

August 2015 | Issue Brief

State Medicaid Eligibility Policies for Individuals Moving Into and Out of Incarceration

Catherine McKee and Sarah Somers, National Health Law Program
Samantha Artiga and Alexandra Gates, Kaiser Family Foundation

Executive Summary

Many individuals in prisons and jails have significant physical and behavioral health care needs, but lack health insurance and regular access to care. Compared to individuals in the community, incarcerated individuals are much more likely to have chronic physical and mental health conditions, such as HIV/AIDS, a serious mental illness, or a substance abuse disorder. Despite having significant health care needs, many individuals do not receive necessary medical care during incarceration. Because the majority of individuals leaving prisons and jails do not have health insurance, they often continue to lack access to care after release.

Medicaid coverage for individuals moving into and out of incarceration may help increase their access to care and improve their health status, and thus contribute to broader benefits. Enrolling these individuals in Medicaid may also contribute to state savings. The Affordable Care Act's (ACA) Medicaid expansion offers a new opportunity for states to connect individuals in prisons and jails to coverage. However, Medicaid eligibility policies for incarcerated individuals vary in both expansion and non-expansion states. These policies affect if and when individuals may be enrolled in coverage and the savings states may achieve from their coverage.

Federal law does not prohibit individuals from being enrolled in Medicaid while incarcerated. However, Medicaid will not cover the cost of care for incarcerated individuals, except for care received as an inpatient in a hospital or other medical institution. Given these broad federal rules, states have flexibility to make policy choices related to eligibility and enrollment of incarcerated individuals. Building on an earlier [brief](#) that provides an overview of health coverage and care for individuals involved with the criminal justice system, this brief highlights how state eligibility policies for incarcerated individuals differ, based on a review of state statutes, regulations, Medicaid eligibility manuals and other Medicaid agency guidance publicly available online and Medicaid managed care contracts. It finds:

A few states do not appear to have any written policies regarding Medicaid eligibility for incarcerated individuals. However, given the program's potentially greater role for this population as a result of the Medicaid expansion, this is an area where states will likely continue to develop policies over time.

Many states terminate eligibility for individuals who become incarcerated, but the number of states that suspend rather than terminate eligibility appears to be growing. Some states have relatively broad suspension policies, while others explicitly limit suspension to certain groups of incarcerated individuals or for a specified length of time. Historically, many states terminated eligibility, as federal law

prohibits Medicaid payment for most services provided to individuals in prisons and jails. However, suspending eligibility allows individuals to receive services immediately after release and may make it easier for states to access federal Medicaid funding for inpatient services provided to incarcerated individuals.

Policies and processes related to accessing Medicaid reimbursement for inpatient services provided to incarcerated individuals vary among states. Many states' policies acknowledge that individuals who are incarcerated may receive Medicaid coverage for inpatient services, and some outline the process for accessing federal reimbursement for these services. Other state policies do not specify this exception for inpatient services, meaning that the states may not be accessing available federal reimbursement. Accessing this federal reimbursement can lead to savings for states. The Medicaid expansion increases this savings potential, as more individuals qualify for the program, and the federal government provides an enhanced match rate for newly eligible adults.

States also vary in whether they allow individuals in prisons and jails to apply for and enroll in Medicaid. If individuals cannot apply and be determined eligible for Medicaid while incarcerated, they may not have access to health care services immediately after release. Policies in several states explicitly allow individuals who are incarcerated to apply for Medicaid before release. A few states also require corrections staff to facilitate the application process for individuals nearing release. Allowing individuals to apply for and enroll in Medicaid prior to release can help ensure timely access to care immediately after release.

Through their contracts with Medicaid managed care entities, some states have established policies to prevent making capitated payments on behalf of individuals who are incarcerated.¹ Some contracts exclude individuals who are incarcerated from enrolling in the managed care plan and/or provide for disenrollment from the plan when an enrollee becomes incarcerated. In addition, some contracts specify that the state will recoup a capitated payment made on behalf of an enrollee who becomes incarcerated. By adopting such policies, states can stop capitated payments to plans for individuals while they are in prison or jail without terminating enrollment in Medicaid.

Several states have Medicaid managed care contract provisions that require plans to provide care coordination services to individuals upon release from jail or prison. Medicaid managed care entities may be well-positioned to help Medicaid enrollees access necessary community-based services upon release. Several states require plans to work with correctional agencies to help individuals returning to the community connect to services, particularly behavioral health services, upon release.

In conclusion, state Medicaid eligibility policies for individuals moving into and out of incarceration vary. These policies affect if and when individuals may enroll in Medicaid and the scope of any resulting savings. Looking ahead, state policies in this area will likely continue to evolve given the larger role of Medicaid for this population under the expansion. It will be important for states to consider the implications of different choices as they develop their policies. Suspending rather than terminating eligibility, allowing individuals to enroll in coverage prior to release, and facilitating enrollment as part of re-entry planning all promote timely access to health coverage upon release. Research suggests that coverage immediately upon release can lead to improved access to care and broader benefits. Expanding health coverage among individuals moving into and out of incarceration may also lead to state savings through federal reimbursement for inpatient services provided to incarcerated individuals, reductions in uncompensated care, and savings in other indigent care programs.

Introduction

Connecting individuals moving into and out of incarceration to health coverage may not only increase their access to care and improve their health status, but may also lead to state savings. The Affordable Care Act's (ACA) Medicaid expansion to low-income adults offers a new opportunity to connect these individuals to health coverage. However, in both expansion and non-expansion states, a range of state policy choices determine if and when individuals moving into and out of incarceration may be enrolled in coverage and the potential savings that states may achieve from increasing coverage for these individuals. Based on a review of state statutes, regulations, publicly available state Medicaid policies, and Medicaid managed care contracts, this brief highlights examples of how Medicaid eligibility policies for incarcerated individuals differ among states and discusses the implications of these state policy choices. This work builds on an earlier [brief](#) that provided an overview of health coverage and care for the criminal justice-involved population and the role of Medicaid.

Background

Many individuals in prisons and jails have significant health care needs, but lack health insurance and regular access to care. As of 2013, approximately 1.5 million individuals were incarcerated in U.S. state and federal prisons and another 730,000 were incarcerated in county and city jails.² These individuals are much more likely to have chronic physical and mental health conditions than individuals in the community.³ For example, HIV/AIDS is two to seven times more prevalent among people in correctional facilities than among individuals in the community.⁴ Similarly, the prevalence of serious mental illness is two to four times higher in state prisons than in the community.⁵ In addition, 68% of people in jails and over 50% of people in state prisons have a diagnosable substance abuse disorder, compared with 9% of the general population.⁶ Despite having these significant health care needs, many individuals do not receive necessary medical treatment during incarceration.⁷ The lack of access to continuous, quality care often persists after release, as the majority of individuals leaving prisons and jails do not have health insurance.⁸

Historically, Medicaid played a limited role for individuals moving into and out of prisons and jails. Prior to the ACA, only certain groups of low-income individuals qualified for the program: pregnant women and children, caretaker relatives, people over age 65, and people with disabilities.⁹ Most adults not living with their minor children were therefore excluded from the program under federal rules. As such, many individuals moving into and out of prisons and jails did not qualify for the program. Moreover, even for individuals enrolled in the program, federal law prohibits federal Medicaid payment for most health care services provided to individuals while incarcerated, with the exception of care received as an inpatient in a hospital or other medical institution (Box 1).¹⁰

The ACA Medicaid expansion provides a new opportunity to increase health coverage among individuals moving into and out of incarceration. The ACA expanded Medicaid to adults who do not fit into an existing Medicaid eligibility category, are not eligible for Medicare, and have incomes up to 138% of the Federal Poverty Level, providing a new coverage option for many individuals involved with the criminal justice system. However, the Supreme Court ruling on the constitutionality of the ACA effectively made the Medicaid expansion a state option. As of July 2015, 31 states have adopted the expansion, while the remaining 20 states have not.¹¹

Box 1: Medicaid Funding for Individuals in Prisons and Jails

There is no federal statute, regulation, or policy that prevents individuals from being enrolled in Medicaid while incarcerated.¹² Notably, in 2004, CMS issued guidance reminding states that “[i]ndividuals who meet the requirements for eligibility for Medicaid may be enrolled in the program *before, during and after* the time in which they are held involuntarily in secure custody of a public institution.”¹³ Federal law requires states to allow individuals to apply for Medicaid at any time.¹⁴

Although individuals may be enrolled in Medicaid while they are incarcerated, Medicaid generally will not cover the cost of their care. Specifically, federal law prohibits the use of federal Medicaid funds to pay for nearly all services for “an inmate of a public institution” regardless of whether they are otherwise eligible for Medicaid.¹⁵

However, states may receive federal Medicaid funds for services provided to individuals who are incarcerated, but are patients of a medical institution.¹⁶ CMS has clarified that this includes individuals admitted to a hospital, nursing facility, juvenile psychiatric facility, or intermediate care facility on an inpatient basis, as long as they remain Medicaid eligible.¹⁷

Increased Medicaid coverage among individuals leaving prisons and jails may improve their access to care and health outcomes. Without access to health services immediately upon release, recently incarcerated individuals’ physical and mental health conditions may deteriorate. In fact, research shows that individuals face a markedly increased risk of death— over 12 times that of other individuals – during the first two weeks after release.¹⁸ Research suggests that providing access to Medicaid upon release can promote more timely access to care, which may reduce that risk, particularly for individuals with chronic physical or mental health conditions.¹⁹ In addition, continuous access to health care immediately after release may reduce the risk of re-arrest and re-incarceration. One study of individuals with a severe mental illness found an association between enrollment in Medicaid before release from jail and fewer subsequent detentions.²⁰

Increasing Medicaid coverage for individuals moving into and out of incarceration may also contribute to state savings. Although federal Medicaid funds are not available for most care provided to individuals while incarcerated, states may receive Medicaid reimbursement for care provided to eligible individuals admitted as inpatients to a medical institution, such as a hospital, nursing facility, psychiatric facility, or intermediate care facility. Prior to the ACA, only a few states pursued Medicaid reimbursement for these services. This decision may have been due in part to the limited share of the incarcerated population that qualified for Medicaid. However, the Medicaid expansion offers greater potential savings to states given that a larger share of the incarcerated population may qualify for Medicaid and that the federal government is providing states an enhanced federal matching rate for newly eligible adults. Increased coverage among individuals returning to the community from jail or prison may also contribute to other state and local savings through reductions in uncompensated care and savings in other indigent care programs, such as state-funded behavioral health services.

Methods

This analysis examines states' policies regarding Medicaid eligibility and enrollment for individuals who are incarcerated. It is based on a review of state statutes, regulations, Medicaid eligibility manuals, and other Medicaid agency guidance that is publicly available online conducted during spring 2015. These resources were reviewed to determine if a state has written policies indicating if the state: (1) suspends or terminates Medicaid eligibility during incarceration; (2) has a process in place to access federal Medicaid funds for individuals who receive inpatient hospital services during incarceration; and (3) explicitly allows individuals to apply and be determined eligible for Medicaid during incarceration, and, if so, facilitates the process. In addition, sample state Medicaid managed care contracts were reviewed to identify any provisions regarding enrollees involved in the criminal justice system.

It is important to note that this review was limited to Medicaid agency guidance that is publicly available online. As a result, it may not have captured all pertinent agency guidance. Moreover, given that this area of policy is rapidly changing, the reviewed materials may not reflect the most current policies in all states. Lastly, this review did not assess whether and how states are implementing their written policies. Given these limitations, this analysis does not present any comprehensive conclusions about policies across all 50 states. Rather, it highlights the range of policies states have adopted in this area and discusses the implications of different policy choices. Future state survey work by the Kaiser Family Foundation will capture more comprehensive information on the status of state policies across the country.

Findings

A few states do not appear to have any statutes, regulations, or written policies regarding Medicaid eligibility for individuals in prisons and jails. Moreover, many states lack complete written policies addressing every aspect of this issue, and several states appear to have internally inconsistent written policies. The dearth of clear and comprehensive policies on these topics in some states could reflect the limited role Medicaid has historically played for individuals moving into and out of incarceration. Given the program's potentially greater role for this population as a result of the ACA Medicaid expansion, more states will likely develop their policies in this area over time.

TERMINATION AND SUSPENSION OF ELIGIBILITY FOR INCARCERATED INDIVIDUALS

Even though federal law does not preclude individuals who are incarcerated from being enrolled in Medicaid, many states have historically terminated coverage for enrollees who become incarcerated. States have found termination attractive from an administrative perspective because it makes improper billing for services provided to incarcerated individuals (who are not eligible for Medicaid coverage for most care) less likely. However, the Department of Health and Human Services encourages states to suspend rather than terminate Medicaid benefits during incarceration.²¹ When states terminate eligibility, individuals must re-apply for Medicaid, which may delay access to services upon release. DHHS has noted that suspending Medicaid eligibility allows individuals to receive services immediately after release, which “may reduce the demand for costly and inappropriate services later.”²² In addition, suspending Medicaid eligibility can make it easier for states to access federal Medicaid funding when individuals who are incarcerated receive inpatient services in a medical institution.

Many states continue to terminate eligibility for individuals who become incarcerated, but a number of states require the Medicaid agency to suspend rather than terminate eligibility. Some of these states specify that eligibility is suspended during incarceration. Others simply indicate that enrollees who become incarcerated retain their Medicaid eligibility, but cannot receive services through Medicaid. This area of state policy is evolving, with more states moving toward suspending Medicaid eligibility during incarceration. For example, in 2015, New Mexico enacted legislation stating that incarceration is not a basis to deny or terminate eligibility for Medicaid and requiring the Medicaid agency to adopt regulations implementing the statute.²³ Other states have introduced similar legislation.²⁴ However, some states that have adopted policies to allow for suspension of eligibility have faced challenges updating their eligibility systems to implement these policies.²⁵

Some states have relatively broad suspension policies, while others explicitly limit suspension of eligibility to certain groups of incarcerated individuals or for a specified length of time. For example, under a Florida state statute, all Medicaid enrollees who become incarcerated in a state, county, or municipal correctional facility remain eligible for Medicaid, but generally cannot receive services through Medicaid.²⁶ Some states provide for suspension of Medicaid enrollees in some, but not all, correctional facilities. For example, North Carolina's written policy suspends eligibility for individuals in state prisons, but not in other correctional facilities.²⁷ Similarly, Arizona's policy provides for suspension of eligibility only for individuals in state prisons and certain county jails.²⁸ In addition, some states explicitly limit the length of time of a suspension. For example, Arizona's policy does not allow for suspended eligibility for Medicaid enrollees who will remain incarcerated for 12 months or longer.²⁹ Iowa and Indiana suspend eligibility for individuals regardless of how long they are expected to remain incarcerated, but the suspension cannot last for more than 12 months (Box 2).³⁰

Box 2: State Examples of Eligibility Suspension Policies

Florida: “[I]n the event that a person who is an inmate in the state’s correctional system...in a county detention facility...or in a municipal detention facility...was in receipt of medical assistance under this chapter immediately prior to being admitted as an inmate, such person shall remain eligible for medical assistance while an inmate, except that no medical assistance shall be furnished under this chapter for any care, services, or supplies provided during such time as the person is an inmate...Upon release from incarceration, such person shall continue to be eligible for receipt of medical assistance furnished under this chapter until such time as the person is otherwise determined to no longer be eligible for such assistance.”³¹

North Carolina: “Beneficiaries who are incarcerated in a federal prison, juvenile justice facility, county or local jail must have their eligibility terminated. Inmates who are incarcerated in a NC Department of Public Safety, Division of Prisons (DOP) facility must have their eligibility placed in suspension, provided they remain otherwise eligible for Medicaid.”³²

Indiana: “When a recipient becomes incarcerated..., the individual’s health coverage is to be suspended, not discontinued...The suspension continues until the individual is released from the facility, but will not exceed 12 months.”³³

ACCESSING FEDERAL MEDICAID FUNDS FOR INPATIENT SERVICES

As noted above, federal law allows states to receive Medicaid reimbursement for inpatient services provided to incarcerated individuals by a hospital outside of a correctional facility. Historically, few states have sought out this reimbursement. This decision may have been due in part to the small share of the incarcerated population that qualified for Medicaid prior to the ACA. However, states may realize savings from accessing this reimbursement, and the savings potential is significantly enhanced by the ACA Medicaid expansion (Box 3).

Box 3: Examples of Estimated State Savings in Correctional Spending Due to Federal Reimbursement for Inpatient Costs for Incarcerated Individuals

Michigan projects a reduction in state correctional spending of \$13.2 million in SFY 2015.³⁴

Colorado expects savings of \$5 million per year in state correctional spending.³⁵

Kentucky has estimated savings of \$5.4 million in SFY 2014 and \$11.0 million in SFY2015.³⁶

Policies and processes related to accessing Medicaid reimbursement for inpatient services differ among states. Many states' written policies acknowledge that individuals who are incarcerated may receive Medicaid coverage for inpatient services. However, others do not specify this exception. Some of the states that do specify this exception have adopted written policies outlining the process for accessing federal Medicaid funds for inpatient services. In many of these states, correctional staff members submit a Medicaid application on behalf of individuals receiving inpatient services. Some states allow submission after an individual is admitted to the hospital, while others do not allow submission until after discharge.³⁷ Accordingly, the process for ensuring that eligibility is terminated or suspended upon discharge from the hospital also varies among states. In Arizona, for example, Medicaid eligibility simply begins on the date of hospital admission and ends on the date of hospital discharge.³⁸ In Colorado, when an individual returns from the hospital to the correctional facility, facility staff must notify the Medicaid agency to properly terminate eligibility.³⁹ Several states only specify a process for accessing Medicaid funding for individuals in certain correctional institutions.⁴⁰

CONNECTING INDIVIDUALS TO COVERAGE UPON RELEASE

Enrolling individuals who are uninsured (including those whose coverage has been terminated upon incarceration) in Medicaid prior to release from prison or jail can help support access to care immediately after release. If individuals cannot apply for Medicaid until after release, they may experience a delay in obtaining coverage and thus, necessary care. As noted above, federal Medicaid law requires states to allow individuals to apply for Medicaid at any time,⁴¹ and CMS has clarified that states may enroll individuals who are incarcerated in Medicaid.⁴² As a practical matter, most individuals in prisons and jails will not be able to apply for Medicaid unless the state actively facilitates the process. States may require correctional or Medicaid agency staff to assist individuals with the application process, and federal Medicaid funding should be available to states for this purpose.⁴³ In addition, outside organizations may coordinate with states to send navigators or certified application counselors into jails and prisons to help individuals enroll in Medicaid.

Current state policies vary with regard to allowing individuals to enroll in Medicaid prior to release. Several states’ policies explicitly allow individuals who are incarcerated to apply for Medicaid (Box 4). Many of these policies specify that individuals who are nearing their release date may apply for Medicaid. Some note that the Medicaid agency must determine eligibility within the standard time period required under federal Medicaid regulations, but that individuals cannot be found eligible or cannot be enrolled in the program until after release.⁴⁴ However, at least two states, Michigan and North Carolina, appear to suspend eligibility for incarcerated individuals found to qualify for Medicaid.⁴⁵ These policies may allow individuals to receive services more quickly after release.

Box 4:
Examples of State Policies Related to Medicaid Applications for Inmates

Washington: “Application for Apple Health (Medicaid) benefits is possible for inmates. Many correctional facilities are incorporating an application for Medicaid into their release planning activities. The agency must accept these applications when an anticipated release date is known that is not over 45 days into the future.”⁴⁶

Arizona: “A person may apply for medical assistance before being released, but cannot be approved until the actual date of release.”⁴⁷

Michigan: “An individual can remain eligible and an applicant can be determined eligible for Medicaid during a period of incarceration.”⁴⁸

A few states require corrections staff to facilitate the application process for individuals nearing release.⁴⁹ For example, in Connecticut, the Department of Corrections and Department of Social Services have partnered to ensure that individuals who are discharged from a Department of Corrections facility continue to receive necessary health care upon re-entry into the community through Medicaid. The Department of Social Services has provided two eligibility workers dedicated solely to processing Medicaid applications for those individuals determined potentially eligible for assistance.⁵⁰ Moreover, in New Hampshire, state prison and county jail staff initiate Medicaid applications for individuals nearing release by using an automated process or by completing and mailing all necessary forms to the Medicaid agency.⁵¹ Similarly, in Virginia, state prison staff must complete and submit a Medicaid application for individuals who need to be placed in a nursing facility upon release.⁵²

OUTLINING RESPONSIBILITIES FOR MANAGED CARE PLANS

Under federal Medicaid law, states may enter into contracts with managed care entities to provide services to Medicaid beneficiaries.⁵³ While federal law allows for several kinds of Medicaid managed care arrangements, most Medicaid managed care plans are “capitated” plans.⁵⁴ This means that states pay plans a set amount each month for providing health care services to an enrollee. Over the past several decades, managed care has come to play an increasingly important role in Medicaid, with almost three-quarters of Medicaid beneficiaries now enrolled in some type of managed care arrangement.⁵⁵ Given this fact, provisions in Medicaid managed care contracts may have implications for coverage and care of incarcerated individuals.

Through their contracts with Medicaid managed care entities, some states have taken steps to ensure that they do not make capitated payments on behalf of individuals who are incarcerated.⁵⁶ As discussed above, individuals who are incarcerated are generally not eligible to receive services through Medicaid. As a result, when individuals who are enrolled in a managed care plan become incarcerated, the plan is no longer responsible for providing their care. States have adopted several approaches to ensure that they do not continue to make capitated payments to managed care plans on behalf of enrollees who become incarcerated. For example, some state contracts exclude individuals who are incarcerated from enrolling in the managed care plan and/or provide for disenrollment from the plan when an enrollee becomes incarcerated.⁵⁷ Adoption of such policies can facilitate the ability of states to discontinue capitated payments to plans during a period of incarceration without terminating Medicaid eligibility. Additionally, several contracts specify that the state will recoup a capitated payment made on behalf of an enrollee who becomes incarcerated. For example, Wisconsin's Medicaid HMO contract indicates that the state will recoup a capitated payment when the enrollee cannot use HMO facilities. As a result, when an enrollee enters a correctional facility before the first day of the month for which the state made the payment, the state will recoup the payment.⁵⁸

Several states have Medicaid managed care contract provisions that require plans to provide care coordination services to individuals upon release from jail or prison. Medicaid managed care entities may be well-positioned to help Medicaid enrollees quickly access necessary community-based services during this time period. Colorado, for example, requires behavioral health plans to “collaborate with agencies responsible for the administration of jails, prisons and juvenile detention facilities to coordinate the discharge and transition” of enrollees.⁵⁹ In addition to ensuring that enrollees leaving incarceration receive medically necessary behavioral health services, plans must propose innovative strategies to meet the needs of enrollees involved with the criminal justice system.⁶⁰ Similarly, Florida requires Medicaid managed care plans to “make every effort...to provide medically necessary community-based services for Health Plan enrollees who have justice system involvement.”⁶¹ Among other things, plans must: (1) provide psychiatric services to enrollees and likely enrollees within 24 hours after release from a correctional facility; (2) ensure that enrollees are linked to services and receive routine care within 7 days after release; (3) conduct outreach to populations of enrollees “at risk of justice system involvement, as well as those Health Plan enrollees currently involved in this system, to assure that services are accessible and provided when necessary.”⁶² In addition, plans must work to develop agreements with correctional facilities that will enable the plans to anticipate the release of individuals who were enrolled prior to incarceration.⁶³

Conclusion

In conclusion, state Medicaid eligibility policies for incarcerated individuals vary significantly, and these policies affect if and when individuals may be enrolled in coverage and the scope of savings states may achieve from their coverage. Looking ahead, state policies will likely evolve given the growing importance of Medicaid for this population under the expansion. As policies continue to develop, it will be important to consider the implications of different state choices. Specifically, suspending rather than terminating eligibility for individuals who become incarcerated may help facilitate timely access to coverage and care upon release and may make it easier for states to access federal Medicaid reimbursement for inpatient services provided to individuals while incarcerated. In addition, explicitly allowing uninsured individuals to apply for and enroll in

coverage prior to release and facilitating enrollment as part of re-entry planning can support timely access to coverage as individuals return to the community. Research suggests that coverage immediately upon release may lead to improved access to care and broader benefits. Gains in coverage among individuals returning to the community may contribute to savings in uncompensated care and other indigent care programs. Lastly, through managed care contracts, states can adopt policies that enable them to discontinue capitated payments to plans for enrollees who become incarcerated without terminating their Medicaid coverage. Moreover, managed care plans can play a key role in supporting individuals' timely access to care as they return to the community, and states can outline and strengthen this role through contract provisions.

This brief was prepared by Catherine McKee and Sarah Somers with the National Health Law Program and Samantha Artiga and Alexandra Gates of the Kaiser Family Foundation.

ENDNOTES

- 1 As noted in the methodology section, *supra*, our review did not assess whether and how states are enforcing their Medicaid managed care contracts.
- 2 E. Ann Carson, U.S. Dep't of Justice, Office of Justice Programs, Bureau of Justice Statistics, Prisoners in 2013 at 1-2 (revised Sept. 30, 2014), available at <http://www.bjs.gov/content/pub/pdf/p13.pdf>; Todd D. Minton and Daniela Golinelli, U.S. Dep't of Justice, Office of Justice Programs, Bureau of Justice Statistics, Jail Inmates and Midyear 2013: Statistical Tables (revised Aug. 14, 2014), available at <http://www.bjs.gov/content/pub/pdf/jim13st.pdf>.
- 3 See, e.g., Nat'l Comm'n on Correctional Health Care, *The Health Status of Soon-To-Be-Released Inmates: A Report to Congress* (2002).
- 4 David Cloud, Vera Institute of Justice, *On Life Support: Public Health in the Age of Mass Incarceration* 10 (2014) (citing Anne C. Spaulding, HIV/AIDS among Inmates of and Releasees from US Correctional Facilities, 2006: Declining Share of Epidemic but Persistent Public Health Opportunity, 4 PLOS One e7558 (2009)).
- 5 *Id.* at 9 (citing Seth J. Prins, Prevalence of Mental Illnesses in US State Prisons: A Systematic Review, 65 *Psychiatric Services* 862 (2014)).
- 6 *Id.* at 10 (citing Jennifer C. Karberg & Doris J. James, U.S. Dep't of Justice, Office of Justice Programs, Bureau of Justice Statistics, Substance Dependence, Abuse, and Treatment of Jail Inmates, 2002 (2005); Seena Fazel et al., Substance abuse and dependence in prisoners: a systematic review, 101 *Addiction* 181 (2006); Bridget F. Grant et al., Prevalence and Co-occurrence of Substance Use Disorders and Independent Mood and Anxiety Disorders: Results From the National Epidemiologic Survey on Alcohol and Related Conditions, 61 *Archives of General Psychiatry* 807 (2004)).
- 7 Andrew P. Wilper et al., The Health and Health Care of US Prisoners: Results of a Nationwide Survey, 99 *Am. J. Pub. Health* 666, 668-69 (2009).
- 8 See, e.g., Emily A. Wang et al., Discharge Planning and Continuity of Health Care; Findings from the San Francisco County Jail, 98 *Am. J. Pub. Health* 2182 (2008) (finding approximately 90% of individuals who enter county jails have no health insurance); Kamala Mallik-Kane & Christy A. Visher, Urban Inst., Justice Policy Ctr., *Health and Prisoner Reentry: How Physical, Mental, and Substance Abuse Conditions Shape the Process of Reintegration* 13 (2008) (finding that 78% of men and 66% of women have no health insurance two to three months after release from prison).
- 9 42 U.S.C. § 1396a(a)(10)(A). In addition, individuals must be residents of the state in which they apply and be citizens or have qualifying immigration status.
- 10 42 U.S.C. § 1396d(a)(29)(A); 42 C.F.R. §§ 435.1009, 435.1010.
- 11 The Kaiser Family Foundation State Health Facts. Data Source: Current status for each state is based on KCMU tracking and analysis of state executive activity. Available at <http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/>
- 12 See Letter from Robert A. Streimer, Dir., Disabled and Elderly Health Programs Grp., Ctr. for Medicaid and State Operations, Dep't of Health & Human Servs., to All Associate Regional Adm'rs., Div. for Medicaid and State Operations 1 (Dec. 12, 1997); see also Health Care Finance Agency Program Issuance Transmittal Notice Region IV (Mar. 6, 1998) (transmitting policies set forth in the December 1997 policy letter to Medicaid agencies in AL, FL, GA, KY, MS, NC, SC, and TN).
- 13 Letter from Glenn Stanton, Acting Dir., Disabled and Elderly Health Programs Grp., Ctr. for Medicaid and State Operations, Dep't of Health & Human Servs., to State Medicaid Directors 2 (May 25, 2004) (discussing strategies for ending chronic homelessness).
- 14 42 U.S.C. § 1396a(a)(8).
- 15 42 U.S.C. § 1396d(a)(29)(A); 42 C.F.R. § 435.1009. Medicaid regulations define inmate[s] of a public institution as individuals who are living in a public institution, unless they are: (1) "in a public educational or vocational training institution for purposes of securing educational or vocational training;" or (2) in a public institution for "a temporary period pending other arrangements appropriate to [their] needs." 42 C.F.R. § 435.1010. A public institution is one that "is the responsibility of a governmental unit or over which a governmental unit exercises administrative control." *Id.* CMS has further explained that the definition includes individuals "serving time for a criminal offense or confined involuntarily in State of Federal prisons, jails, detention facilities, or other penal facilities." Letter from Robert A. Streimer, *supra* note 12, at 1. It also includes individuals held involuntarily in detention centers awaiting trial, people required to reside in wilderness camps that are under governmental control, and involuntary residents of halfway houses under governmental control. Letter from Robert A. Streimer, *supra* note 12, at 4.
- 16 42 U.S.C. § 1396d(a)(29)(A); 42 C.F.R. §§ 435.1009, 435.1010.
- 17 Letter from Robert A. Streimer, *supra* note 12, at 3.
- 18 Ingrid A. Binswanger et al., Release from Prison – A High Risk of Death for Former Inmates, 356 *N Eng. J. Med.* 157, 160 (2007).
- 19 *Id.* at 165. See also Joseph P. Morrissey et al., Medicaid Enrollment and Mental Health Service Use Following Release of Jail Detainees with Severe Mental Illness, 57 *Psychiatric Services* 809 (2006) (finding that among individuals with severe mental illness, those enrolled in Medicaid at the time of their release from jail were more likely to use services, accessed the services more quickly, and received more days of services than those who were not enrolled in Medicaid).

-
- 20 Joseph P. Morrissey et al., The Role of Medicaid Enrollment and Outpatient Service Use in Jail Recidivism Among Persons With Serious Mental Illness, 58 *Psychiatric Services* 794 (2007).
- 21 See Letter from Glenn Stanton, *supra* note 13, at 1-2.
- 22 *Id.*
- 23 See 2015 N.M. Laws 127 (to be codified at N.M. Stat. Ann. § 27-2-4).
- 24 See, e.g., Unicameral Leg., LB12 (Neb. 2015).
- 25 See Colo. Rev. Stat. Ann. § 25.5-4-205.5; Colo. Dep't of Health Care Policy and Fin., HCPF 14-006, Medicaid Policy for Incarcerated or Inmates in a Correctional Facility 2 (2014), available at https://www.colorado.gov/pacific/sites/default/files/2014_Agency_Letters_Number_14-006.pdf. See also Ct. Gen. Assembly, Office of Legislative Research, 2013-R-0288, The Affordable Care Act and Prisoners (2013), available at <http://www.cga.ct.gov/2013/rpt/2013-R-0288.htm>.
- 26 Fla. Stat. Ann. § 409.9025.
- 27 N.C. Dep't of Health & Human Servs., Div. of Medical Assistance, Family And Children's Medicaid Manual §3360 (updated 2015), available at <http://info.dhhs.state.nc.us/olm/manuals/dma/fcm/man/>. Moreover, individuals in certain eligibility categories cannot have their eligibility suspended. The Medicaid agency must evaluate these individuals for eligibility in other categories and transfer or terminate their eligibility as appropriate. *Id.*
- 28 Ariz. Health Care Cost Containment Sys., Eligibility Policy Manual § 1502 (updated 2014), available at https://www.healthearizonaplus.gov/PolicyManual/eligibilitypolicymanual/MA/MA1500/MA1502.V_Incarcerated.html
- 29 *Id.* Oregon also only suspends eligibility for Medicaid enrollees expected to remain incarcerated for no more than 12 months. Or. Rev. Stat. Ann. § 411.447.
- 30 See Iowa Code Ann. § 249A.38; Iowa Admin. Code R. § 75.12(1); Indiana Health Coverage Program Policy Manual § 2237.05.00 (undated), available at http://in.gov/fssa/files/Medicaid_Combined_PM.pdf.
- 31 Fl. Stat. Ann. § 409.9025(1)-(2).
- 32 N.C. Dep't of Health & Human Servs., Div. of Medical Assistance, Family And Children's Medicaid Manual §3360 (updated 2015), available at <http://info.dhhs.state.nc.us/olm/manuals/dma/fcm/man/>
- 33 Indiana Health Coverage Program Policy Manual § 2237.05.00 (undated), available at http://in.gov/fssa/files/Medicaid_Combined_PM.pdf.
- 34 Deborah Bachrach, Patricia Boozang, & Dori Glanz, State Health Reform Assistance Network, The Report Wood Johnson Fdtn., States Expanding Medicaid see Significant Budget Savings and Revenue Gains, (2015), <http://www.rwjf.org/en/library/research/2015/04/states-expanding-medicaid-see-significant-budget-savings-and-rev.html>
- 35 *Ibid.*
- 36 Deloitte commissioned by Kentucky, Report on Medicaid Expansion in 2014, (2015), http://governor.kv.gov/healthierky/Documents/medicaid/Kentucky_Medicaid_Expansion_One-Year_Study_FINAL.pdf
- 37 Cf. Colo. Dep't of Health Care Policy and Fin., HCPF 14-006, Medicaid Policy for Incarcerated or Inmates in a Correctional Facility 2 (2014), available at <https://www.colorado.gov/pacific/sites/default/files/2014%20Agency%20Letters%20Number%202014-006.pdf> (indicating that applications can be filed 24 hours after admission) with Kan. Dep't of Health & Environment, Div. of Health Care Finance, Policy No: 2012-09-01, Inpatient Hospital Coverage for Inmates of State Correctional Institutions (2012), available at <https://kchap.kdhe.state.ks.us/kfmam/policydocs/Inmate%20Memo.pdf> (indicating that applications should be filed after discharge).
- 38 Ariz. Health Care Cost Containment Sys., Eligibility Policy Manual § 1312 (updated 2014), available at <https://www.healthearizonaplus.gov/PolicyManual/EPMPlus/index.html#page/MA/MA1300/MA1312.html>.
- 39 Colo. Dep't of Health Care Policy and Fin., HCPF 14-006, Medicaid Policy for Incarcerated or Inmates in a Correctional Facility 2 (2014), available at <https://www.colorado.gov/pacific/sites/default/files/2014%20Agency%20Letters%20Number%202014-006.pdf>. Similarly, in Oregon, the county jail must notify the Medicaid agency when an individual returns from the hospital so that the Medicaid agency can suspend eligibility. See Or. Health Authority, Div. of Medical Assistance Programs, Medicaid Eligibility for Inmates of Jails and Prisons 11, 23 (updated Sept. 2014), available at http://www.orpca.org/Oregon_Medicaid_Eligibility_Determinations_for_Inmates-UPDATED_9-14.pdf.
- 40 See, e.g., Kan. Dep't of Health & Environment, Div. of Health Care Finance, Policy No: 2012-09-01, Inpatient Hospital Coverage for Inmates of State Correctional Institutions (2012), available at <https://kchap.kdhe.state.ks.us/kfmam/policydocs/Inmate%20Memo.pdf> (outlining process for individuals in state custody); N.H. Dep't of Health & Human Servs., Div. of Family Assistance, Medical Assistance Manual (updated 2014), available at http://www.dhhs.nh.gov/MAM_HTML/newmam.htm (outlining process for individuals in state custody).
- 41 42 U.S.C. § 1396a(a)(8).
- 42 See Letter from Robert Streimer, *supra* note 12, at 1; Letter from Glenn Stanton, *supra* note 13, at 2.
- 43 See 42 U.S.C. § 1396b(a)(7).
- 44 See, e.g., Va. Dep't of Social Servs., Medicaid Manual § MO120.400F (updated 2013), available at https://www.dss.virginia.gov/files/division/bp/medical_assistance/manual_transmittals/manual/mo1r.pdf; Ariz. Health Care Cost

Containment Sys., Eligibility Policy Manual §§ 1302, 1309, 1310 (updated 2014), available at <https://www.healthearizonaplus.gov/PolicyManual/EPMPlus/index.html#page/MA/MA1300/MA1312.html>.

45 See Mich. Comp. Laws Ann. § 400.106b; N.C. Dep't of Health & Human Servs., Div. of Medical Assistance, Family And Children's Medicaid Manual § 3360 (updated 2015), available at <http://info.dhhs.state.nc.us/olm/manuals/dma/fcm/man/>.

46 WA Health Care Authority, Apple Health (Medicaid) Manual Incarceration Overview (updated November 10, 2014), available at <http://www.hca.wa.gov/medicaid/manual/Pages/90-110.aspx>

47 AZ Health Care Cost Containment System (AHCCCS) Eligibility Policy Manual for Medical, Nutrition, and Cash Assistance §525, available at <https://www.healthearizonaplus.gov/PolicyManual/eligibilitypolicymanual/index.html#page/MA/MA500/MA0525.html>

48 Michigan Department of Community Health Modified Adjusted Gross Income (MAGI) Related Eligibility Manual, available at http://www.michigan.gov/documents/mdch/MAGI_Manual_457706_7.pdf

49 State or local corrections policies may also contain such requirements. Examining these corrections policies was beyond the scope of our review, which focused on Medicaid statutes, regulations, and policies.

50 Cohen, R., OLR Research Report, The Affordable Care Act and Prisoners, August 13, 2013, available at: <http://www.cga.ct.gov/2013/rpt/2013-R-0288.htm>

51 N.H. Dep't of Health & Human Servs., Medical Assistance Manual § 175.01 (2014), available at http://www.dhhs.nh.gov/MAM_HTML/newmam.htm.

52 Va. Dep't of Social Servs., Medicaid Manual § MO120.500F (updated 2013), available at https://www.dss.virginia.gov/files/division/bp/medical_assistance/manual_transmittals/manual/mo1r.pdf

53 See generally 42 U.S.C. §§ 1396b(m), 1396d(t), 1396u-2.

54 See 42 U.S.C. §§ 1396u-2(a)(1)(B), 1396b(m)(1)(A) (managed care organizations), 1396d(a)(25), 1396d(t) (primary care case managers); 42 C.F.R. § 438.2 (prepaid health plans).

55 Ctrs. For Medicare & Medicaid Servs., Medicaid Managed Care Enrollment Report: Summary Statistics As Of July 1, 2011, at 4, available at <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/Downloads/2011-Medicaid-MC-Enrollment-Report.pdf>.

56 As noted in the methodology section, *supra*, our review did not assess whether and how states are enforcing their Medicaid managed care contracts.

57 See, e.g., Ky. Dep't for Medicaid Servs., Medicaid Managed Care Contract Between the Commonwealth of Kentucky on Behalf of Department for Medicaid Services and Anthem Health Plans of Kentucky, Inc. 86-88 (undated) (contract to expire June 30, 2015).

58 Wis. Dep't of Health Servs., Contract for BadgerCare Plus and/or Medicaid SSI HMO Services for Jan. 1, 2014 – Dec. 31, 2015, at 144 (2014). The term “public institution” is not limited to penal institutions. See *id.* at 19; 42 C.F.R. § 435.1010.

59 See, e.g., Colo. Dep't of Health Care Policy & Financing, Contract with Behavioral Healthcare, Inc. for Behavioral Health Services Program 17 (undated) (contract to expire June 30, 2015 unless sooner terminated or further extended).

60 *Id.* at 17-18.

61 Fla. Agency for Health Care Admin., 2012-2015 Health Plan Model Contract Attachment II – Core Contract Provisions 125 (undated).

62 *Id.*

63 *Id.*