

# STATE OF NORTH CAROLINA

**PERFORMANCE AUDIT**

**DEPARTMENT OF CORRECTION  
INMATE MEDICAID ELIGIBILITY**

**AUGUST 2010**

**OFFICE OF THE STATE AUDITOR**

**BETH A. WOOD, CPA**

**STATE AUDITOR**

**PERFORMANCE AUDIT**

**DEPARTMENT OF CORRECTION  
INMATE MEDICAID ELIGIBILITY**

**AUGUST 2010**



Beth A. Wood, CPA  
State Auditor

STATE OF NORTH CAROLINA  
**Office of the State Auditor**

2 S. Salisbury Street  
20601 Mail Service Center  
Raleigh, NC 27699-0601  
Telephone: (919) 807-7500  
Fax: (919) 807-7647  
Internet  
<http://www.ncauditor.net>

August 18, 2010

The Honorable Beverly Eaves Perdue, Governor  
Members of the North Carolina General Assembly  
Mr. Alvin W. Keller, Jr., Secretary, Department of Correction

Ladies and Gentlemen:

We are pleased to submit this performance audit titled *Inmate Medicaid Eligibility*. The audit objective was to determine if the Department of Correction could reduce inmate health care costs by requiring hospitals and other medical service providers to bill Medicaid for eligible inmate inpatient hospital and professional services. Mr. Keller reviewed a draft copy of this report. His written comments are included in the appendix.

The Office of the State Auditor initiated this audit to identify opportunities for cost-savings.

We wish to express our appreciation to the staff of the Department of Correction for the courtesy, cooperation, and assistance provided us during the audit.

Respectfully submitted,

A handwritten signature in cursive script that reads "Beth A. Wood".

Beth A. Wood, CPA  
State Auditor

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## **SUMMARY**

### **PURPOSE**

This audit report evaluates whether the Department of Correction (Department) could reduce inmate health care costs by requiring hospitals and other medical service providers to bill Medicaid for eligible inmate inpatient hospital and professional services and makes recommendations so Department management can take appropriate corrective action.

### **RESULTS**

The Department could save about \$11.5 million a year by requiring hospitals and other medical service providers to bill Medicaid for eligible inmate inpatient hospital and professional services. Because the federal government reimburses the State approximately \$.65 for every \$1.00 spent on Medicaid, billing Medicaid for eligible inmate health care would reduce the Department's costs by transferring those costs to the federal government. The Department would also realize reduced costs because hospital and medical services for eligible inmates would be paid at Medicaid rates that are lower than the rates currently paid by the Department.

To realize these savings, the Department may need to obtain or train Medicaid eligibility specialists and establish procedures to determine Medicaid eligibility for inmates and ensure that Medicaid eligibility is not terminated when inmates return from medical institutions. Federal reimbursement is available to offset some of the administrative costs that the Department may incur.

Although not within the scope of this audit, local governments could also realize savings by requiring medical providers to bill Medicaid for eligible inmate health care. Inquiry of officials in two counties and an organization that manages inmate health care for 45 counties indicates that local governments do not bill Medicaid for any inmate health care.

### **RECOMMENDATIONS**

The Department should require hospitals and other medical providers to bill Medicaid for eligible inmate inpatient health care costs. The Department should work with the Department of Health and Human Services, County Directors of Social Services, and local governments to establish the necessary policies and procedures.

### **AGENCY'S RESPONSE**

The Agency's response is included in the Appendix A.

## INTRODUCTION

### **BACKGROUND**

The Eighth Amendment of the United States Constitution requires states to provide inmates with adequate medical treatment. In accordance with the Constitution, North Carolina General Statute 148-19 requires the Department of Correction (Department) to provide health services to prisoners.

The Department cooperates with 35 hospitals to provide medical services for over 40,000 inmates housed in 71 prison facilities across the State.

During the 2008 and 2009 calendar years, the Department paid about \$159.8 million for inmate health care.

### **OBJECTIVES, SCOPE, AND METHODOLOGY**

The audit objective was to determine if the Department could reduce inmate health care cost by requiring hospitals and other medical service providers to bill Medicaid for eligible inmate inpatient hospital and professional services.

The Office of the State Auditor initiated this audit to identify opportunities for cost-savings.

The audit scope included the Department's inmate medical costs and inmate medical information for calendar years 2008 and 2009. We conducted the fieldwork from March to June 2010.

To determine if the state could reduce inmate health care costs, we interviewed Department staff and reviewed inmate medical claims data. We obtained the services of specialists to identify inmates who were likely Medicaid eligible and to calculate potential savings. We obtained a letter from the Centers for Medicare & Medicaid Services to clarify federal regulations concerning inmate Medicaid eligibility. We interviewed Department of Health and Human Services, Division of Medical Assistance staff. We interviewed personnel from states that charge Medicaid for inmate health care costs.

Because of the test nature and other inherent limitations of an audit, together with limitations of any system of internal and management controls, this audit would not necessarily disclose all performance weaknesses or lack of compliance.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

We conducted this audit under the authority vested in the State Auditor of North Carolina by *North Carolina General Statute 147.64*.

## FINDINGS AND RECOMMENDATIONS

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### **\$11.5 MILLION A YEAR IN INMATE HEALTH CARE COST SAVINGS IS AVAILABLE**

The Department of Correction (Department) could save about \$11.5 million a year by requiring hospitals and other medical service providers to bill Medicaid for eligible inmate inpatient hospital and professional services.<sup>1</sup> The amount of potential savings will increase when health care reform expands Medicaid eligibility in 2014. To realize these savings, the Department will need to determine Medicaid eligibility for inmates and ensure that Medicaid eligibility is not terminated when inmates return from medical institutions. Although not within the scope of this audit, it is also possible that local governments could reduce costs by charging eligible inmate health care to Medicaid.

#### **Bill Eligible Inmate Inpatient Health Care Costs to Medicaid**

Currently, the Department does not require hospitals or other medical service providers to bill Medicaid for any inmate health care costs. The Department pays for inmate health care at rates significantly higher than Medicaid rates. A previous state audit concluded that the Department pays an average of 467% (from 198% to as high as 879%) of Medicaid rates for inmate health care costs.<sup>2</sup>

The Department could reduce its inmate health care costs if medical providers billed Medicaid for inpatient services provided to Medicaid-eligible inmates. Inmates could be Medicaid eligible if they meet the Medicaid eligibility requirements, which include income and resource limits, citizenship and alien status, state of residence, 20 years old or younger, 65 years old or older, pregnant, blind, or disabled. Inmates could also be Medicaid eligible if they are considered physically or mentally disabled under the federal Supplemental Security Income (SSI) program. There are nine diagnostic categories of mental disorders under SSI including personality disorders and substance addiction disorders, which may establish disability.

Generally, the federal government will not reimburse states (called federal financial participation or FFP) for inmate medical care under the Medicaid program. However, an exception is allowed “during that part of the month in which the individual is not an inmate of a public institution.”<sup>3</sup> For purposes of FFP, guidance from the Centers for Medicare and Medicaid Services<sup>4</sup> (CMS) indicates that inmates lose their “inmate status” and obtain “inpatient status” when treated in an inpatient hospital setting that is not under the control of a state’s correction system. Consequently, FFP is available for an inmate’s health care expenses if the inmate is Medicaid eligible and he or she is an inpatient of a medical institution.

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<sup>1</sup> Medicaid is a health insurance program funded by a state and federal partnership for low-income parents, children, seniors, and people with disabilities. The federal government provides a federal match to state government funding by reimbursing states a percentage of their Medicaid expenditures.

<sup>2</sup> Office of the State Auditor. Department of Correction Fiscal Control Audit. February 2010

<sup>3</sup> 42 CFR 435.1008

<sup>4</sup> CMS is part of the US Department of Health and Human Services. CMS is the federal agency that administers Medicare, Medicaid, and the Children’s Health Insurance Program.

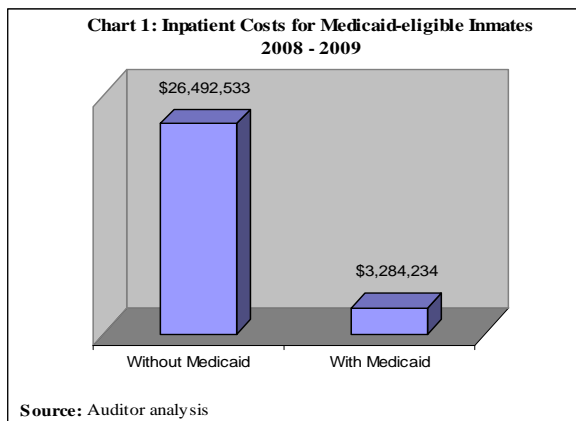
## FINDINGS AND RECOMMENDATIONS

Correspondence from the CMS, formerly known as the Health Care Finance Administration (HCFA), a letter from the North Carolina Department of Health and Human Services (DHHS), and the experiences of five states confirm that FFP is available for inmate inpatient health care. Specifically:

- A May 4, 2010, CMS letter to the State Auditor says, “The North Carolina Medicaid program potentially could have been billed by enrolled Medicaid hospitals for services provided to inmates that are inpatients and are also Medicaid beneficiaries. Charges for professional services that occurred during the inpatient stays may also be billed on the Medicaid program.”<sup>5</sup>
- HCFA letters from 1997 and 1998 state, “An exception to the prohibition of FFP is permitted when an inmate becomes a patient in a medical institution. This occurs when the inmate is admitted as an inpatient in hospital, nursing facility, juvenile psychiatric facility, or intermediate care facility. Accordingly, FFP is available for any Medicaid covered services provided to an ‘inmate’ while an inpatient in these facilities provided the services are included under a State’s Medicaid plan and the ‘inmate’ is Medicaid eligible.”<sup>6</sup>
- An August 27, 2008, DHHS letter to County Directors of Social Services notes that “medical services received during an inpatient hospital stay for an incarcerated recipient” who is Medicaid eligible can be charged to Medicaid.<sup>7</sup>
- Five states (Louisiana, Mississippi, Nebraska, Oklahoma, and Washington) report that they charge eligible inmate inpatient health care to their Medicaid programs.

Billing Medicaid for eligible inmate health care costs would reduce the Department’s costs in two ways. First, the Department would realize reduced costs because hospital and medical services for eligible inmates would be reimbursed at Medicaid rates that are lower than the rates currently paid by the Department. Second, billing Medicaid for eligible inmate health care would reduce the Department’s costs by transferring those costs to the federal government because the federal government reimburses the State about \$.65 for every \$1.00 spent on Medicaid.

For example, Chart 1 shows that the Department paid about \$26.5 million in inpatient medical care for inmates who were potentially Medicaid eligible during the 2008 and 2009 calendar years. At Medicaid rates, those services would have only cost the Department about \$9.2 million, a \$17.3 million savings. Additionally, the federal government would have reimbursed the State about \$5.9 million. As a result, total cost to the



<sup>5</sup> See appendix

<sup>6</sup> See appendix

<sup>7</sup> Division of Medical Assistance. DMA Administrative Letter No: 09-08, Medicaid Suspension. August 27, 2008



## FINDINGS AND RECOMMENDATIONS

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State would have been about \$3.3 million instead of \$26.5 million, a two-year savings of \$23 million or \$11.5 million a year.

Assuming that CMS does not change its current policy on inmate Medicaid eligibility, the Department could realize additional savings from the new health care reform law. Beginning January 1, 2014, the Patient Protection and Affordable Care Act “establishes a new eligibility category for all non-pregnant, non-Medicare eligible childless adults under age 65 who are not otherwise eligible for Medicaid and requires minimum Medicaid coverage at 133% FPL [federal poverty level].”<sup>8</sup> Consequently, more inmates will become Medicaid eligible in 2014. Furthermore, states will receive 100% federal reimbursement for “newly eligible individuals” during the first three years: January 2014 through December 2016.<sup>9</sup>

### **Determine Inmate Medicaid Eligibility and Prevent Eligibility Termination**

The Department does not currently have procedures in place to determine if an inmate who needs inpatient medical services is Medicaid eligible. Furthermore, the Department does not have personnel assigned to determine Medicaid eligibility.

To realize the potential cost-savings described above, the Department may need to obtain or train Medicaid eligibility specialists and will need to establish procedures to determine if inmates who are sent to medical institutions for inpatient services are Medicaid eligible. Medicaid eligibility for inmates can be determined at any time before, during, or after incarceration. In a 2004 letter to State Medicaid Directors,<sup>10</sup> CMS said:

As a reminder, the payment exclusion under Medicaid that relates to individuals residing in a public institution or an IMD [Institute for Mental Disease] 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.

Additionally, the State should be able to recover 50% of administrative costs the Department incurs for staffing, training, and performing Medicaid eligibility determinations. Federal regulations state FFP is available for salaries, fringe benefits, travel, training, and necessary administrative costs incurred in determining Medicaid eligibility.<sup>11</sup>

Failure to timely determine Medicaid eligibility, however, can cost the Department money. For example, the Department cannot recover about \$23.2 million in potential savings for calendar years 2008 and 2009. During that period, the Department paid

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<sup>8</sup> The Henry J. Kaiser Family Foundation. Medicaid and Children’s Health Insurance Program Provisions in the New Health Reform Law. April 2010

<sup>9</sup> Patient Protection and Affordable Care Act, Section 2001.(a)(3)

<sup>10</sup> Letter from CMS to State Medicaid Directors dated May 25, 2004. Subject: Ending Chronic Homelessness.

<sup>11</sup> 42 CFR 432.50 and 42 CFR 435.1001

## FINDINGS AND RECOMMENDATIONS

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inpatient health care costs for 646 inmates who were potentially eligible for Medicaid. Federal regulations allow states two years to file and recover reimbursement for Medicaid claims if the individual was Medicaid eligible at the time of service.<sup>12</sup> But states can only look back three months before the eligibility application was filed to obtain retroactive reimbursement for Medicaid-eligible expenses.<sup>13</sup> Consequently, the Department cannot recover the potential savings identified for calendar years 2008 and 2009.

After determining eligibility, the Department will also need to ensure that Medicaid eligibility is not terminated when inmates return from the hospital. CMS recommends, “Once determined eligible, the inmates remain eligible and their cases should be placed in a suspension status during their incarceration.”<sup>14</sup>

It may also be advantageous for the Department to work with DHHS and local governments to ensure that Medicaid-eligible inmates do not have their eligibility status terminated when they are first incarcerated. In a September 2008 letter, DHHS directed County Directors of Social Services to suspend the Medicaid benefits of newly incarcerated individuals for the remainder of his or her “certification/payment review period.”<sup>15</sup> However, the Department may want to work with the County Directors of Social Services to ensure that the counties are aware of and follow the DHHS policy.

### **Savings Possible for Local Governments**

Although not within the scope of this audit, local governments could also realize savings by requiring medical providers to bill Medicaid for eligible inmate health care. Inquiry of officials in two counties and an organization that manages inmate health care for 45 counties indicates that local governments do not bill Medicaid for any inmate health care.

The amount of savings that local governments will realize will depend on the number of inmates that are Medicaid eligible and on the rates currently paid for inmate care. As noted above, however, the amount of potential savings will increase in January 2014 when the new health care reform law expands Medicaid eligibility.

**Recommendation:** The Department should charge Medicaid for eligible inmate inpatient health care costs. The Department should work with DHHS, County Directors of Social Services, and local governments to establish the necessary policies and procedures.

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<sup>12</sup> 45 CFR 95.7

<sup>13</sup> 42 U.S.C. 1396a.(a)(34)

<sup>14</sup> Letter from CMS to the State Auditor dated May 4, 2010.

<sup>15</sup> Division of Medical Assistance. DMA Administrative Letter No: 09-08, Medicaid Suspension. August 27, 2008

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## APPENDIX

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### Auditee Response



### North Carolina Department of Correction

214 West Jones Street • 4201 MSC • Raleigh, NC 27699-4201

Beverly Eaves Perdue  
Governor

Alvin W. Keller, Jr.  
Secretary

August 9, 2010

The Honorable Beth A. Wood, State Auditor  
Office of the State Auditor  
2 South Salisbury Street  
20601 Mail Service Center  
Raleigh, North Carolina 27699-0601

Dear Ms. Wood:

This letter is in response to your performance audit entitled “Inmate Medicaid Eligibility”. We are constantly seeking ways to improve the performance of our operations and your audit staff is always helpful to us in evaluating how we conduct our business.

#### **Finding: \$11.5 Million a Year in Inmate Health Care Cost Savings is Available**

##### **Section 1: Bill Eligible Inmate Inpatient Health Care Costs to Medicaid**

The Department of Correction agrees with the finding that it currently does not require hospitals or other medical service providers to bill Medicaid for any inmate care cost. The Department agrees that savings can be realized once it has implemented the procedures for determining inmate eligibility for Medicaid. However, the Department is not certain it will realize the “potential” savings noted in the audit findings, as shown in Chart 1. It is anticipated that a portion of the amount of prospective “potential” savings associated with Medicaid reimbursement will be offset by the implementation of the provisions in Senate Bill 897, which allows the Department to reimburse medical service providers at a rate not to exceed 70% of billed charges. It is anticipated that some portion of future potential savings will be realized as a result of more favorable contracts with the hospitals and other medical service providers.

The Department is currently developing the policies and procedures for the identification of Medicaid eligibility for inmates being admitted to community hospitals for in-patient services, as well as for the procedures to ensure the costs for such services are reimbursed by Medicaid. The Department, working jointly with DHHS, is working for a September 2010 implementation date, and to review all hospital admissions beginning July 1, 2010 for possible reimbursement through Medicaid. The Department is also working to establish new contracts with medical service providers to incorporate Medicaid reimbursement, when and where applicable.

The costs for implementation has not yet been substantiated, however, it is expected to be between \$100,000 to \$200,000. There is likely to be additional costs realized by both DOC and DHHS as we develop methods for data collection and exchange. Likewise, we are examining

## APPENDIX

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the need for additional staff resources to manage the process for identifying Medicaid eligibility, as well as the costs associated with training staff across the state.

Implementation of procedures to determine Medicaid eligibility for inmates and requiring Medicaid reimbursement for inpatient hospital admissions is expected to create a savings to the Department's medical budget. In light of the \$20.5 million dollar budget reduction taken by the Department during FY 2010-11, these potential savings will, in part, provide the Department with a better opportunity to manage the medical budget. Implementation will also ensure compliance with Section 19.6(c) of Senate Bill 897.

### **Section 2: Determine Inmate Medicaid Eligibility and Prevent Eligibility Termination**

We do not disagree with this issue. However, it is important to note that NCDOC has established a workgroup, in partnership with DHHS, to establish such a procedure.

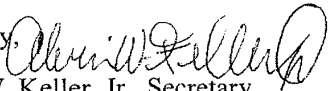
The goal of this workgroup is to create and implement a process to identify and access Medicaid eligibility for inmates in the Department of Correction pursuant to Section 19.6 (c) of Special Provision entitled Inmate Medical Cost Containment that was passed by the General Assembly in its most recent session. This provision is a part of Senate Bill 897.

Having inmates who are eligible for Medicaid coverage during hospitalization is anticipated to facilitate cost containment in provision of health care services to inmates during incarceration as well as expedite the Medicaid eligibility determination process in aftercare planning. Participation in this project is also expected to assist the Department of Health and Human Services/Division of Medical Assistance to more readily identify those Medicaid recipients who are incarcerated and have had their benefits suspended. The process/procedures established are intended to enable NCDOC to identify those entering prison who are Medicaid eligible, thereby allowing NCDOC to have on record eligibility status of its inmate.

Through all planned processes/procedures, DHHS/DMA will be able to identify inmates whose incarceration has not been reported and they continue to receive Medicaid benefits during a period of ineligibility, frequently resulting in Medicaid fraud. The work done in this partnership will benefit the two agencies and help the State of North Carolina in its efforts to reduce spending.

We appreciate the objectivity, expertise and professionalism exhibited by your staff during the course of the audit. We wish to express our appreciation for the audit work performed by your staff and for their recommendations which will guide us in improving the way we conduct business.

Sincerely,

  
Alvin W. Keller, Jr., Secretary

N.C. Department of Correction

# Office of the State Auditor



**Beth A. Wood, CPA**  
State Auditor

2 S. Salisbury Street  
20601 Mail Service Center  
Raleigh, NC 27699-0601  
Telephone: (919) 807-7500  
Fax: (919) 807-7647  
Internet  
<http://www.ncauditor.net>

April 8, 2010

Ms. Jackie Glaze, Associate Regional Director  
Center for Medicare and Medicaid Services  
Office of the Regional Administrator  
Atlanta Federal Center  
61 Forsyth Street, SW, Suite 4T20  
Atlanta, Georgia 30303-8909

RE: Medicaid Coverage Policy for Inmates of a Public Institution

Dear Ms. Glaze:

My Office is conducting a performance audit of the North Carolina Department of Correction. Specifically, we are addressing the Department's expenditures attributable to inpatient care for inmates.

As part of this audit we are addressing whether the State's Medicaid program could have been billed by enrolled Medicaid hospitals for inpatient services provided to inmates that otherwise met qualifications to be Medicaid beneficiaries. Similarly, we are assessing whether professional service charges associated with these inpatient episodes would have been Medicaid eligible.

The Social Security Act excludes Federal Financial Participation (FFP) for medical care provided to inmates of a public institution. In reviewing all available guidance from CMS and other applicable regulations, however, there appears to be clear, consistent language supporting a process whereby inmates lose their "inmate status" and garner "inpatient status" when being treated in a non-Correction, inpatient, hospital setting.

Specifically, a 1998 HCFA Program Issuance Transmittal Notice Region IV on the subject "Clarification of Medicaid Coverage Policy for Inmates of a Public Institution" reads in part:

An exception to the prohibition of FFP is permitted when an inmate becomes a patient in a medical institution. This occurs when the inmate is admitted as an inpatient in hospital, nursing facility, juvenile psychiatric facility, or intermediate care facility. Accordingly, FFP is available for any Medicaid covered services provided to an 'inmate' while an inpatient in these facilities provided the services are included under a State's Medicaid plan and the 'inmate' is Medicaid-eligible.

Ms. Jackie Glaze, Associate Regional Director

April 8, 2010

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Although North Carolina's State Plan, like many others we have reviewed, stipulates that inmates are not Medicaid eligible, my staff views this as general guidance consistent with the Social Security Act, CMS policy, and the Code of Federal Regulations. My staff does not see this language as precluding inmates from accessing Medicaid if the inmates are treated in an inpatient hospital (acute or psych) setting that is not part of the Department of Correction.

Will you please assist me by clarifying that Medicaid inpatient hospital services and associated professional services would be available to incarcerated individuals that otherwise meet the State's Medicaid eligibility criteria?

Would the State need to revise its Medicaid State Plan in any manner in order to avail itself of FFP for these inpatient hospital and professional services?

Lastly, would the State be able to retroactively claim FFP for these individuals for a period of twenty-four months?

I very much appreciate your time and consideration in assisting me with these questions and I look forward to your reply.

Sincerely,



BETH A. WOOD, CPA  
STATE AUDITOR

Department of Health & Human Services  
Centers for Medicare & Medicaid Services  
61 Forsyth Street, Suite 4T20  
Atlanta, Georgia 30303-8909



May 4, 2010

Ms. Beth A. Wood, CPA  
State Auditor  
2 S. Salisbury Street  
20601 Mail Service Center  
Raleigh, NC 27699-0601

Dear Ms. Wood:

This letter is in response to your letter dated April 8, 2010 regarding Medicaid coverage policy for inmates of a public institution.

Eligibility must be determined for each inmate in accordance with the standard eligibility determination process used by North Carolina Medicaid. Once determined Medicaid eligible, the inmates remain eligible and their cases should be placed in a suspension status during their incarceration. While incarcerated, Medicaid payment is only available when the inmate is an inpatient in a medical institution not under the control of the corrections system. Such institutions include a hospital, nursing facility, juvenile psychiatric facility, or intermediate care facility.

The North Carolina Medicaid program potentially could have been billed by enrolled Medicaid hospitals for inpatient services provided to inmates that are inpatients and are also Medicaid beneficiaries. Charges for professional services that occurred during the inpatient stays may also be billed to the Medicaid program. However, FFP is not available for professional services that occurred when the inmate is not an inpatient in a hospital, nursing facility, juvenile psychiatric facility, or intermediate care facility. Since inpatient services and professional services are already covered services under the State Plan, we do not believe that the North Carolina State Plan would have to be changed.

In accordance with 45 CFR Part 95.13(b), we consider a State agency's expenditures for services under Title XIX to have been made in the quarter in which any State agency made a payment to the service provider. We will only consider FFP for services provided to individuals currently eligible for Medicaid.

If you have any further questions regarding this letter please contact Elaine Elmore of my staff at (404) 562-7408.

Sincerely,

A handwritten signature in cursive script that reads "Jackie L. Glaze".

Jackie L. Glaze  
Acting Associate Regional Administrator  
Division of Medicaid & Children's Health Operations



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**HCFA PROGRAM ISSUANCE**  
**Transmittal Notice**  
**REGION IV**

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**DATE:** March 6, 1998

**PROGRAM IDENTIFIER:** MCD-05-98

**TO:** Title XIX Agencies and Welfare Agencies  
in AL, FL, GA, KY, MS, NC, SC, TN

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**SUBJECT:** Clarification of Medicaid Coverage Policy for Inmates of a Public Institution

The purpose of this Health Care Financing Administration Program Issuance Transmittal Notice (PITN) is to clarify current Medicaid coverage policy for inmates of a public institution.

Statute and Parameters

Section 1905(a)(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. The first distinction that should be made is that the statute refers only to FFP not being available. It does not specify, nor imply, that Medicaid eligibility is precluded for those individuals who are inmates of a public institution. Accordingly, inmates of a public institution may be eligible for Medicaid if the appropriate eligibility criteria are met.

The next significant distinction is that under current Medicaid coverage policy for inmates there is no difference in the application of this policy to juveniles than the application to adults. For purposes of excluding FFP, for example, a juvenile awaiting trial in a detention center is no different than an adult in a maximum security prison. For application of the statute, both are considered inmates of a public institution.

Criteria for Prohibition of FFP

When determining whether FFP is prohibited under the above noted statute, two criteria must be met. First, the individual must be an inmate; and second, the facility in which the individual is residing must be a public institution. 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.

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An individual who is voluntarily residing in a public institution would not be considered an inmate, and the statutory prohibition of FFP would not apply. 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. It is important to note that the exception to inmate status based on 'while other living arrangements appropriate to the individual's needs are being made' does not apply when the individual is involuntarily residing in a public institution awaiting criminal proceedings, penal dispositions, or other involuntary detainment determinations. Moreover, the duration of time that an individual is residing in the public institution awaiting these arrangements does not determine inmate status.

Regarding the second criteria necessary for determining whether FFP is prohibited, 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 when 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.

#### Privatization of Prisons

Some States have contracted with a private health care entity to provide medical care in the public institution to its inmates. We have determined that FFP would not be available for the medical services provided in this situation. We believe that the inmates are not receiving services as a patient in a medical institution. Rather, they are continuing to receive medical care in a public institution because governmental control continues to exist when the private entity is a contractual agent of a governmental unit.

Some States are also considering the feasibility of selling or transferring ownership rights of the prison's medical unit (including the housing facility and the immediate grounds) to a private health care entity, thereby potentially establishing the unit as a medical institution for which FFP may be available on the greater grounds of the public institution. We do not believe this arrangement is within the intent of the exception specified in the statute. We adhere to the policy that FFP is unavailable for any medical care provided on the greater premises of the prison grounds where security is ultimately maintained by the governmental unit.

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Page 3  
March 6, 1998

Exception to Prohibition of FFP

As noted in the above cited statute, an exception to the prohibition of FFP is permitted when an inmate becomes a patient in a medical institution. This occurs when the inmate is admitted as an inpatient in a hospital, nursing facility, juvenile psychiatric facility, or intermediate care facility. Accordingly, FFP is available for any Medicaid covered services provided to an 'inmate' while an inpatient in these facilities provided the services are included under a State's Medicaid plan and the 'inmate' is Medicaid-eligible. We would note that in those cases where an 'inmate' becomes an inpatient of a long-term care facility, other criteria such as meeting level of care and plan of care assessments would certainly have to be met in order for FFP to be available.

FFP, however, is not available for services provided at any of the above noted medical institutions including clinics and physician offices when provided to the inmate on an outpatient basis. Nor is FFP available for medical care provided to an inmate taken to a prison hospital or dispensary. In these specific situations the inmate would not be considered a patient in a medical institution.

Policy Application

As a result of a significant number of recent inquiries from the internet we have provided policy guidance involving issues where inmates are receiving medical care in various settings and under unique situations. The following examples will help in determining whether FFP is available or not. Please keep in mind that these are broad and general examples and extenuating circumstances may exist which could effect this determination.

Examples when FFP is available:

1. Infants living with the inmate in the public institution
2. Paroled individuals
3. Individuals on probation
4. Individuals on home release except during those times when reporting to a prison for overnight stay
5. Individuals living voluntarily in a detention center, jail, or county penal facility after their case has been adjudicated and other living arrangements are being made for them (e.g., transfer to a community residence)

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6. Inmates who become inpatients of a hospital, nursing facility, juvenile psychiatric facility or intermediate care facility for the mentally retarded (Note: subject to meeting other requirements of the Medicaid program)

Examples when FFP is unavailable:

1. Individuals (including juveniles) who are being held involuntarily in detention centers awaiting trial
2. Inmates involuntarily residing at a wilderness camp under governmental control
3. Inmates involuntarily residing in half-way houses under governmental control
4. Inmates receiving care as an outpatient
5. Inmates receiving care on premises of prison, jail, detention center, or other penal setting

If you have any questions, please contact Carol Langford at 404-562-7412 or Johnny Reed at 404-562-7417.



Vernell S. Britton, Branch Chief  
Operations Branch  
Division of Medicaid and State Operations



## DEPARTMENT OF HEALTH &amp; HUMAN SERVICES

7500 SECURITY BOULEVARD  
BALTIMORE MD 21244-1850

DEC 12 1997

FROM: Director  
Disabled and Elderly Health Programs Group  
Center for Medicaid and State Operations

SUBJECT: Clarification of Medicaid Coverage Policy for Inmates of a Public Institution

TO: All Associate Regional Administrators  
Division for Medicaid and State Operations

The purpose of this memorandum is to clarify current Medicaid coverage policy for inmates of a public institution. Recently, central office staff have become aware of a number of inconsistencies in various regional office directives on this subject which have been sent to States. Moreover, the growing influx of inquiries from the internet has prompted us to expand and, in some cases, refine our coverage policy in this area. Therefore, in the interest of insuring consistent and uniform application of Medicaid policy on inmates of a public institution, we believe that this communication is necessary.

Statute and Parameters

Section 1905(a)(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. The first distinction that should be made is that the statute refers only to FFP not being available. It does not specify, nor imply, that Medicaid eligibility is precluded for those individuals who are inmates of a public institution. Accordingly, inmates of a public institution may be eligible for Medicaid if the appropriate eligibility criteria are met.

The next significant distinction is that under current Medicaid coverage policy for inmates there is no difference in the application of this policy to juveniles than the application to adults. For purposes of excluding FFP, for example, a juvenile awaiting trial in a detention center is no different than an adult in a maximum security prison. For application of the statute, both are considered inmates of a public institution.

Criteria for Prohibition of FFP

When determining whether FFP is prohibited under the above noted statute, two criteria must be met. First, the individual must be an inmate; and second, the facility in which the individual is residing must be a public institution. 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, and the statutory prohibition of FFP would not apply. 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. It is important to note that the exception to inmate status based on 'while other living arrangements appropriate to the individual's needs are being made' does not apply when the individual is involuntarily residing in a public institution awaiting criminal proceedings, penal dispositions, or other involuntary detainment determinations. Moreover, the duration of time that an individual is residing in the public institution awaiting these arrangements does not determine inmate status.

Regarding the second criteria necessary for determining whether FFP is prohibited, 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 when 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.

Privatization of Prisons

Some States have contracted with a private health care entity to provide medical care in the public institution to its inmates. We have determined that FFP would not be available for the medical services provided in this situation. We believe that the inmates are not receiving services as a patient in a medical institution. Rather, they are continuing to receive medical care in a public institution because governmental control continues to exist when the private entity is a contractual agent of a governmental unit.

Some States are also considering the feasibility of selling or transferring ownership rights of the prison's medical unit (including the housing facility and the immediate grounds) to a private health care entity, thereby potentially establishing the unit as a medical institution for which FFP may be available on the greater grounds of the public institution. We do not believe this arrangement is within the intent of the exception specified in the statute. We adhere to the policy that FFP is unavailable for any medical care provided on the greater premises of the prison grounds where security is ultimately maintained by the governmental unit.

Exception to Prohibition of FFP

As noted in the above cited statute, an exception to the prohibition of FFP is permitted when an inmate becomes a patient in a medical institution. This occurs when the inmate is admitted as an inpatient in a hospital, nursing facility, juvenile psychiatric facility, or intermediate care facility. Accordingly, FFP is available for any Medicaid covered services provided to an 'inmate' while an inpatient in these facilities provided the services are included under a State's Medicaid plan and

the 'inmate' is Medicaid-eligible. We would note that in those cases where an 'inmate' becomes an inpatient of a long-term care facility, other criteria such as meeting level of care and plan of care assessments would certainly have to be met in order for FFP to be available.

FFP, however, is not available for services provided at any of the above noted medical institutions including clinics and physician offices when provided to the inmate on an outpatient basis. Nor is FFP available for medical care provided to an inmate taken to a prison hospital or dispensary. In these specific situations the inmate would not be considered a patient in a medical institution.

### Policy Application

As a result of a significant number of recent inquiries from the internet and regional offices, we have provided policy guidance involving issues where inmates receiving medical care in various settings and under unique situations. The following examples will help in determining whether FFP is available or not. Please keep in mind that these are broad and general examples and extenuating circumstances may exist which could effect this determination.

#### Examples when FFP is available:

1. Infants living with the inmate in the public institution
2. Paroled individuals
3. Individuals on probation
4. Individuals on home release except during those times when reporting to a prison for overnight stay
5. Individuals living voluntarily in a detention center, jail, or county penal facility after their case has been adjudicated and other living arrangements are being made for them (e.g., transfer to a community residence)
6. Inmates who become inpatients of a hospital, nursing facility, juvenile psychiatric facility or intermediate care facility for the mentally retarded (Note: subject to meeting other requirements of the Medicaid program)

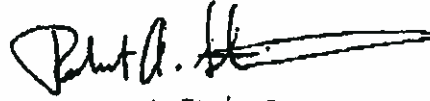
#### Examples when FFP is unavailable:

1. Individuals (including juveniles) who are being held involuntarily in detention centers awaiting trial
2. Inmates involuntarily residing at a wilderness camp under governmental control
3. Inmates involuntarily residing in half-way houses under governmental control



- 4. Inmates receiving care as an outpatient
- 5. Inmates receiving care on premises of prison, jail, detention center, or other penal setting

If there are any questions concerning this communication, please contact Thomas Shenk or Verna Tyler on 410 786-3295 or 410 786-8518, respectively.



Robert A. Streimer

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