

Returning Home

Access to Health Care After Prison



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Incarcerated people experience increased rates of mental illness, substance abuse, and chronic and infectious disease. These populations also frequently are adversely affected by socioeconomic risk factors for poor health, including lower educational attainment and higher rates of poverty. Given this risk, such populations are in clear need of significant health services. Particularly upon release from an institution or correctional facility, former inmates may require substantial assistance in securing health care benefits and access. Without Medicaid or other programs, however, many individuals do not have access to appropriate care.

Some states have developed strategies and programs to improve access to health care and social services for prisoners released from institutions. These include reentry planning, pre-release screening and assistance with Medicaid applications. In a few states, “suspension,” rather than termination, of Medicaid benefits has been used to ensure access to health care and other needed support.

This brief provides background on the unique health care concerns at community reentry, policy experiences of states in reentry planning, integration of services and Medicaid suspension.

HEALTH NEEDS OF THE POPULATION

Incarcerated people experience significant health care needs while in jail or prison. Up to 44 percent of state prison inmates report a health problem beyond a cold or virus,¹ although fewer than 70 percent see a health care professional as a result of their complaint.² About one-quarter (24 percent) of inmates report chronic problems such as hypertension, diabetes or heart trouble;³ another 15 percent suffer from arthritis.⁴ Infectious diseases are equally problematic: Almost 10 percent of state prison inmates have tuberculosis,⁵ and the rate of HIV infection is triple that of the total U.S. population.⁶

Mental illness also is prevalent in corrections facilities. A 2006 Department of Justice report found that more than half (56 percent) of inmates in state prisons reported some

form of mental problem.⁷ Substantial proportions of state prison inmates reported symptoms that met the criteria for diagnosis of mania (43 percent), major depression (23 percent) or a psychotic disorder (15 percent).⁸ These proportions are even larger in local jail prisoners.

People with mental illness also are several times more likely to be incarcerated than those without—at a rate as much as eight times higher for women, in particular.⁹ This picture is further complicated by the high rate of co-occurrence of mental illness and substance abuse disorders (which may be a cause of incarceration).¹⁰ Nearly half (45 percent) of state prison inmates report problems with alcohol dependence or abuse, and a similar number (44 percent) suffer from drug dependence or abuse.¹¹ Three-quarters of state and local inmates with some form of mental problem also report co-occurring substance abuse or dependence.¹²

Correctional facilities provide health care for inmates and screen inmates for various conditions. Nine in 10 inmates report giving a health or medical history at admission,¹³ and the same proportion report being asked if they think about suicide.¹⁴ Some 70 percent of state prison inmates have been screened for HIV at some point since admission.¹⁵



EFFECTIVENESS OF REENTRY POLICIES

Policies and approaches that link those reentering their communities with needed mental health care, substance abuse services, or other health services yield clear benefits, including reduced recidivism, increased use of treatment for substance abuse and dependence, and increased use of health services.¹⁶

Reduced recidivism has obvious benefits, not least of which is the cost to the state. The Pennsylvania Department of Corrections, for example, estimates its cost for incarcerating prisoners is \$80 per day; for mentally ill inmates the cost is significantly higher at \$140 per day.¹⁷

Improved infectious and chronic disease management also reduce direct and indirect health care costs to the state and private sector.

MEDICAID SUSPENSION

Medicaid policy often is central to the reentry debate, due to its role as the principal financing source of care for many former prisoners. Medicaid coverage can be a boon to newly released prisoners, enabling access to care and services; equally important is the need to provide the information and support necessary to obtain such services in the community.

Federal financial participation rules prohibit use of federal funds to provide Medicaid services for prisoners.¹⁸ States traditionally have terminated Medicaid benefits upon incarceration to eliminate the possibility of incorrect billing. Suspension, rather than termination, of Medicaid benefits avoids inappropriate billing to the federal government and eases reentry to coverage upon release. Implementation of such a policy requires significant intraagency cooperation and communication. For example, some states establish memorandums of understanding or significant liaison between departments of health and corrections or other involved state agencies. Administrative obstacles exist not only at incarceration (and benefit suspension), but also at release.

Although several program evaluations reveal the benefits of health care access in transition periods, few studies have specifically examined the effectiveness of Medicaid suspension. Data from a preliminary study shows that

enrollment in Medicaid upon release from corrections facilities can contribute to reduced recidivism; inmates enrolled in Medicaid on the day of release committed fewer repeat offenses, and the time between offenses was longer.¹⁹ This research lends support to the practice of pre-release reenrollment as well, because merely having Medicaid benefits on the day of release—rather than suspension of benefits specifically—demonstrated improved results. A Virginia analysis addresses this point, suggesting there is no practical difference between suspension and termination because individuals are subject to eligibility review after any change in personal circumstances, including incarceration or release.²⁰ Ultimately, although research shows that being enrolled in Medicaid is helpful to released prisoners, no research indicates suspension is preferable to reenrollment.

REENTRY PLANNING AND CONNECTION WITH COMMUNITY SERVICES

Other reentry programs that focused on maintaining or implementing health management or mental health treatment programs also yielded reduced rates of rearrest.

The Nathaniel Project, a transition program for mentally ill felons in New York City, showed more than a tenfold reduction in rearrests (among 53 participants, rearrests dropped from 101 in the previous year to seven in the year after they entered the program).²¹ The recidivism rate for participants in a Pennsylvania mental health program was reduced to only 10 percent.²² Another study revealed that participation in a substance abuse aftercare program reduced rearrest rates among released inmates by 50 percent.²³ (Department of Justice statistics estimate that, overall, approximately two-thirds of those released from prison are re-arrested within three years.²⁴) Although these results are promising, more research is required to determine which programs—and which program elements—have the most positive effect on recidivism rates.

POLICY EXPERIENCES IN STATES

States have attempted to implement policies that improve inmates' transition into their communities, particularly related to guaranteeing access to health care and mental health support and other social services.

Such policies include suspension of Medicaid benefits, as described earlier, as well as pre-release reentry planning and collaboration with other agencies and community organizations.

Some jurisdictions, such as Hampden County, Mass., have initiated efforts to collect better information about post-release offenders, particularly monitoring recidivism in an attempt to determine some of its causes.²⁵ Advocates note that, without good information about the health needs of exiting prisoners, any effort to identify resources and opportunities to address health problems is a daunting task.²⁶

SUSPENSION OF MEDICAID BENEFITS

Suspension, rather than termination, of Medicaid benefits allows the state to reinstate benefits when a prisoner is released, providing continuity of access to care that otherwise would not be available to most corrections releasees. As recently as 1999, no states used this approach; all simply terminated Medicaid benefits upon incarceration.²⁷

Since then, however, letters from the Centers for Medicare and Medicaid Services (CMS) have clarified federal policy and encouraged state action in this area. In 2001, then-Secretary Tommy Thompson of the U.S. Department of Health and Human Services (HHS) stated that federal rules require no termination of benefits, but merely preclude federal financial participation.²⁸ CMS also has stated that matched administrative funding can be used to implement and operate Medicaid suspension programs²⁹ and help inmates apply, pre-release, for Medicaid benefits upon reentry.³⁰

Research indicates that four states have implemented requirements to suspend, rather than terminate, prisoners' Medicaid benefits.

New York established a suspension requirement in April 2008 through an administrative directive.³¹ At incarceration, Medicaid cases are switched to suspension status (and disenrolled from managed care, if necessary). At release, the inmate's information is forwarded to the appropriate agency and benefits are reinstated for at least four months, at which point the case is subject to eligibility review.³² Medical Assistance office staff report

that implementation has been uneventful, but that it is too early to determine the policy's effect on recidivism.³³

Florida has a similar provision in law, which states that anyone entering prison who is receiving Medicaid benefits shall have those benefits reinstated upon leaving prison. The individual will be subject to eligibility review at some point after release.³⁴ Maryland's statute, passed in 2005, requires suspension of benefits and prohibits termination of Medicaid benefits at incarceration.³⁵ North Carolina requires suspension under a 2008 administrative directive to county directors of social services.³⁶

Other states protect short-term inmates. Oregon's Interim Incarceration Disenrollment Policy prohibits an individual's disenrollment from a health plan for the first 14 days of incarceration.³⁷ Similarly, Texas and Washington do not disenroll individuals during the first 30 days of incarceration.³⁸

Despite significant potential for improved access to health care, suspension of benefits clearly offers no solution for individuals who are unenrolled or ineligible at incarceration.³⁹

PRE-RELEASE REENTRY PLANNING

Many states and local agencies use other strategies to coordinate reentry into the community, particularly focusing on access to health care and mental health or substance abuse services.

California's Department of Corrections and Rehabilitation established a stand-alone office to deal with reentry planning in 2006. The Division of Reentry and Recidivism Reduction must deal with several key elements of prisoner reentry, including "...improved offender risk and needs assessments; improved case management; improving wrap around services for the offender; a continuity of support between custody and parole; and improving collaborative partnerships between corrections, law enforcement and local community service providers."

Some corrections facilities and agencies provide some type of "reentry packages" or provisions. New York City jails provide personal care and harm reduction kits (in English and Spanish) that contain items such as condoms or personal hygiene products and information about local

social services.⁴⁰ Travis County, Texas, jails give releasees contact sheets with telephone numbers of substance abuse services and medical providers.⁴¹ Other facilities issue copies of inmates' updated medical histories,⁴² including any prescribed medications or test results.

Some facilities complete full-fledged, individually tailored reentry plans. Advocates suggest that these plans should be completed in collaboration and reviewed with the inmate. The Assessment, Planning, Identification, Coordination (APIC) model, promoted by the Substance Abuse and Mental Health Services Agency (SAMHSA) and piloted in Rensselaer County, N.Y., and Montgomery County, Md., underscores a cooperative effort between the inmate, corrections staff and community providers.⁴³ To improve inmate buy-in and participation, New York City inmates are required to sign their plans.⁴⁴

The Riker's Island Discharge Enhancement (RIDE) program in New York includes early screening and assessment, access to employment programs, streamlined processing for government forms, pre-release application for Medicaid benefits, and connection to case management in the community.⁴⁵ Davidson County, N. C., reentry planning includes providing information about medical and mental health appointments and referrals.⁴⁶ Making appointments with community providers may be necessary to ensure out-of-institution care, particularly for high-need inmates who must deal with HIV, mental illness or substance abuse issues.

An administrator's "tool kit" for reentry planning released by the John Jay College of Criminal Justice suggests that written reentry plans cover the following:⁴⁷

- Mental health care
- Medical care
- Medications
- Appointments
- Housing
- Employment
- Substance/alcohol abuse
- Health care/benefits
- Income/benefits
- Food/clothing
- Transportation
- Identification
- Life skills
- Family/children
- Emergency numbers for assistance
- Referrals to other services, court dates
- Summary of jail/prison-based medical history

COLLABORATION WITH OTHER STATE/LOCAL AGENCIES

In a 2003 study, 39 states and the District of Columbia reported at least 90 transition-specific or joint in-house and transition programs that involved collaboration by state or local corrections agencies with public health agencies.⁴⁸ Collaboration most frequently focuses on HIV-positive inmates or mental health services provision.⁴⁹

The Florida Department of Health has used grant funding to support pre-release counselors for HIV-positive inmates in correctional facilities; the counselors continue to provide care for 30 days following release.⁵⁰ Other state programs provide a limited supply of AIDS/HIV medication upon release (often via Ryan White funding).⁵¹ The Community Reentry for Women (CREW) program in Suffolk County, Mass., partners with the South End Community Health Center to provide health services to female inmates after release.⁵² Iowa's Department of Public Health provides on-site substance abuse treatment and counseling and discharge planning for inmates admitted to the program. The same case managers who work with prisoners continue to monitor their progress and outcomes after community reentry.⁵³

Virginia's Department of Corrections partners with local participating jails to administer a three-phase reentry program. Phases I and II occur before release and incorporate education about community resources and work-release programs. Phase III is a 45-day post-release support period, during which program staff continue to help participants and connect them with services in the community.⁵⁴

New York's Medication Grant Program pays for psychiatric medication for people leaving jails or prisons, with the provision that the individual must apply for Medicaid before or within seven days of release.⁵⁵ Georgia's Transition and Aftercare for Probationers and Parolees (TAPP) program paired newly-released mentally ill inmates with case managers from the Department of Human Resources' Mental Health Division. They help former inmates find housing, schedule and attend medical appointments, and secure other services.⁵⁶ Funding for this program recently cut, highlighting the effects of a struggling economy on reentry programs.

Partnerships with state Medicaid agencies also can be fruitful; as noted above, states can use Medicaid administrative funds to help inmates apply for Medicaid before release. Medicaid agencies can partner with corrections facilities to provide this assistance and to ensure that the necessary forms and information are available to inmates.⁵⁷ California's Department of Health Care Services and the state's Department of Corrections and Rehabilitation, for example agreed on a process to secure Medi-Cal benefits for new releasees; responsibility is shared for various steps of the process.⁵⁸

CMS RECOMMENDATIONS

On several occasions, CMS has explicitly urged states to ensure Medicaid benefits for eligible, newly released prisoners. A letter from then-Secretary Tommy Thompson to U.S. Representative Charles Rangel stated that, "Unless a state determines that an individual is no longer eligible for Medicaid, states must ensure that incarcerated individuals are returned to the Medicaid eligibility rolls immediately upon release."⁵⁹ In a 2004 letter to state Medicaid directors, Glenn Stanton, then-acting director of the Disabled and Elderly Health Programs Group at CMS, cited the importance of "...establishing a continuum of care and ongoing support that may reduce the demand for costly and inappropriate services later."⁶⁰

CMS also highlights best practices for reentry planning, particularly for prisoners who are at risk of becoming homeless when they are released or those who have mental illness and substance abuse problems.⁶¹ These best practices include the following:

- Pre-release planning, including pre-release application for Medicaid;
- Suspension of Medicaid enrollment;
- Partnerships between criminal justice and other state agencies;
- Case management, pre- and post-release; and
- Discharge planning, including planning for health services, such as making appointments for community-based care or obtaining prescription drugs.

RECOMMENDATIONS FOR STATE HEALTH POLICYMAKERS

Establishing policies and programs to ensure access to health care and mental health services for this particularly at-risk population can dramatically improve personal results, both in terms of physical and mental health and in reducing recidivism. Such policies and programs have the potential to significantly affect state corrections and public health expenditures.

States have addressed this issue in a number of ways, including innovative reentry planning, collaboration with local care providers and public health agencies, and suspending, rather than terminating, Medicaid benefits.

Programs that engage the inmate in his or her reentry planning and transition can offer an opportunity for greater buy-in and increased long-term success. Collaboration that develops stronger relationships between corrections staff, local providers and public health agencies enable smoother transitions and greater continuity of care at reentry.

This policy area requires significant additional research and evaluation. Study of the comparative benefits of various programs, pre-release Medicaid enrollment and Medicaid suspension could shed new light on health and behavioral results. Improved data collection also would s better inform policymaking and program design.

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