MEDICAID AND PRISONER REENTRY: SUSPENSION IS THE NEW BLACK

*By Elizabeth Snyder**

I. INTRODUCTION

Almost forty years ago, the Supreme Court ruled that a failure to provide medical care to prisoners[1] is a violation of the Eighth Amendment's prohibition against cruel and unusual punishment.[2] Due to this ruling and other shifts in the infrastructure of correctional facilities, prisons became one of the largest healthcare providers in the United States.[3] The prison system also provides an opportunity for many offenders to meaningfully address their medical conditions and health concerns by receiving a consistent source of medical care.[4] However, this gives rise to a problem. Many inmates[5] are

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1. For the purposes of this article, I use the words "prisoners" and "inmates" interchangeably. *See generally* Letter from Robert A. Streimer, Director of the Disabled and Elderly Health Programs Group, Center for Medicaid and State Operations, to All Associate Regional Administrators, Division for Medicaid and State Operations (Dec. 12, 1997) https://csgjustice center.org/wp-content/uploads/2014/06/PolicyforInmatesofPublicInst1997.pdf ("An individual is an inmate when serving time for a criminal offense or confined involuntarily in State or Federal prisons, jails, detention facilities, or other penal facilities. An individual who is voluntarily residing in a public institution would not be considered an inmate. . . Likewise, an individual, who is voluntarily residing in a public educational or vocational training institution for purposes of securing education or vocational training or who is voluntarily residing in a public institution while other living arrangements appropriate to the individual's needs are being made would not be considered an inmate. . . . [A] facility is a public institution when it is under the responsibility of a governmental unit, or over which a governmental unit exercises administrative control. This control can exist when a facility is actually an organizational part of a governmental unit, or over which a governmental unit exercises final administrative control, including ownership and control of the physical facilities and grounds used to house inmates. Administrative control can also exist when a governmental unit is responsible for the ongoing daily activities of a facility, for example, when facility staff members are government employees or when a governmental unit, board, or officer has final authority to hire and fire employees.").

2. *See* Estelle v. Gamble, 429 U.S. 97, 104 (1976).

3. *See* Shane Levesque, *Closing the Door: Mental Illness, the Criminal Justice System, and the Need for a Uniform Mental Health Policy*, 34 NOVA L. REV. 711, 718 (2010).

4. *See generally id.* (discussing the fact that the prison system can be viewed as an

released from prison with no access to affordable health care.[6] This means that inmates who were receiving consistent care for mental illnesses, physical illnesses, or substance abuse problems are abruptly cut off from treatment.[7] The continuum of care[8] for many inmates is severed during one of the most vulnerable times in their lives—the first six months after being released from prison.[9]

Providing access to affordable healthcare for inmates immediately upon release from prison should be of the utmost priority for states. Providing a continuum of care for inmates from when they were incarcerated to the first six months post-release will lead to a reduction in recidivism rates, a reduction in the rates of homelessness for recently released inmates, and an increase in employment rates of recently released inmates.[10] States that expanded Medicaid coverage under the Patient Protection and Affordable Care Act (PPACA)[11] have a unique opportunity to provide this continuum of care by suspending, rather than terminating, Medicaid enrollment for inmates.[12] States that have adopted suspension policies are able to reactivate inmates' Medicaid enrollment immediately upon release from prison, and at very minimal administrative burden.[13] Additionally, states that allow for suspension of Medicaid enrollment for inmates may file to receive federal reimbursement for some of the medical care provided to inmates.[14]

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opportunity for mentally ill individuals to receive adequate treatment).

5. 42 C.F.R. § 435.1010 (2015) ("Inmate of a public institution means a person who is living in a public institution.").

6. *See* COUNCIL OF STATE GOVERNMENTS JUSTICE CTR., MEDICAID AND FINANCING HEALTH CARE FOR INDIVIDUALS INVOLVED WITH THE CRIMINAL JUSTICE SYSTEM 1 (2013), https://csgjusticecenter.org/wp-content/uploads/2013/12/ACA-Medicaid-Expansion-Policy-Brief.pdf.

7. *See id.*

8. *See generally* HEALTH INFO. EXCH. COMM. CONTINUITY OF CARE WORKGROUP, HEALTHCARE INFORMATION AND MANAGEMENT SYSTEMS SOCIETY, DEFINITION: CONTINUUM OF CARE (May 14, 2014), http://www.himss.org/ResourceLibrary/genResourceDetailPDF.aspx?ItemNumber=30272 ("Continuum of care is a concept involving a system that guides and tracks patients over time through a comprehensive array of health services spanning all levels and intensity of care. The continuum of care covers the delivery of healthcare over a period of time, and may refer to care provided from birth to end of life.").

9. *See* Levesque, *supra* note 3 at 726.

10. *See* COUNCIL OF STATE GOVERNMENTS JUSTICE CTR., *supra* note, 6 at 1.

11. Medicaid is a federally funded healthcare plan offered to individuals aged 65 and older, pregnant women, and the disabled. Under the Patient Protection and Affordable Care Act, states were given the option to expand Medicaid to include persons aged 19 to 64 who are not disabled or pregnant if they fall at 133 percent of the FPL.

12. *See* ALEXANDRA GATES, ET AL., THE HENRY J. KAISER FAMILY FOUNDATION, HEALTH COVERAGE AND CARE FOR THE ADULT CRIMINAL JUSTICE-INVOLVED POPULATION 4 (2014) https://kaiserfamilyfoundation.files.wordpress.com/2014/09/8622-health-coverage-and-care-for-the-adult-criminal-justice-involved-population1.pdf.

13. *See* NATIONAL ASS'N OF COUNTIES, HEALTH COVERAGE AND COUNTY JAILS: SUSPENSION VS. TERMINATION 2 (Dec. 2014), http://www.naco.org/sites/default/files/documents/Suspension-termination_2015.pdf.

14. *See* 42 U.S.C. § 1396d(a)(29)(A) (2006).

Part II of this article will provide an overview of prison healthcare, discuss why Medicaid eligibility for inmates is of key importance, and propose a solution to the problem addressed in this introduction. Part III of this article will discuss why most states have not yet adopted a suspension policy, despite the urging of the Centers for Medicare & Medicaid Services.[15] Part III will also discuss the actions a state would have to take to implement a suspension policy, as well as several examples of successful implementations of such a policy. Part IV of this article will discuss the various benefits of implementing a policy for suspending Medicaid enrollment, including the reduction in recidivism rates for newly released individuals who receive a continuum of care. Part IV will also discuss the statutory exception that allows states with suspension policies to save millions of dollars per year.

II. BACKGROUND

A. Prisons must provide inmates with medical care.

In *Estelle v. Gamble*, the Supreme Court concluded "the Eighth Amendment's prohibition against cruel and unusual punishment . . . mandates that states provide adequate medical care to all of their prisoners."[16] The rationale for this decision, which became known as the *Estelle* rule, states, "when the State takes a person into its custody and holds him there against his will, the Constitution imposes upon it a corresponding duty to assume some responsibility for his safety and general well-being."[17] Thus, when a State restrains an individual's liberty, through incarceration or some other means, the State has a duty to provide for his basic human needs, including medical care.[18]

The *Estelle* rule is less clear with regards to inmates' health insurance and other medical coverage. The statutory federal financial participation (FFP) exclusion states that Medicaid eligible individuals may use their Medicaid coverage to assist in paying for a wide variety of medical care or services, unless the individual is an inmate of a public institution.[19] "Generally, federal law mandates that states may not receive matching Medicaid funds for medical services provided to qualified individuals during periods of incarceration."[20] However, there are two notable caveats to this statutory provision. First, the

15. U.S. DEP'T OF HEALTH & HUMAN SERVS., *About CMS* (last visited Nov. 13, 2015), https://www.cms.gov/About-CMS/About-CMS.html ("The Centers for Medicare & Medicaid Services, CMS, is part of the Department of Health and Human Services (HHS). . . The programs CMS administers include: Medicare, Medicaid, the Children's Health Insurance Program (CHIP), and the Health Insurance Marketplace.").

16. Wakefield v. Thompson, 177 F.3d 1160, 1163–64 (9th Cir. 1999) (citing Estelle v. Gamble, 429 U.S. 97, 104–05 (1976)).

17. *Id.* at 1164 (quoting DeShaney v. Winnebago Cty. Dep't of Soc. Servs., 489 U.S. 189, 199–200 (1989)).

18. *Id.*

19. *See* 42 U.S.C. § 1396d(a)(29)(A) (2006).

20. Levesque, *supra* note 3, at 731.

statutory language of this exclusion, often referred to as the "inmate exclusion," contains an exception for when the inmate is a patient in a medical institution, such as when an inmate must be hospitalized.[21] The "inmate exclusion" exception will be discussed further in Part IV of this article. Second, the inmate exclusion only excludes federal *payments* for medical care and services; the exclusion does not expressly terminate Medicaid eligibility and enrollment of inmates, but rather the inmates' ability to use federal Medicaid funds for payment of medical care and services.[22]

Historically, many states have read the inmate exclusion rule as terminating Medicaid eligibility, rather than the payment status, upon incarceration. Thus, most states terminate inmates' Medicaid coverage upon incarceration because they think it is necessary to adequately comply with the statutory provisions of 42 U.S.C. § 1396d (a)(29)(A). As a result, hundreds of thousands of inmates are released from prisons and jails each year with no medical coverage.[23] Not only are these individuals attempting to secure adequate housing and employment post-release, but they must also go through the tedious process of applying for a new eligibility determination for Medicaid coverage,[24] which can take a minimum of 45 to 90 days.[25]

The Centers for Medicare & Medicaid Services attempted to address this problem in a 2004 letter sent to all State Medicaid Directors and CMS Associate Regional Administrators for Medicaid.[26]

> CMS is encouraging states with this letter to "suspend" and not "terminate" Medicaid benefits while a person is in a public institution or Institute for Mental Disease (IMD). Persons released from institutions are at risk of homelessness; thus, access to mainstream services upon release is important in establishing a continuum of care and ongoing support that may reduce the demand for costly and inappropriate services later.
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> As a reminder, the payment exclusion under Medicaid that relates to individuals residing in a public institution or an IMD does not affect the *eligibility* of an individual for the Medicaid program. Individuals 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 or as a resident of an IMD. The statutory federal financial

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21. *See* 42 U.S.C. § 1396d(a)(29)(A) (2006).

22. FED. INTERAGENCY REENTRY COUNCIL, REENTRY MYTHBUSTER! ON MEDICAID SUSPENSION VS. TERMINATION 1 (2011) https://csgjusticecenter.org/documents/0000/1181/Reentry_Council_Mythbuster_Medicaid_Suspension.pdf.

23. COUNCIL OF STATE GOVERNMENTS JUSTICE CTR., *supra* note 6, at 1.

24. *See* HEATHER BARR, CORRECTIONAL ASSOCIATION OF NEW YORK & URBAN JUSTICE CENTER, PRISONS AND JAILS: HOSPITALS OF LAST RESORT 14 (1999), *reproduced in* Prison Legal News (Nov. 26, 2003), https://www.prisonlegalnews.org/media/publications/prisons_and_jails_hospitals_of_last_resort_heather_barr_2003.pdf.

25. *See* COUNCIL OF STATE GOVERNMENTS JUSTICE CTR., *supra* note 6, at 4.

26. FED. INTERAGENCY REENTRY COUNCIL, *supra* note 22, at 2.

> participation (FFP) exclusion applying to inmates of public institutions and residents of IMDs affects only the availability of federal funds under Medicaid for health services provided to that individual while he or she is an inmate of a public institution or a resident of an IMD.

This letter introduced[27] and encouraged the idea of Medicaid suspension for inmates as an alternative to termination.[28] It also spoke directly to the ambiguity present in both the *Estelle* rule and the FFP with regards to inmates' health insurance or other medical coverage.[29] Although the court in *Estelle* determined that states must provide adequate medical care prisoners, it did not address whether states could allow inmates to use their own health insurance to cover medical costs.[30] The statutory federal financial participation exclusion spoke to this ambiguity by stating that Medicaid can be used to pay for a wide variety of medical care or services, unless the individual covered under Medicaid is an inmate of a public institution.[31] However, neither the federal financial participation exclusion nor the *Estelle* decision discuss whether individuals may still be enrolled in Medicaid while they are inmates of a public institution. The above CNS letter gave a clear answer to the ambiguity. To date, twelve states[32] have adopted a policy of suspending rather than terminating Medicaid eligibility for inmates.[33] Thus, thirty-eight states and the District of Columbia still terminate[34] Medicaid for inmates upon incarceration.[35]

B. Medicaid expansion under the PPACA means more prisoners will be eligible for Medicaid coverage.

"Each year more than 700,000 individuals are released from state and federal prisons."[36] Additionally, approximately 9 million individuals cycle through local jails[37] each year.[38] Of these 10 million, an estimated 70 to 90

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27. U.S. GOV'T ACCOUNTABILITY OFFICE, GAO-14-752R, MEDICAID: INFORMATION ON INMATE ELIGIBILITY AND FEDERAL COSTS FOR ALLOWABLE SERVICES 3 (2014), http://gao.gov/assets/670/665552.pdf (stating that CMS first issued guidance addressing continued Medicaid eligibility for inmates in 1997).

28. *See* FED. INTERAGENCY REENTRY COUNCIL, *supra* note 22, at 2.

29. DeShaney v. Winnebago Cty. Dep't of Soc. Servs., 489 U.S. 189, 199–200 (1989).

30. *See* Estelle v. Gamble, 429 U.S. 97 (1976).

31. *See* 42 U.S.C. § 1396d(a)(29)(A) (2006).

32. NATIONAL ASS'N OF COUNTIES, *supra* note 13, at 2 (listing California, Colorado, Florida, Iowa, Maryland, Massachusetts, Minnesota, New York, North Carolina, Ohio, Oregon and Texas as the states that currently suspend Medicaid coverage for inmates).

33. *Id.*

34. *Id.* ("Some states have passed laws to expand that timeframe to avoid terminating coverage for those being detained or serving short sentences.").

35. *See id.*

36. FED. INTERAGENCY REENTRY COUNCIL, *supra* note 22, at 2.

37. U.S. GOV'T ACCOUNTABILITY OFFICE, *supra* note 27, at 1 ("For purposes of this report, we define inmates as individuals incarcerated in state prisons, local jails, or facilities under contract with states or local authorities, such as counties. Inmates in state prisons are typically individuals sentenced for more than one year. Inmates in local jails are typically individuals with

percent are uninsured upon release.[39] In a survey conducted of 1,100 prison inmates, 84 percent of men and 92 percent of women reported at least one physical health, mental health, or substance abuse problem.[40] The rates of physical illness, mental illness, and substance abuse problems among prisoners are much higher than the general population.[41] In most cases, these health problems will continue to affect inmates after they are released from prison.

The enactment of the Patient Protection and Affordable Care Act opened the doors for Medicaid expansion.[42] In the past, Medicaid eligibility for adults was limited to pregnant women, the disabled, and adults over 65 years old.[43] The PPACA gave states the option to expand Medicaid coverage to include adults with incomes up to 133 percent[44] of the federal poverty level (FPL).[45] In 2013, Medicaid covered health care services for more than 72 million individuals at a cost to the federal government of $262 billion.[46] To date, 31 states and the District of Columbia have expanded Medicaid under the PPACA.[47] Due to this expansion, an estimated 8 million people may gain access to Medicaid.[48] Other groups estimate that up to 15.1 million previously uninsured, low-income adults ages 19 to 64 may become Medicaid eligible.[49]

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a sentence of less than one year or awaiting adjudication. We did not include federal prisoners in the scope of our work, because officials from the Federal Bureau of Prisons, which oversees federal prisons, told us that the Bureau is not enrolling prisoners in Medicaid for purposes of obtaining federal Medicaid funds for inpatient services that qualify for such funds.").

38. FED. INTERAGENCY REENTRY COUNCIL, *supra* note 22, at 2.

39. COUNCIL OF STATE GOVERNMENTS JUSTICE CTR., *supra* note 6, at 1.

40. KAMALA MALLIK-KANE & CHRISTY A. VISHER, HEALTH AND PRISONER REENTRY: HOW PHYSICAL, MENTAL, AND SUBSTANCE ABUSE CONDITIONS SHAPE THE PROCESS OF REINTEGRATION, URBAN INSTITUTE 12 (2008), http://www.urban.org/sites/default/files/alfresco/publication-pdfs/411617-Health-and-Prisoner-Reentry.PDF.

41. *See id.*

42. GATES, *supra* note 12, at 5.

43. Levesque, *supra* note 3, at 734.

44. U.S. GOV'T ACCOUNTABILITY OFFICE, *supra* note 27, at nn. 6–7 ("Under federal law, states are required to cover certain populations, such as pregnant women with incomes up to 133 percent of the federal poverty level (FPL) and have the option to cover additional populations, such as pregnant women with income between 133 and 185 percent FPL. FPL is a measure of income level that is set annually by the Department of Health and Human Services and used to determine eligibility for certain programs, including Medicaid. PPACA also provides for a 5 percent disregard when calculating income for determining Medicaid eligibility for this population, which effectively increases this income level to 138 percent FPL. In 2014, 138 percent FLP for a family of four was $32,913.").

45. *Id.*

46. *Id.* at 1.

47. *A 50-State Look at Medicaid Expansion*, FAMILIES USA (Jan. 12, 2016), http://familiesusa.org/product/50-state-look-medicaid-expansion (listing Alaska, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Hawaii, Illinois, Indiana, Iowa, Kentucky, Maryland, Massachusetts, Michigan, Montana, Minnesota, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Dakota, Ohio, Oregon, Pennsylvania, Rhode Island, Vermont, Washington, and West Virginia as the states that expanded Medicaid under the PPACA).

48. *See id.*

49. COUNCIL OF STATE GOVERNMENTS JUSTICE CTR., *supra* note 6, at 1.

The expansion of Medicaid will have a significant impact on the U.S. prison population. Approximately 35 percent of people gaining Medicaid eligibility under the PPACA will have a history of criminal justice system involvement.[50] Data suggests "around 45 percent of prison inmates are in states that expanded Medicaid."[51] At the end of 2012, there were about 1.4 million inmates in state prisons, of which about 600,000 were in prisons in the 27 states that expanded Medicaid eligibility at that time.[52] In a study conducted in two states that expanded Medicaid eligibility, an estimated "80 to 90 percent of state prison inmates were likely eligible for Medicaid as of 2014."[53] An extremely large percentage of the United States prison population is now Medicaid eligible.[54] Thus, changing policies to suspend rather than terminate Medicaid eligibility for inmates will now have a much greater impact than it did even a few years ago.

Of the 38 states that terminate Medicaid enrollment upon incarceration, 21 expanded Medicaid eligibility under the PPACA.[55] These 21 states have a unique opportunity to modify state plans[56] to suspend rather than terminate Medicaid enrollment for inmates upon incarceration because (1) there is a significant benefit to newly released individuals who receive a continuum of health care when leaving prison, (2) there is a significant benefit to states and communities in the form of reduced rates of recidivism and a lesser administrative burden on CMS offices when newly released individuals try to re-enroll in Medicaid, and (3) there is an opportunity for states to save a significant amount of money via federal reimbursement by filing Medicaid claims under the exception listed in 42 U.S.C. § 1396d(a)(29)(A).

III. WHY ARE SOME STATES CONCERNED ABOUT ADOPTING A SUSPENSION POLICY?

Medicaid allows for continued eligibility of coverage for a person who is

50. *Id.*

51. U.S. GOV'T ACCOUNTABILITY OFFICE, *supra* note 27, at 4.

52. *Id.*

53. *Id.*

54. *See id.* at 7 ("With the expansion of Medicaid eligibility as allowed under PPACA, understanding the characteristics and costs of the newly eligible will be important to future policymaking. Inmates in state prisons and local jails who meet state program requirements have long been eligible for Medicaid, and some states have previously obtained federal matching funds for allowable services. However, the proportion of inmates eligible in many states was likely small prior to PPACA when eligibility for adults was generally limited to certain populations, such as pregnant women and individuals who are aged or disabled. . . . In 2014, the number of inmates eligible for Medicaid likely increased in the 27 states that expanded eligibility for low-income adults, a population that includes inmates.").

55. *See* NAT'L ASS'N OF COUNTIES, *supra* note 13, at 2; *see* FAMILIES USA, *supra* note 47, at 2–3.

56. Officials from CMS have stated that it is not necessary for states to modify state plans in order to implement a suspension policy. This will be discussed further in section III.

incarcerated.[57] In fact, the Centers for Medicare & Medicaid Services, a division of the Department of Health & Human Services, encourage continued eligibility of coverage for incarcerated individuals.[58] It appears that everyone agrees—so what is the holdup? There is a common misconception that adopting a suspension policy could be considered expanding Medicaid under the PPACA. It is exactly that: a misconception. As noted above, implementing a suspension policy will not provide Medicaid to individuals who would not otherwise qualify for or receive Medicaid. The difference between a suspension policy and a termination policy is how *quickly* people will receive access to Medicaid services, not whether they will qualify for Medicaid services. There are two other reasons that have stopped states from only suspending Medicaid coverage for inmates. First, some states have concerns regarding the potential administrative burden of adopting a suspension policy.[59] Other states fear that implementing a new policy will require them to pass legislation or amend their state plan.[60] However, these fears have no merit as can be seen if one looks to Maricopa County, Arizona where suspension has been implemented.

A. The administrative burden of implementing a suspension policy is minimal.

A concern for many states when determining whether to implement a suspension policy is the potential administrative burden of implementing a new policy.[61] States fear they would need to purchase new software for their prison systems and hire new employees or train current employees to handle the implementation of the policy.[62] Unfortunately, some administrative burden is unavoidable. States will likely have to designate someone to handle the burden of this new workload. In California, Assembly Bill 720 authorized the Board of Supervisors in each county to designate an entity to cover the work generated by the state's new suspension policy.[63]

However, this new burden on states must be weighed against the months of tedious work surrounding new Medicaid eligibility determinations that inmates would file upon release from prison if their eligibility was terminated. The burden of adding new offices or hiring new personnel to handle the administrative side of a newly implemented suspension policy would not outweigh the administrative burden of having to process new Medicaid eligibility determination filings every time an inmate reapplies. "The workload would be comparable for terminating or suspending benefits on initial

57. NAT'L ASS'N OF COUNTIES, *supra* note 13, at 2.

58. FED. INTERAGENCY REENTRY COUNCIL, *supra* note 22, at 2.

59. *See* COUNCIL OF STATE GOVERNMENTS JUSTICE CTR., *supra* note 6, at 3.

60. *See id.* at 26.

61. *Id.* at 3 ("However, states and localities often misinterpret the exclusion to require the termination of Medicaid enrollment, and some states' information technology systems are simply unable to accommodate a suspension of Medicaid enrollment.").

62. *Id.*

63. NAT'L ASS'N OF COUNTIES, *supra* note 13, at 3.

incarceration whether it is done manually or through some electronic process . . . the number of new applications that need to be filled-out and processed would be reduced with suspension, gaining efficiencies for both the corrections and Medicaid work forces."[64]

Another common claim made by states in favor of termination policies is that termination policies are "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."[65] This claim is a fallacy. Imagine a typical hospital or doctor's office visit. When an inmate of a public institution goes through the process of an off-campus hospital visit, they would be accompanied by a prison guard and wearing a prison uniform. It would be abundantly clear to all doctors, nurses, and hospital administration that the patient is an inmate, thus alerting them to bill through the Department of Corrections rather than Medicaid or any other health insurance plan. If the presence of a prison guard or the prison uniform were not enough, it would become clear when the inmate filled out hospital intake forms. Suspending Medicaid would not increase the chance of improper billing. However, suspending eligibility can make it easier for states to access federal Medicaid funding when individuals who are incarcerated receive inpatient services in a medical institution.[66] Since the Medicaid coverage would only be suspended rather than terminated, the inmate's Medicaid coverage could be briefly reactivated in order to receive federal funds covering the treatment costs. The availability of these federal Medicaid funds for states will be discussed in more detail in Part IV of this article.

B. States do not need to pass new legislation or amend state plans in order to implement a suspension policy.

As seen in correspondence between Colorado State prison systems and the CMS Director, states do not need to enact new legislation or amend old state plans in order to implement a suspension policy.[67] The question of how to adopt and implement a suspension policy is addressed in correspondence between Richard Allen, Associate Regional Administrator for the Division of Medicaid & Children's Health Operations and Joan Henneberry, Executive Director of the Colorado Department of Health Care Policy and Financing.[68] Richard Allen works from the Centers for Medicare & Medicaid Services office in Denver, Colorado.[69] In this letter, Allen responded to questions from Henneberry regarding suspension of Medicaid eligibility for incarcerated

64. JOAN M. SHOEMAKER, BUREAU OF JUSTICE ASSISTANCE, HEALTH CARE REFORM: A PRACTICAL GUIDE FOR CORRECTIONS AND CRIMINAL JUSTICE PROFESSIONALS 16 (July 18, 2016), http://www.aca.org/ACA_Prod_IMIS/DOCS/OCHC/HealthCareReform.pdf.

65. GATES, *supra* note 12, at 5.

66. *Id.* at 4.

67. *See* COUNCIL OF STATE GOVERNMENTS JUSTICE CTR., *supra* note 6, at 26.

68. *Id.* at 21–29.

69. *Id.* at 21.

persons and clarified a few aspects of suspension that were still ambiguous.[70] First, there is no need for the state to implement a suspension policy to pass new legislation or amend the state plan.[71] Next, states do not need approval from the CMS before implementing a suspension policy.[72] The implementation of a suspension policy can simply be an administrative change on the part of the state.[73] It would only require the joint cooperation of the Department of Corrections and the state Medicaid authority.[74] Allen even alluded to the idea that Medicaid for an incarcerated individual could be suspended indefinitely.[75] Allen then suggested Henneberry contact officials in New York and Pennsylvania, two states that had already adopted suspension policies at the time of this correspondence.[76]

What remains is the issue of technology and administrative burden on implementing a new policy. The technological burden of keeping track of each inmate's Medicaid status is not as taxing as one might think. "The workload would be comparable for terminating or suspending benefits on initial incarceration whether it is done manually or through some electronic process."[77] Additionally, the American Correctional Association is currently working to develop technical assistance surrounding some of these issues.[78]

C. A case study: Maricopa County, Arizona and the implementation of a new Medicaid policy

Maricopa County, Arizona, provides an example of how easy it could be to adopt a suspension policy.[79] Maricopa County is a county of approximately 4 million people, situated in the southwestern portion of Arizona.[80] The

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70. *Id.* at 21–29.

71. *Id.* at 26 ("Q: To implement a suspension of Medicaid eligibility would the Department need to modify the State Plan? Is there any notification to, or approval from, CMS that is needed prior to implementation? A: The State would not have to amend its Medicaid State Plan in order to establish suspension of Medicaid eligibility for incarcerated individuals. This is not part of the State Plan. The State would not need CMS approval prior to implementation.").

72. *Id.*

73. *See* COUNCIL OF STATE GOVERNMENTS JUSTICE CTR., *supra* note 6, at 26.

74. *Id.*

75. *Id.* at 25 ("Federal statute or regulations do not specify time limitations for suspending Medicaid eligibility.").

76. *Id.* at 26–27.

77. SHOEMAKER, *supra* note 64, at 16.

78. ANDREA A. BAINBRIDGE, BUREAU OF JUSTICE ASSISTANCE, THE AFFORDABLE CARE ACT AND CRIMINAL JUSTICE: INTERSECTIONS AND IMPLICATIONS 19 (July 2012), https://csgjusticecenter.org/wp-content/uploads/2013/06/The-Affordable-Care-Act-and-Criminal-Justice-Intersections-and-Implications.pdf (listing the areas the ACA is developing technical assistance programs for as "steps to determine existing coverage; enrolling inmates in Medicaid or other insurance; filing claims on existing coverage; using existing health coverage; and steps involved in engaging Medicaid representatives and others in the state to enroll eligible inmates in Medicaid.").

79. NAT'L ASS'N OF COUNTIES, *supra* note 13, at 3.

80. *QuickFacts: Maricopa County, Arizona*, U.S. CENSUS BUREAU, http://quickfacts.census.

county, which houses Phoenix and all of its residents, initiated an intergovernmental agreement (IGA) with the state Medicaid authority to allow individuals to have their Medicaid eligibility suspended rather than terminated during their incarceration.[81]

The procedure implemented by Maricopa County is quite simple. First, the County "electronically submits a list of all individuals booked or released from jails in the county for the preceding 24 hours."[82] Next, the state Medicaid authority "checks the list against their database and either suspends or reinstates all of the matches."[83] Finally, the state Medicaid authority "provides a daily list of results identifying the action taken and the renewal of eligibility dates, when applicable."[84] This procedure essentially amounts to county jail officials and state Medicaid agency employees emailing a Microsoft Excel spreadsheet back and forth once per day. All things considered, this is a relatively light administrative burden for the overwhelming amount of positive benefits resulting from the process.

Maricopa County's use of a daily list could be problematic if an individual is only incarcerated for a day. While Maricopa County has not published anything indicating whether they go through the suspension process for individuals who are only incarcerated for a day, other states have addressed this issue. The issue of timing varies state to state, but some states have passed laws to define a timeframe that allows them to avoid termination for those serving short sentences.[85] For example, in New York, individuals who are incarcerated less than 30 days are able to retain their enrollment status.[86]

D. States should adopt broad suspension policies that do not place restrictions on the length of time an inmate's Medicaid coverage can be suspended.

The adoption of suspension policies is entirely up to the states. Thus, suspension policies vary drastically from state to state.[87] New York is

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gov/qfd/states/04/04013.html (last visited Oct. 2, 2015).

81. NAT'L ASS'N OF COUNTIES, *supra* note 13, at 3.

82. *Id.*

83. *Id.*

84. *Id.*

85. *Id.* (citing to this document's end note 13 which states "Oregon passed the Interim Incarceration Disenrollment Policy that prohibits termination of an individual's enrollment in Medicaid for the first 14 days of incarceration. Texas and Washington do not terminate coverage for the first 30 days of incarceration.").

86. NAT'L ASSOCIATION OF COUNTIES, COUNTY JAILS AND THE AFFORDABLE CARE ACT: ENROLLING ELIGIBLE INDIVIDUALS IN HEALTH COVERAGE 7 (Mar. 2012), http://www.naco.org/sites/default/files/documents/WebVersion_PWFIssueBrief.pdf.

87. CATHERINE MCKEE, ET AL., THE HENRY J. KAISER FAMILY FOUNDATION, STATE MEDICAID ELIGIBILITY POLICIES FOR INDIVIDUALS MOVING INTO AND OUT OF INCARCERATION 6 (2015), http://files.kff.org/attachment/issue-brief-state-medicaid-eligibility-policies-for-individuals-moving-into-and-out-of-incarceration ("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

currently the only state to allow inmates to retain their Medicaid suspension status indefinitely.[88] Other states, including Iowa and Indiana[89], suspend Medicaid eligibility, but the suspension cannot last for more than 12 months.[90] North Carolina only suspends eligibility for individuals in state prisons.[91] Arizona allows for suspension of eligibility in state prisons and certain county jails.[92] Arizona also does not allow for suspension if the individual is to remain incarcerated for 12 months or longer.[93] This is different than the policy adopted by Iowa and Indiana because Arizona determines whether to suspend or terminate Medicaid eligibility based on the length of their sentence, whereas Iowa and Indiana will allow an inmate to suspend eligibility for the first 12 months of their sentence, regardless of the length of the sentence.[94] The significance of the minutiae between Arizona's suspension policy and the suspension policy adopted by Iowa and Indiana is relevant to the discussion about federal reimbursements, which will be discussed in Part IV of this article.

Adopting an indefinite suspension policy modeled after New York could lessen the already light administrative burden surrounding suspension policies. Removing the complication of time would allow for an easier transition from termination policies to suspension policies. An indefinite suspension policy would also allow for states to receive federal reimbursement for longer periods of time. This will be discussed further in Part IV.

IV. THE BENEFITS OF ADOPTING A SUSPENSION POLICY

Establishing a continuum of care for inmates is of critical importance because "prisoners have significantly higher rates of physical and mental

being admitted as an inmate, 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.'").

88. COUNCIL OF ST. GOV'TS JUST. CTR., *supra* note 6, at 7–8 ("However, New York's approach is more administratively complicated than approaches in which states require the treating medical facility to bill Medicaid directly, and it fails to capture available federal funds that could be used to reimburse providers for allowable inpatient medical services provided to state prisoners. New York is working to change its policy to allow the state to access federal Medicaid funds for care provided to its incarcerated population in all allowable circumstances, i.e., for inmates of both jails and prisons, as well as to require health care providers to bill Medicaid directly rather than submitting for retroactive reimbursement.").

89. MCKEE, *supra* note 87, at 6 ("Indiana: 'When a recipient becomes incarcerated..., the individual's health coverage is to be suspended, not discontinue....The suspension continues until the individual is released from the facility, but will not exceed 12 months.'").

90. *Id.*

91. *Id.* ("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.'").

92. The Maricopa County Jail is the only county jail in Arizona that allows suspension of Medicaid eligibility for inmates. *Id.*

93. *Id.*

94. *Id.*

illness" compared to the general population.[95] This phenomenon is especially distinct with respect to HIV/AIDS, Hepatitis B and C, tuberculosis, chronic diseases, and mental illnesses.[96] In a study conducted in 2008 of 1,100 returning prisoners, "nearly all prisoners had chronic health conditions requiring treatment or management."[97]

A. Providing reentering prisoners with medical coverage immediately upon release will have a positive benefit on public health and welfare.

The high rate of chronic illness[98] in newly released inmates[99] only furthers the argument that inmates who enter prison with Medicaid eligibility should have that medical coverage immediately reinstated upon release. In the study conducted by Kamala Mallik-Kane and Christy A. Visher, 68 percent of men and 58 percent of women were without health insurance for eight to 10 months after release.[100] Most healthy individuals can survive eight to 10 months without seeing a doctor, but for the chronically ill, eight to 10 months is too long to wait. Mallik-Kane and Visher found that returning prisoners with physical or mental health conditions were "heavy consumers of health services, including emergency room visits and hospitalizations."[101] Despite the heavy consumption of health services, the "rates of treatment for specific health conditions deteriorated, suggesting that they received episodic care for acute problems but that continuous treatment of specific health conditions suffered."[102] Meaning, a newly released inmate who has asthma but does not have health insurance would likely go to the emergency room during an asthma attack, but they likely did not receive consistent treatment for asthma.

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95. Evelyn Malavé, Note, *Prison Health Care After the Affordable Care Act: Envisioning an End to the Policy of Neglect*, 89 N.Y.U. L. REV. 700, 701 (2014).

96. *Id.* at 701–02.

97. MALLIK-KANE, *supra* note 40, at 1.

98. *See id.* at 21 ("Asthma, hepatitis infection, and high blood pressure were the top three conditions reported. Men most commonly reported having high blood pressure (20 percent), hepatitis (11 percent), asthma (10 percent), high cholesterol (8 percent), and arthritis (7 percent). Women reported similar ailments, with asthma (25 percent), high blood pressure (23 percent), hepatitis (15 percent), back pain (15 percent), and arthritis (14 percent) being the most prevalent conditions.").

99. *See id.* at 1 ("Nearly all returning prisoners–8 in 10 men and 9 in 10 women–had chronic health conditions requiring treatment or management. One-half of men and two-thirds of women had been diagnosed with chronic physical health conditions such as asthma, diabetes, hepatitis, or HIV/AIDS. Fifteen percent of men and over one-third of women reported having been diagnosed with depression or another mental illness; the actual prevalence of mental health conditions is likely to be double the self-reported amount. About two-thirds of men and women reported active substance abuse in the six months before this incarceration. Returning prisoners often had more than one type of health problem. Roughly 4 in 10 men and 6 in 10 women reported a combination of physical health, mental health, and substance abuse conditions, including an estimated one-tenth of men and one-quarter of women with co-occurring substance abuse and mental health conditions.").

100. *Id.* at 2.

101. *Id.*

102. *Id.*

Without health insurance, individuals let their health deteriorate until they are in a situation so severe that it warrants a trip to the emergency room.

This situation is often referred to as a "sick care system" rather than a "health care system" by the media.[103] It draws upon the idea that health care should focus on preventing illness rather than reacting to illnesses as they occur.[104] When the uninsured allow their health to deteriorate to the point that a visit to the emergency room is necessary, they are embodying the worst aspects of reactive health care. This is especially alarming when considered in conjunction with the rate of chronic communicable diseases in prisons.[105]

Mallik-Kane and Visher found that released prisoners return in high volume to a small number of socioeconomically disadvantaged communities.[106] Mallik-Kane and Visher state that "if individuals are engaged in treatment, either in prison or after release, there is the potential to reduce the burden of illness and prevent further disease transmission."[107] Although Mallik-Kane and Visher do not have significant empirical data supporting their conclusions, the conclusions follow logically. Providing newly released inmates with health insurance immediately upon release could prevent further disease transmission.

B. Providing reentering prisoners with medical coverage immediately upon release will lead to a reduction in recidivism rates.

A study conducted by Joseph P. Morrissey, Ph.D., examined the relationship between inmates with severe mental illnesses[108] who were

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103. Jeffrey Levi, *Will We Have a Health Care System or a Sick Care System? A Tale of Two Futures*, HUFFINGTON POST (Jan. 19, 2013), http://www.huffingtonpost.com/jeffrey-levi/health-care_b_2427433.html.

104. *See id.*

105. MALLIK-KANE, *supra* note 40, at 21 ("Chronic communicable diseases are of particular importance to the public health since, without intervention, they can be transmitted to other prisoners, correctional staff, and the families and communities to which prisoners return. One-fifth of returning prisoners reported having been diagnosed with a chronic communicable disease (i.e., hepatitis, tuberculosis, and HIV). Hepatitis B or C infection (11 percent) was the most common communicable disease reported by men, followed by tuberculosis infection (5 percent), and HIV or AIDS (2 percent). Women reported similar rates of hepatitis (15 percent) and tuberculosis (4 percent), but were more likely to report having HIV or AIDS (6 percent).").

106. *Id.* at 8 ("Addressing the health problems of returning prisoners has the potential to improve individual health and reentry outcomes. The benefits may also extend beyond the individual to the communities in which returning prisoners reside. Released prisoners return in high concentrations to a small number of socioeconomically disadvantaged communities in America's urban centers. For example, Houston received one-quarter of all persons returning from Texas prisons, and 25 percent of those returned to just seven neighborhoods. Given the extent to which many individuals cycle in and out of correctional facilities, former prisoners comprise a respectable share of the population in certain communities. This concentration in some of the most disadvantaged urban areas has created a public health opportunity whereby attending to the health needs of prisoners and former prisoners may affect the course of a number of epidemics.").

107. *Id.*

108. Joseph P. Morrissey, Ph.D., et al., *The Role of Medicaid Enrollment and Outpatient*

receiving Medicaid benefits at release and those who were not and compared them on three indicators.[109] Of the three indicators Dr. Morrissey studied, the most notable was finding the number of subsequent arrests for former inmates in each category.[110] It is important to note that Morrissey only studied data from two counties during a two-year period.[111] These data cannot be generalized across the entire prison population, but the results warrant discussion.[112] Morrissey found that "having Medicaid at release was associated with a 16 percent reduction in the average number of subsequent detentions."[113]

Although a 16 percent reduction in subsequent detentions may seem insignificant, it is important to consider this in two different contexts. First, people are detained (incarcerated) for committing a crime. Thus, a 16 percent reduction in subsequent detentions is effectively a 16 percent reduction in crimes committed by this population. Second, each detention essentially represents an allocation of taxpayer dollars. Therefore, a 16 percent reduction in subsequent detentions could also represent a portion of tax dollars that are now available to be allocated to a different project. In his findings, Morrissey notes, "about 8 percent of all jail detainees have a severe mental illness. With more than 13 million annual admissions to U.S. jails, this means that about one million bookings of persons with severe mental illness occur each year."[114] If Morrissey's findings are extrapolated to the entire U.S. jail population, there could be a 16 percent reduction in the average number of subsequent detentions for approximately one million people each year.

To further emphasize Morrissey's findings, a study from Monterey County, California found that "inmates from the county jail who received treatment for behavioral health disorders after release spent an average of 51.74 fewer days in jail per year than those who did not receive treatment."[115] While this study was conducted on a relatively small population, the findings show that "[w]ithout access to housing, income, necessary mental health care

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Service Use in Jail Recidivism Among Persons With Severe Mental Illness, 58 PSYCHIATRIC SERVICES 794, 795 (2007), http://ps.psychiatryonline.org/doi/pdf/10.1176/ps.2007.58.6.794 (describing the identification of inmates with severe mental illness as "Medicaid claims files were used to identify all individuals with one of the following *DSM-IV* codes: schizophrenia. . . , affective disorders. . . , delusional disorder. . . , and psychotic disorder not otherwise specified. . . . The list of persons with severe mental illness obtained from the Medicaid records was lined to a detention file to identify all persons with severe mental illness who were detained during the study period.").

109. *Id.* at 794.

110. *Id.*

111. *Id.* at 795–96 ("The study was carried out in King County (Seattle) and in Pinellas County (Clearwater-St. Petersburg), Florida. These sites were selected because of the availability of administrative data that could be linked across Medicaid, jail, and mental health agency records.").

112. *Id.* at 799.

113. *Id.* at 794.

114. Morrissey, *supra* note 108, at 794.

115. NAT'L ASS'N OF COUNTIES, *supra* note 13, at 2.

or safety net programs, the mentally ill former inmate will almost certainly be re-incarcerated, typically within the first six months following release."[116]

C. Providing a continuity of health care will ease some of the pressures newly released inmates face when they return to the community.

When inmates are released from prison, they are at a highly vulnerable point in their lives. Inmates are often released only with the possessions they had upon incarceration and a small amount of money. For example, inmates "finishing their sentences at Rikers Island in New York are driven to Queens Plaza and released between 2 and 4 in the morning with three subway tokens."[117] Long periods of incarceration pose many challenges for inmates upon release. These challenges include loss of housing, unemployment, turbulence in social and familial relationships, and access to medical care.[118] Among those challenges, newly released inmates also face a "twelve-fold increase in the risk of death in the first two weeks after release."[119] Not only are reentering prisoners twelve times more likely to die from health problems within the first two weeks of release, they are also 129 times more likely to die of a drug overdose in those first two weeks than the general population.[120] Medicaid does not always cover all aspects of addiction treatment, but it may cover both inpatient and outpatient rehabilitation for drug addiction.[121] Many prisons provide newly released inmates with a supply of medication upon release, but oftentimes that portion of the discharge procedure is overlooked.[122] When the supply of medication runs out and the newly released inmates are faced with the pressures of reintegration, "many mentally ill former inmates turn to alcohol and drugs as a form of self-medication, become homeless, and eventually recidivate."[123]

In an ideal world, a reentering prisoner in a termination state will recognize that it is of the utmost importance to reapply for Medicaid immediately upon release. Nonetheless, the reentering prisoner may still face barriers to applying. The following is an example of how difficult it can be to apply for Medicaid in New York:

> To apply for Public Assistance, Food Stamps and Medicaid, an applicant must first figure out which Income Support Center to go to. The closest Income Support Center is not necessarily the right one; Income Support Centers are down-sizing and merging, and Income Support Centers' overworked staff sometimes tell new applicants

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116. Levesque, *supra* note 3, at 726.

117. Barr, *supra* note 24, at 14.

118. Levesque, *supra* note 3, at 724.

119. *See* COUNCIL OF ST. GOV'TS JUST. CTR., *supra* note 6, at 1.

120. Malavé, *supra* note 97, at 708.

121. *Alcohol and Drug Rehabs that Accept Medicaid*, REHABCENTER.NET, http://www.rehab
center.net/rehabs-that-accept-medicaid/ (last visited Nov. 13, 2015).

122. Levesque, *supra* note 3, at 729.

123. *Id.* at 724.

> that the Center is not taking any more applications. Once the appropriate center is located, the applicant must arrive before 9 a.m., complete a complicated application form, present identification and documentation of rent expenses and/or lack of cooking facilities, and be interviewed by a caseworker.
>
> The applicant will then be directed to the Eligibility Verification Review office in Brooklyn Heights for a painstaking interview intended to detect fraud. Then, Eligibility Verification Review will send the Front End Detection System workers, who carry badges and announce themselves as "the FEDS," to visit the applicant's house and verify residence. If, after three visits, the FEDS have not found the applicant at home, the case will be closed.[124]

It is important to note that the above excerpt was taken from an interview conducted in 2003. The procedure has changed in the past 13 years, but it is still difficult.[125] There are new challenges facing newly released individuals trying to apply for Medicaid that were not an issue at the time of the interview, including the rapid digitalization of many things and the difficulty a newly released inmate would have accessing the internet. As if this procedure is not daunting enough, most people who must go through these steps are physically or mentally ill and in need of continued or immediate medical assistance without the 45-to-90-day delay.

Although newly released inmates likely recognize the importance of promptly submitting an application for an eligibility determination under Medicaid, the basic human needs of food and shelter often take priority.[126] Former inmates tend to first focus on finding a source of income and

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124. Barr, *supra* note 24, at 20–21.

125. In order to understand the new challenges facing recently released individuals, I attempted to apply for Medicaid. I began by searching the phrase "how to apply for Medicaid" on Google.com. Google attempted to answer my question directly with a quote from a website. The Google-generated answer stated "You can also apply by phone by calling your local Medicaid office. In most states, you can also apply online, or find an application online that you can complete and mail to the local office. Contact your State Medical Assistance Office to find out where and how you can apply for Medicaid benefits." *Applying for Medicaid*, LONGTERMCARE.GOV, http://longtermcare.gov/medicare-medicaid-more/medicaid/applying-for-medicaid/ (last visited Feb. 9, 2016). I continued to the next link, which directed me to www.medicaid.gov. As I continued through the steps on the website, I was faced with difficult question after difficult question. The application was so overwhelming that I gave up after about 45 minutes. I was not dealing with any of the challenges that inmates face when they are released from prison, and I could not handle the intensity of the application process. We have a tendency to assume that online applications have made everything simpler, but to someone who has had limited or no computer access for a long period of time, the idea of applying for Medicaid online could seem like a daunting task. This daunting task is only made more impossible when you consider that many recently released individuals do not have regular and reliable computer or internet access.

126. MALLIK-KANE, *supra* note 40, at 14 ("Returning prisoners face a challenging transition regardless of their health conditions. They must find housing and a means to support themselves, both of which often depend on their ability to reconnect with family members and social networks. Maintaining sobriety and refraining from criminal activity are also important to avoiding a return to prison.").

somewhere to live.[127] One study found that as many as "40 percent of men and 59 percent of women reported at least one change in residence" over the course of the first eight to ten months after release.[128] This delays their Medicaid eligibility determination application, which results in a longer amount of time spent without adequate medical care. Former inmates, especially those with serious mental illness or substance abuse problems, may run out of medication or relapse, raising the risk of recidivism.[129] Providing a continuum of care for inmates provides a level of stability that is necessary for a smooth transition from prison to society and then to stay out of prison.

D. States have an opportunity to save a significant amount of money by filing for federal reimbursement.

Perhaps the most convincing argument in favor of adopting a suspension policy is the chance for states to save significant amounts of money. "Although federal Medicaid funds are not available for most care provided to individuals while incarcerated, states may receive Medicaid reimbursement for care provided to [Medicaid] eligible individuals admitted as inpatients to a medical institution, such as a hospital, nursing facility, psychiatric facility, or intermediate care facility."[130] In states with suspension policies, inmates may receive Medicaid coverage for inpatient services.[131] That is, any time an inmate who is Medicaid eligible is admitted as an inpatient to a medical institution, the state may receive Medicaid reimbursement for the services provided.

To fully understand federal reimbursements, we must turn back to *Estelle v. Gamble* and the Eighth Amendment.[132] In *Estelle*, the Supreme Court noted that the Eighth Amendment forbids more than just physically barbarous punishments.[133] The Eighth Amendment "embodies 'broad and idealistic concepts of dignity, civilized standards, humanity, and decency' against which we must evaluate penal measures."[134] The language of the Eighth Amendment also establishes the government's duty to provide medical care for those whom it is punishing by incarceration.[135] If authorities fail to provide adequate medical care to inmates, that failure could produce "physical torture or a

127. *Id.* at 15 ("Finding a place to live is perhaps the first challenge that returning prisoners face upon release. When we surveyed respondents in the month before release, nearly one-third had not made arrangements for a place to live.").

128. *Id.* (Medicaid applications require applicants to list their current address. Whenever someone with Medicaid coverage changes residence, they must amend their Medicaid application so that it lists their new address. I was unable to find a source that described what would happen if a Medicaid applicant attempted to update their address while awaiting their initial eligibility determination.).

129. Levesque, *supra* note 3, at 724.

130. MCKEE, *supra* note 87.

131. *Id.*

132. Estelle v. Gamble, 429 U.S. 97, 102 (1976).

133. *Id.* at 102.

134. *Id.*

135. *Id.* at 103.

lingering death."[136]

Just as the government has a duty to provide medical care for those whom it punishes by incarceration, the government does not have a duty to provide medical care for individuals who are not inmates of a public institution. When an inmate becomes a patient in a medical institution, the inmate exclusion rule goes into effect, allowing the use of federal Medicaid funding.[137] A letter from the Department of Health and Human Services addressed to all Associate Regional Medicaid Administrators stated, "Section 1905(a)(29)(A) of the Social Security Act specifically excludes Federal Financial Participation (FFP) for medical care provided to inmates of a public institution, except when the inmate is a patient in a medical institution."[138] Federal Financial Participation is not available for when states have contracted with a private health care entity to provide medical care inside the public institution to its inmates.[139] The exception to the prohibition of FFP is only permitted when an inmate is "admitted as an inpatient[140] in a hospital, nursing facility, juvenile psychiatric facility, or intermediate care facility."[141]

As discussed earlier, the statutory federal financial participation exclusion precludes inmates of public institutions from using Medicaid coverage to assist in paying for medical care or services.[142] The reconciliation between these two competing Medicaid provisions is described in a letter authored by Richard Allen, a CMS Associate Regional Administrator in Part III(B).[143] Allen writes, "if the setting [of the medical care] is a hospital accredited as such and not created for the purposes of law enforcement and incarceration (which is separate from the law enforcement system), then the individual is not considered and [*sic*] inmate. FFP would be available."[144] Simply, the Medicaid "inmate exclusion" rule would not apply because the individual would not be considered an inmate[145] during the hospital stay. Essentially, the states would be able to ask the government to pay them back for some medical expenses.

In suspension states that expanded Medicaid coverage under the PPACA, the savings have been quite substantial. In 2013, California received $38.5

136. *Id.*

137. Letter from Streimer, *supra* note 1, at 2.

138. *Id.* at 1.

139. *Id.* at 2.

140. *Id.* ("The inmate must be admitted as an inpatient. Medical care administered on an outpatient basis does not qualify for FFP. FFP is also not available when an inmate is taken to a prison hospital or dispensary.").

141. *Id.*

142. 42 U.S.C. § 1396d(a)(29)(A) (2006).

143. *See* COUNCIL OF ST. GOV'TS JUST. CTR., *supra* note 6, at 21–27.

144. *Id.* at 22 (answering the question "if an individual is incarcerated in a state prison or county jail and then transferred to the inpatient hospital setting, is the individual still considered an inmate under 42 C.F.R. § 435.1010 and ineligible for FFP?").

145. *Id.* at 21 ("If the individual is in a hospital that is separate from the prison system and the individual becomes and [*sic*] inpatient of that hospital, then the individual is not considered to be an inmate of a public institution.").

million by taking advantage of this statutory exception.[146] Even states that did not expand Medicaid coverage under the PPACA can receive a substantial amount of money. In 2013, North Carolina, a non-expansion state, received $2.5 million in federal reimbursements.[147] Similarly, Kentucky saved an estimated $11 million in correctional spending due to federal reimbursement for inpatient costs for incarcerated individuals in the 2015 fiscal year.[148] Michigan and Colorado expect to save $13.2 million and $5 million respectively in 2015.[149]

These reimbursements only amount to between 0.3 and 1 percent of the state prison health care budget, but these small reductions in spending can amount to huge amounts of progress for states. For example, Michigan is expected to save approximately $13.2 million in FY 2015 due to federal reimbursements for inmates under Medicaid.[150] For a state with an annual budget of approximately $51 billion, the savings may seem nominal.[151] However, several of the initiatives in Governor Rick Snyder's planned budget for FY 2014–15 could be entirely funded with Michigan's predicted savings.[152] One provision recommends a "2 percent increase ($5.8 million) be allocated for the community colleges," with an additional $1.1 million set aside for a "Virtual Learning Collaborative" to "increase student access to online courses."[153] With the money saved, the Governor could fully fund these two projects with enough left over to invest the recommended $2.5 million to "reduce Michigan's infant mortality rate."[154] The potential to alleviate state budgets should be more than enough to convince reluctant states to adopt suspension policies. These federal reimbursements would make up for any initial financial burden states would incur in the course of implementing a suspension policy.

V. CONCLUSION

The Supreme Court ruled that states must provide inmates with medical care in accordance with the Eighth Amendment's prohibition on cruel and unusual punishment.[155] Currently, that affirmative duty does not extend to reuniting inmates with the health care coverage they had prior to incarceration.

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146. 42 U.S.C. § 1396d(a)(29)(A) (2006); U.S. GOV'T ACCOUNTABILITY OFFICE, *supra* note 27, at 5–6.

147. U.S. GOV'T ACCOUNTABILITY OFFICE, *supra* note 27, at 6.

148. MCKEE, *supra* note 87.

149. *Id.*

150. DEBORAH BACHRACH, ET. AL., STATES EXPANDING MEDICAID SEE SIGNIFICANT BUDGET SAVINGS AND REVENUE GAINS, ROBERT WOOD JOHNSON FOUNDATION (Apr. 2015), http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2015/rwjf419097.

151. DEP'T OF TECH., MGMT. AND BUDGET, EXECUTIVE BUDGET: FISCAL YEARS 2014 AND 2015 A-2 (Feb. 7, 2013), http://www.michigan.gov/documents/budget/1_410735_7.pdf.

152. *Id.*

153. *Id.* at A-5.

154. *Id.* at A-7.

155. *See* Estelle v. Gamble, 429 U.S. 97, 104 (1976).

The policies in place to terminate Medicaid eligibility for inmates upon incarceration are outdated and burdensome for every party involved.

The benefits of modifying policies and procedures so that Medicaid eligibility is suspended rather than terminated far outweigh the administrative burden that would arise out of the policy change. Newly released inmates would benefit substantially from having a continuity of care. Additionally, states stand to gain many benefits in the form of federal reimbursements and reduced rates of recidivism. Finally, the Centers for Medicare and Medicaid Services not only allow, but also encourage states to adopt a suspension policy. State Medicaid administrators and Departments of Corrections must amend their policies to suspend, rather than terminate, Medicaid for incarcerated individuals. Implementing suspension policies across the United States would be a drastic improvement upon the system that is currently in place.