Medicaid and the Criminal Justice System

Medicaid and the criminal justice system share responsibility for providing health care to justice-involved populations. With a few exceptions, Medicaid is the payer of health care services for eligible and enrolled individuals who are subject to parole and probation, while correctional institutions, including federal and state prisons and local jails, must pay for health care costs while individuals are confined to their facilities. Although inmates of public institutions can remain eligible for Medicaid in many states, federal law prohibits use of federal Medicaid funds for most health care services for inmates of public institutions except in cases of inpatient care lasting 24 hours or more.

This issue brief describes how Medicaid and the State Children's Health Insurance Program (CHIP) interact with the criminal justice system. We examine the roles of Medicaid and the correctional system in providing health care, including Medicaid eligibility and payment policies applicable to individuals who are inmates of a public institution. We also examine CHIP eligibility rules for justice-involved youth. Finally, we highlight state efforts to enroll individuals in Medicaid and address the health care needs of the justice-involved population.

The Justice-Involved Population

Criminal justice-involved individuals include adults serving sentences in prisons and jails, awaiting trial or sentencing, and those under community supervision, such as parole or probation.[1] They also include youth who may be served in a separate system; most youth are under community supervision through orders of probation and parole. Compared to the general population, those involved in the criminal justice system tend to have more complex and unmet health care needs.

Adult population

At the end of 2015, an estimated 6.7 million individuals were under the supervision of the adult correctional system, including 4.6 million on probation or parole, and 2.1 million under the custody of state or federal prisons or local jails (BJS 2016b). In addition, there were 10.9 million admissions to jails in 2015.

Men are most likely to be incarcerated. In 2015, 93 percent of individuals sentenced to federal and state prisons and 85.7 percent of individuals in local jails were male (BJS 2016a, BJS 2016b). Black men are incarcerated at rates six times higher than the rate for white men and nearly two and half times higher than the rate for Hispanic men (McDaniel et al., 2013).

Adults involved in the criminal justice system have a higher prevalence of HIV/AIDS, tuberculosis, sexually transmitted diseases, and hepatitis B and C than the general population (NCCHC 2002). They also have higher rates of chronic conditions such as asthma, diabetes, and hypertension, as well as behavioral health

disorders. An estimated 65 percent of incarcerated individuals have a substance use disorder (CASA 2010, Greifinger 2007, James and Glaze 2006).

Historically, most justice-involved adults were uninsured. In expansion states, many are now eligible for Medicaid coverage upon release. For example, officials from New York and Colorado estimate that 80 and 90 percent of state prison inmates respectively, were likely eligible for Medicaid. In North Carolina, which has not expanded Medicaid, only 2 percent of state prison inmates are eligible for Medicaid at any given time (GAO 2014).

Juvenile population

Juveniles involved in the criminal justice system include those between the ages of 10 and 17 charged with a misdemeanor or felony, delinquency, or non-criminal status offenses such as truancy and running away.[2] Most juveniles are placed on community probation, and a small number are placed in residential treatment (NCJJ 2017). Of those in residential placements, 87 percent are male and about two-thirds are minorities (Acoca, Stephens, and Van Vleet 2014).

Many youth served in the juvenile justice system are Medicaid or CHIP eligible, although this varies by state. A recent survey of seven states found Medicaid enrollment ranging from one-third of justice-involved youths in one state to 60 percent in three states, to 100 percent in one state (Zemel and Kaye 2009).

Justice-involved youth have high rates of tuberculosis, dental problems, and sexually transmitted infections such as HIV (Teplin et al. 2013). Approximately two-thirds of justice-involved youths have a diagnosable mental health or substance use disorder (NCMHJJ 2015). However, fewer than half of juvenile correctional facilities provide mental health evaluations to all youths. About half of youths in custody (53 percent) say they have personally met with a counselor at their current facility (Sedlak and McPherson 2010).

Medicaid and CHIP Eligibility for Criminal Justice-Involved Individuals

Medicaid eligibility is not affected by an individual's involvement with the criminal justice system. By contrast, children and pregnant women cannot be enrolled in CHIP if they are inmates of public institutions (42 USC § 2110(b)(2)(A) and § 2112(d)(2)(C)). Thus, if a CHIP-enrolled child or pregnant woman is confined to an institution, CHIP coverage is terminated.

There are some cases, however, in which incarceration can affect Medicaid eligibility, including:

Supplemental Security Income-based (SSI) eligibility. SSI payments are suspended while an individual is incarcerated. If the individual's confinement lasts for 12 consecutive months or longer, eligibility for SSI benefits terminates. At the point of SSI eligibility termination, an individual who is eligible for Medicaid on the basis of SSI also becomes ineligible for Medicaid benefits. If an individual's SSI benefits are

terminated, it can take several months for benefits to be reinstated upon release. Similarly, if a new application and disability determination is required upon release, a decision about a person's disability may take anywhere from three to five months (SSA 2017).

Low-income parent or caretaker relative eligibility. If an individual who is eligible for Medicaid through this eligibility pathway is incarcerated, he or she will no longer be considered the custodial parent or caretaker of a child, and will thus no longer be eligible for Medicaid coverage through this pathway.

Change in household income. An individual's incarceration may change family household size, as well as monthly household income. These changes can affect the entire family's eligibility for Medicaid and CHIP.

Medicaid Financing for Services in Correctional Settings

As mentioned above, federal law prohibits states from using federal Medicaid matching funds for health care services provided to adult and juvenile inmates of public institutions, except when the inmate is admitted to an off-site hospital or other qualifying facility for at least 24 hours (42 USC § 1393d(a)(29)(A)). To be considered an inmate of a public institution, an individual must be held involuntarily by law enforcement authorities (CMS 2016).[3] In 2015, the Centers for Medicare & Medicaid Services (CMS) issued guidance further clarifying when an individual is considered an inmate of a public institution.

Specifically, federal matching funds are available for individuals who are:

- on parole, probation, or released to the community pending trial;
- living in a halfway house where individuals can exercise personal freedom;
- voluntarily living in a public institution; or
- on home confinement.

Federal financial participation is not available for individuals living in:

- state or federal prisons, local jails, or detention facilities;
- federal residential reentry centers;
- residential mental health and substance use disorder treatment facilities for incarcerated individuals; or
- hospitals or nursing facilities that exclusively serve incarcerated individuals (CMS 2016).

States have an incentive to enroll individuals in Medicaid to claim federal funds for hospital stays that are over 24 hours. New Jersey attributed a 20 percent reduction in the department of correction's hospitalization costs due to its efforts to enroll individuals in Medicaid. Ohio saw a more dramatic decline, reducing hospital costs by more than half, and attributed the availability of Medicaid to the reduction in prison health spending (Pew 2017). However, the extent to which Medicaid is the payer of eligible hospital services varies by state. Some states do not have written policies regarding Medicaid enrollment for incarcerated individuals, and other states have inconsistent policies (McKee et al. 2015).

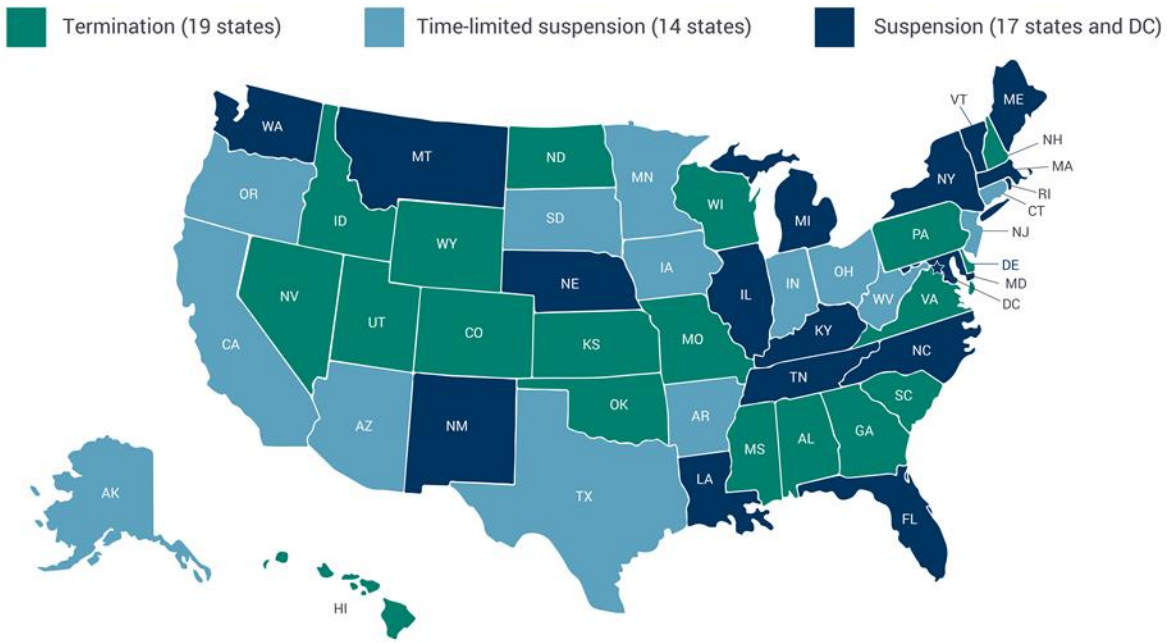
Policies to Coordinate Medicaid and Correctional Agencies

With expansion of Medicaid to the new adult group under the Patient Protection and Affordable Care Act (ACA, P.L.111-148, as amended), more incarcerated individuals became eligible for Medicaid, prompting some states to evaluate their policies and improve communication with state and local correctional partners. Several states are reexamining Medicaid benefits, enrollment, and retention policies for the justice-involved population, and are collaborating with corrections agencies on reentry efforts.

Termination or suspension of enrollment for justice-involved individuals

Most states suspend rather than terminate Medicaid benefits during periods of incarceration (Figure 1). Suspending Medicaid allows states to reactivate coverage more quickly than reenrolling individuals after their release and allows correctional agencies to bill Medicaid for allowable inpatient expenses. In some states, suspensions are limited to short periods (e.g. 30 days). Other states suspend Medicaid eligibility for up to one year and others for the full duration of incarceration. Some states specify correctional facilities to which such policies apply, such as state prisons or certain county jails (KFF 2017).

FIGURE 1. State Policies on Medicaid Enrollment during Incarceration, 2018



Notes: Colorado and Hawaii recently passed laws to suspend rather than terminate Medicaid enrollment, and are in the process of implementing the law. Some states specify that suspension policies apply to specific prisons and jails.

Sources: KFF 2017 and Families USA 2016.

CMS recommends that states establish agreements with Medicaid managed care plans to ensure timely reporting of incarceration status in order to prevent capitated payments being made erroneously (CMS

2016). Massachusetts suspends Medicaid payments to plans for incarcerated individuals, and covers qualifying inpatient stays under fee for service (Ryan et al. 2016).

Suspending coverage requires extensive coordination between correctional agencies and Medicaid eligibility systems. Coordinating efforts between multiple county jail systems and the state Medicaid agency can be burdensome (Ryan et al. 2016). In Arizona, each participating jail or prison sends a daily Excel file of bookings to the state Medicaid agency; this is matched against Medicaid eligibility information to suspend enrollment for newly incarcerated individuals, or reinstate coverage for released individuals (AHCCCS 2018). Other states, such as Connecticut and Louisiana have shared data through a centralized state correctional agency. CMS guidance notes that enhanced federal funding for new or improved eligibility systems can be used to create or update computer systems that allow for the tracking of incarceration status (42 CFR 433.112, CMS 2016).

Timely reactivation of eligibility can be challenging, particularly because an individual's incarceration status can change with little notice. To prevent individuals from losing coverage in these circumstances, some states have a waiting period before suspending Medicaid enrollment. Arizona, a managed care state, waits 24 hours, while Connecticut, which operates a fee-for-service program, waits 60 days.

Reentry programs

Many incarcerated individuals need care upon release to treat their chronic medical conditions and behavioral health disorders. To address these needs, many state Medicaid programs (primarily in expansion states) are collaborating with correctional agencies on reentry programs that allow individuals to have Medicaid coverage upon release. Most programs begin 30 to 90 days prior to an individual's set release date and may include additional assistance beyond Medicaid enrollment, including care coordination or case management. More than half of states have efforts in place to facilitate enrollment in Medicaid at jails in 31 states or prisons in 39 states (KFF 2017).[1]

Enrollment assistance. Ohio uses peers to help incarcerated individuals learn about plan enrollment and how to apply for Medicaid. Other states use Medicaid funds specifically set aside for enrollment assistance. For example, Illinois assists individuals in large jails with Medicaid enrollment through its navigator program. Massachusetts and other states work with medical vendors contracted by the state department of corrections to assist enrolling individuals either at the time of hospitalization or prior to release. Massachusetts also offers assistance in accessing care upon reentry (MA EOHHS 2015).

Presumptive eligibility. Medicaid programs often require multiple forms of identification for enrollment. Many incarcerated individuals may not have such identification, which may have been confiscated or absent at booking. Presumptive eligibility determinations can be used to ensure justice-involved individuals have access to health care upon release. Such determinations are made immediately by some states; however since enrollment is temporary, individuals must complete a full Medicaid application in order to keep coverage after the initial presumptive eligibility period ends.

Examples of states using presumptive eligibility include:

- Connecticut provides a streamlined, two-page eligibility application to simplify the process for incarcerated persons who do not have access to documentation while in detention. The state reported that 60 percent of the incarcerated population is enrolled in Medicaid prior to release (Ryan et al. 2016).
- New Mexico uses juvenile justice agents to presumptively determine eligibility for justice-involved youth (Zemel and Kaye 2009).
- Maryland permits state and local correctional facilities to make presumptive eligibility determinations under the state plan.

Care coordination. Both Connecticut and Rhode Island have implemented post-release programs to increase access to medications. Connecticut provides individuals released from jail or prison with a Medicaid prescription voucher valid for a 30-day supply of medically necessary prescription medications. While most individuals who receive this voucher are eligible for Medicaid, if they are not eligible, the state covers the full cost of the voucher (Clemans-Cope et al. 2017). In states that provide case management services for incarcerated individuals prior to release, services may be funded through Medicaid as a contractual condition to a health plan receiving capitation for the individual. Under fee for service, Medicaid or the corrections agency may fund the services.

Other Medicaid programs for justice-involved individuals

States are also taking other steps to facilitate access to care for formerly incarcerated individuals.

Health homes. Medicaid coverage of behavioral health services upon reentry is associated with reduced recidivism (Morrissey et al. 2007). New York has piloted six health homes specifically targeting justice-involved individuals with behavioral health needs.[1] Case managers at the health homes work with the corrections department and law enforcement to identify eligible individuals, provide discharge planning, and make connections to health care (New York DOH 2015). While Rhode Island does not have a separate health home program for justice-involved individuals, discharge planners at jails and hospitals identify individuals with substance use disorders to direct them to health homes where they may be connected to care pending an eligibility determination (Clemans-Cope et al. 2017).

Section 1115 waivers. Some states are using waivers under Section 1115 of the Social Security Act to target the justice-involved population. California's Medi-Cal 2020 waiver includes Whole Person Care pilots that enable counties to provide coordinated care to vulnerable populations, including those involved with the criminal justice system. The waiver also allows counties to provide extended stays for withdrawal and residential substance use disorder services for this population. Utah's Section 1115 demonstration allows the state to grant eligibility to justice-involved adults with substance use or mental health needs. Individuals may not have dependent children, and must have incomes at zero percent of the federal poverty level, with a 5 percent income disregard (CMS 2017).

Endnotes

[1] For adults, correctional facilities include federal or state prisons in which an individual is convicted of a felony and sentenced for at least one year, and jails, which are operated by local governments for detainees awaiting trial, sentencing, or both, or are serving a sentence of less than one year.

[2] Status offenses are non-criminal acts such as truancy, curfew violations, and running away from home. States differ in how they define juveniles, with the lower age limit generally beginning at age 10 and the upper age set at 17. Some states include youth as young as age six or set the upper limit at age 15 or 16 (Open Minds 2015).

[3] There are separate definitions for "child care institutions" and "publicly operated community residences". CMS does not include these as public institutions for the purposes of identifying who is an inmate (CMS 2016).

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