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How Medicaid Enrollment of Inmates Facilitates Health Coverage After Release

Overview

As more states and localities have begun to re-evaluate and reform their criminal justice systems in recent years, policymakers have devoted increased attention to the health care provided to individuals transitioning in and out of prisons and jails. Health care and corrections have each emerged as fiscal pressure points, and so too has the intersection of these two spheres: health care for inmates. States alone spent \$7.7 billion on health care for prison inmates in fiscal year 2011.¹ Moreover, because of the extensive and, in some cases, communicable health conditions of many inmates, officials recognize that facilitating seamless access to health care upon re-entry into society improves the individuals' prospects for successful reintegration and benefits the public's health and safety. Offenders frequently enter jail or prison with a substance use disorder and/or a mental illness² and have high rates of chronic medical conditions (such as hypertension and diabetes) and infectious diseases (such as HIV and hepatitis C).³ Care continuity can be especially critical with the treatment of behavioral health conditions.⁴

Health insurance is a key ingredient of access to quality care for all Americans, including individuals involved with the justice system. But many offenders—nearly 80 percent, according to some estimates—have historically returned to their communities uninsured because they were initially without access to employer-sponsored insurance, unable to afford insurance in the individual market, or did not qualify for safety net health programs such as Medicaid.⁵ The Affordable Care Act (ACA) created an opportunity for states to change this situation by providing additional federal money to states that expand their eligibility criteria for Medicaid coverage under the terms set forth in the law. States may elect not to participate in the optional ACA expansion and instead adopt a partial eligibility expansion, but they will not receive enhanced federal support. Several jurisdictions have found that providing coverage contributes to improved care continuity among returning inmates, especially when paired with additional actions such as connecting individuals with community health providers and case management, thereby preserving the benefits of care delivered during a jail or prison stay and reducing reliance on expensive, uncoordinated emergency department care.

Making Medicaid available to inmates

Medicaid, the joint federal-state health care program covering about 70 million Americans, is the primary means through which states and localities provide health care access to vulnerable populations.⁶ But while jurisdictions have never been precluded by inmates' incarceration status from enrolling them in Medicaid, such coverage has historically been unavailable to most jail and prison inmates because, as nondisabled adults without dependent children, they did not meet many states' eligibility criteria.

Jails vs. Prisons

Jails are facilities that house inmates awaiting trial and those convicted of misdemeanors who are serving sentences of less than one year. In most states, they are run by counties or cities. Prisons are state (or federal) facilities that incarcerate convicted inmates serving sentences of more than one year. From June 2013 to June 2014, jails held approximately 11.4 million inmates.⁷ States prisons housed 1.4 million on a typical day in 2014.⁸ Owing to the much shorter nature of jail stays—frequently mere hours or days—and the sheer volume of individuals cycling through, state and local officials face different challenges as they design programs to enroll inmates in Medicaid.

In a 2004 letter to state Medicaid directors, the Centers for Medicare & Medicaid Services (CMS) reiterated its long-held policy that individuals who meet states' Medicaid eligibility criteria "may be enrolled in the program before, during, and after the time in which they are held" in jail or prison.⁹ CMS also encouraged states not to "terminate" coverage for inmates based solely on their status as inmates, but rather to temporarily "suspend" their coverage status until they were released from the correctional facility. Suspension allows Medicaid services to resume soon after re-entry, while helping to ensure that federal reimbursement for health care services provided to enrolled inmates is not sought by the state, as this is generally prohibited by federal law. As of December 2014, 12 states had a policy in place to suspend coverage for incarcerated individuals.¹⁰

Massachusetts was one of the first states to take steps to increase Medicaid enrollment among its incarcerated population. Employing a model similar to the ACA, the state reformed its health care system in 2006 and, operating under a Section 1115 waiver, expanded Medicaid eligibility for nondisabled childless adults who met certain criteria. Such waivers allow states to operate Medicaid programs outside of traditional federal rules. They were common prior to the ACA, as states sought flexibility to modify the design of their systems.

In 2008, once reform was fully implemented, prison officials began enrolling inmates six months before their release and connecting them with a primary care physician in their community who accepted Medicaid patients.¹¹ A 2011 study of the program found that 91 percent of inmates released from correctional facilities between July 1, 2008, and Dec. 31, 2008, were enrolled in MassHealth, the state's Medicaid program, at some point during the year of their release.¹² Eighty-four percent of this group used at least one of MassHealth's services, including medical care, behavioral health treatment, and prescription drug medication. The state has since added other elements to its discharge planning, such as scheduling primary care and specialist appointments, connecting those with HIV or AIDS with case managers, and linking people who take anti-addiction medications with substance use disorder treatment centers.

The ACA offered a chance for states and localities to cover more individuals involved with the criminal justice system with additional federal support, beginning in January 2014. Those that elect to expand their Medicaid program in accordance with the ACA—30 states and the District of Columbia, as of November 2015—make coverage available to all individuals, including nondisabled adults without dependent children who earn up to 138 percent of the federal poverty level (\$16,242 for a single adult in 2015).¹³ Nearly all inmates' income falls below this threshold while they are in jail or prison, and most continue to be eligible for at least the first several weeks after release. This eligibility expansion removes a key barrier so that states and localities can enroll more inmates—or keep them enrolled during incarceration with suspended coverage—and can seek federal reimbursement for certain covered services. The federal government is initially reimbursing 100 percent of the cost of covered services for all newly eligible enrollees, including inmates. The federal match will gradually decrease to 90 percent by 2020.

Coverage Through ACA Marketplaces

Inmates whose income exceeds the eligibility threshold for Medicaid in their state may enroll in subsidized health insurance through state and federal insurance marketplaces, or exchanges. Individuals are eligible if they are in jail or prison pending disposition of charges (i.e., held but not convicted of a crime) and after they leave, even if they remain on probation, parole, or home confinement. They may receive federal tax credits to help defray the cost of premiums if their income ranges between 100 percent (138 percent in states that have expanded Medicaid in accordance with the ACA) and 400 percent of the federal poverty level.

Additional states have begun putting programs in place to enroll inmates. In September 2014, the Ohio Department of Rehabilitation and Correction partnered with the state's Medicaid agency to begin enrolling inmates and facilitating their selection of a Medicaid managed care plan 90 days prior to their release.¹⁴ To help administer the program, inmates selected by corrections officials have the option of serving as peer counselors,

helping soon-to-be-released inmates navigate the enrollment process. The application itself is completed through a dedicated phone line that connects applicants with a representative of the Ohio Medicaid Consumer Hotline. As of July 2015, more than 700 inmates had been enrolled across four participating facilities. The state aims to have all 27 facilities participating by the end of 2016. Corrections officials believe that Medicaid coverage will help departing inmates more successfully access appropriate medical, mental health, and substance use disorder services, which they view as having the potential to reduce recidivism.¹⁵

In April 2015, New Mexico enacted a law prohibiting state and local agencies from denying Medicaid eligibility solely on the basis of incarceration, and requiring suspension of benefits, rather than termination, until the day of release for enrolled individuals who enter jail or prison.¹⁶ Bernalillo County, the state's most populous, began a pilot program to enroll eligible inmates within three days of entering its Metropolitan Detention Center. A one-day snapshot of the jail's population on June 18, 2015, found that 58 percent of all inmates were enrolled.¹⁷

Importantly, states need not expand their Medicaid programs in accordance with the ACA to make coverage available to inmates. Wisconsin, for example, has not adopted the ACA's Medicaid expansion but provides coverage to nondisabled childless adults whose incomes do not exceed 100 percent of the federal poverty level.¹⁸ With assistance from corrections staff, the state allows soon-to-be-released inmates to apply for benefits over the phone at the end of the month prior to their release.¹⁹ Coverage goes into effect on the first day of the month in which inmates are released.

To provide this coverage, Wisconsin received federal approval through a Section 1115 waiver. Under this waiver, the state receives the same level of federal support for covering this population as it does for other eligible enrollees—but not the enhanced funding match states receive when they expand their programs as outlined by the ACA. Other states that elect not to participate in the ACA expansion may seek similar federal authorization.

States May Receive Federal Support for Enrollment Activities and Case Management

Correctional agencies may receive federal financial support—typically a 50 percent match of state expenditures—for enrolling inmates in Medicaid and for certain services that connect them with appropriate care in the community upon release under a program called Medicaid Administrative Claiming.²⁰ Examples of reimbursable activities include assisting individuals with an enrollment application, referring inmates to medical providers, helping with appointment scheduling, and monitoring a parolee's progress with substance use disorder treatment. Corrections agencies can participate in this program by coordinating with their state Medicaid agency and completing the process for qualifying as a Medicaid claiming unit.

Medicaid reimbursement for inpatient costs

States may not seek federal reimbursement for health care services provided to jail or prison inmates, with one exception: care delivered outside of correctional facilities, such as at a hospital or nursing home, when the inmate has been admitted for more than 24 hours. Under these circumstances, states can obtain federal reimbursement that covers at least 50 percent of prisoners' offsite inpatient costs, as long as they are Medicaid-eligible and enrolled in the program. States may save additional dollars as well, because Medicaid typically pays the lowest provider rates of any payer in a state, including departments of correction.

States that expand their Medicaid eligibility under the ACA will generally reap the largest savings from this option because most inmates, as nondisabled adults without dependent children, will become eligible for Medicaid coverage only under the expansion. So while this opportunity is available to all states, those that elect not to expand their programs may have relatively few individuals under their custody who are eligible for Medicaid.

States have begun to report savings. Arkansas, Colorado, Kentucky, and Michigan report combined fiscal 2014 and 2015 savings of \$2.8 million, \$10 million, \$16.4 million, and \$19.2 million, respectively, according to an April 2015 study by the Robert Wood Johnson Foundation.²¹ Throughout 2015, Alaska Governor Bill Walker advocated expanding the state's Medicaid program based, in part, on savings the state would incur.²² Alaska expects that much of these savings—\$4.1 million in fiscal 2016; \$7 million annually from fiscal 2017 to fiscal 2021—will come from federal reimbursements it will receive for inmates' inpatient health costs.²³

Others are recognizing that they are not making full use of this opportunity. After legislators in Massachusetts directed Medicaid officials to seek all appropriate federal reimbursements, the state auditor reviewed correctional health costs from 2011 and 2012. She found that over the two-year period, the Commonwealth had failed to submit reimbursement claims for roughly \$11.6 million in eligible inpatient services.²⁴ These lost reimbursements were split between county jails (\$7.6 million) and state facilities (\$4.1 million).

Conclusion

Providing inmates with health coverage is an important element of ensuring access to quality care after release. While states and localities have never been prohibited from enrolling offenders in Medicaid, as long as they met other criteria, the Affordable Care Act created an opportunity for policymakers to make this coverage more widely available with additional federal support. In addition to contributing to care continuity as individuals transition in and out of incarceration, this also increases states' chance of receiving federal assistance for offsite inpatient care costs covered by Medicaid. Several jurisdictions are acting to make greater use of these options.

Endnotes

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