

## **Elderly Prisoners and Medicare**

**Vivek Pande**

**University of Wisconsin - La Crosse**

**James Gillespie**

**University of Wisconsin - La Crosse**

**Andrew Stapleton**

**University of Wisconsin - La Crosse**

*The healthcare costs of elderly inmates are a major concern for state governments. This paper (i) discusses the recent surge in the elderly inmate population; (ii) analyzes the eligibility of prisoners for Medicare coverage, including an exception that allows coverage under certain circumstances; (iii) describes how states can circumvent restrictions on Medicare coverage of the incarcerated by using the aforementioned exception; (iv) explains why, for policy reasons, it may be wiser to allow Medicare coverage for all elderly inmates; and (v) makes policy recommendations for the treatment of the healthcare needs of elderly inmates in the future.*

### **INTRODUCTION**

The United States has seen a surge in the number of older prisoners, an unfortunate trend that shows no signs of abating. The demographics of the incarcerated are enough to tell the story. In 1981, there were 8,853 state and federal prisoners age 55 and older (Goetting, 1984). By 2010, this number had jumped to 124,900 (U.S. Department of Justice, Bureau of Justice [BOJ], 2011). And in 2030, it is predicted that at least one-third of all prisoners in the United States (approximately 400,000 prisoners) will be age 55 or older - in other words, an increase of 4,500% over 50 years (Chettiar, Bunting, & Schotter, 2012). The reasons for this astronomical growth are many: (i) the U.S. population is getting older in general; (ii) U.S. prisons are increasingly overcrowded as a result of the “get tough on crime” and “war on drugs” policies of the 1980s and 1990s; and (iii) inmates are staying incarcerated longer as a result of mandatory minimums, truth-in-sentencing, and three-strikes laws (Yamamoto, 2009).

Not surprisingly, state governments are rather alarmed at the prospect of paying the enormous tab for this graying prison population. According to the U.S. Department of Justice, National Institute of Corrections [NIC] (2004), it costs twice as much annually to incarcerate someone age 50 or older when compared to the average prisoner (\$68,270 v. \$34,135). A major factor in this cost discrepancy is the cost of healthcare.

## **ELDERLY INMATES AND HEALTHCARE**

Under the Eighth Amendment, prisoners are constitutionally entitled to receive medical care that does not demonstrate “deliberate indifference to serious medical needs” (Estelle v. Gamble, 1976, p. 104). Naturally, aging prisoners have far greater and costlier medical needs. Estimates of the healthcare costs of elderly inmates range from 2-3 times in California (Hill, Williams, Cobe, & Lindquist, 2006) to 4 times in North Carolina (North Carolina Department of Corrections, Division of Prisons, 2007) the costs of their younger counterparts. In dollar terms, the amounts are staggering. According to NIC (2004) data, it costs taxpayers approximately \$16 billion per year to incarcerate prisoners 50 and older of which the major share goes towards healthcare costs.

Given these escalating costs, states have been exploring methods to reduce the elderly inmate population. Policy measures that have been discussed and/or implemented include segregation of elderly prisoners in lower cost minimum security facilities, construction of prison nursing homes and hospices, and expanded compassionate/medical release/parole programs (Yamamoto, 2009).

## **MEDICAID**

States have also been looking to shift some of the medical costs of aging inmates to the federal government via federal healthcare entitlement programs. Much has been in the news lately about one of the effects of the implementation of the Patient Protection and Affordable Care Act [PPACA], namely the expansion of Medicaid coverage to the incarcerated. As the New York Times reported:

In a little-noticed outcome of President Obama’s Affordable Care Act, jails and prisons around the country are beginning to sign up inmates for health insurance under the law, taking advantage of the expansion of Medicaid that allows states to extend coverage to single and childless adults - a major part of the prison population . . . . Although Medicaid does not cover standard healthcare for inmates, it can pay for their hospital stays beyond 24 hours - meaning states can transfer millions of dollars of obligations to the federal government. (Goode, 2014, p. A1)

As the U.S. Government Accountability Office [GAO] (2014) further explained, in 2013, the Medicaid program financed health care services for more than 72 million individuals, and an additional 7 million beneficiaries were expected to enroll in 2014 as a result of states choosing to expand Medicaid eligibility as allowed under the Patient Protection and Affordable Care Act [PPACA]. Most of these newly eligible individuals were low-income adults, a population that included individuals who were inmates in state prisons and local jails. In the 27 states that opted to expand Medicaid eligibility as allowed under the PPACA, the majority of inmates had incomes that would qualify them for Medicaid - a circumstance that did not generally exist before 2014 (GAO, 2014). As the Council of State Governments Justice Center (2013) reported, states have of course jumped at this opportunity to offload healthcare costs to the federal government:

North Carolina has reported that it saved \$10 million in the first year of billing Medicaid for eligible inpatient services, while California saved about \$31 million by doing so in FY 2013. To qualify for federal financial participation, the prisoner must be admitted for at least 24 hours and the facility must be community-based and separate from the corrections system. Once an inmate has been admitted in the appropriate inpatient setting for at least 24 hours, all medically necessary Medicaid covered services provided to that inmate while admitted can be billed by the provider to Medicaid. At least 14 states - Arkansas, California, Colorado, Delaware, Louisiana, Michigan, Mississippi, Nebraska, New York, North Carolina, Oklahoma, Pennsylvania, Vermont, and Washington -

currently bill Medicaid for at least some eligible inpatient health services provided to incarcerated individuals, and additional states are exploring this option. (p. 4)

Though undoubtedly this will continue to provide some financial relief to the states, it may not be the bonanza they are expecting. As the GAO (2014) pointed out:

The proportion of inmates with inpatient stays that qualify for federal Medicaid funds is likely small. For example,

- Inmates who were eligible for Medicaid and received allowable inpatient services ranged from 1 percent to 2.3 percent in 2013 in four of six states GAO contacted that could provide data on allowable services; and
- Data from California and Washington indicated that - even with increases in eligibility - the percentage of inmates with allowable services remained relatively small, less than 5 percent. Therefore, while states may have efforts underway to increase federal Medicaid funds obtained for inmate inpatient care, data from selected states indicates that increases in federal spending on inmate care due to Medicaid expansion are likely to be limited. (p. 5)

## **MEDICARE**

Lost in this debate over Medicaid coverage of the prison population, is any discussion of *Medicare* as a source of federal reimbursement for healthcare services provided to elderly prisoners. Medicare has been ignored and analysis of its applicability to older prisoners remains absent from scholarly literature on the subject. There is perhaps a good reason for this. Most commentators have conservatively concluded that inmates do not qualify for Medicare. For example, the American Civil Liberties Union's [ACLU] (2012) exhaustive study on "Mass Incarceration of the Elderly" states: "When behind bars, prisoners lose their eligibility for both [Medicare and Medicaid] programs for the full duration of their prison term" (p. 33), though an endnote discusses the prospects for expanded Medicaid coverage under the PPACA as described earlier in this paper (p. 68). Similarly, the leading law review article on the topic of the elderly in prison, also concludes that American prisoners are not eligible for the benefits of the Medicare and Medicaid programs, though again, a footnote correctly cites the law which does provide for Medicare coverage under certain limited circumstances, discussed more fully below (Yamamoto, 2009).

Accordingly, this paper will go on to (i) clearly outline the law governing the (non-)eligibility of prisoners for Medicare coverage, including an exception that allows coverage under certain circumstances; (ii) describe how states can circumvent restrictions on Medicare coverage of the incarcerated by using the aforementioned exception; (iii) explain why, for policy reasons, it may be wiser to allow Medicare coverage for all elderly inmates without restrictions and/or exceptions; and (iv) make policy recommendations for the treatment of the healthcare needs of elderly inmates in the future.

## **MEDICARE LAW**

Under Sections 1862(a)(2) and (3) of the Social Security Act of 1935, the Medicare program does not pay for services if the beneficiary has no legal obligation to pay for the services and if the services are paid for directly or indirectly by a governmental entity. These provisions are implemented by regulations 42 CFR § 411.4(a) and (b), respectively. Medicare excludes from coverage items and services furnished to beneficiaries in state or local government custody under a penal statute, unless it is determined that the state or local government enforces a legal requirement that all prisoners/patients repay the cost of all healthcare items and services rendered while in custody, and also pursues collection efforts against such individuals in the same way, and with the same vigor, as it pursues other debts (42 CFR § 411.4).

The U.S. Department of Health and Human Services, Centers for Medicaid and Medicare Services [CMS] (2015) presume that a state or local government that has custody of a Medicare beneficiary under a penal statute has a financial obligation to pay for the cost of healthcare items and services. Therefore,

Medicare denies payment for items and services furnished to beneficiaries in state or local government custody, unless a modifier QJ is appended to indicate otherwise (CMS, 2015). Language approved for the QJ modifier reads: “Services/items provided to a prisoner or patient in State or local custody, however, the State or local government, as applicable, meets the requirements in 42 CFR 411.4(b)” (CMS, 2015). This modifier indicates that the physician or other supplier has been instructed by the state or local government agency that requested the healthcare services, that State or local law makes the prisoner or patient responsible to repay the cost of these services, and that it pursues collection of debts incurred for such services with the same vigor and in the same manner as any other debt (CMS, 2015). In addition, to use the exception set forth in 42 CFR 411.4(b), CMS requires that the state or local entity be able to provide: (i) evidence that routine collection efforts include the filing of lawsuits to obtain liens against incarcerated individuals’ assets outside the prison and income derived from non-prison sources; and (ii) rules and procedures it employs to bill and collect amounts paid for incarcerated individuals’ medical expenses (such as regulations, manual instructions, or directives) (CMS, 2015).

## **INTERPRETATION AND ENFORCEMENT OF THE LAW**

The interpretation and enforcement of the law barring Medicare payments for services provided to incarcerated beneficiaries has been the subject of review over the years. One such comprehensive audit took place in 2001-2002. At the request of Senator Grassley of the Senate Finance Committee, the Department of Health and Human Services, Office of the Inspector General [OIG] undertook a review of Medicare payments for services provided to incarcerated beneficiaries after a report found that Medicare had paid \$32 million in fee-for-service benefits on behalf of 7,438 incarcerated beneficiaries in 1997-1999 (OIG Report No. A-04-00-05568, 2001). The objective of the review was to determine whether Medicare fee-for-service claims paid in 10 states (representing about 70% of the \$32 million paid) during the three-year period between January 1, 1997 and December 31, 1999 were in compliance with Federal regulations and CMS guidelines. The 10 states examined were California, Florida, Louisiana, Maryland, Michigan, Missouri, New York, Ohio, Texas, and Virginia, and a brief summary of the audit results can be found in Appendix A.

It is abundantly clear from these audit reports that the OIG confirmed the plain meaning of the law - all that is required for states to seek Medicare reimbursement for healthcare services provided to prison inmates, is that such prisoners be legally required to pay for the healthcare services provided, and that the state pursue uniform collection efforts to enforce payment.

Medicare payments for services provided to incarcerated beneficiaries were the subject of yet another comprehensive OIG audit in 2013 (OIG Report No. A-07-12-01113, 2013). The review was meant to determine whether Medicare payments were made for incarcerated beneficiaries who did not meet the criteria for exception identified in the regulations. As the review indicated, the following procedures had been adopted by CMS:

CMS which administers the Medicare program, contracts with Medicare contractors to process and pay Medicare Part A and Part B claims submitted by health care providers. Under Federal requirements, Medicare generally does not pay for services rendered to incarcerated beneficiaries. As such, when claims for services furnished to beneficiaries who are incarcerated are submitted to Medicare claims processing contractors, the claims are rejected by the Common Working File and denied by the claims processing contractors. Federal requirements, however, allow Medicare payment if State or local law requires incarcerated beneficiaries to repay the cost of medical services. Health care providers indicate this exception by placing a specific code on the claims submitted for payment. We refer to this code as “exception code.” The Social Security Administration [SSA] is CMS’s primary source of information about incarcerated beneficiaries. Generally, SSA collects information, such as the names of beneficiaries and the dates on which beneficiaries begin and/or end periods of incarceration, directly from penal

authorities. SSA also collects incarceration end dates from beneficiaries' requests for reinstatement of Social Security benefits. (pp. 1-2)

During the 2013 audit, CMS records identified 135,805 Medicare beneficiaries who had been incarcerated at some point during calendar years 2009 through 2011. As the audit uncovered:

[W]hen CMS data systems indicated at the time that a claim was processed that a beneficiary was incarcerated, CMS controls were adequate to prevent payment for Medicare services. Specifically, CMS had a prepayment edit that flagged claims so that Medicare contractors could deny payments to providers when the incarceration dates and the dates of service on the claims overlapped. When CMS data systems did not indicate until after a claim had been processed that a beneficiary was incarcerated, CMS controls were not adequate to detect and recoup the improper payment. (p. 3)

Accordingly, the auditors recommended that, among other things, the CMS and Medicare contractors (i) recoup the \$33,587,634 in improper payments, (ii) implement policies and procedures to detect and recoup improper payments made for Medicare services rendered to incarcerated beneficiaries when incarceration information is received on previously paid Medicare claims, (iii) work with other entities, including SSA, to identify ways to improve the timeliness with which CMS receives incarceration information before Medicare contractors pay providers on behalf of incarcerated beneficiaries, and (iv) work with Medicare contractors to ensure that all claims with exception codes are processed consistently and pursuant to Federal requirements. (OIG Report No. A-07-12-01113, 2013, pp. 7-8)

Many believe that part of the problem lies with the definition of "incarcerated." CMS considers a beneficiary to be "incarcerated" or "in custody of penal authorities" in circumstances beyond situations involving physical confinement. According to commentary on 42 CFR 411.4, as well as the related CMS Bulletin, individuals in "custody" include those who are: (i) under arrest, (ii) incarcerated, (iii) imprisoned, (iv) escaped from confinement, (v) under supervised release, (vi) on medical furlough, (vii) required to reside in a mental health facility, (viii) required to reside in a halfway house, (ix) required to live under home detention, (x) confined completely or partially in any way under a penal statute or rule. In comments regarding the proposed rule in question, providers initially expressed valid concerns about the implementation of this definition of "custody" (Wachler and Associates Health Law Blog, 2013).

Commentators pointed out the lack of incentives for patients to disclose their criminal status, the practical problem for hospitals to identify individuals in "custody," and the burden on healthcare providers to seek payments from the proper sources. As some commentators clearly anticipated, the issuance of demand letters and recoupment of funds are burdensome for Medicare providers partially as a result of this broad definition of "custody." Specifically, this Medicare payment prohibition is problematic because if a patient is not under physical confinement, providers may not know - or be able to find out - whether he or she is barred from being eligible for covered services. It may be unlikely that an individual would identify him or herself as such. Without taking precautionary steps, hospitals may be unable to discern whether a patient is on parole, on probation, out on bail, or under supervised release. (Wachler and Associates Health Law Blog, 2013).

## **CURRENT CMS PROCEDURES AND FUTURE GUIDANCE**

In response to the concerns outlined above, in October 2013, CMS issued a Fact Sheet outlining its current policy regarding beneficiaries who are incarcerated or in custody:

Pursuant to 42 C.F.R. §§ 411.4, 411.6 and 411.8, where a beneficiary is in custody on the date items or services are provided, Medicare will typically not cover the items or services . . . . The Remittance Advice for the denial will include the code RARC N103, the current language of which has been updated. A beneficiary's eligibility status can be

confirmed through a 270/271 eligibility query in the HIPAA Eligibility Transaction System or by Medicare Administrative Contractor interactive voice response units and provider internet portals. . . . The only exception to this policy occurs when a state or local law requires repayment of the cost of medical services received in custody **and** the state or local government entity enforces this payment requirement by billing and seeking collection from all such individuals. *See* 42 C.F.R. § 411.4(b). According to CMS, to document eligibility for this exception, appropriate claims should be submitted using the relevant CPT or HCPCS code as well as the QJ modifier . . . . To ensure state or local entities are billing and collecting such payment appropriately, MACs randomly evaluate a sample of these cases. (CMS Report No. ICN 908084, 2013, p. 3)

Finally, under 42 CFR 411.4, and as listed on the CMS notice, there are three regulatory conditions under which Medicare payments may be made for incarcerated individuals: (i) state or local law must require the prisoner to repay the cost of medical services they receive while in custody and this must apply to all individuals and not be limited to those individuals with Medicare, (ii) the state or local government entity must enforce the requirement to pay by billing all prisoners whether covered by Medicare or any other health insurance, and (iii) the state or local entity must have documentary evidence to support their billing and collection efforts (CMS Report No. ICN 908084, 2013, p. 4)

Therefore, any state that wishes to have Medicare pick up part of the tab for the healthcare costs of elderly prisoners, merely has to enact a law making all prisoners financially responsible for their healthcare bills, and pursue collection diligently. This does not seem either especially difficult or controversial. As discussed earlier, many states already have such laws and are offloading related costs to Medicare and/or taking advantage of the expansion of Medicaid coverage under the PPACA. Though there will undoubtedly be additional issues related to dual eligibility and payment of the necessary Medicare premiums and copays, it is somewhat fiscally irresponsible for states to not explore all potentially available sources of funding for inmate healthcare.

Requiring inmates to pay for healthcare services passes constitutional muster as well. As the Third Circuit stated almost twenty years ago in *Reynolds v. Wagner* (1997):

Although the Supreme Court has held that a state must provide inmates with basic medical care, the Court has not tackled the question whether that care must be provided free of charge. Cf. *City of Revere v. Massachusetts Gen. Hosp.*, 463 U.S. 239, 245 n. 7, 103 S.Ct. 2979, 2984 n. 7, 77 L.Ed.2d 605 (1983) (“Nothing we say here affects any right a hospital or government entity may have to recover from a detainee the cost of medical services provided to him.”). The district court here held that there is nothing unconstitutional about a program that “require[s] that inmates with adequate resources pay a small portion of their medical care.” *Reynolds*, 936 F.Supp. at 1224. We agree. We reject the plaintiffs’ argument that charging inmates for medical care is per se unconstitutional. If a prisoner is able to pay for medical care, requiring such payment is not “deliberate indifference to serious medical needs.” *Helling*, 509 U.S. at 32, 113 S.Ct. at 2480. Instead, such a requirement simply represents an insistence that the prisoner bear a personal expense that he or she can meet and would be required to meet in the outside world. See, e.g., *Shapley v. Nevada Bd. of State Prison Commissioners*, 766 F.2d 404, 408 (9th Cir.1985) (nothing per se unconstitutional about charging an inmate \$3 for every medical visit; such a charge, by itself, did not constitute deliberate indifference under *Estelle*). (p. 174)

As far back as 1998, 37 states had implemented an inmate copayment for medical services (Vogt, 2002). To date, the judiciary has consistently upheld the use of co-pay programs stating that they do not go against the deliberate indifference standard set in *Estelle v. Gamble* (Vogt, 2002). It is important to

note that an inmate cannot be denied care if they do not have funds, but inmate copays have resulted in a reduction of sick call use and decreased costs for departments of corrections (Vogt, 2002).

So states can collect reimbursement of healthcare costs from elderly inmates who have the ability to pay (probably very few) and those that cannot pay or later reimburse can have their bills covered by Medicare when they are otherwise eligible. This will result in millions of dollars in additional savings for the states, and it is unclear why they are not more actively exploring this possibility.

## **WHY THE CURRENT APPROACH IS DEFICIENT FROM A POLICY PERSPECTIVE**

The increased focus on the impact of incarceration on health and society is a positive development. Cost is the driver for this increased attention. Healthcare and prisons are two of the most significant portions of spending at the state level, and in most states, both items have been increasing in recent years. The issue of inmate healthcare represents the intersection of these two trends, so this is a particularly important issue - heightening the fiscal importance of getting it right from a policy perspective. Unfortunately, the current approach to elderly inmate healthcare makes little to no sense. It is less cost efficient in the long run, less healthcare outcome-effective in the short run, and at some basic level, immoral.

Not only can this issue not be ignored from a cost standpoint, it also has profound legal implications because, as noted earlier in the paper, prisoners have a basic constitutional right of access to adequate medical care (Raimer, Murray, & Pulvino, 2010). Failure to comply can result in lawsuits and intervention by state and federal courts.

Even though, as described earlier, Medicaid and Medicare CAN cover current and former inmates under certain circumstances, if those circumstances are not met (eligibility, premiums, copays etc.), the incarcerated are mostly excluded. Moreover, although the U.S. criminal justice system is based on a presumption of innocence for those accused of crimes, in many states individuals lose their Medicaid and Medicare benefits upon entering jail, even before trial. With passage of the PPACA and its survival of repeated constitutional challenge, the issue of Medicaid coverage for released elderly prisoners is more important than ever. Under the new health reform expansion, it is estimated that approximately 1/6<sup>th</sup> of those enrolling in Medicaid, and 1/10<sup>th</sup> of those enrolling in qualified health plans via health insurance marketplaces, will have been in jail at some time within the past year (Regenstein & Rosenbaum, 2014).

We know the prison population is getting older. Twenty-eight states now have more than 1,000 older prisoners in contrast to only two states in 1990 (Williams, Goodwin, Baillargeon, Ahalt, & Walter, 2012). Approximately 1 in 11 prisoners nationally are serving life sentences, and in some states, as many as 1 in 6 are serving life sentences without possibility of parole. The main culprit for this is the stringent sentencing guidelines (e.g., three strikes laws) adopted in the 1980s and 1990s (Vesely, 2010).

The cost of imprisoning those over 55 years old is about three times that of the under-55 prisoner, and most of this difference is driven by higher medical spending (Vesely, 2010). Why does the elderly inmate population disproportionately use healthcare resources? The answer is partially similar to the conditions which prevail in society as a whole - older adults have a higher incidence of atherosclerotic heart disease, diabetes, hypertension, and other medical conditions which typically involve chronic, expensive treatment. In prison this age effect is accentuated by the increased stresses of prison life, the cumulative negative consequences of poverty, substandard nutrition, and frequently drug abuse and mental illness. Thus, those over 50 who are incarcerated are generally considered elderly and equivalent from a health profile standpoint to the average 60-65 year old in general society (Vesely, 2010).

In comparison to younger prisoners, older prisoners tend to have several chronic conditions, including hypertension, diabetes mellitus, and pulmonary problems. Within the Texas prison system for example, in the treatment of chronic conditions, older prisoners are prescribed an average of 7.3 classes of chronic medications. In addition, older prisoners are afflicted with a high rate of geriatric syndromes which typically accompany the aging process. These include visual or hearing impairment, incontinence, and falls, and they adversely impact quality of life, morbidity, and healthcare costs. As a result, in many

states, it is not unusual for just 1% of the inmate population to account for over 1/3<sup>rd</sup> of outside medical costs (Williams et al., 2012).

Even with the large number of life sentences, more than 95% of prisoners are eventually released back into society, with disproportionate placement in lower socioeconomic urban communities where healthcare resources are severely limited, and existing healthcare disparities are already profound (Ahalt, Trestman, Rich, Greifinger, & Williams, 2013). Released prisoners often have to cope with unemployment, poverty, homelessness, family problems, stress, and reduced social support. Given these pressing priorities, maintaining sound physical and mental health - especially from a preventive perspective - often becomes a lower priority, although it should be one of the highest priorities. Good healthcare for the elderly in prison increases the probability of successful reintegration into the community post-prison (Patel, Boutwell, Brockmann, & Rich, 2014). Also, the majority of HIV and HCV infected prisoners will eventually return to their communities with the unfortunate potential to spread these diseases to broader society by infecting others. Thus, there can be collateral damage from the failure to provide effective healthcare internally in prisons.

The intersection of prison and healthcare also generates profound ethical conundrums. For example, should a convicted armed robber in California receive and have the state pay 100% for a new heart transplant? Or should a convicted first-degree murderer in a Minnesota prison receive and have the state pay 100% for a life-saving, \$900,000 bone marrow transplant? In both cases, the states gave approval because a “no” answer would contravene the Constitution’s ban on cruel and unusual punishment. This paper does not explore these ethical issues in depth, but such cases will continue to put into sharp relief the policy problems attendant to our current approach to elderly inmate healthcare.

## **UNINTENDED CONSEQUENCES OF CURRENT POLICY**

The current policy has the unintended consequence of increasing disease exposure for broader society. Incarceration substantially increases the risk of both acute (e.g., HIV, hepatitis C, and tuberculosis) and chronic (e.g., diabetes, hypertension) health problems. The incidence of HIV in the U.S. prison population is five times higher than in the non-incarcerated population, hepatitis C is nearly ten times higher, and tuberculosis may be as much as 17 times higher (Katzen, 2011). The cost of treating Hepatitis C can easily exceed \$30,000 per inmate annually. The disease is widely prevalent in captive society. For example, in one prison in California, over 50% of the 3,200 inmates were estimated to be afflicted with the virus (Nelson, 2012). Not only do inmates tend to have significantly higher rates of these chronic conditions, their diseases tend to be at a more advanced, serious stage.

The current approach also has the unintended consequence of increasing recidivism. Research provides clear evidence that effective healthcare provided in prison, especially treatment for substance abuse and serious mental health conditions, substantially decreases the probability that released inmates will commit parole violations or new crimes. There is strong state-level empirical support (e.g., in the states of Florida, Michigan, and Washington) for the notion that providing recently released inmates with healthcare does reduce recidivism (Patel et al., 2014).

In the U.S., prisoners are usually automatically stripped of their eligibility for several key public benefit programs, including Medicare, Medicaid, Social Security Insurance, and benefits provided by the Veterans Health Administration. Many states struggle to reenroll eligible individuals in these programs while part of community supervision or upon their complete release. It is estimated that over 90% of released inmates lack health insurance upon reentering the community (Patel et al., 2014). Because most recently released inmates do not have health insurance, health facilities and physicians are unsurprisingly reluctant to provide them with care.

Post release, the lag time for reinstatement can be lengthy, during which time many former inmates can experience a significant, adverse, and potentially irreversible health decline. Moreover, most states provide released inmates with no more than a couple of weeks of medication so these individuals quickly dissipate this supply as they await healthcare program reenrollment and their first medical appointment. During this period of limbo, if an acute incident arises, these former prisoners are forced to use expensive

and inefficient emergency room services. For example, one analysis showed that within 12 months of being released, about 30% of former prisoners with physical or mental health conditions resorted to emergency department care, and over 20% were hospitalized (Williams et al., 2012). The elderly who are released can be particularly susceptible to mortality during that two-week post prison period. In comparison to the baseline of others in free society, released inmates are almost 13 times more likely to die in the two-week period after exiting prison (Allen, Wakeman, Cohen, & Rich, 2010).

As a society, we should endeavor to eliminate invisible punishments for elderly current and former inmates. Because of unintended consequences, we are currently imposing a substantial invisible punishment on geriatric inmates during their prison stay and - even more morally indefensible - upon release after they have paid their debt to society. And worse yet, the current approach to elderly healthcare and the healthcare of all inmates, has the unintended consequence of imposing a substantial “disease tax” on the communities to which these former inmates return. These tend to be communities that already have a deficit of healthcare resources so are particularly poorly positioned to integrate this additional burden. These communities end up being twice victimized: first typically when the inmate commits the original crime(s), and second once the state returns a potentially diseased and infected healthcare-less former inmate back into that community.

## **RECOMMENDED SOLUTIONS**

Below we outline some potential solutions to the complicated issue of elderly inmate healthcare.

### **Collect More and Better Data**

Surprisingly little is known about the availability, use, quality, and costs of prison healthcare services. The first step is to collect comprehensive data on inmates. Without that, to some great extent, trying to set policy in the absence of data is akin to operating in the dark. State and local governments have not collected comprehensive data on inmate health issues, the level and quality of services, and what gap may exist between the two. There is also no systematic monitoring of trends. The foundational step in developing better policies for geriatric inmate care should be developing better data.

The integrated short-term data collection of a random sample of older prisoners in the U.S. could generate the data needed to significantly improve correctional healthcare decision -making. The analyses would require national longitudinal data that is currently unavailable but which could be collected at a reasonable cost. One approach is to use chart review to follow-up on those remaining in prison, while using Medicare and Medicaid claims data to follow-up on those released from prison. In combination, this would provide a reasonably comprehensive view of healthcare use and outcomes for elderly adults, whether current or former inmates.

Collection of data for evidence-based innovation and policy change is crucial for the optimization of healthcare for elderly inmates. Entities that could collaborate on data collection include the Bureau of Justice Statistics, the National Commission on Correctional Health Care, and various universities. In addition to directly improving care and lowering costs, electronic health records are one key way to systematize ongoing data collection. It would particularly facilitate the gathering of longitudinal data as to whether elderly inmates remained in prison, were released, or moved in and out of incarceration. In many cases though, regulatory alignments and policy guidance are required to support the proper exchange of information between the criminal justice system and community healthcare resources.

### **Maximize Reimbursement for Services under Medicaid and/or Medicare**

As described earlier, current law does not always remove the limitation on Medicaid and Medicare payment for in-prison healthcare. Yet it still provides for coverage of inpatient healthcare provided outside the prison, typically when an inmate is hospitalized. While relatively infrequent, this is an expensive portion of inmate healthcare costs. The PPACA expanded Medicaid coverage to all adults with incomes up to 138% of the federal poverty line, which is currently \$11,490. Given that criteria, the vast majority of those incarcerated will qualify. In the case of eligible adults, the federal government will pay

all of the costs from 2014-2016 and gradually slope down its contribution to 90% by 2020 (Pew Report, 2014). The criteria for Medicaid payment is that the healthcare services must be provided outside the prison, and the inmate must be admitted for at least 24 hours, often in a hospital, nursing home, or psychiatric center. In essence, for that purpose, Medicaid no longer considers these individuals inmates.

States that are innovative enough to pursue Medicaid financing for inmate healthcare achieve two savings. First, federal reimbursements often pay for at least 50% of inmate inpatient hospitalization, and second, because of its significant negotiating power, Medicaid typically has the lowest rates of any payer. Therefore, by leveraging this approach, states can simultaneously realize an important new funding source and implement a cost-containment strategy.

And, as described earlier, states can be reimbursed under Medicare for healthcare costs when they seek to recoup the costs from prisoners. It is still unclear under what circumstances the healthcare must be provided (on-prison premises or off), and raises issues of premiums, copays, and dual eligibility, but the potential savings for the states make this quirk in the law impossible to ignore any further.

### **Extend, Suspend, and Pre-Reinstate**

Most states completely terminate an enrollee's Medicare and/or Medicaid coverage once he or she is incarcerated, which then requires reenrollment upon release. Within this, there are three areas for improvement. First, under the rubric of presumed innocence, states should continue to extend coverage until a person is convicted. And in some cases of course, the person will be found not guilty. The basic idea is to first keep benefits in place as long as possible before suspension, allowing Medicare and Medicaid to cover any costs occurred during this interim process.

Second, once an inmate serves his or her time and is released, there is often a difficult process to reestablish healthcare benefits which complicates the transition from prison to community. One solution is for states to suspend, rather than terminate, an inmate's coverage, allowing for reinstatement upon release from prison. A Medicare or Medicaid beneficiary who becomes an inmate can then retain their eligibility and membership in these programs. The difference is that coverage and payments for any normally covered services are suspended until release back into the community. The basic idea is to suspend rather than terminate.

Related to this recommendation, getting reinstated in government programs can take several months after release and prisons can help ameliorate this issue by getting a jump on the process and initiate coverage as part of prerelease planning. This would provide a head start on the process of moving from suspension to reinstatement.

### **Leverage Case Management Techniques More Effectively**

States could utilize several strategies to encourage uniform, cost-effective clinical management of the often complex medical needs of geriatric inmates. This could feature the use of chronic care clinics to coordinate the management of increasing numbers of prisoners suffering from chronic diseases such as diabetes, HIV infection, and hypertension. This case management approach increases the probability that inmates at high risk of developing disease complications would receive timely access to appropriate medical care so as to minimize hospitalizations and other expensive interventions. In addition, evidence-based guidelines can be employed to manage a number of long-term diseases. The guidelines can help institutions implement standards of care that satisfy national consensus recommendations and also limit inappropriate utilization of limited resources.

### **Build Strategic Outsourcing Alliances**

One technique is to leverage more outside strategic partners (e.g., public university medical centers, community based clinics, for-profit healthcare providers) to provide all or a portion of medical, mental health, and dental services for prisons. This outsourcing can often lower costs while keeping quality at the same or even a higher level. Often these arrangements include a capitated contracts model where providers deliver healthcare services at a fixed reimbursement rate, with continued monitoring by the state to insure timely and quality delivery. To facilitate this, it would be wise for health plans and policy

makers to include key safety net providers (e.g., public hospitals and community health centers) in Medicaid and private insurance plan networks (Regenstein & Rosenbaum, 2014).

### **Telemedicine**

Telemedicine typically involves two-way audio and video communication between inmates and a healthcare provider, usually a physician or nurse. It can positively impact cost and quality in two respects. First, it saves the cost and risk of transporting inmates to and from an outside provider and/or bringing outside providers into the dangerous environment of prisons. The expenses related to corrections officers supervising the process can be significant. Second, it allows for a substantial increase in the quantity and quality of potential healthcare providers who can treat patients. For example, many physicians are reluctant to treat inmates primarily because of the need to physically go into prisons. In small, resource-constrained prison systems, this can require an increased use of unlicensed staff. When leveraged for appropriate medical cases, telemedicine helps institutions avoid or at least minimize use of unlicensed and under-qualified healthcare providers.

Because telemedicine start-up costs can range from \$50,000-\$75,000, an institution needs to have certain economies of scale to deliver a sound return on investment. Ohio and Texas experienced a savings of \$200-\$1,000 per each inmate using telemedicine (Schaenman, Davies, Jordan, & Chakraborty, 2013). Telemedicine is particularly effective for specialties such as dermatology, psychiatry, and radiology. Telemedicine also has the advantage of being able to provide relatively prompt service.

### **Broader Use of Compassionate Medical Release**

Greater use of medical release could serve to reduce the elderly inmate population, especially those with the most costly ailments including advanced Alzheimer's disease, and prisoners in comas and/or on ventilator support. Forty-one states currently have provisions to allow for medical release, including nearly 20 states which have moved to further streamline the process and expand eligibility (Vesely, 2010). While utilization of medical release varies substantially, and on the whole it is not widely used by most states, in recent years a few states (e.g., Maine, New York, and Wisconsin) have broadened coverage of medical release cases. For example, Maine changed the eligibility criteria from "terminally ill" to "terminal or severely incapacitating medical condition." Frequently, inmates qualify for compassionate medical release, but because the full process can take months to conclude, they often die before release. One positive policy step forward would be to accelerate consideration of these requests.

### **More Seamless Healthcare Transitions from Prison to Community**

There is a notable lack of coordinated discharge planning between jails/prisons and community healthcare resources. Cross-agency collaboration is essential to provide effective healthcare to released inmates. The transitions clinics model, which is used in at least 10 cities nationwide, provides transitional and primary care with case management to former inmates with chronic health needs. The clinics are sited in areas with significant percentages of former inmates. Among other key services, these clinics provide care from physicians experienced with this population, referrals to social support services, and case management from experienced community health workers who are themselves former inmates. The program is undergirded by fluid information exchange between all the key entities involved.

Another successful approach is to provide elderly inmates with a transition coach, often a nurse or advanced practice nurse, who can provide guidance, education, and training on navigating the healthcare systems that exists in free society. The goal should be to maintain continuity of care regardless of the elderly patient's place of residence (i.e., whether inside or outside prison walls). This will require a stronger integration of corrections and community care.

### **Miscellaneous**

Below are a group of additional, potentially highly effective approaches state governments can use to improve the efficiency of elderly inmate healthcare.

- States can allow direct purchase of over-the-counter [OTC] drugs by inmates, which would reduce costly medical visits and also frequently allow for the substitution of less expensive medicines. For example, one year the Federal Bureau of Prisons saved \$1.2 million by granting inmates permission to purchase 36 types of OTC drugs (Schaenman et al., 2013).
- States can use fully licensed but more appropriately skilled and lower paid healthcare professionals (e.g., physician's assistants and nurse practitioners) for non-critical medical services (e.g., taking vital signs or recording patient history for medical exams). This is routinely done in hospitals and doctors' offices outside of prison, but this efficiency step is not consistently taken in prison healthcare systems.
- Consider taking a more specialized approach by separating elderly inmates residentially. For example, the state of Washington has been grouping its aging prison populations separately from younger offenders. States have to determine the financial costs and benefits of integrating elderly inmates within the overall inmate population versus grouping them separately, and the cost-benefit analysis will likely be different for different states.
- Deployment of an integrated computerized pharmacy network can make the process of prescription orders from individual prison units much more efficient. Related cost-saving measures can include development of a medication formulary and a medication reclamation effort. Related to this, group pharmaceutical purchasing contracts can be an effective means of saving costs.

## REFERENCES

- Ahalt, C., Trestman, R. L., Rich, J. D., Greifinger, R. B., & Williams, B. A. (2013). Paying the price: the pressing need for quality, cost, and outcomes data to improve correctional health care for older prisoners. *Journal of the American Geriatrics Society*, 61, (11), 2013-2019.
- Allen, S. A., Wakeman, S. E., Cohen, R. L., & Rich, J. D. (2010). Physicians in U.S. prisons in the era of mass incarceration. *International Journal of Prisoner Health*, 6, (3), 100-106.
- Chettiar, I. M., Bunting, W. C., & Schotter, G. (2012). *At America's Expense: The Mass Incarceration of the Elderly*. American Civil Liberties Union. Retrieved from <https://www.aclu.org/americas-expense-mass-incarceration-elderly>
- Council of State Governments Justice Center (2013). *Medicaid and Financing Health Care for Individuals Involved with the Criminal Justice System*. Retrieved from <https://csgjusticecenter.org/wp-content/uploads/2013/12/ACA-Medicaid-Expansion-Policy-Brief.pdf>
- Curran, N. (2000). Blue hairs in the bighouse: The rise in the elderly inmate population, its effect on the overcrowding dilemma and solutions to correct it. *New England Journal on Criminal & Civil Confinement*, 26, 225-264.
- Estelle v. Gamble, 429 U.S. 97 (1976).
- Goetting, A. (1984). The elderly in prison: A profile. *Criminal Justice Review*, 9, (2), 14-24.
- Goode, E. (2014, March 9). Little-known health act fact: Prison inmates are signing up. *The New York Times*, A1.
- Hill, T., Williams, B., Cobe, G., & Lindquist, K. (2006). *Aging inmates: Challenges for healthcare and custody*. A report for the California Department of Corrections and Rehabilitation. Retrieved from <http://www.cphcs.ca.gov/docs/resources/AgingInmatesByLumetra0506.pdf>
- Katzen, A. L. (2011). African American Men's Health and Incarceration: Access to Care upon Reentry and Eliminating Invisible Punishments. *Berkeley Journal of Gender Law & Justice*, 26, (2), 221-252.
- Nelson, R. (2012). Challenges to Health Care Delivery in U.S. Prisons. *American Journal of Nursing*, 112, (1), 19-20.

- North Carolina Department of Corrections, Division of Prisons. (2007). *Aging Inmate Population 2007 Addendum Report*. Retrieved from [http://www.doc.state.nc.us/Publications/Add\\_age\\_study\\_2007.pdf](http://www.doc.state.nc.us/Publications/Add_age_study_2007.pdf)
- Patel, K., Boutwell, A., Brockmann, B. W., & Rich, J. D. (2014). Integrating correctional and community health care for formerly incarcerated people who are eligible for Medicaid. *Health Affairs*, 33, (3), 468-473.
- Pew Charitable Trusts (2014). *Managing Prison Health Care Spending*. Retrieved from <http://www.pewtrusts.org/en/research-and-analysis/reports/2014/05/15/managing-prison-health-care-spending>
- Raimer, B. G., Murray, O. J., & Pulvino, J. (2010). Health care in the Texas prison system: A looming fiscal crisis. *Texas Public Health Journal*, 62, (4), 12-17.
- Regenstein, M., & Rosenbaum, S. (2014). What the Affordable Care Act means for people with jail stays. *Health Affairs*, 33, (3), 448-454.
- Reynolds v. Wagner, 128 F.3d 166 (1997).
- Schaenman, P., Davies, E., Jordan, R., & Chakraborty, R. (2013). *Opportunities for cost savings in corrections without sacrificing service quality: Inmate health care*. The Urban Institute. Retrieved from <http://www.urban.org/research/publication/opportunities-cost-savings-corrections-without-sacrificing-service-quality-inmate-health-care>
- Services for which neither the beneficiary nor any other person is legally obligated to pay, 42 CFR § 411.4 (2007).
- U.S. Department of Health and Human Services, Centers for Medicaid and Medicare Services. (2013). Medical coverage of items and services furnished to beneficiaries in custody under a penal authority (Report No. ICN 908084). Retrieved from <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Items-Services-Furnished-to-Beneficiaries-in-Custody-Under-Penal-Authority-Fact-Sheet-ICN908084.pdf>
- U.S. Department of Health and Human Services, Centers for Medicaid and Medicare Services. (2014). Medicare Claims Processing Manual (Publication No. 100-04). Retrieved from <https://www.cms.gov/regulations-and-guidance/guidance/manuals/internet-only-manuals-ioms-items/cms018912.html>
- U.S. Department of Health and Human Services, Office of Inspector General. (2001). Review of Medicare payments for services provided to incarcerated beneficiaries (Report No. A-04-00-05568). Retrieved from <http://oig.hhs.gov/oas/reports/region4/40005568.pdf>
- U.S. Department of Health and Human Services, Office of Inspector General. (2002). Review of Medicare payments for services provided to incarcerated beneficiaries in the Commonwealth of Virginia (Report No. A-03-02-00003). Retrieved from <http://oig.hhs.gov/oas/reports/region3/30200003.pdf>
- U.S. Department of Health and Human Services, Office of Inspector General. (2002). Medicare payments for services provided to California residents identified as incarcerated (Report No. A-09-02-00050). Retrieved from <http://oig.hhs.gov/oas/reports/region9/90200050.pdf>
- U.S. Department of Health and Human Services, Office of Inspector General. (2002). Review of Medicare payments for services provided to incarcerated beneficiaries in the State of Maryland (Report No. A-03-02-00004). Retrieved from <http://oig.hhs.gov/oas/reports/region3/30200004.pdf>
- U.S. Department of Health and Human Services, Office of Inspector General. (2002). Review of Medicare payments for beneficiaries incarcerated in the State of Michigan (Report No. A-05-02-00029). Retrieved from <http://oig.hhs.gov/oas/reports/region5/50200029.pdf>
- U.S. Department of Health and Human Services, Office of Inspector General. (2002). Review of Medicare payments for services provided to incarcerated beneficiaries in the State of Missouri (Report No. A-07-02-03008). Retrieved from <http://oig.hhs.gov/oas/reports/region7/70203008.pdf>
- U.S. Department of Health and Human Services, Office of Inspector General. (2002). Review of

- Medicare payments for services provided to incarcerated beneficiaries in New York State (Report No. A-02-02-01002). Retrieved from <https://oig.hhs.gov/oas/reports/region2/20201002.pdf>
- U.S. Department of Health and Human Services, Office of Inspector General. (2002). Review of Medicare payments for incarcerated beneficiaries in the State of Ohio (Report No. A-05-02-00028). Retrieved from <https://oig.hhs.gov/oas/reports/region5/50200028.pdf>
- U.S. Department of Health and Human Services, Office of Inspector General. (2002). Review of Medicare payments for services provided to incarcerated beneficiaries in the State of Florida (Report No. A-04-02-05012). Retrieved from <http://oig.hhs.gov/oas/reports/region4/40205012.pdf>
- U.S. Department of Health and Human Services, Office of Inspector General. (2002). Review of Medicare payments for services provided for incarcerated beneficiaries in the State of Louisiana (Report No. A-06-02-00036). Retrieved from <http://oig.hhs.gov/oas/reports/region6/60200036.pdf>
- U.S. Department of Health and Human Services, Office of Inspector General. (2002). Review of Medicare payments for services provided for incarcerated beneficiaries in the State of Texas (Report No. A-06-02-00008). Retrieved from <http://oig.hhs.gov/oas/reports/region6/60200008.pdf>
- U.S. Department of Health and Human Services, Office of Inspector General. (2013). Medicare improperly paid providers millions of dollars for incarcerated beneficiaries who received services during 2009 through 2011 (Report No. A-07-12-01113). Retrieved from <http://oig.hhs.gov/oas/reports/region7/71201113.pdf>
- U.S. Department of Justice, National Institute of Corrections. (2004). Correctional Health Care: Addressing the Needs of Elderly, Chronically Ill, and Terminally Ill Inmates. Retrieved from <http://nicic.gov/library/018735>
- U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics. (2011). Prisoners in 2010 (Report No. NCJ 236096). Retrieved from <http://www.bjs.gov/content/pub/pdf/p10.pdf>
- U.S. Government Accountability Office. (2014). Information on Inmate Eligibility and Federal Costs for Allowable Services (Report No. GA 14-752R). Retrieved from <http://www.gao.gov/products/GAO-14-752R>
- Vesely, R. (2010). Another aging population: More states considering early-release programs for older, infirm inmates. *Modern Healthcare*, 40, (13), 32-33.
- Vogt, R. (2002). *Inmate Co-Pay Finds Support in the Courts*. National Commission on Correctional Health Care. Retrieved from [http://www.ncchc.org/pubs/CC\\_archive/co-pay.html](http://www.ncchc.org/pubs/CC_archive/co-pay.html)
- Wachler and Associates Health Law Blog. (2013). CMS issues demand letters to providers and suppliers with claims for services provided to allegedly incarcerated beneficiaries. Retrieved from <http://www.wachlerblog.com/2013/07/cms-issues-demand-letters-issued-to-providers-and-suppliers-with-claims-for-services-provided-to-all.html>
- Williams, B. A., Goodwin, J. S., Baillargeon, J., Ahalt, C., & Walter, L. C. (2012). Addressing the aging crisis in U.S. criminal justice health care. *Journal of the American Geriatrics Society*, 60, (6), 1150-1156.
- WPS Government Health Administrators. (2015). *Modifier QJ Fact Sheet*. Retrieved from <http://www.wpsmedicare.com/j5macpartb/resources/modifiers/modifier-qj.shtml>
- Yamamoto, L. (2009). Overcrowded Prisons and Filial Responsibility: Will States Utilize Support of the Indigent Statutes to Solve the Baby Boomer and Prison Crises. *Rutgers Law Journal*, 41, 435-478.

**APPENDIX A**

<b>2015 OIG AUDIT RESULTS - MEDICARE PAYMENTS FOR INCARCERATED BENEFICIARIES IN 10 STATES</b>	
<b>Proper Claims (in sample of 100) and Reasons for Claims Being Proper</b>	<b>Improper Claims (in sample of 100) and Reasons for Claims Being Improper</b>
<b>California:</b> 30,992 total claims of \$6,680,655 (OIG Report No. A-09-02-00050, 2002)	
<p>58 claims totaling \$18,074</p> <ul style="list-style-type: none"> <li>• 45 claims were for California DMH beneficiaries. The 45 DMH beneficiaries were committed to 4 state-operated psychiatric hospitals under various California Penal and Welfare and Institutions Codes that met Medicare reimbursement criteria. “We determined that payments made on behalf of the 45 DMH patients were allowable and consistent with Medicare reimbursement requirements because California law required that incarcerated beneficiaries pay for their own healthcare costs and uniform collection procedures were enforced. Our review of DMH’s collection procedures on Medicare and non-Medicare claims showed that collection procedures were adequate and applied uniformly for all claims.”</li> <li>• 12 claims were for beneficiaries who were not in custody on the sampled dates of service. These 12 claims were submitted for beneficiaries who were either on state parole, county probation or held for evaluation at a county jail under a Welfare and Institutions Code, which met Medicare reimbursement requirements.</li> <li>• The remaining beneficiary was in a state mental hospital in New York for the sample date of service. This state mental hospital holds all patients financially responsible for services provided to them and uniform collection procedures were enforced. Therefore, the Medicare payment for the service provided to this beneficiary was allowable.</li> </ul>	<p>12 claims totaling \$1,467</p> <ul style="list-style-type: none"> <li>• 9 claims were submitted for DMH beneficiaries who were committed under California Penal and Welfare and Institutions Codes that were not allowable under Medicare reimbursement criteria. Of the 9 DMH claims, 7 claims were submitted for beneficiaries committed under Penal Codes 2962 and 2972. The eligibility of claims for beneficiaries held under Penal Codes 2962 and 2972 is covered under Penal Code 2976(a), which states: “The cost of inpatient or outpatient treatment under Section 2962 or 2972 shall be a state expense while the person is under the jurisdiction of the Department of Corrections or the State Department of Mental Health.”</li> <li>• The 2 other DMH claims were submitted for beneficiaries committed under Welfare and Institutions Code 5008. These beneficiaries were being held by the state as being “gravely disabled” individuals. One of the facts that must exist for a person to be considered “gravely disabled” under Welfare and Institutions Code 5008 is that the indictment or information pending against the defendant has not been dismissed. Since the indictment or information was not dismissed, the beneficiary was in custody of the state for a penal code violation.</li> <li>• The remaining 3 unallowable claims were submitted for beneficiaries who were incarcerated at state correctional facilities on the dates of service. Under Title 15 of Penal Code Section 5054, the state is responsible for the health care costs of prisoners who are in the custody of the state correctional system. Section 5054 of the Penal Code states: “The supervision, management and control of the State prisons, and the responsibility for the care, custody, treatment, training, discipline and employment of persons confined therein are vested in the director.”</li> </ul> <p>30 claims: Unable to determine the whereabouts of the beneficiary at the time of the claim.</p>

<b>Florida:</b> 3,343 total claims of \$1,385,806 (OIG Report No. A-04-02-05012, 2002)	
71 claims totaling \$24,349 <ul style="list-style-type: none"> <li>• 70 claims were submitted on behalf of beneficiaries not incarcerated at the time of the service.</li> <li>• 1 claim was allowable because though Florida pays the health care costs for prisoners under the Department of Correction jurisdiction and Florida does not have a law requiring prisoners to pay for their own health care costs while in the custody of the state correctional system, Florida Statute 951.032 and Section 916.107(2)(a) of the Florida statute for Mentally Deficient and Mentally Ill Defendants requires inmates to pay for their health care costs while in custody of county or mental health facilities. Therefore, Medicare would pay for the cost of health care services if the facilities pursue collection of health care debts for all individuals in custody. One claim was allowable because the facility pursued collection of the debt.</li> </ul>	24 claims totaling \$3714 <ul style="list-style-type: none"> <li>• 19 were improper because the facilities did not use due diligence in pursuing collection of the cost of health care services. “In our testing of collection efforts, we noted in several instances that the county jails and/or mental facilities could not provide documentation of their collection efforts. Even when we requested documentation on current billings these facilities were unable to provide collection documentation. Based on our review, collection of health care costs by entities were nonexistent or token efforts.”</li> <li>• 1 was improper because the beneficiary was incarcerated in a state prison.</li> <li>• 4 were improper because the beneficiaries were housed or being held for federal agencies such as the U.S. Marshal’s office, the Drug Enforcement Agency and the Federal Bureau of Prisons and are unallowable as each of these agencies has fiscal responsibility for the health care of persons in their custody.</li> </ul> 5 claims: Unable to determine the custody status of the beneficiaries at the time of medical services.
<b>Louisiana:</b> 1,633 total claims of \$1,254,806 (OIG Report No. A-06-02-00036, 2002)	
75 claims totaling \$108,474 <ul style="list-style-type: none"> <li>• 35 claims were submitted on behalf of beneficiaries not in custody.</li> <li>• 18 claims were on behalf of prisoners in custody and 22 on behalf of beneficiaries placed in state-operated psychiatric hospitals. Louisiana law requires individuals who are in custody in parish or state correctional facilities or state-operated psychiatric hospitals to repay the cost of medical services and because collection of these medical expenses was pursued, Medicare reimbursement was allowable.</li> </ul>	18 claims totaling \$688 <ul style="list-style-type: none"> <li>• 7 claims were for prisoners in parish prisons with policies that did not allow Medicare to be billed on behalf of prisoners.</li> <li>• 3 claims were for prisoners in a state hospital with a policy that did not allow Medicare to be billed on behalf of prisoners.</li> <li>• 4 claims were for prisoners in parish prisons where the parish is responsible for all medical bills, and the prisoners have no legal obligation to pay for medical services.</li> <li>• 1 claim was submitted to Medicare on behalf of a Federal prisoner whereas this claim should have been submitted to Federal Prisons.</li> <li>• 2 claims had no supporting medical documentation.</li> <li>• 1 claim was for a service not provided.</li> </ul> 7 claims: Unable to determine if the claims were allowable. Could not determine the exact whereabouts of 3 beneficiaries and could not obtain provider information for the remaining 2.
<b>Maryland:</b> 1,500 total claims of \$604,649 (OIG Report No. A-03-02-00004, 2002)	
70 claims totaling \$53,820	2 claims totaling \$2,328

<ul style="list-style-type: none"> <li>• 35 claims for beneficiaries in state psychiatric hospitals after finding of NGRI/IST (Not guilty by reason of insanity) and Title 16-102 of Maryland Health Care Code requires that patients admitted to any state hospital pay their own expenses for their medical and psychiatric care and treatment.</li> <li>• An additional 35 claims were proper because the beneficiaries were not in custody under penal statute at the time services were rendered. 27 claims were for beneficiaries who were found to be NGRI but had been released on probation to halfway homes on the dates of service, and were therefore, not in custody. According to a state DHMH official, the department is not financially responsible for conditionally released beneficiaries after they are released from the state psychiatric hospitals. For the remaining 8 claims, evidence suggested they were not in custody at the times of service.</li> </ul>	<ul style="list-style-type: none"> <li>• The 2 claims were submitted on behalf of beneficiaries who were inmates in local county correctional facilities at the time of services. Though Title 11, Section 203, of the Maryland Correctional Services Code states that inmates in local correctional facilities are liable for their health care costs, the due diligence requirement was not met because neither the county detention centers nor their health care contractors make any attempt to collect health care costs from inmates.</li> </ul> <p>28 claims: Unable to determine the whereabouts of the beneficiary at the time of the claim.</p>
<p><b>Michigan:</b> 3,921 total claims of \$1,428,463 (OIG Report No. A-05-02-00029, 2002)</p>	
<p>93 claims totaling \$23,854</p> <ul style="list-style-type: none"> <li>• 63 claims for beneficiaries in psychiatric hospitals operated by the Michigan Department of Community Health and Section 330.1804 of the Mental Health Code for the Michigan Department of Community Health provides that individuals receiving mental health care are financially liable for the cost of services. The Administrative Rules also state that delinquent accounts be turned over to the Department of Treasury for collection.</li> <li>• 30 additional claims were also allowable because the beneficiaries were not incarcerated on the day of the medical service.</li> </ul>	<p>3 claims totaling \$724</p> <ul style="list-style-type: none"> <li>• 3 unallowable claims for a Federal prisoner in a county jail and two State prisoners in Michigan prisons. The Federal prisoner was taken from the county jail to a hospital and Medicare was incorrectly billed for the service. Claims applicable to both State prisoners were for durable medical equipment. These claims should not have occurred because State prisoners are not responsible for the costs of their medical care. The State of Michigan has an agreement with a private contractor to arrange for medical services for individuals in the custody of the State prison system.</li> </ul> <p>4 claims: Unable to determine the whereabouts of the beneficiary at the time of the claim.</p>
<p><b>Missouri:</b> 22,404 total claims of \$1,989,310 (OIG Report No. A-07-02-03008, 2002)</p>	
<p>100 claims totaling \$18,359</p> <ul style="list-style-type: none"> <li>• All made on behalf of forensic beneficiaries placed in psychiatric hospitals after finding of NGRI/IST. Missouri Statute Section 552.080 requires all state mental health patients to reimburse the state for their cost of care and the state “follows all of the various laws and regulations regarding the diligent pursuit of payments and therefore all of the payments made by Medicare for these claims were allowable.”</li> <li>• For other incarcerated individuals, Missouri Statute, Sections 217.829 requires these</li> </ul>	<p>0 claims</p>

<p>individuals to reimburse the DOC for the cost of their care while incarcerated. This law, if followed, would allow the Missouri state prisons to bill Medicare. However, the Missouri DOC has a contract with Correctional Medical Services to pay for all care provided to state prisoners. Therefore, the state prisons should not bill any other insurance company, including Medicare, for medical services provided to state prisoners.</p>	
<p><b>New York:</b> 6,370 total claims of \$3,060,595 (OIG Report No. A-02-02-01002, 2002)</p>	
<p>74 claims totaling \$27,248</p> <ul style="list-style-type: none"> <li>• 50 claims for 29 beneficiaries who were committed by court order to mental health facilities under Section 330.201 of NY’s Criminal Procedure Law. Since these beneficiaries, under NY law, had an obligation to repay the state for their medical services, the Medicare payments were considered allowable.</li> <li>• 3 claims for 2 beneficiaries who were placed in NY psychiatric facilities for non-criminal reasons (i.e., civil commitments). Under a civil commitment in NY, the individual is considered liable for services received. Therefore, the Medicare payments were considered allowable.</li> <li>• 21 claims for 10 beneficiaries who were not incarcerated on the date of service.</li> </ul>	<p>16 claims totaling \$597</p> <ul style="list-style-type: none"> <li>• 13 claims for 5 beneficiaries, totaling \$476, were unallowable under Medicare regulations, because the beneficiaries did not have a legal obligation to pay for the medical services received. The improper billing of these services occurred due to a misinterpretation by the NY Office of Mental Retardation and Developmental Disabilities (OMRDD) of the State Mental Hygiene Law, regarding the financial liability of patients receiving medical services under a CPL 730.30 (fitness to proceed) criminal court order.</li> <li>• 3 claims for 3 beneficiaries, totaling \$122, were inappropriately billed to Medicare for individuals residing in Federal or local correctional facilities. The Medicare providers apparently were unaware the individuals were incarcerated.</li> </ul> <p>10 claims: Unable to confirm the whereabouts of the beneficiaries at the time the services were rendered.</p>
<p><b>Ohio:</b> 12,195 total claims of \$2,237,619 (OIG Report No. A-05-02-00028, 2002)</p>	
<p>100 claims totaling \$12,774</p> <ul style="list-style-type: none"> <li>• 92 claims for beneficiaries in psychiatric hospitals operated by the Ohio Department of Mental Health and Ohio Revised Code 5121 provides that beneficiaries in the custody of the Department of Mental Health are responsible for the costs of medical care regardless of legal status. Ohio Revised Code 131.02 states that delinquent accounts will be turned over to the Attorney General for collection. The collection procedures at the Department of Mental Health are adequate and applied uniformly to all individuals.</li> <li>• 8 claims were for beneficiaries who were not incarcerated on the day of the medical service.</li> </ul>	<p>0 claims</p>
<p><b>Texas:</b> 3,873 total claims of \$1,798,523 (OIG Report No. A-06-02-00008, 2002)</p>	
<p>90 claims totaling \$45,034</p> <ul style="list-style-type: none"> <li>• 55 because beneficiaries were not incarcerated at</li> </ul>	<p>5 claims totaling \$150</p> <ul style="list-style-type: none"> <li>• 2 for services provided to incarcerated</li> </ul>

<p>the time of the service.</p> <ul style="list-style-type: none"> <li>• 34 because beneficiaries placed in state-operated psychiatric hospitals after finding of NGRI/IST and Texas law requires the client, the client’s spouse, or other person of legal responsibility to pay expenses.</li> <li>• 1 because the beneficiary was placed in county-operated psychiatric facility and “Texas law applicable to this facility also requires that payment for services be based on an individual’s ability to pay.”</li> </ul>	<p>beneficiaries in state prison for whom health care is funded by the state of Texas.</p> <ul style="list-style-type: none"> <li>• 3 for services provided to incarcerated beneficiaries in county jails. Though Texas law states that prisoners who receive medical services while in custody of a county jail are required to pay for such services, the counties involved were not enforcing the law and therefore Medicare reimbursement was improper.</li> </ul> <p>5 claims: Unable to determine the whereabouts of the beneficiary at the time of the claim.</p>
<p><b>Virginia:</b> 3,585 total claims of \$1,561,725 (OIG Report No. A-03-02-00003, 2002)</p>	
<p>81 claims totaling \$22,589</p> <ul style="list-style-type: none"> <li>• Beneficiaries placed in state-operated psychiatric hospitals after finding of NGRI/IST. Section 37.1-105 of the Virginia Code requires patients admitted to any state hospital pay their own expenses for their medical and psychiatric care and treatment. Collection procedures were “adequate and uniformly applied for all claims.”</li> </ul>	<p>8 claims totaling \$6,550</p> <ul style="list-style-type: none"> <li>• Services provided to incarcerated beneficiaries and Virginia does not have a law requiring prisoners to pay for their own health care costs while in the custody of the state correctional system and there are no local laws that require inmates to pay for their health care costs while in custody.</li> </ul> <p>11 claims: Unable to determine the whereabouts of the beneficiary at the time of the claim.</p>