Insight

Termination of Medicaid for Inmates

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Interactions with the criminal justice system can have varied short and long-term effects, but one that is frequently overlooked is the long-term health impact of even a short encounter with the criminal justice system. An unfortunate application of federal and constitutional laws has created a health care vacuum which is politically difficult to address. The result is a criminal justice system that makes people sicker, poorer, and more vulnerable to subsequent incarceration.

GROWTH OF THE CRIMINAL JUSTICE SYSTEM

The second-half of the twentieth century saw an unparalleled growth in prison populations. This change can be attributed to a number of factors from population growth and urbanization to privatized prison complexes and enhanced enforcement capabilities, but the two reasons many experts will offer as the driving forces behind prison population growth are deinstitutionalization of the mentally ill and the war on drugs.[1]

Deinstitutionalization of Mentally Ill

In 1955 the U.S. inpatient population in psychiatric facilities peaked at 560,000.[2] Not long after, the publication of books such as *One Flew Over the Cuckoo's Nest* began to draw public attention to the plight of institutionalized patients. This publicity, along with the introduction of the first major antipsychotic drug, Thorazine, contributed to a push for deinstitutionalization.[3] This goal was largely achieved in the 1960s with the passage of the Social Security Act and resulting establishment of the Medicaid program; the Medicaid IMD exclusion prohibited Medicaid reimbursement for any care provided in "institutions for the treatment of mental diseases."[4]

By shutting down these facilities, states were able to shift a large portion of the cost of providing care to the mentally ill onto the federal government.[5] Unfortunately, the mentally ill are not particularly good at navigating Medicaid and the health care system, nor are they reliable when it comes to treatment compliance in outpatient settings without oversight. The result, therefore, has been a nearly complete absence of access to meaningful mental health services.

Today, severely mentally ill individuals make up one-third of the US homeless population, and about 20 percent of the prison population; it is estimated that there are 356,000 people with serious mental illnesses in American prisons.[6] In fact, there are more mentally ill Americans in prison than in psychiatric hospitals.[7]

The War on Drugs

Another major contributing factor to prison population growth is the US war on drugs. Half of all male inmates

and 60 percent of female prisoners have been convicted of a drug crime.[8] Over 80 percent of these convicts were charged with possession of an illegal drug with no intent to distribute.[9] The fastest-growing population of federal prisoners is drug offenders, and mandatory minimum sentencing for drug violations has significantly expanded the number of drug offenders in prison—this population has increased ten-fold since 1980.[10]

These factors, among others, have contributed significantly to the growth of the U.S. prison population, and to the need for adequate health services for individuals involved with the criminal justice system.

A CONFLICT OF LAWS

Health care gaps among those recently released from law enforcement custody arise, like so many problems, as a result of well-meaning federal legislation. In 1976, the Supreme Court ruled that the adequate provision of health care services is a right guaranteed to any individual in state custody under the Eighth Amendment's prohibition on cruel and unusual punishment.[11] Because the state is required to provide these services, Congress, in the Social Security Act, prohibited any federal Medicaid payments "with respect to care or services for any individual who is an inmate of a public institution (except a patient at a medical institution)."[12]

Thirty-eight states currently interpret this legislative language to require that Medicaid enrollees be dropped from the program upon being brought into custody,[13] though states and counties do delay termination of Medicaid benefits for a period of time that ranges from thirty days to a year.[14]

Being an 'inmate of a public institution' does not require that the individual be convicted or even charged with a crime, nor that there be a sentence of any specific length of time for Medicaid enrollment to be terminated. In practice, termination occurs when an enrollee's Medicaid card is collected on intake and never returned.

The remaining twelve states read the legislative language to mean that Medicaid funds may not be used to pay for health care provided *in the prison*, but if an inmate who is enrolled in Medicaid becomes seriously ill and is transferred to a "public… medical institution," Medicaid may pay for those services. This reading of the law seems to counter Congress' intent because it results in the federal government paying for health care provided to someone who is still in the custody of the state and is therefore ineligible to receive Medicaid benefits. However, this counter-intuitive reading does enable those twelve states to maintain inmates' Medicaid enrollment.[15] Even in those states where enrollment is suspended, information submitted to the Social Security Administration (SSA) may lead to termination of benefits for individuals whose eligibility is based on Social Security eligibility.[16]

Local social security offices, under authority of the SSA, run the Bounty Update Control System (BUCS) on the first business day of each month, which reports the social security numbers of new inmates. This information is used to terminate benefits for which inmates of institutions are otherwise eligible, including Social Security Disability Insurance and Medicaid. To encourage jails and prisons to participate in this program, social security agencies offer a 'bounty' of up to $400 per inmate whose benefits are terminated.[17] The $400 is paid directly to the state or local institution out of the Social Security trust fund.[18]

The program stipulates that the incentive payments should not be paid if the inmate is released within 30 days of arrest; however, if the payment is paid out before the state or municipality updates its records, the erroneous payments cannot be recovered and the SSA will not litigate.[19]

This ‘snapshot’ approach to collecting social security numbers of inmates is a burden on those inmates who are eligible for Medicaid. It is like a game of Russian roulette: the more nights spent in jail, and the closer they are to the end of the month, the more likely an individual is to have their personal information reported to BUCS and have their benefits revoked.[20] As the Affordable Care Act shifts more Americans into the Medicaid program, more people will be put at risk of losing access to services.

OUTCOMES OF MEDICAID TERMINATION

Individuals who have recently been released from prison or state custody may soon find that their Medicaid enrollment has been terminated as a result of that institutionalization. Estimates show that 70-90 percent of recently released individuals are uninsured, and one-third of uninsured Americans have recently been in contact with the criminal justice system.[21] This is especially troubling in light of the fact that these same people experience mental illness, substance abuse disorders, chronic conditions, and infectious disease at a rate seven times higher than the general population.[22]

Once an individual’s Medicaid enrollment has been terminated, he or she must re-apply for coverage. The application process is limited by law to no more than 90 days (depending on the basis for eligibility), in addition to the time it takes to find an appointment.[23]

During the up to 90 days between submitting an application for Medicaid and enrollment, these individuals may be unable to access necessary yet expensive health care services or prescription drugs unless their condition deteriorates and they are forced to go to an emergency room where EMTALA mandates that they be provided care, regardless of ability to pay.

This disruption in care during the initial transition period has been linked to poorer health outcomes. One study found that recent releases experienced a twelve-times higher risk of death than the general population.[24] This spike in mortality is attributable, at least in part, to substance abuse relapse, prescription drug non-compliance, and gaps in treatment for mental illness during a particularly vulnerable time of life.

Access to appropriate health services not only impacts individuals’ long-term health outcomes, but also the likelihood of subsequent reincarceration. An Urban Institute study found that recent releases with physical illnesses had poorer employment outcomes and were more likely to be reincarcerated for parole violations.[25] Similarly, a 2011 Pew study found that continuous access to mental health and substance abuse treatment during reintegration was correlated with lower rates of recidivism.[26] By making health care available, states were able reduce the burden of crime, as well as the expenses of enforcing, prosecuting, and housing convicts of additional crimes.[27]

ADDRESSING THE PROBLEM

On April 28, 2016, CMS reiterated earlier guidance explaining its position that Medicaid enrollees may have their enrollment ‘suspended’ rather than terminated in order to preserve access for individuals who are temporarily involved with the criminal justice system.[28]

This guidance addresses one problem in the system—that individuals with shorter stays in institutions may lose Medicaid enrollment. While it is only guidance and though the April 2016 guidance does contain some clarifying information about provision of care while under community supervision, it did not provide any new

information or incentive to encourage states to adopt Medicaid 'suspension' rather than termination policies.[29] In fact, a 2014 Office of Inspector General's (OIG) report estimated that between 2008 and 2013 BUCS paid over $141 million to state and local corrections facilities. [30] OIG also estimated that about a quarter of those payments were improper.

The guidance itself is problematic as it completely ignores both Congressional intent and the plain meaning of the words in the Social Security Act. The coverage exception was intended to limit Federal liability for health care costs incurred by individuals in jails and prisons, and the only way that intent is satisfied is for all inmates' coverage to be terminated.

A New Proposal

Any plan to address the problems associated with terminating Medicaid eligibility should contain three key elements: congressional action, differentiation between the accused and convicted, and state involvement in pre-release enrollment programs.

Congress' intent to limit Federal liability for health expenses incurred by incarcerated individuals was clear. It is in keeping with the language of the Eighth Amendment and the fact that no similarly situated individuals with private insurance are expected to maintain enrollment over the course of an extended sentence. Therefore, it will be necessary for Congress to clearly articulate that the federal match should not be applied to *any* health care expenses of any *prisoner* from intake through release.

Congress should also clarify that inmates who have not been sentenced, or convicted prisoners who will serve no more than 90 days, should not have their enrollment terminated. Instead, suspending enrollment pending their release will close the 90-day gap between when an inmate is released and when Medicaid enrollment will be re-established.

States should take on the task of implementing a program to help inmates slated to be released within 90 days to re-enroll in the appropriate programs and to find local health care providers accepting Medicaid enrollees to enhance continuity of care. Prisons may receive up to a 50 percent match for programs that help inmates enroll in Medicaid or access post-release care through Medicaid Administrative Claiming if they are a qualified Medicaid claiming facility.[31] CMS could further encourage this practice by re-directing 'bounty' funds towards re-enrollment programs.

Some states, such as Ohio, have already implemented programs like this to assist inmates with Medicaid enrollment as they approach their release date.[32] The Ohio program trains inmates to serve as peer counselors to others approaching release, and assists them with filing the appropriate paperwork.[33] Officials anticipate that this new program will increase continuity of care and reduce recidivism.

CONCLUSION

Both the Eighth Amendment and the Social Security Act that created Medicaid were intended to help and protect the most vulnerable individuals in our society. Yet, the combination of the two has created a perfect storm where some of the most vulnerable people are stripped of the safety-net Medicaid provides and left in a situation where they are more prone to failure and reincarceration. Current laws too often funnel at-risk individuals into a cycle of illness, incarceration, treatment, release, loss of services, and reincarceration.

[1]http://law.stanford.edu/wpcontent/uploads/sites/default/files/childpage/632655/doc/slspublic/Report_v12.pdf; http://harvardjol.com/wp-content/uploads/2015/06/HLL104_crop1.pdf.

[2] http://www.pbs.org/wgbh/amex/nash/timeline/timeline2.html.

[3] http://www.pbs.org/wgbh/amex/nash/timeline/timeline2.html.

[4] http://americanactionforum.org/insights/the-problems-with-the-imd-exclusion.

[5] http://americanactionforum.org/insights/the-problems-with-the-imd-exclusion.

[6] http://www.theepochtimes.com/n3/1919593-funneling-the-mentally-ill-into-the-criminal-justice-system/.

[7] http://www.treatmentadvocacycenter.org/a-failed-history; http://www.treatmentadvocacycenter.org/storage/documents/final_jails_v_hospitals_study.pdf.

[8] http://www.bjs.gov/content/pub/pdf/p14.pdf.

[9] http://www.drugpolicy.org/sites/default/files/DPA%20Fact%20Sheet_Drug%20War%20Mass%20Incarceration%20and

[10] http://www.drugpolicy.org/sites/default/files/DPA%20Fact%20Sheet_Drug%20War%20Mass%20Incarceration%20and

[11] *Estelle v. Gamble*, 429 U.S. 97 (1976).

[12] http://americanactionforum.org/insights/the-problems-with-the-imd-exclusion; 42 CFR §435.1009; http://www.gpo.gov/fdsys/pkg/CFR-2002-title42-vol3/pdf/CFR-2002-title42-col3-sec435-vol3-sec435-1009.pdf.

[13] https://csgjusticecenter.org/wp-content/uploads/2013/12/ACA-Medicaid-Expansion-Policy-Brief.pdf.

[14] http://www.disabilitybenefitscenter.org/faq/health-insurance-in-prison.

[15] https://csgjusticecenter.org/wp-content/uploads/2013/12/ACA-Medicaid-Expansion-Policy-Brief.pdf.

[16] https://secure.ssa.gov/poms.nsf/lnx/0202607800.

[17] https://www.ssa.gov/pubs/EN-05-10088.pdf ; Bill Thomas, Committee on Ways and Means, Subcommittee on Human Resources Report, *A Decade Since Welfare Reform: Ending Waste, Fraud and Abuse of Welfare Benefits* 2 (June 1, 2006) (reporting bounties up to $400 per prisoner).

[18] https://oig.ssa.gov/sites/default/files/audit/full/pdf/A-01-14-24100.pdf.

[19] https://oig.ssa.gov/sites/default/files/audit/full/pdf/A-01-14-24100.pdf.

[20] Bill Thomas, Committee on Ways and Means, Subcommittee on Human Resources Report, *A Decade Since Welfare Reform: Ending Waste, Fraud and Abuse of Welfare Benefits* 2 (June 1, 2006) (reporting bounties up to $400 per prisoner).

[21] http://www.urban.org/sites/default/files/alfresco/publication-pdfs/411617-Health-and-Prisoner-Reentry.PDF; 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.

[22] https://www.federalregister.gov/articles/2011/07/06/2011-16844/solicitation-for-a-cooperative-agreement-evaluating-early-access-to-medicaid-as-a-reentry-strategy.

[23] 42 CFR 435.11.

[24] http://www.ncbi.nlm.nih.gov/pubmed/17215533.

[25] http://www.urban.org/sites/default/files/alfresco/publication-pdfs/411617-Health-and-Prisoner-Reentry.PDF

[26] https://www.michigan.gov/documents/corrections/Pew_Report_State_of_Recidivism_350337_7.pdf.

[27] http://www.ncsl.org/documents/health/lb_2215.pdf

[28] https://www.medicaid.gov/federal-policy-guidance/downloads/sho16007.pdf

[29] https://www.medicaid.gov/federal-policy-guidance/downloads/sho16007.pdf

[30] https://oig.ssa.gov/sites/default/files/audit/full/pdf/A-01-14-24100.pdf

[31] https://www.medicaid.gov/medicaid-chip-program-information/by-topics/financing-and-reimbursement/medicaid-administrative-claiming.html.

[32] http://www.pewtrusts.org/en/research-and-analysis/issue-briefs/2015/12/how-medicaid-enrollment-of-inmates-facilitates-health-coverage-after-release.

[33] http://www.pewtrusts.org/en/research-and-analysis/issue-briefs/2015/12/how-medicaid-enrollment-of-inmates-facilitates-health-coverage-after-release.