

compliance

Billing for Incarcerated Patients

BY CINDY PARMAN, CPC, CPC-H, RCC

As part of the judicial system, law enforcement officers are authorized by federal, state, and local lawmakers to arrest and confine individuals, either juveniles or adults, suspected of crimes. This confinement, whether before or after a criminal conviction, is called incarceration. According to the National Library of Medicine, the prison population of the United States has quadrupled in the past 25 years, and the country now incarcerates more people per capita than any other nation. Worldwide, imprisonment per 100,000 ranges from 30 in India to 75 in Norway, 119 in China, 148 in the United Kingdom, 628 in Russia, and 750 in the United States.

Healthcare Payments While Incarcerated

Currently, nearly 2.3 million U.S. inmates (about 1 percent of U.S. adults) must rely on their jailers for healthcare. However, there is little nationally available data on the health and healthcare of America's prisoners.

"Corrections Health Care Costs," published by The Council of State Governments, states:¹

There are two main reasons why states must pay for inmate health care. First, states are constitutionally mandated and court ordered to provide reasonable levels of care to inmates, including the provision for health care. Otherwise, states are subject to lawsuits brought on by mistreated inmates, which can cost millions of dollars. Secondly, thousands of prisoners are released back into communities each year. Inmates are more likely to acquire communicable diseases while

incarcerated and, likewise, share those diseases once released. The identification of diseases upon entry and the treatment of diseases during incarceration protect inmates and communities from the spread of infection, ultimately saving long-term costs and lives.

Today the most widely accepted policy is to provide inmates with a community standard of care. The community standard of care is based on the level of care someone in the community would normally receive. Despite attempts to regulate a community standard of care, states maintain definitions such as:

- Providing patients what they need medically, not what they want
- Providing care comparable to what a beneficiary of insurance, a government program such as Medicaid or Medicare, a health maintenance organization, or a private patient would medically receive
- Providing care that is medically necessary, not necessarily care that is medically acceptable, yet allowing practitioners to make exceptions to the policy on a case-by-case basis.

As a result, the provision of healthcare varies significantly across states and types of correctional facilities. Some larger prisons have infirmaries onsite, and many prisons hire independent physicians or contract with private or hospital staff to provide care with the majority of prisons, creating a hybrid system. In jails, healthcare is primarily provided through contracts with local healthcare providers, such as public hospitals or other safety-net providers, who come to the jails to provide services.² A

2009 study found that among inmates with a persistent medical problem, approximately 14 percent of federal inmates, 20 percent of state inmates, and 68 percent of local jail inmates did not receive a medical examination while incarcerated. For example, the state of Tennessee includes the following Q&A on its website:³

Does providing medical care include payment for the treatment? *Not necessarily. The county has fulfilled its constitutional obligation by seeing that the inmate is taken promptly to a hospital or other appropriate facility that provides the necessary treatment, and as long as the county ensures that the medical care is provided, the Constitution does not dictate how the cost of the care should be allocated as between the county and the medical provider. That is a matter of state law. See City of Revere v. Massachusetts General Hospital, 463 U.S. 239 (1983). The state statute requires only that the county ensures medical treatment is provided; it does not require that the county pay for the treatment. See Williams v. Anderson County, et al., an unpublished opinion of the Tennessee Court of Appeals issued December 20, 1988. The county's obligation is to ensure that the inmate receives the necessary medical treatment. If the only way the county can fulfill this obligation is to agree to pay for the services, then the county must do so.*

While correctional facilities must provide health services to people who are incarcerated, that does not mean that the care delivered is free of charge. According to the study, "Charging Inmates Perpetuates Mass Incarceration," inmates may owe copay-

ments ranging from a few dollars to as much as \$100 for medical care.⁴ At least 35 states authorize copayments and other fees for medical services at state prisons or county jails, according to the analysis by the Brennan Center for Criminal Justice at New York University School of Law.⁵

The Affordable Care Act (ACA) offers new opportunities to increase health coverage among individuals transitioning back into the community from prisons and jails. According to HealthCare.gov, special rules apply to healthcare options for individuals who are incarcerated, which is defined for the Marketplace as serving a term in prison or in jail.⁶ While incarcerated, individuals cannot buy insurance through the Marketplace, but once released there is a 60-day special enrollment period to sign up for private health insurance coverage. In addition, individuals who are in prison can apply for Medicaid coverage in their state, but Medicaid generally does not pay for any medical care for incarcerated individuals. Once released, however, these patients may be able to access healthcare quickly through the Medicaid program.

Medicare Coverage

According to MedicareInteractive.org:⁷

Medicare generally will not pay for your healthcare while you are incarcerated. Instead, your correctional facility will typically provide and pay for medical care while you are in custody. Once you are released, Medicare will cover your care as long as you remain enrolled in Medicare and follow Medicare's rules.

According to the CMS publication, "Medicare Coverage of Items and Services Furnished to Beneficiaries in Custody Under a Penal Authority" (July 2016), beneficiaries in custody (or incarcerated) include, but are not limited to, those individuals who are:

- Under arrest
- Incarcerated
- Imprisoned
- Escaped from confinement
- Under supervised release
- On medical furlough

- Required to reside in mental health facilities
- Required to reside in halfway houses
- Required to live under home detention
- Confined completely or partially in any way under a penal statute or rule.

Healthcare for incarcerated patients has been an ongoing problem; the Office of Inspector General (OIG) published a special report, *Review of Medicare Payments for Services Provided to Incarcerated Beneficiaries*, in October 2002.⁸ Medicare acknowledged the overpayments detected in that report, which were attributed to the fact that incarceration data from the Social Security Administration was not contained in the CMS records, and Medicare contractors did not have controls in place to detect claims submitted on behalf of incarcerated patients.

This report was followed by the January 2013 OIG document, "Medicare Improperly Paid Providers Millions of Dollars for Incarcerated Beneficiaries Who Received Services During 2009 Through 2011."⁹ According to this publication, CMS controls were adequate to prevent payment of Medicare services when the data systems indicated that the beneficiary was incarcerated. However, when the systems were not updated until after a claim had been processed, CMS controls were not adequate to detect and recoup the improper payment.

A recent HHS OIG semiannual report to Congress (October 1, 2016 – March 31, 2017) includes the following area of concern:¹⁰

"Medicare Improperly Paid Providers Millions of Dollars for Incarcerated Beneficiaries Who Received Services During 2013 and 2014." The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) requires CMS to establish policies and implement claim edits to ensure that payments are not made for Medicare services rendered to incarcerated beneficiaries. Our audit found that CMS's policies and procedures did not allow CMS to detect and recoup improper payments to beneficiaries who were incarcerated. CMS has not taken steps to determine

whether any of the \$34.6 million in potentially improper payments (for claims for incarcerated beneficiaries) made in 2013 and 2014 should have been denied.

CMS concurred with our recommendations to review the \$34.6 million in claims to determine which portion, if any, was not claimed in accordance with Medicare requirements; direct the Medicare contractors to recoup any ensuing improper payments; and identify improper payments made on behalf of incarcerated beneficiaries after our audit period to ensure that Medicare contractors recoup those payments.

This echoes information in the 2017 OIG Work Plan, which adds that Medicare does not pay for services rendered to incarcerated beneficiaries because they do not have a legal obligation to pay for medical care (Social Security Act, §1862).¹¹ However, the Code of Federal Regulations [42 CFR § 411.4(b)] allows Medicare payment when an incarcerated beneficiary has an obligation for the cost of care. This means that services furnished for incarcerated beneficiaries are covered by Medicare when *both* of the following criteria are met:


- State or local law requires those individuals or groups of individuals to repay the cost of medical services they receive while in custody.
- The state or local government entity enforces the requirement to pay by billing and seeking collection from all such individuals or groups of individuals in custody with the same legal status (for example, not guilty by reason of insanity), whether insured or uninsured. It must also pursue collection of the amounts owed in the same manner and with the same vigor that it pursues the collection of other debts. This includes the collection of any Medicare deductible and coinsurance amounts and the costs of items and services that are not covered by Medicare.

When both criteria are satisfied, the healthcare services are billed with modifier:

- **OJ.** Services provided to a prisoner or patient in state or local custody, however, the state or local government, as applicable, meets the requirements of 42 CFR § 411.4(b).

Closing Considerations

Individuals moving into and out of the criminal justice population are a low-income population, often with significant physical and mental health needs. Historically, this population has had high uninsured rates and very limited access to Medicaid coverage given the program's limited eligibility for adults prior to the ACA. The ACA's Medicaid expansion and Marketplaces, coupled with targeted outreach and enrollment efforts, provide opportunities to increase coverage among this population that should improve their ability to access needed care and contribute to greater stability in their lives.

Now is a good time for all cancer program providers to revisit policies, procedures, and billing protocols for incarcerated patients; and to review, revise, or implement contracts and set payment rates with local law enforcement authorities regarding these patients. Lastly, all providers should ensure that their billing staff remain aware of the special rules regarding incarcerated patients so that these services are not billed to insurance in error. 

Cindy Parman, CPC, CPC-H, RCC, is a principal at Coding Strategies, Inc., in Powder Springs, Ga.

References

1. The Council of State Governments. "Corrections Health Care Costs. Available online at: prisonpolicy.org/scans/csg/Corrections+Health+Care+Costs+1-21-04.pdf. Last accessed July 27, 2017.
2. Gates A, Artiga S, Rudowitz R. Health Coverage and Care for the Adult Criminal Justice-Involved Population. Available online at: kff.org/uninsured/issue-brief/health-coverage-and-care-for-the-adult-criminal-justice-involved-population. Last accessed July 27, 2017.
3. County Technical Assistance Service: Institute for Public Service. Who Pays the Medical Bills for Inmates in the County Jail? Available online at: ctas.tennessee.edu/content/who-pays-medical-bills-inmates-county-jail. Last accessed July 27, 2017.
4. Brennan Center for Justice. Charging Inmates Perpetuates Mass Incarceration. Available online at: brennancenter.org/publication/charging-inmates-perpetuates-mass-incarceration. Last accessed July 27, 2017.
5. Brennan Center for Justice. Is Charging Inmates to Stay in Prison Smart Policy? Available online at: brennancenter.org/states-pay-stay-charges. Last accessed July 27, 2017.
6. Healthcare.gov. Incarcerated People. Available online at: healthcare.gov/incarcerated-people. Last accessed July 27, 2017.
7. Medicare Interactive.org. Introduction to Medicare and Incarceration. Available online at: medicareinteractive.org/get-answers/medicare-and-other-types-of-insurance/medicare-and-incarceration/introduction-to-medicare-and-incarceration. Last accessed July 27, 2017.
8. OIG. Review of Medicare Payment for Services Provided to Incarcerated Beneficiaries. Available online at: oig.hhs.gov/oas/reports/region7/70203008.pdf. Last accessed July 27, 2017.
9. OIG. Medicare Improperly Paid Providers Millions of Dollars for Incarcerated Beneficiaries Who Received Services During 2009 through 2011. Available online at: oig.hhs.gov/oas/reports/region7/71201113.pdf. Last accessed July 27, 2017.
10. OIG. Spring 2017 Semiannual Report to Congress. Available online at: oig.hhs.gov/reports-and-publications/semiannual/index.asp#sar. Last accessed July 27, 2017.
11. OIG. Archives: Workplans. Available online at: oig.hhs.gov/reports-and-publications/archives/workplan/index.asp. Last accessed July 27, 2017.