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# Medicaid and Inmates of Public Institutions

Medicaid is a means-tested entitlement program that finances the delivery of primary and acute medical services, as well as long-term services and supports, to eligible, low-income individuals. Medicaid is a joint federal-state program that provided health care services to an estimated 63 million individuals at a total cost of $494 billion in FY2014, with the federal government paying $299 billion (about 61%) of that total. This enrollment figure represents *average monthly enrollment.* It differs from *ever enrolled* counts, which measure the number of people covered by Medicaid for any period of time during the year. Each state designs and administers its own version of Medicaid under broad federal rules. State variability is the rule rather than the exception in terms of eligibility levels, covered services, and how those services are delivered. (For more information about Medicaid, see CRS Report R43357, *Medicaid: An Overview*.)

This report describes Medicaid policy with respect to inmates of public institutions, including prisoners. In general, no federal financial participation, meaning federal matching dollars, is available to states for medical services delivered to inmates of public institutions. Inmates of nonfederal correctional facilities are wards of the state. Thus, states—not the federal government—are responsible for their care. This inmate exclusion rule delineates when the federal government will not share in the cost of Medicaid services and is not tied to an individual's Medicaid eligibility status. The federal statute (§1905(a)(29)(A) of the Social Security Act) and the implementing regulation (42 C.F.R. 435.1009) provide an exception to the prohibition on federal matching funds when a Medicaid-eligible inmate becomes an inpatient in a medical institution (e.g., hospital).

## General Medicaid Eligibility and Coverage

Historically, to be eligible for Medicaid, a person must (1) be a member of a "coverable" group (e.g., parents, children, pregnant women, persons with disabilities, the elderly) and (2) meet the applicable financial requirements (e.g., have low income). As a result of the Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended) and the recent Supreme Court decision in *NFIB v. Sebelius*, beginning in 2014, states have the option to expand Medicaid eligibility beyond the historical eligibility groups to non-elderly adults, who are not otherwise eligible for Medicaid, with income at or below 133% of the federal poverty level, or FPL (effectively 138% of FPL, based on an additional 5% disregard of income).

Similar to this ACA Medicaid expansion group, other Medicaid eligibility pathways also have upper income standards tied to a percentage of FPL (e.g., 133% of FPL applicable to pregnant women and children through the age of 18). In general, states must redetermine Medicaid eligibility with respect to circumstances that may change at least every 12 months. For individuals whose Medicaid eligibility is based on modified adjusted gross income methods, an assessment of continued eligibility must be renewed every 12 months, and no more frequently than once every 12 months (as per 42 C.F.R. 435.916).

Traditional Medicaid state plan coverage includes a number of both mandatory services (e.g., inpatient hospital care, lab and x-ray services, physician care, nursing facility services for individuals aged 21 and over) and optional benefits (e.g., prescribed drugs, personal care services, clinic services, physical therapy, and prosthetic devices). Medicaid also provides coverage in alternative benefit plans (ABPs) that meet the ACA essential health benefits requirements. There are 10 EHBs that include, for example, emergency services, hospitalization, prescribed drugs, lab services, and pediatric services, including oral and vision care. In general, states may enroll certain Medicaid beneficiaries in ABPs that include four choices: (1) the standard Blue Cross/Blue Shield preferred provider plan under the Federal Employees Health Benefits Program; (2) a plan offered to state employees; (3) the largest commercial health maintenance organization in the state; and (4) other coverage appropriate for the targeted population, subject to approval by the Secretary of Health and Human Services.

## Inmates of Public Institutions

For Medicaid purposes, an individual in a jail or prison is considered to be an *inmate of a public institution* when certain conditions are met. While serving time for a criminal offense or confined involuntarily, no federal matching funds are available to pay for Medicaid services delivered to that inmate. This exclusion applies to both traditional Medicaid state plan coverage and coverage provided in ABPs that meet the ACA essential health benefits requirements.

Additional federal regulations (42 C.F.R. 435.1010(a)-(b)) further specify that an inmate of a public institution means a person who is living in a public institution. An individual is *not* considered an inmate if he or she is (1) in a public educational or vocational training institution or (2) in a public institution for a temporary period pending other arrangements appropriate to his or her needs. A facility is a public institution when it is under the responsibility or administrative control of a governmental unit.

The Government Accountability Office (GAO) recently investigated inmate eligibility for Medicaid in response to a congressional committee request. For this analysis, GAO defined inmates to mean individuals incarcerated in state prisons (typically individuals sentenced to more than one year); local jails (typically individuals with a sentence of

less than one year or who are awaiting adjudication); or facilities under contract with states or local authorities, such as counties. GAO did not include federal prisoners in its analysis because officials from the Federal Bureau of Prisons indicated that the bureau is not enrolling prisoners in Medicaid for purposes of obtaining federal Medicaid funds for inpatient services that qualify for such funds. (For additional details, see GAO, *Medicaid: Information on Inmate Eligibility and Federal Costs for Allowable Services*, GAO-14-752R, publicly released on October 6, 2014.)

## Inmates and the ACA Medicaid Expansion

The ACA's optional Medicaid eligibility expansion was implemented by 27 states in 2014. Since 2014, four more states have implemented the expansion. GAO concluded that the majority of inmates in these states were likely to have income that would qualify them for Medicaid, a circumstance that did not generally exist prior to the implementation of the ACA Medicaid eligibility expansion. The implications of this analysis are twofold.

First, in these 27 states, there could be an increase in the number of inmates in state prisons, local jails, and facilities under contract with states or local authorities who are eligible for hospital services while they are inmates in a public institution. Because more inmates in states that have implemented the expansion are eligible for Medicaid, the percentage of inmates receiving allowable services (e.g., inpatient hospital stays) is likely to increase. However, the increases to federal Medicaid expenditures are likely to be limited because only a small portion (i.e., 5% or less) of all inmates are likely to have inpatient stays.

Second, eligibility changes made by the ACA could include inmates once such individuals are no longer inmates. Information from the National Academy for State Health Policy provides state-specific examples relevant to this issue, three of which are summarized below.

In Illinois, after the Governor's Health Care Reform Implementation Council was created in 2010, there was early recognition of the importance of looking at the justice-involved population independently because there was a high volume of individuals in this population who were newly eligible for Medicaid via the ACA.

In North Carolina, legislation was passed in 2010 requiring the state's Department of Corrections to consult with the state's Medicaid office to develop protocols allowing those prisoners who would be eligible for Medicaid if they were not incarcerated to access Medicaid services while in custody or under extended limits of confinement.

In Rhode Island, the majority of discharged inmates with medical or behavioral health needs were eligible for Medicaid via the ACA Medicaid eligibility expansion. The state modified its Medicaid enrollment assistance contracts to include working with the Department of Corrections discharge planners.

For more state-specific information, see the 2014 resources available at the National Academy for State Health Policy (www.nashpcloud.org) website.

According to an analysis in the March 2014 *Health Affairs* publication entitled "Medicaid Expansion: Considerations for States Regarding Newly Eligible Jail-Involved Individuals," states' decisions on whether to expand Medicaid will have significant implications for adults involved in the criminal justice system, particularly the 10 million people moving through local jails. As reported in the same article, 90% of people who enter county jails have no health insurance.

The ACA eligibility expansion has the potential to significantly increase access to care for such people when they are released from jail, which in turn could improve health outcomes and lower rates of recidivism. The jail-involved population is largely male, members of a minority group, and poor. Such individuals also have high rates of mental and substance abuse problems. These individuals are expected to comprise a substantial portion of the new ACA eligibility group in states that have implemented this enrollment pathway into Medicaid.

The *Health Affairs* article also suggests that states could ensure connections to needed services upon release from jail and could help inmates to determine their eligibility for, and to enroll in, the applicable state Medicaid program. States could also take advantage of federal grants to automate systems that determine eligibility, and they could include an array of behavioral health services in their Medicaid benefit packages. Finally, the article notes that in most states, new partnerships between Medicaid and corrections agencies at both the state and local levels would be needed to support these activities.

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