USING HEALTH REFORM TO ENHANCE HEALTH OUTCOMES FOR FORMER INMATES

10 STEPS TO IMPROVE THE RETURN

REFORM TOOLS

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In March of 2010, the Patient Protection and Affordable Care Act (PPACA), Public Law 111-148, and the Health Care and Education Reconciliation Act, Public Law 111-152, were passed and signed into law. Together, they became known as the Affordable Care Act or National Health Care Reform.

A noteworthy element of the PPACA, which becomes fully enacted in 2014, is the opportunity for states to expand Medicaid eligibility to all individuals at or below 133% of the federal poverty level, regardless of their parental or marital status, disability determination, age, or justice-system involvement.[2]

The Affordable Care Act Opportunity

It is believed that at least 35% of new Medicaid enrollees under the PPACA will have a history of involvement in the justice system.[3]

Adults returning from jails and prisons are high-volume consumers of costly, but often low-value care that fails to provide for their long-term health. Returning inmates often have significant physical and behavioral health issues, with limited access to routine diagnostic services and low adherence to preventative care. With repeated cycles through emergency rooms, detox centers, crisis centers, and psychiatric hospitals, their care is inefficient, uncoordinated, and costly. As a result, county and state healthcare systems are paying higher costs for poorer health outcomes.[4]

While jails and prisons are responsible for providing medical care to incarcerated individuals, there is generally a disconnect between correctional medicine and community healthcare. Historically, correctional administrators have relied on community services for released inmates, which are underfunded, time-limited, and stretched to capacity—reaching only a tiny proportion of the population in need.

Further, in most states, Medicaid eligibility is currently limited to adults with disabilities, those who are actively parenting (not including incarcerated parents), and those 65 and older. As a result, most offenders must rely on insufficient treatment resources that are typically funded through a combination of state general revenues, federal block grants, and county and municipal funds. To maximize the tremendous benefit PPACA will provide to correctional populations, correctional administrators and programs need to build and enhance their relationships with community providers to support successful reentry, thereby reducing the potential for relapse and recidivism.

Correctional Healthcare Planning

Jails and public health systems see a lot of the same people over and over again at different points in time. National health reform presents an opportunity for corrections to alter its practices to improve effectiveness and efficiency. While many correctional institutions have begun to shift practices in alignment with forthcoming reform policies, others are lagging behind.

Ten basic action steps—spanning intake into prisons and jails through return to the community—can prepare county and state correctional programs for Health Care Reform enactment in 2014. To implement these steps, both county and state systems may require fundamental legislative, policy, administrative, and operational reforms.

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Correctional Phase: Intake/Pre-treatment

Step 1: Standardize screens for behavioral health needs. Inmates should receive standardized, evidence-based screenings that indicate next steps to address healthcare needs. Screenings should be universal and help to identify the segment of the correctional population that does not require further assessment. Some states already use standardized best practice screening tools in all of their correctional facilities, and some use screening tools that are also used by community providers; however, other states and jurisdictions need to begin such screening programs.

Step 2: Begin screening for benefit eligibility at intake. As Medicaid eligibility is uncommon among inmates, currently initial intake screening does not include a benefit eligibility screening. Correctional staff should now include questions about prior and current (pre-incarceration) receipt of public benefits. Under Health Care Reform, information on pre-incarceration income levels confirm that the inmate's income was below 133% of the poverty level will facilitate Medicaid eligibility.

A "flag" should be added to client files to reflect benefit status and eligibility to assist in enrollment during the pre-release phase. You will first need to establish legal residency.

Step 3: Preserve existing benefits. Particularly relevant to jail and county correctional facilities, federal Social Security policy currently allows states to suspend, rather than terminate, Medicaid coverage for inmates incarcerated for less than 12 consecutive months. For this reason, corrections facilities should develop a process to also flag inmates who received benefits and take steps to preserve their eligibility to continue to receive them upon release. Even inmates in work release programs may be able to re-open their disability cases if they are no longer covered by correctional health services and if they have not been in prison for 12 consecutive months. This action step may necessitate collaboration with the state agency that "switches on" Medicaid. In some states this is the Medicaid Authority; in others it is the Department of Human Services; and yet in others, it is the Department of Insurance.

Correctional Phase: Pre-release/Transition

Step 4: Assist prisoners to complete applications for benefits. Pre-release planning staff should check if a benefit "flag" exists in the inmate's file. Once the PPACA takes effect, the application for Medicaid will be much shorter and requires basic information, including: name, address, social security number, employment and income status, and number of dependent children. All applications for benefits should be completed within 60-90 days prior to inmate release.

Step 5: Identify diversified payment strategies. Many inmates are eligible for federal benefits that supplement or enhance Medicaid benefits. These may include veterans' benefits for those who have served in the military, Medicare, or Ryan White CARE Act-funded services for people living with HIV. If inmates were receiving medical care prior to incarceration, planning can include moving them back to that familiar healthcare environment upon release whenever possible.

Step 6: Develop information-sharing processes. All inmates should complete consent-to-share information and other necessary privacy documentation to allow for an information flow of health records beginning at intake. County jails should transfer health-related information for inmates who received screening, assessment, and health services pre-trial or while detained if defendants are subsequently incarcerated elsewhere.

With the advent of national health reform come new and expanded electronic record-sharing requirements between justice and health and human services agencies and organizations. Aside from reductions in duplicative information collection and data entry, there are numerous benefits resulting from health information technology to correctional institutions. These include improved access to prior healthcare information and better communication between community providers and correctional staff to prepare for release. The PPACA encourages the use of a statewide central health information technology system and provides incentives to states that comply. Correctional administrators should collaborate with health and human service agencies to coordinate mandated data collection and record-sharing to ensure former inmates' needs are considered. The extent to which you can share information will depend on whether the county jail is a covered entity (all prisons are covered entities) and whether your state has state-specific information sharing protocols around behavioral health information sharing.

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Step 7: Facilitate benefit enrollment. Inmates should complete the enrollment materials for Medicaid or the new subsidized insurance programs during incarceration, thereby reducing the wait time for enrollment once they are released. If inmates walk out the door with coverage, they can go straight into health and behavioral healthcare services without having to worry about whether the agencies have been funded and have room for them. Documentation upon release is also a crucial component of securing benefits. This includes release documentation, medical summaries, diagnostic information, and treatment records.

Step 8: Facilitate enrollment into healthcare services. If healthcare appointments are scheduled for inmates before they are released, re-entering offenders can go straight into treatment programs and have access to primary care without having to wait for treatment. As ample research has documented, the first few days post-release is the most crucial time for individuals to successfully seek services and engage in services that reduce relapse and recidivism.

Correctional Phase: Post-release/Time Served or Parole

Step 9: Build and enhance community partnerships. Creating reentry programs that are linked with community services can significantly reduce rearrests, recidivism, and technical violations. Jails and prisons must have strong relationships with community providers of substance abuse and mental health treatment, as well as medical providers to care for released inmates with chronic illness. Now is the time to initiate or solidify relationships with these community health resources. Foundational steps include making sure specific contacts are identified at each relevant organization or agency. Jails and prisons should have dedicated transitional planning staff to assist inmates successfully link up with relevant and appropriate community health resources.

Step 10: Provide adequate medication to inmates upon release. In most states, inmates who are on parole are given a limited supply of medication if needed. Often, however, this medication is depleted before the former inmates have obtained appointments with healthcare providers. Correctional administrators should build relationships with community health centers to develop a strategy for using Medicaid to support an uninterrupted medication regimen after release. This is particularly crucial for substance abusers receiving medication assisted treatment, or those with acute or chronic health conditions to avoid relapses and hospitalization.

Correctional Healthcare Implementation

In summary, planning for and implementing the rules within the PPACA requires recognition of both opportunities and challenges. Jail and prison administrators and policymakers should:

- Share data across different disciplines and technological systems.
- Provide input to states about the types of healthcare services that should be included in benefits for correctional populations.
- Work with community healthcare providers to increase service capacity to address the needs of released inmates. The criminal justice system is a major source of customers for substance abuse and mental health treatment. It is important for jail and prison administrators to talk with providers about the increase in utilization once reentering offenders have coverage. Planning for expanded capacity is difficult when states are struggling to meet the current needs of Medicaid recipients.
- Develop new relationships with providers such as community health centers and providers that did not previously serve individuals without private insurance.

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The PPACA presents an opportunity to bolster post-release engagement and sustainment in health and human services for corrections populations. Enormous cost savings for corrections and significant increases in public safety can be realized through a sophisticated strategy, which leverages national health reform through Medicaid expansion and improved linkages to the community-based healthcare system.

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[2] States may choose not to expand Medicaid coverage to 133% above the federal poverty level without losing their current federal Medicaid funding. Persons who are below the filing threshold for federal income taxes would be exempt from the mandate to carry a minimum level of coverage.

[3] Solicitation for a Cooperative Agreement-Evaluating Early Access to Medicaid as a Reentry Strategy. A Notice by the National Institute of Corrections on 07/06/2011. Document Citation: 76 FR 39438; Page: 39438–39443. Retrieved on July 24, 2012 at: https://federalregister.gov/a/2011–16844

[4] M. McDonnell, et al. (2011). Realizing the Potential of National Health Care Reform to Reduce Criminal Justice Expenditures and Recidivism among Jail Populations, COCHS Issue Paper.