?" (Washington: Urban Institute, 2012), available at urban.org/UploadedPDF/412630-opting-in-medicaid.pdf.
[32] National Institute of Corrections, "Solicitation for a Cooperative Agreement - Evaluating Early Access to Medicaid as a Reentry Strategy (76 FR 39438)," (Washington: Federal Register, July 6, 2011).
[33] Genevieve M. Kenney, et al., "Variation in Medicaid Eligibility and Participation among Adults: Implications for the Affordable Care Act," *Inquiry* 49 (2012): 231-253.
[34] §1905(y)(1) of the Social Security Act designates the FMAP rate for the newly eligible adults at 100 percent for years 2014-2016, 95 percent in 2017, 94 percent in 2018, 92 percent in 2019, and 90 percent in 2020 and thereafter.
[35] §1905(z), Social Security Act.
[36] CMS has not yet identified which states qualify as expansion states. A recent report by the Congressional Research Service speculated that 11 states and D.C. would qualify as expansion states, including Arizona, Delaware, Hawaii, Maine, Massachusetts, Minnesota, New York, Pennsylvania, Vermont, Washington, Wisconsin, and the District of Columbia. Alison Mitchell and Evelyne P. Baumrucker, *Medicaid's Federal Medical Assistance Percentage (FMAP), FY2014* (Washington: Congressional Research Service, January 30, 2013), available at fas.org/sgp/crs/misc/R42941.pdf.
[37] Kaiser Family Foundation, *Medicaid and the Uninsured, Governors' Budgets for FY 2013 - What is Proposed for Medicaid?* (Washington: Kaiser Commission on Medicaid and the Uninsured, Kaiser Family Foundation, March 2012), available at kaiserfamilyfoundation.files.wordpress.com/2013/01/8294.pdf.
[38] §1937 of the Patient Protection and Affordable Care Act outlines five alternative benefit or benchmark plan options, including: 1) the standard Blue Cross/Blue Shield Preferred Provider Option offered through the Federal Employees Health Benefit program, 2) state employee coverage that is offered and generally available to state employees, 3) the commercial HMO with the largest insured, commercial, non-Medicaid enrollment in the state, 4) benchmark-equivalent coverage that is provided when the aggregate actuarial value of the benefit package is at least actuarially equivalent to the coverage provided by one of the benefit packages described above, or 5) a coverage option approved by the Secretary of Health and Human Services, known as "Secretary-approved coverage." §440.330, Public Heath, Title 42, Code of Federal Regulations (42 CFR 440.330) gives states the flexibility to use the Secretary-approved option to extend comprehensive Medicaid coverage to the newly-eligible expansion population.
[39] §1302(b) of the Patient Protection and Affordable Care Act outlines ten categories of Essential Health Benefits, including: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.
[40] §2001(c)(6) of the Patient Protection and Affordable Care Act requires that mental health and substance abuse benefits meet the requirements of the Mental Health Parity and Addiction Equity Act of 2008.
[41] Allison C. Colker, "Treatment of Alcohol and Other Substance Use Disorders: What Legislators Need to Know" (paper presented at National Conference of State Legislatures, Washington, January 2004).
[42] §2001 of the Patient Protection and Affordable Care Act. As defined in §1937(2)(A) of the Social Security Act, those exempt from enrollment in a Medicaid alternative plan include individuals in the following categories: those who are blind or disabled, terminally ill hospice patients, eligibility due to institutionalization, medically frail and special needs individuals, and children in foster care receiving welfare services and children receiving foster care or adoption assistance.
[43] §440.315(f), Public Health, Title 42, Code of Federal Regulations [42 CFR 440.315(f)] defines medically frail individuals as children with serious emotional disturbances, individuals with disabling mental disorders, individuals with serious and complex medical conditions, individuals with physical and/or mental disabilities that significantly prevent them from performing one or more activities of daily living, adults with serious mental illness, individuals with a disability determination based on Social Security criteria, and individuals with a chronic substance use disorder.
[44] William W. Lawrence, Jr., to County Directors of Social Services, "DMA Administrative Letter No: 09-08, Medicaid Suspension" (Raleigh: North Carolina

Department of Health and Human Services, August 27, 2008) available at info.dhhs.state.nc.us/olm/manuals/dma/abd/adm/MA_AL09-08.htm.

[45] Wood, *Performance Audit: Department of Correction Inmate Medicaid Eligibility, August 2010.*

[46] §19.8, North Carolina Session Law 2010-31, "An Act to Modify the Current Operations and Capitol Improvements Appropriations Act of 2009 and for Other Purposes."

[47] Wood, *Performance Audit: Department of Correction Inmate Medicaid Eligibility, August 2010.*

[48] On February 12, 2013, North Carolina Governor Pat McCrory announced that the state would not participate in the ACA's Medicaid expansion. The U.S. Department of Health and Human Services has said that there is no deadline for states to expand Medicaid, and a state can opt-in at any time.

[49] Substance Abuse and Mental Health Services Administration, *Establishing and Maintaining Medicaid Eligibility upon Release from Public Institutions—(SMA) 10-4545* (Washington: U.S. Department of Health and Human Services, 2010); New York State Department of Health, "Maintaining Medicaid Eligibility for Incarcerated Individuals," *Medicaid Reference Guide* (New York State Department of Health, updated January 2012), 545-546, available at health.ny.gov/health_care/medicaid/reference/mrg/january2012/pages545-546.pdf; New York State Department of Health, "Administrative Directive to Commissioners of Social Services: Maintaining Medicaid Eligibility for Incarcerated Individuals," (Albany: New York State Department of Health, April 21, 2008), available at health.ny.gov/health_care/medicaid/publications/docs/adm/08adm-3.pdf.

[50] Kathryn Kuhmerker to Local District Commissioners, "Retroactive Federal Financial Participation (FFP) Reimbursement for Inpatient Medical Costs for Involuntarily Confined Individuals" (Albany: Department of Health, State of New York, May 3, 2001) available at wnylc.net/pb/docs/01OMMLCM4.PDF.

[51] Betty Rice to Local District Commissioners, Medicaid Directors, Temporary Assistance Directors, and CNS Coordinators, "Revenue Reimbursement Project: Retroactive FFP Claiming of Certain Inpatient Medical Claims for Inmates of Correctional Facilities" (Albany: Office of Medicaid Management, February 15, 2005), available at health.ny.gov/health_care/medicaid/publications/docs/gis/05ma008.pdf. This memo directs that local jurisdictions in New York only seek reimbursement if the incarcerated patient was enrolled in Medicaid at the time of incarceration, if a Medicaid application was previously submitted and denied due to the individual's incarcerated status, or if the inpatient services were provided to an otherwise eligible individual in the three months prior to the date in which the local jurisdiction submitted the reimbursement forms to the state (§435.91, Public Health, Title 42, Code of Federal Regulations [42 CFR 435.914] states that Medicaid coverage may start retroactively for up to three months prior to the month of application).

[52] New York State Office of the State Comptroller, *Payments for Inmate Health Care Services: Department of Corrections and Community Supervision.*

[53] Rice, "Revenue Reimbursement Project: Retroactive FFP Claiming of Certain Inpatient Medical Claims for Inmates of Correctional Facilities."

[54] Jason A. Helgerson, "13ADM-02: Medicaid Payment of Inpatient Hospital Claims for Incarcerated Individuals and Individuals Age 21-64 Who Are Admitted to a Psychiatric Center" (Albany: New York State Department of Health, July 9, 2013), available at health.ny.gov/health_care/medicaid/publications/adm/13adm2.htm.

[55] New York State Office of the State Comptroller, *Payments for Inmate Health Care Services: Department of Corrections and Community Supervision.*

[56] §3661(a), New York State Social Services Law provides that: "Notwithstanding any other provision of law, in the event that a person who is an inmate of a state or local correctional facility, as defined in section two of the correction law, was in receipt of medical assistance pursuant to this title immediately prior to being admitted to such facility, such person shall remain eligible for medical assistance while an inmate, except that no medical assistance shall be furnished pursuant to this title for any care, services, or supplies provided during such time as the person is an inmate; provided, however, that nothing herein shall be deemed as preventing the provision of medical assistance for inpatient hospital services furnished to an inmate at a hospital outside of the premises of such correctional facility, to the extent that federal financial participation is available for the costs of such services. Upon release from such facility, such person shall continue to be eligible for receipt of medical assistance furnished pursuant to this title until such time as the person is determined to no longer be eligible for receipt of such assistance. To the extent permitted by federal law, the time during which such person is an inmate shall not be included in any calculation of when the person must recertify his or her eligibility for medical assistance in accordance with this article."

[57] "An Act Concerning Suspension of Medicaid Benefits for Persons Confined Pursuant to a Court Order and Making an Appropriation Therefor," Senate Bill 08-006, Colorado State Legislature, 2008.

[58] The letters between state representatives and HHS are available on the website of the Colorado Department of Health Care Policy and Financing, available at colorado.gov/cs/Satellite/HCPF/HCPF/1247146939485.

[59] Richard C. Allen to Joan Henneberry, Question 1.

[60] *Ibid.,* Question 2.

[61] *Ibid.,* Question 9.

[62] Donna E. Shalala to Honorable Charles L. Rangel (Washington: Department of Health and Human Services, April 6, 2000); Tommy G. Thompson to Honorable Charles L. Rangel (Washington: Department of Health and Human Services, October 1, 2001).

[63] §4011.11, California Penal Code, California Statutes.

[64] §409.9025, "Eligibility While an Inmate," Title 30, Social Welfare, Florida Statutes.

[65] §249A.38, "Inmates of Public Institutions—Suspension or Termination of Medical Assistance," Iowa Statutes.

[66] Lawrence, "DMA Administrative Letter No: 09-08, Medicaid Suspension."

[67] Ohio Department of Rehabilitation and Correction, "Reinstatement of Medicaid for Public Institution Recipients: 07-ORD-14" (Columbus: Ohio Department of Rehabilitation and Correction, November 10, 2009) available at drc.ohio.gov/web/drc_policies/documents/07-ORD-14.pdf.

[68] §411.439, "Suspension of Medical Assistances of Persons with Serious Mental Illness Under Certain Circumstances," Volume 10, Oregon Revised Statutes.

[69] Substance Abuse and Mental Health Services Administration, *Establishing and Maintaining Medicaid Eligibility upon Release from Public Institutions- (SMA) 10-4545.*

[70] National Association of Counties, "County Jails and the Affordable Care Act: Enrolling Eligible Individuals in Health Coverage" (Washington: National Association of Counties, March 2012), available at naco.org/programs/csd/Documents/Health%20Reform%20Implementation/County-Jails-HealthCare_WebVersion.pdf.

[71] Centers for Medicare & Medicaid Services, "Medicaid Program: Federal Funding for Eligibility Determination and Enrollment Activities (76 FR 21949)" (Washington: Federal Register, April 19, 2011).

[72] §435.908, "Assistance with Application," Public Health, Title 42, Code of Federal Regulations [42 CFR 435.908].

[73] Centers for Medicare & Medicaid Services, "Medicaid Program: Eligibility Changes Under the Affordable Care Act of 2010 (77 FR 17143)" (Washington: Federal Register, March 23, 2012).

[74] Centers for Medicare & Medicaid Services, "Medicaid Program: Federal Funding for Eligibility Determination and Enrollment Activities (76 FR 21949)."

Appendix

1. Letter on "Clarification of Medicaid Coverage Policy for Inmates of a Public Institution." Health Care Financing Administration [now called the Centers for Medicare & Medicaid Services], Washington, DC, December 1997.

2. Letter on Medicaid Eligibility of Inmates in the New York City Jail System. Secretary of Health and Human Services, Washington, DC, April 2000.

3. Letter on Medicaid Eligibility of Inmates upon Release from Prison. Secretary of Health and Human Services, Washington, DC, October 2001.

4. Letter on "Suspension of Medicaid Eligibility for Incarcerated Persons." Centers for Medicare & Medicaid Services, Washington, DC, December 2008.

5. Letter on Federal Medicaid Policy for Medicaid Eligible Individuals that Become Incarcerated and Subsequently Need Medical Care. Centers for Medicare & Medicaid Services, Washington, DC, August 2010.

1.

DEPARTMENT OF HEALTH & HUMAN SERVICES — Health Care Financing Administration

7500 SECURITY BOULEVARD
BALTIMORE MD 21244-1850

DEC 12 1997

FROM: Director
Disabled and Elderly Health Programs Group
Center for Medicaid and State Operations

SUBJECT: Clarification of Medicaid Coverage Policy for Inmates of a Public Institution

TO: All Associate Regional Administrators
Division for Medicaid and State Operations

The purpose of this memorandum is to clarify current Medicaid coverage policy for inmates of a public institution. Recently, central office staff have become aware of a number of inconsistencies in various regional office directives on this subject which have been sent to States. Moreover, the growing influx of inquiries from the internet has prompted us to expand and, in some cases, refine our coverage policy in this area. Therefore, in the interest of insuring consistent and uniform application of Medicaid policy on inmates of a public institutution, we believe that this communication is necessary.

Statute and Parameters

Section 1905(a)(A) of the Social Security Act specifically excludes Federal Financial Participation (FFP) for medical care provided to inmates of a public institution, except when the inmate is a patient in a medical institution. The first distinction that should be made is that the statute refers only to FFP not being available. It does not specify, nor imply, that Medicaid eligibility is precluded for those individuals who are inmates of a public institution. Accordingly, inmates of a public institution may be eligible for Medicaid if the appropriate eligibility criteria are met.

The next significant distinction is that under current Medicaid coverage policy for inmates there is no difference in the application of this policy to juveniles than the application to adults. For purposes of excluding FFP, for example, a juvenile awaiting trial in a detention center is no different than an adult in a maximum security prison. For application of the statute, both are considered inmates of a public institution.

Criteria for Prohibition of FFP

When determining whether FFP is prohibited under the above noted statute, two criteria must be met. First, the individual must be an inmate; and second, the facility in which the individual is residing must be a public institution. An individual is an inmate when serving time for a criminal offense or confined involuntarily in State or Federal prisons, jails, detention facilities, or other penal facilities. An individual who is voluntarily residing in a public institution would not be

considered an inmate, and the statutory prohibition of FFP would not apply. Likewise, an individual, who is voluntarily residing in a public educational or vocational training institution for purposes of securing education or vocational training or who is voluntarily residing in a public institution while other living arrangements appropriate to the individual's needs are being made, would not be considered an inmate. It is important to note that the exception to inmate status – based on 'while other living arrangements appropriate to the individual's needs are being made' does not apply when the individual is involuntarily residing in a public institution awaiting criminal proceedings, penal dispositions, or other involuntary detainment determinations. Moreover, the duration of time that an individual is residing in the public institution awaiting these arrangements does not determine inmate status.

Regarding the second criteria necessary for determining whether FFP is prohibited, a facility is a public institution when it is under the responsibility of a governmental unit, or over which a governmental unit exercises administrative control. This control can exist when a facility is actually an organizational part of a governmental unit or when a governmental unit exercises final administrative control, including ownership and control of the physical facilities and grounds used to house inmates. Administrative control can also exist when a governmental unit is responsible for the ongoing daily activities of a facility, for example, when facility staff members are government employees or when a governmental unit, board, or officer has final authority to hire and fire employees.

Privatization of Prisons

Some States have contracted with a private health care entity to provide medical care in the public institution to its inmates. We have determined that FFP would not be available for the medical services provided in this situation. We believe that the inmates are not receiving services as a patient in a medical institution. Rather, they are continuing to receive medical care in a public institution because governmental control continues to exist when the private entity is a contractual agent of a governmental unit.

Some States are also considering the feasibility of selling,or transferring ownership rights of the prison's medical un including the housing facility and the immediate grounds) to a private health care entity, thereby potentially establishing the unit as a medical institution for which FFP may be available on the greater grounds of the public institution. We do not believe this arrangement is within the intent of the exception specified in the statute. We adhere to the policy that FFP is unavailable for any medical care provided on the greater premises of the prison grounds where security is ultimately maintained by the governmental unit.

Exception to Prohibition of FFP

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

the inmate is Medicaid-eligible. We would note that in those cases where an inmate becomes an inpatient of a long-term care facility, other criteria such as meeting level of care and plan of care assessments would certainly have to be met in order for FFP to be available.

FFP, however, is not available for services provided at any of the above noted medical institutions including clinics and physician offices when provided to the inmate on an outpatient basis. Nor is FFP available for medical care provided to an inmate taken to a prison hospital or dispensary. In these specific situations the inmate would not be considered a patient in a medical institution.

Policy Application

As a result of a significant number of recent inquiries from the internet and regional offices, we have provided policy guidance involving issues where inmates receiving medical care in various settings and under unique situations. The following examples will help in determining whether FFP is available or not. Please keep in mind that these are broad and general examples and extenuating circumstances may exist which could effect this determination.

Examples when FFP is available:

1. Infants living with the inmate in the public institution
2. Paroled individuals
3. Individuals on probation
4. Individuals on home release except during those times when reporting to a prison for overnight stay
5. Individuals living voluntarily in a detention center, jail, or county penal facility after their case has been adjudicated and other living arrangements are being made for them (e g , transfer to a community residence)
6. Inmates who become inpatients of a hospital, nursing facility juvenile psychiatric facility or intermediate care facility for the mentally retarded (Note: subject to meeting other requirements of the Medicaid program)

Examples when FFP is unavailable:

1. Individuals (including juveniles) who are being held involuntarily in detention centers awaiting trial
2. Inmates involuntarily residing at a wilderness camp under governmental control
3. Inmates involuntarily residing in half-way houses under governmental control
4. Inmates receiving care as an outpatient
5. Inmates receiving care on premises of prison, jail, detention center, or other penal setting

If there are any questions concerning this communication, please contact Thomas Shenk or Verna Tyler on 410 786-3295 or 410 786-8518, respectively.

Robert A. Streimer

2.

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

APR 6 2000

The Honorable Charles B. Rangel
House of Representatives
Washington, D.C. 20515-3215

Dear Mr. Rangel

Thank you for your letter requesting clarification of Federal law regarding the eligibility of detainees/inmates in the New York City jail system. You asked if Federal policy requires or allows States to suspend (or end) Medicaid eligibility for inmates entering the New York City Jail System at Rikers Island. You also asked about Federal policy on reinstating Medicaid eligibility upon release of such an inmate. I regret the delay in this response.

Since Federal Financial Participation is not available for services rendered to a Medicaid-eligible individual during the period of incarceration (see section 1905(a) of the Social Security Act), Federal policy permits (but does not require) States to use administrative measures that include temporarily suspending an eligible individual from payment status during the period of incarceration to help ensure that no Medicaid claims are filed. In addition, for inmates with longer periods of incarceration, a State can periodically redetermine eligibility as required by 42 CFR 435.916, but use simplified procedures to do so. Regardless of the simplified procedures used, a State must ensure that the incarcerated individual is returned to the rolls immediately upon release, unless the State has determined that the individual is no longer eligible for some other reason.

I have asked Ms. Judy Berek, the Health Care Financing Administration's Regional Administrator for the New York area, to contact the State and ensure that Federal policy is understood and implemented correctly.

I appreciate your bringing this matter to our attention.

Sincerely,

Donna E. Shalala

3.

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

OCT 0 1 2001

The Honorable Charles L. Rangel
House of Representatives
Washington, DC 20515

Dear Mr. Rangel:

Thank you for your letter inquiring about the Department's policy on the Medicaid eligibility of inmates when they are released from prison.

I share your concern about the ability of inmates who entered jail enrolled in Medicaid to retain Medicaid coverage. The letter correctly describes the Department's policy, which is aimed at preventing the kinds of situations you describe. The September 14, 2000, letter stated that States may not terminate incarcerated individuals from Medicaid until a redetermination has been conducted, including an ex-parte review.

In addition, unless a state determines that an individual is no longer eligible for Medicaid, states must ensure that incarcerated individuals are returned to the Medicaid eligibility rolls immediately upon release, thus allowing individuals to go directly to a Medicaid provider and demonstrate his/her Medicaid eligibility. Please be assured that this is CMS current policy and there are plans to disseminate it to all states.

This policy is clearly advantageous for those whose incarceration is relatively brief. If they are released during a normal period of eligibility and before the State's usual, periodic redetermination of eligibility takes place, then our policy should ensure immediate resumption of Medicare coverage upon their release.

Please feel free to call me if you have any further questions or concerns.

Sincerely,

Tommy G. Thompson

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DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
1600 Broadway, Suite 700
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CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Region VIII

December 2, 2008

Joan Henneberry
Executive Director
Colorado Department of Health Care Policy and Financing
1570 Grant Street
Denver, CO 80203-1818

Re: Suspension of Medicaid Eligibility for Incarcerated Persons

This is in response to your letter dated July 31, 2008 requesting clarification on Federal Medicaid policy for Medicaid eligible individuals that become incarcerated. Please note that federal financial participation at the administrative match rate is available for States that want to implement suspension status for Medicaid eligible individuals that become incarcerated. We researched your questions and consulted with CMS Central Office to provide the following responses (in bold). The responses are based 42 CFR 435.110 and Health Care Financing Administration Letter dated December 12, 1997. Please note that this is the current policy and is subject to change based on appropriate regulatory processes by CMS.

1. Under the above *(inserted in State's letter)* definition of an inmate, would an individual be considered an inmate if they are in an inpatient hospital setting that is a locked acute forensic medicine inpatient care unit specifically designed for those incarcerated, awaiting criminal proceedings, or awaiting penal dispositions?

   An individual would be considered an inmate if he or she is residing in this setting involuntary because the setting is acting on behalf of a law enforcement public institution for incarceration. Therefore there is no Federal Financial Participation (FFP) available.

   An individual may be under arrest or even under investigation (not charged with any crime) by a local sheriff's department or that state patrol, but are confined involuntarily in the inpatient hospital setting. Would such an individual be considered an inmate even if they were not in a locked acute forensic medicine inpatient care unit specifically designed for those incarcerated but instead in an inpatient hospital room designed for normal, daily use?

   If the individual is in a hospital that is separate from the prison system and the individual becomes and inpatient of that hospital, then the individual is not considered to be an inmate of a public institution.

   If an individual is incarcerated in a state prison or county jail and then transferred to the inpatient hospital setting, is the individual still considered an inmate under 42 CFR § 435.1010 and ineligible for FFP?

If the setting is a hospital accredited as such and not created for the purposes of law enforcement and incarceration (which is separate from the law enforcement system), then the individual is not considered and inmate. FFP would be available.

If an individual is incarcerated in a state prison or county jail and then transferred to a nursing facility setting, is the individual considered an inmate under 42 CFR § 435.1010 and ineligible for FFP? Does the response change if the inmate is hospitalized or in the nursing facility for an indefinite amount of time? For example, the individual requires a ventilator and remaining in a state prison or county jail is no longer medically feasible.

If the inmate becomes an inpatient of a nursing facility or a hospital, FFP is available for that individual under the exception of the inmate provision. This continues as long as the individual is an inpatient of the medical facility. Federal policy and regulations do not place a time limit for FFP availability as long as individual continues to be eligible for Medicaid and residing as an inpatient in the medical facility.

2. Under the above definition of an inmate, would an individual required to reside in privately-owned center (such as a halfway house) that is not an organizational part of any governmental unit, nor does any such unit exercise final administrative control over the private facility, considered an inmate under 42 CFR § 435.1010 and ineligible for FFP? For example, the state's Community Corrections programs provide services for persons convicted of less severe felony offenses who are diverted from prison by the courts and services for persons who are being transitioned back to the community from prison. In addition, individuals in Community Corrections programs may have been released from a state prison or county jail, but have yet to be released on parole and are required to return to the privately-owned center nightly. We further note that the state does not exert any significant indicia of control over the Community Corrections facilities. Employees are private employees, each facility has a large degree of discretion in setting its own administrative and disciplinary policies and procedures, and the facilities retain the power to remand residents back to prison in a variety of situations.

   If facilities under the State's Community Corrections programs are limiting the individual's ability to leave the facility on permanent basis, such as the requirement for the individual to return to the center at night, CMS interprets these facilities as institutions for incarceration. While the State provides information that the centers are separate from any governmental unit, we would like additional clarification for the facility's legal basis to restrict an individual's ability to leave the facility. From the information we have, we conclude that Colorado Community Corrections programs are an integral part of the State's criminal justice system and act on the behalf of an overburden traditional prison system.

   If so, if the individual is transferred to the inpatient hospital setting during their stay in such a facility, is the individual still consider an inmate and should benefits remain to be suspended?

   See response to question #1: if the individual becomes an inpatient of a hospital, then FFP is allowed as long as he or she is an inpatient of the hospital and eligible for Medicaid.

3. Under the above definition of an inmate, would an individual only needing temporary detoxification services be considered an inmate if they are in held in a locked facility that provides non-medical, clinically managed detoxification from alcohol and drugs in a clean and safe environment? All individuals are provided sleeping accommodations and well-balanced meals during their stay. The individual is normally held in these facilities until their blood alcohol level is negligible. Even though these services are not normally billable to Medicaid, the Department requests clarification to understand if these individuals are inmates and would qualify to have their benefits suspended during their stay.

   It depends on whether the facility is acting on behalf of a public institution for incarceration and it carries out law enforcement duties. Please provide additional information about these facilities: location, organizational structure, funding, etc. Please clarify whether individuals go to these facilities voluntarily or whether they are placed in these facilities by law enforcement personnel.

   If so, if the individual is transferred to the inpatient hospital setting during their stay in such a non-medical, clinically managed facility, does the individual remain an inmate and should benefits remain suspended?
   Depends on nature of facility. Please provide additional information per previous response.

   Since many of the individuals covered under Medicaid, qualify due to their status of having children in the household, the Department has the following questions to operationalize the suspension of Medicaid eligibility.

4. If one member of the household becomes incarcerated, does that action alone trigger a "change in circumstance" under 42 CFR § 435.916?

   Yes, this would be a change is circumstance that must be reported and for which eligibility must be re-determined pursuant to 42 CFR 435.916 (change in household composition and change in residency for member of the household).

   a. If so, must the Department re-determine eligibility for the entire household and exclude the incarcerated individual from the household's application? Such an action would likely render the incarcerated individual ineligible for Medicaid. Further, if the individual incarcerated is the only child in the household, the re-determination would likely also cause the parents or other adult members of the household to become ineligible.

   Per previous response, State must re-determine eligibility and remove incarcerated individual from household application because individual is no longer living in the same household. This could have an impact on the eligibility of other household members.

   b. If not, is it acceptable to suspend the Medicaid benefits of the incarcerated individual without changing the Medicaid eligibility status of the remaining members of the household?
   No, per previous response.

c. Does the answer change if the member of the household that is incarcerated is considered head-of-household? Currently all Medicaid households must have a "head-of-household" that resides at the residence. All correspondence is mailed to the head-of-household.

Federal regulations do not establish that there must be a "head of household" in order for individuals to be eligible for Medicaid. Pursuant to 42 CFR 435.401, the State may not impose eligibility requirements that are more restrictive than the AFDC or SSI programs. Please clarify whether it is a requirement in Colorado Medicaid to have a "head-of household" for purposes of Medicaid eligibility.

d. Does the answer change if the member of the household that is incarcerated is earning income and that income is no longer available to the household?

Yes, this would change financial circumstances for the members remaining in the household and eligibility must be re-determined.

e. If the Medicaid eligibility of an inmate is suspended upon incarceration, should it be "unsuspended" as a procedural matter if the inmate is transferred to an inpatient hospital setting (as referred to in Question 1)?

This is a State decision as federal law and regulations do not specify provisions on the process used to suspend Medicaid eligibility. The fact that a Medicaid eligible client becomes incarcerated does not make them ineligible for Medicaid, but FFP is not available while they are incarcerated.

If the eligibility is "unsuspended," will the inmate's nominal household revert back to his or her household prior to incarceration?

No, because they are no longer living in the household.

If the nominal household does not revert back and the inmate previously was Medicaid-eligible as a result of residing in a household with qualifying children, how can the inmate retain eligibility?

If the only basis for eligibility for the inmate was being a caretaker relative under section 1931 of the Act, the individual would not be eligible for Medicaid.

5. For disabled adults receiving Social Security Income (SSI), the Department operates Medicaid under a Section 1634 agreement with the Social Security Administration (SSA). As such, individuals are automatically enrolled or disenrolled from Medicaid depending solely in the information received from the SSA.
The SSA has the ability to transmit to the Department when an individual's SSI benefits are suspended. Currently, the Department terminates Medicaid eligibility for these individuals. Once SSA lifts the suspension of SSI, Medicaid is automatically reinstated. Would it be appropriate for the Department to suspend Medicaid eligibility in accordance with the SSI suspension instead of terminating Medicaid eligibility?

Page #5 - Suspension of Medicaid Eligibility for Incarcerated Persons

If the Department receives information that an SSI individual is incarcerated but their SSI benefits continue, would it be appropriate to suspend Medicaid eligibility?

Because Colorado only covers individuals receiving SSI payments pursuant to section 1634 of the Act and 42 CFR 435.120, but not the "eligible but not receiving" group in 42 CFR 435.210, if the individual stops receiving SSI payments when he or she becomes incarcerated, this individual can no longer be eligible for Colorado Medicaid.

If the Department has suspended Medicaid eligibility for an inmate on SSI, would it be appropriate for the Department to maintain the suspension of Medicaid eligibility after SSI benefits have been terminated? SSI benefits are normally terminated after an individual has been incarcerated for over a year.
Upon the conclusion of the incarceration, can the Department "un-suspend" (*i.e.*, reinstate) an individual's Medicaid eligibility if that individual had his or her SSI benefits terminated or suspended by SSA solely due to incarceration without the reinstatement of SSI benefits by SSA?

If SSA terminates SSI benefits, Medicaid must do the same because the only reason for those individuals to be eligible for Medicaid was due to the receipt of SSI payments.

6. Depending on the facility, inmates may spend various lengths of time involuntarily confined. In state prisons the average stay is well over a year, while in county jails the stay may only be for a few days. Is there any specific length of time that Medicaid eligibility may be suspended for inmates?

Federal statute or regulations do not specify time limitations for suspending Medicaid eligibility.

a. If not, is it appropriate to indefinitely suspend Medicaid eligibility?
If so, and the individual is a member of a household, can the individual remain part of that household indefinitely during the incarceration period?

Per response to question #5, an incarcerated individual is no longer a member of a household because they are no longer living there.

If so, and an eligibility redetermination required upon the conclusion of the incarceration period? The Department is concerned about those individuals who are incarcerated for several years and may not return to the same household under which Medicaid eligibility was originally established.

b. Medicaid eligibility is re-determined annually. Can Medicaid eligibility be suspended beyond the individual's re-determination date? Is an annual redetermination required if the individual is still an inmate?

If the individual continues to be eligible for Colorado Medicaid when they become incarcerated, the State must do annual re-determination of eligibility pursuant to 42 CFR 435.916.

c. Can the Medicaid agency specify a length of time beyond which Medicaid eligibility can be suspended? For example, Medicaid eligibility may be suspended while an individual is incarcerated up to one year but not beyond the individual's Medicaid re-determination date. **Federal statute or regulations do not specify time limitations for suspending Medicaid eligibility.**

7. Would it be appropriate to set a policy for the suspension of Medicaid eligibility that treated Medicaid individuals differently?

   No, this would violate comparability requirements in section 1902(a)(10(B) of the Act.

   If so, could that policy be set to treat SSI-disabled individuals different from AFDC adults? For example, SSI-disabled individuals would not be eligible to have their Medicaid eligibility suspended, but AFDC adults could.
   If so, could that policy be set to treat adult individuals differently from children? For example, adults would not be eligible to have their Medicaid eligibility suspended but children would be, and that policy would be enforced even when adults and children are in the same household (such as with AFDC households).
   If so, could the policy be different based on the individual's status in the household? For example, anyone designated as head-of-household would not be eligible to have their Medicaid eligibility suspended, but other adults and children in the household would be.
   Suspension of Medicaid Eligibility for Incarcerated Persons July 31, 2008 Page 5

   No, this would violate comparability requirements in section 1902(a)(10(B) of the Act.

8. What would be the process for suspending Medicaid eligibility for those individuals who have submitted a Medicaid application but have not received an eligibility determination prior to incarceration? Under this scenario, Medicaid eligibility could be backdated to the period prior to the incarceration, but then suspended once the incarceration began. Would such an action be acceptable?

   If the individual meets eligibility criteria when the application is processed, they would be eligible for Medicaid even though he or she later becomes incarcerated. No FFP can be claimed as long as they are inmates of the public institution.

9. To implement a suspension of Medicaid eligibility would the Department need to modify the State Plan? Is there any notification to, or approval from, CMS that is needed prior to implementation?

   The State would not have to amend its Medicaid State Plan in order to establish suspension of Medicaid eligibility for incarcerated individuals. This is not part of the State Plan. The State would not need CMS approval prior to implementation.

10. Does CMS have any information regarding other states that have successfully implemented a policy to suspend Medicaid eligibility that they could share with the Department? If so, the Department would appreciate any assistance CMS could provide in contracting those states.

New York and Pennsylvania have implemented suspension status for Medicaid eligible individuals that become incarcerated.

11. Does CMS have any additional guidance on the issue of inmate eligibility other than the December 12, 1997 letter that can be provided?

    Not at this time.

12. Is it possible to apply the same suspension of eligibility to State Children's Health Insurance Program ("SCHIP") individuals? If so, would any of the above responses to Medicaid eligibility be significantly different?

    Section 2110(b)(2) of the Social Security Act excludes children that are inmates of public institutions from the SCHIP program, therefore similar suspension policies would apply.

Please contact Diane Dunstan if you have questions regarding this letter. She can be reached at (303) 844-7040 or at Diane.Dunstan@cms.hhs.gov .

Sincerely,

Richard C. Allen
Associate Regional Administrator
Division of Medicaid & Children's Health Operations

Cc: Chris Underwood

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CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Region VIII

August 16, 2010

Joan Henneberry
Executive Director
Colorado Department of Health Care Policy and Financing
1570 Grant Street
Denver, CO 80203-1818

Dear Ms. Henneberry:

This is in response to your letter dated December 23, 2009, requesting clarification on Federal Medicaid policy for Medicaid eligible individuals that become incarcerated and then subsequently need medical care. We apologize for the delay in responding.

Specifically, you are asking if services provided to the inmates who are receiving care from the Correctional Care Medical Facility of Denver Health Medical Center, is eligible for Federal Financial Participation (FFP). In your letter you describe the Correctional Care Medical Facility of Denver Health Medical Center as a unit that is designed exclusively to treat inpatient referrals from the Denver County detention facility but is a part of and operates under the accredited inpatient hospital license of the Denver Health Medical Center.

Please be advised the costs of care, treatment and services described above and in your letter dated December 23, 2009, is entitled to FFP. The basis for this technical assistance is based on 42 CFR 435.1009 and 42 CFR 435.1010 and the State Medicaid letter dated April 10, 1998. While Federal law at 1905(a)(A) of the Social Security Act prohibits FFP for medical care or services for inmates in a public institution there is the exclusion when the inmate who is otherwise Medicaid eligible receives medical care in a medical institution.

The situation you describe in your letter is inmates on occasion are admitted into this special unit of the Denver Health Medical Center for inpatient care. Denver Health Medical Center is a licensed, accredited inpatient hospital and otherwise meets the definition of a medical institution as defined at 435.1010(b)(2)(b). The inmates in question are expected to remain in Denver Health Medical Center for a period of 24 hours or longer. Denver Health Medical Center is an accredited and licensed hospital and not created for the purposes of law enforcement and incarceration (which is separate from the law enforcement system) and is not under the authority of any correctional unit. As long as these conditions are met FFP is available.

Additionally, if the inmate becomes an inpatient of a nursing facility or a hospital, FFP is available for that individual under the exception of the inmate provision. This continues as long as the individual is an inpatient of the medical facility. Federal policy and regulations do not place a time limit for FFP availability as long as the individual continues to be eligible for Medicaid and residing as an inpatient in the medical facility.

If you have any questions please contact Diane Dunstan-Murphy of my staff at (303) 844-7040 or via email at Diane.Dunstan-Murphy@cms.hhs.gov.

Sincerely,

Richard C. Allen
Associate Regional Administrator
Division of Medicaid & Children's Health Operations

cc: Chris Underwood

Acknowledgments

The Council of State Governments Justice Center thanks the Legal Action Center for their work in developing this policy brief. Contributors to this report include Dan Belnap, Senior Health Policy Analyst, Legal Action Center; Gabrielle de la Gueronniere, Director for National Policy, Legal Action Center; and Paul Samuels, Director/President, Legal Action Center.

The Legal Action Center (LAC) is the only nonprofit law and policy organization in the United States whose mission is to advocate for sound substance use, criminal justice, and HIV/AIDS public policies and to fight discrimination against and protect the privacy of people with these backgrounds. Since 1973, LAC has worked to improve our nation's public policies to promote drug and alcohol prevention, treatment and recovery, and smarter criminal justice and HIV policies. LAC is committed to helping people reclaim their lives, maintain their dignity, and participate fully in society as productive, responsible citizens.

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