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IN FOCUS

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Medicaid and Incarcerated Individuals

Medicaid is a joint federal-state means-tested entitlement program that finances the delivery of primary and acute medical services, as well as long-term services and supports, for a diverse low-income population. States that operate their programs within broad federal rules are entitled to federal Medicaid matching funds.

The Patient Protection and Affordable Care Act (ACA; P.L. 111-48, as amended), and a subsequent Supreme Court decision (*National Federation of Independent Business v. Sebelius*), made it optional for states to expand Medicaid coverage to non-elderly adults with income up to 133% of the federal poverty level beginning in 2014. In states that expanded Medicaid, many individuals transitioning into and out of incarceration—a population that tends to have higher rates of substance use disorder, mental illness, and chronic disease than the general population—were eligible for Medicaid for the first time. This In Focus describes how incarceration can impact the availability of federal Medicaid payment and an individual's Medicaid coverage.

Medicaid Inmate Payment Exclusion

Historically, Medicaid has not been a major source of funding for the health care of incarcerated individuals. This is mainly because federal Medicaid statute generally prohibits the use of federal Medicaid funds to pay for the health care of an "inmate of a public institution" (hereinafter referred to as the *inmate payment exclusion*) except when the individual is a "patient in a medical institution" that is organized for the primary purpose of providing medical care. Additionally, pre-ACA, many incarcerated individuals did not meet Medicaid eligibility criteria, so when the inmate was a patient in a medical institution, the stays were not billable to Medicaid (see "Medicaid Payment During Incarceration").

Inmates of Public Institutions

Generally, an individual detained in a local jail, state or federal prison, detention facility, or other setting organized for the primary purpose of involuntary confinement is considered an *inmate of a public institution* under Medicaid. A *public institution* is defined in federal regulation as "an institution that is the responsibility of a governmental unit or over which a governmental unit exercises administrative control," with exceptions for certain settings such as medical institutions. Federal regulations define *inmate* as someone living in a public institution, with certain exceptions for individuals living in public educational/vocational institutions to secure education or vocational training or individuals residing in a public institution temporarily (e.g., pending arrangements for community residence).

In a 2016 State Health Official (SHO) letter, the Centers for Medicare and Medicaid Services (CMS) provided additional guidance on the definition of *inmate*, stating, "CMS considers an individual of any age to be an inmate if the individual is in custody and held involuntarily through operation of law enforcement authorities in a public institution." Thus, under Medicaid, CMS generally does not distinguish between individuals who are detained in a public institution pending disposition of charges and those who are incarcerated post-sentencing (for an exception, see "Special Rules for Eligible Juveniles"). Individuals are *not* considered inmates under Medicaid if they have "freedom of movement" (e.g., ability to work outside a facility). Therefore, individuals on probation or parole, under home confinement, residing in halfway houses under the jurisdiction of state or local governments, etc., are generally *not* considered inmates.

Medicaid Payment During Incarceration

Public institutions are required to provide medical care to inmates as a consequence of the 1976 Supreme Court ruling *Estelle v. Gamble*, which found that deliberate indifference to a prisoner's serious injury or illness constitutes cruel and unusual punishment. Inmate health care can be costly for state and local governments, and billing Medicaid can offset a portion of these expenses for coverable services when eligible inmates are inpatient for 24 hours or longer in a medical institution. CMS provides guidance on which settings qualify as *medical institutions.* Among the criteria, care settings (e.g., hospitals, nursing facilities) must be certified Medicaid providers, serve members of the general public, and house and provide treatment based on medical need rather than incarceration status.

Services provided to inmates in medical institutions on an *outpatient* basis still are subject to the inmate payment exclusion. Similarly, any inpatient and outpatient medical services provided in settings that "primarily or exclusively" treat inmates are subject to the inmate payment exclusion because they are considered correctional (not medical) settings. Separate 2016 CMS guidance provides that such settings can, among other things, limit personal privacy, restrict choice of physician, and use nonmedical restraint, all of which would disqualify them from obtaining certification as a Medicaid provider.

Medicaid's "patient in a medical institution" exception applies to federal inmates, but the Bureau of Prisons chooses to retain responsibility for the payment of health care services for its inmates, so in practice, the policy is not applied to inmates in federal prisons.

Medicaid Eligibility for Inmates

Inmates who are eligible for, or enrolled in, Medicaid do not become ineligible for Medicaid based on their inmate status alone. The statutory inmate payment exclusion is a *coverage* (not an eligibility) exclusion. However,

historically, most states had policies to terminate an inmate's Medicaid enrollment, in part as a way to avoid inappropriate billing. If the inmate needed an inpatient hospitalization, the public institution would need to facilitate Medicaid enrollment of the inmate to bill Medicaid for the stay. In addition, inmates whose Medicaid was terminated during incarceration had to reapply and be deemed eligible to have full Medicaid coverage upon release (statute requires that states accept inmates' Medicaid applications). Since the reapplication process could lead to a gap in Medicaid coverage following incarceration (due to uncertain release dates, delayed eligibility determinations, etc.), CMS sought to address this issue via guidance that permits states to suspend rather than terminate Medicaid for incarcerated individuals. Beginning January 1, 2026, the Consolidated Appropriations Act, 2024 (CAA 2024; P.L. 118-42), prohibits states from terminating Medicaid eligibility for individuals who are considered an "inmate of a public institution," while retaining the state option to suspend Medicaid coverage for such individuals.

Medicaid Suspension for Inmates

Early CMS Guidance on Medicaid Suspension

In 2004 guidance, CMS permitted states to suspend an inmate's Medicaid so that it could be more quickly reinstated upon release from incarceration (or during an inpatient hospitalization). The 2016 CMS SHO letter offered similar direction by recommending that states place "the inmate in a suspended eligibility status" or "suspend coverage by establishing markers and edits in the claims processing system to deny claims for excluded services." An eligibility suspension effectively pauses an inmate's Medicaid eligibility without terminating it, while a coverage suspension maintains an inmate's eligibility but limits coverage to allowable inpatient services. Both suspension methods can achieve the same goal of faster reinstatement of full Medicaid coverage upon release from incarceration. Public institutions, states, and local jurisdictions were not required to actively facilitate Medicaid suspension (or enrollment) for inmates until recent changes to law required them to do so for certain inmates (see "Special Rules for Eligible Juveniles).

Timing of Medicaid Suspension

The process of Medicaid suspension can require extensive coordination between corrections and state Medicaid agencies, as well as information technology systems changes. This, in addition to unique state and local policies and processes, contributes to variability in when states or jurisdictions initiate Medicaid suspension during an incarceration. For example, one jurisdiction could wait 24 hours, whereas another could wait 60 days. The full range of when jurisdictions suspend Medicaid is challenging to determine. Similarly, data on the average length of time between an inmate entering jail or state or federal prison and Medicaid suspension are not readily available. Waiting to implement a Medicaid suspension can reduce administrative burden and the potential for unnecessary interruption in Medicaid coverage, but it also can create the risk of inappropriate billing of Medicaid.

In an effort to address these and other operational barriers, the CAA 2024 appropriates $113.5 million to the HHS Secretary to award grants to states by March 2025 to develop operational capabilities and continuity of care for Medicaid enrollees who are inmates of a public institution.

Special Rules for Eligible Juveniles

Recent laws modify the treatment of "eligible juveniles;" defined as individuals under 21 years of age and former foster youth up to the age of 26 who become incarcerated while enrolled in Medicaid or who are determined eligible for Medicaid while incarcerated. Specifically, the Substance Use-Disorder Prevention That Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT Act; P.L. 115-271) prohibits states from terminating Medicaid eligibility for "eligible juveniles" who become inmates of public institutions on or after October 24, 2019; instead, the law allows states to suspend Medicaid eligibility. The SUPPORT Act also requires states to redetermine the eligibility of eligible juveniles whose Medicaid is suspended, or to accept and make timely eligibility determinations on new Medicaid applications for eligible juveniles, to enable full coverage upon release. A separate provision directs the HHS Secretary to release guidance for the Medicaid Reentry Section 1115 Demonstration Opportunity under which the HHS Secretary is permitted to waive certain federal Medicaid rules to allow states to test strategies to support community reentry and improve care transitions for *all* incarcerated enrollees for a temporary period prior to release. As of July 2024, CMS granted nine states (California, Illinois, Kentucky, Massachusetts, Montana, Oregon, Utah, Vermont, and Washington) approval to cover specified Medicaid services for incarcerated enrollees under this initiative; additional state submissions are pending approval.

Under the Consolidated Appropriations Act, 2023 (CAA 2023; P.L. 117-328) states are permitted to receive federal payment for allowable medical assistance services provided to "eligible juveniles" while detained pending disposition of charges, beginning January 1, 2025. Under CAA 2024, states are prohibited from terminating Medicaid eligibility for such individuals during such period, beginning January 1, 2026. The CAA 2023 further directs states to establish a plan within 30 days of the date that an "eligible juvenile" is scheduled for release that provides for specified screenings and treatment referrals. While the SUPPORT Act did not change the inmate payment exclusion, Medicaid coverage for eligible juveniles is still generally limited to inpatient services; the CAA 2023 provision specifies that services provided under such plans are *not* subject to Medicaid's inmate payment exclusion.

Recent Legislation

Bills addressing Medicaid coverage for inmates have been introduced in the 118th Congress. The Medicaid Reentry Act of 2023 (H.R. 2400/S. 1165) would remove the Medicaid payment exclusion for *all* Medicaid enrolled inmates in the 30 days prior to release from a public institution, thereby allowing states to receive federal matching funds for state plan services during the specified period.

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