Medicaid for Medical-Correctional Care: Time to Manage What is Reimbursed

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INTRODUCTION

Approximately two million people are incarcerated in jails and prisons in the Unites States. Mass incarceration disproportionately affects Black and Latino men and other racially and ethnically minoritized groups, with individuals who are incarcerated experiencing a higher burden of chronic medical conditions, psychiatric illness, and substance use as well as a shorter life expectancy relative to the non-incarcerated population.[1]

Under Eighth Amendment protections, incarcerated persons have a constitutional guarantee to have their serious medical needs addressed, though the treatment these patients receive in both carceral and community facilities differs from that provided to free patients, with access to quality health care often deficient.[2,3] The medical care delivered to people who are incarcerated lacks oversight from usual governing bodies.[4]

Here we provide historical context for the exclusion of individuals experiencing incarceration from federally funded health insurance, describe the lack of oversight that follows the absence of federal reimbursement mandates, and reveal lessons learned about quality of care from the treatment of incarcerated individuals who are transferred to community hospitals. We then put forth suggestions for improved governance of medical-correctional care in carceral facilities and community medical centers under current and planned Medicaid expansion.

THE INMATE EXCLUSION POLICY

Medicaid is a joint federal and state health insurance program created alongside Medicare as part of the 1965 Social Security Act. Medicaid provides medical insurance to low-income families, pregnant people, individuals with disabilities, and those requiring long-term care. There remains wide variation in the services offered nationally, as each state may tailor their Medicaid program to serve their residents.

During its inception, the Social Security Act explicitly prohibited the use of federal funds for medical care to individuals who are incarcerated, an exception known as the "inmate exclusion policy," which persists today.[5] As a result, most states suspend coverage for the period of incarceration, though some terminate an individual's Medicaid enrollment upon incarceration. Those who are held in jail but not convicted of a crime or who are on probation, parole, or house arrest are not subject to exclusion.

Funding health care for those in jail or prison then arises from county, state, or federal budgets depending on association of the carceral facility. This results in collective health expenditures of billions of dollars annually by carceral agencies, with the largest percentage going towards general medical care followed by on-site and off-site hospitalization, pharmaceuticals, and mental health treatment.[6]

HEALTH CARE QUALITY OVERSIGHT

The Centers for Medicare and Medicaid Services (CMS) mandate minimum standards for participating health care organizations to obtain reimbursement through their "Conditions of Participation." These conditions ensure CMS standards regarding value, patient safety, and quality are followed. The standards apply to a range of sites including, hospitals, ambulatory surgery centers, community mental health facilities, federally qualified health centers, and intermediate and long-term care facilities.[7] Formal accreditation may occur via overarching national agencies such as the Joint Commission or state-specific certifying agencies, securing patients a level of uniform care across institutions.

When medical care is not reimbursed through usual pathways, as for individuals experiencing incarceration, the monitoring and protections enforced via conditions of participation and accreditation can fall by the wayside, leaving those in jails and prisons with little oversight of medical practices that deviate from community standards. Currently, only 17 state prison systems and the District of Columbia have any independent oversight entity. Each of these entities has variation in strength, staffing, and mission, resulting in a lack of unified independent oversight nationally.[8] Voluntary forms

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of oversight and accreditation exist for carceral facilities, such as through the National Commission on Correctional Health Care (NCCHC), though determining the impact of such programs remains difficult and the NCCHC, by policy, does not disclose whether a given facility is accredited.[9] Minimum standards of care for those incarcerated are instead reinforced through constitutional protections, changes to state or federal policy, or reactive legal action on the part of patients who are incarcerated (a right curtailed by the Prison Litigation Reform Act of 1996, which limits prisoners' ability to file suit in federal court).[1]

INSTITUTIONAL MEDICAID

When the medical needs of individuals experiencing incarceration exceed resources available at their carceral facility, patients are transferred to community medical centers for care. If incarcerated patients are admitted for over 24 h, institutions may enroll these individuals and bill Medicaid; this offsets the costs of hospitalization from carceral budgets. Some agencies, such as the Bureau of Prisons, choose to pay for all health care services for those in their custody, even for patients admitted to qualifying medical facilities.

Qualifying facilities for "institutional Medicaid" include hospitals, nursing homes, or intermediate care facilities that also serve members of the public and provide treatment based on medical need rather than incarceration status. Integrated correctional-medical centers, where higher level care is provided on carceral premises, are uncommon. Those that exist remain subject to the inmate exclusion policy because they are considered carceral settings, which enforce policies to limit personal privacy, restrict choice of physician, and allow use of non-medical restraints—factors that disqualify them from obtaining certification as a Medicaid provider.[10]

Once discharged from the hospital back to a carceral facility, a patient's Medicaid is usually again suspended or terminated. Most individuals in jail or prison eventually return to the community where they subsequently face insurance coverage gaps, which adversely affects their access to care[11] and may lead to increased recidivism, shorter time to re-incarceration, and an increased utilization of emergency resources for medical care.[12,13]

HOSPITAL CARE

When patients who are incarcerated receive medical care outside of jail or prison, it is common for policies and procedures from the carceral setting to follow. Security in most community medical facilities does not approximate carceral standards so correctional representatives have broad discretion over security practices when reasonably related to preventing escape or harm to others.[14] When caring for such patients, clinicians follow correctional principles embedded into medical center policy and often defer to custody officers when presented with conflicts to usual care.[2]

Yet practices that benefit correctional needs rarely benefit patient care. For example, when outside dedicated medical forensic units, incarcerated patients in community hospitals are regularly shackled indefinitely with metal cuffs to mitigate escape risk and are kept unaware of discharge plans to facilitate safe transport back to the carceral facility. This is far from the treatment norms provided to non-incarcerated patients, but rather medical care tailored to the usual practices of the correctional system, described as "incarceration-specific care practices."[15]

Without mandated accreditation required for provision of medical care in either carceral facilities or community centers, the harmful anomalies patients who are incarcerated experience often go without scrutiny. And despite the ability of hospitals to bill Medicaid for inpatient services for incarcerated individuals, inpatient management of these patients commonly diverges from the mandates put forth for accreditation and reimbursement under CMS Conditions of Participations (Table 1).

MEDICAID EXPANSION

The Affordable Care Act (ACA) allowed states to expand Medicaid eligibility to adults with incomes up to 138% of the federal poverty level. While the ACA did not change the quality of health care in carceral settings, it did increase eligibility for those from socioeconomically disadvantaged backgrounds, improve access to care before and after incarceration, and mandate mental health and substance use services.[18] Some states that chose to expand Medicaid have experienced an increase in prerelease enrollment for individuals experiencing incarceration with an increase in Medicaid coverage upon community reentry.[19]

The proposed Medicaid Reentry Act of 2023 currently in Congress (H.R. 2400/S. 1165) would take the next step forward by allowing Medicaid payment for services furnished to an individual experiencing incarceration during the 30 days preceding release, effectively eliminating the inmate exclusion policy towards the end of a sentence.[20] The Medicaid Reentry Act has the potential to facilitate warm hand-offs between carceral and community health care professionals and providers, eliminate post-release coverage gaps, and expedite engagement with outpatient medical, psychiatric, and substance use treatment.[21] With opioid overdose the leading cause of post-release mortality,[22] this is especially valuable in initiating effective opioid treatment while in jail or prison and linking to outpatient services on community reentry.

While the Medicaid Reentry Act has not been passed, as of last year, states may apply for a Medicaid Reentry Sect. 1115 Demonstration Opportunity, which allows approved states to cover select services for incarcerated patients up to 90 days prior to that person's release date.[23]

Table 1 Common Inpatient Deviations to Medicaid Conditions of Participation due to Incarcerated Status

Patient right	Condition of Participation[16]	Current practice
Notice of patient rights	• A hospital must inform each patient, or when appropriate, the patient's representative (as allowed under State law), of the patient's rights, in advance of furnishing or discontinuing patient care whenever possible	• Incarcerated patients may not have a right to receive a copy of a medical center's notice of patient rights with restrictions of rights determined and enforced by the custody officer[2]
Health privacy	• The patient has the right to personal privacy • The patient has the right to the confidentiality of his or her clinical records	• Custody officers acquire protected health information about incarcerated patients due to continual correctional presence at the bedside, operating room, or through disclosures from treating clinicians[4]
Restraint	• All patients have the right to be free from restraint or seclusion, of any form, imposed as a means of coercion, discipline, convenience, or retaliation by staff • Restraint or seclusion may only be used when less restrictive interventions have been determined to be ineffective to protect the patient a staff member or others from harm • The type or technique of restraint or seclusion used must be the least restrictive intervention that will be effective to protect the patient, a staff member, or others from harm	• Incarcerated patients are placed in metal shackles throughout the duration of hospitalization when outside of dedicated hospital medical forensic units and during transport within medical facilities[14]
Decision making	• The patient has the right to participate in the development and implementation of his or her plan of care • The patient or his or her representative (as allowed under State law) has the right to make informed decisions regarding his or her care. The patient's rights include being informed of his or her health status, being involved in care planning and treatment, and being able to request or refuse treatment • The patient has the right to have a family member or representative of his or her choice and his or her own physician notified promptly of his or her admission to the hospital	• Clinicians may believe, or correctional authorities may assert, that incarcerated individuals may not make their own medical decisions • Medical decisions for incapacitated incarcerated patients may be made by, or involve, correctional authorities rather than family or other designated surrogates[17]
Discharge Planning	• The hospital must have an effective discharge planning process that focuses on the patient's goals and treatment preferences and includes the patient and his or her caregivers/support person(s) as active partners in the discharge planning for post-discharge care	• Transportation between carceral facilities and medical centers is a potentially vulnerable time in security measures, so clinicians are instructed to withhold discharge plans from patients to mitigate the risk of coordinated attempts at escape[4]

Conditions of Participation taken from Code of Federal Regulations Sections 482.13 and 482.43

Currently three states (California, Montana, and Washington) have received approval under the waiver opportunity and 19 states are pending waiver approval.[24] Formal passage of the Reentry Act would mean that pre-release coverage will no longer be heterogenous across states nor dependent on a state proactively applying for a demonstration opportunity—notably different than the current state and leading to more accessible coverage for individuals who are incarcerated and approaching transition back to the community.

OPPORTUNITIES FOR REFORM

While the expansion of Medicaid funding into carceral settings has the potential to bring CMS mandates and quality oversight into jails and prisons, as we have seen in the hospital, the ability to bill Medicaid for services does not necessarily come with oversight specific to the unique aspects of medical care provided to patients who are incarcerated. These patients continue to experience exceptions to health privacy, restraint, informed decision making, and transitions of care at odds with conditions of participation in accredited institutions.[2]

With new scrutiny on Medicaid's role in carceral health care, now is the time to reexamine the absence of medical-correctional CMS standards. At a hospital and health care provider level, we suggest enrolling patients in Medicaid during hospitalization, whenever administrative resources are available to facilitate. We also recommend that enrollment is suspended, rather than terminated, upon a patient's return to a carceral setting to mitigate insurance coverage gaps upon eventual community reentry. This aligns with recent federal policy change requiring that as of 2026, all states suspend, rather than terminate, Medicaid coverage when people are incarcerated.[25] In coordination with the receiving carceral facility, arrangements for community follow-up, including mental health and substance use treatment, should be made at discharge if within 30 days of a patient's expected jail or prison release.

At a health systems level, CMS has an opportunity to correct, codify, and monitor medical-correctional standards of care for reimbursement. An awareness of incarceration-specific care practices and their divergence from community standards can ensure that conditions of participation are created that address an individual's medical and security needs during treatment in both carceral and community settings. For example, in the hospital, this could mean aligning

policies around shackling restraint for patients who are incarcerated with typical medical restraint policies mandating the least restrictive means of detainment along with frequent assessment for delirium and injury.[26] In carceral facilities, the Reentry Act could ensure those with opioid use disorder receive access to effective medication-assisted treatment and confirmed follow-up in community substance use treatment centers.[27] All carceral facilities should be required to report quality measures as other payers and providers are typically required to do, adding transparency to health care processes delivered in jails and prisons and ingraining the quality and safety practices standard in community health systems.

CONCLUSION

The medical treatment provided to people experiencing incarceration has historically been excluded from traditional oversight mechanisms that ensure quality care, but the time is ripe for reevaluation. With Medicaid expansion and proposals on the horizon to advance reimbursement into carceral settings, now is the time to examine the unique medical care provided to patients who are incarcerated and ensure that whenever reimbursement is offered, conditions of participation are appropriately adjusted to ensure enhanced quality that reflects the unique experience and needs of the incarcerated individual.

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