Ensuring Access to Medicaid During and After Incarceration:

Key Policy Considerations in the Wake of Medicaid Expansion in North Carolina

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Executive Summary

Medicaid is a federal and state government program providing health insurance for approximately 85 million individuals with financial need, effectively addressing health disparities and lowering mortality rates.[1] With the passage of the Affordable Care Act in 2010, states have had the option to expand Medicaid to certain individuals based on financial need without requiring that those individuals meet any additional eligibility criteria. Although the specific income requirements vary by state, in North Carolina, adults making up to 138 percent of the federal poverty level will be eligible.[2] On March 27, 2023, North Carolina joined 40 other states and DC in expanding Medicaid eligibility.[3] It is estimated that an additional 600,000 people will be newly eligible for Medicaid in North Carolina as a result of the expansion.[4] The expansion will take effect upon signing of the North Carolina FY2023-24 budget appropriations act.[5]

While implementation of expanded Medicaid will take months, the time for strategizing and planning to make expansion as smooth and impactful as possible is now. Formerly incarcerated individuals frequently lack any form of health insurance and face considerable barriers to enrolling in Medicaid, often due to rules requiring suspension or termination of Medicaid during incarceration and difficulty in obtaining required documentation to be re-instated or enroll de novo.[6] These individuals return to the community with no means to pay for needed medical care and medications. Experience from other expansion states shows that to maximize the benefits of Medicaid expansion, North Carolina state policymakers should consider how best to design systems to ensure that justice-involved individuals, both while incarcerated and after returning to communities, have equitable access to Medicaid coverage. Numerous studies demonstrate that consistent access to healthcare in the reentry period reduces mortality and recidivism.[7] Additionally, to equitably enroll justice-involved individuals in Medicaid, policymakers must expand the current reentry programming and support across the state.

For these reasons, this report suggests that policymakers consider the following when implementing Medicaid expansion:

- **Amend NC's Section 1115 Waiver to allow incarcerated individuals to receive treatment with community providers under Medicaid up to 90 days prior to release, including case management services and institutional in-reach.** Under the Medicaid Inmate Exclusion Policy, incarcerated individuals' Medicaid enrollment is typically either terminated or suspended while incarcerated, creating harmful gaps in coverage and access to healthcare. This includes the many individuals merely awaiting trial who have never been convicted of a crime. Additionally, providing access to care coordination and connection to community health care promotes continuity of care for individuals. NC should file an amended Section 1115 waiver to allow for incarcerated individuals to receive treatment services up to 90 days prior to release.

- **Fully implement NC FAST data sharing system between North Carolina jails and NC DHHS.** Currently, prisons share data through NC FAST on Medicaid enrollment status with NC DHHS, facilitating immediate reinstated coverage for individuals returning to communities. However, jails do not participate in the same data sharing system, leading to harmful gaps in coverage for individuals returning to communities from jails. State policymakers should work to connect NC jails with the NC FAST system to allow coverage to be reinstated for individuals leaving jails.

- **Use the Medicaid expansion bonus funds to support reentry services across the state.** NC will be eligible for approximately $1.75 billion in additional funding from the federal government for Medicaid expansion.[8] Policymakers should support Governor Cooper's request that portion of these funds should be prioritized to support reentry services across the state, funding additional state resourced as well as non-profits and local reentry councils.[9] A portion of these funds should be used to support universal pre-release Medicaid screening in jails and prisons.

- **Require Medicaid managed care plans to provide care coordination services in jails and prisons to improve continuity of care.** Managed care plans contracted with NC Medicaid should be required to provide care coordination services in jails and prisons. These programs may reduce recidivism rates and emergency department use among participants.

- **Implement universal Medicaid screening for individuals sentenced to probation.** Individuals under community supervision outnumber incarcerated individuals in North Carolina. These individuals also face barriers in accessing Medicaid insurance, with individuals under community supervision having higher rates of uninsurance than the general public. Probation and parole officers should receive training to facilitate applications and enrollments.

- **In partnership with local jails and the DMV, DAC or DHHS should create a standardized jail release form.** Standardized forms and guaranteed acceptance by DMV would ensure that formerly incarcerated individuals can obtain required identification documents for Medicaid enrollment.

Justice-Involved Individuals Disproportionately Face Barriers Accessing Healthcare

Justice-involved people are more likely than the general population to lack private insurance. While no state-level insurance data is available for North Carolina's incarcerated individuals, the Bureau of Justice Statistics' National Survey of Prison Inmates in 2016 found that 50% of individuals in state prisons lacked health insurance at the time of their arrest.[10] The federal Medicaid Inmate Exclusion Policy is one significant barrier, because it forbids Medicaid reimbursement for services provided in jail or prison settings. As a result of this policy, Medicaid coverage is terminated or suspended when a person is incarcerated. The only exception is inpatient services in a medical institution lasting more than 24 hours, including hospitals, nursing facilities, and intermediate care facilities.[11] This provision does not revoke the Medicaid eligibility of justice-involved individuals, but simply removes their ability to access Medicaid while detained. Because a high proportion of recently incarcerated people come from low-income backgrounds or have serious mental illnesses or other medical conditions that may qualify them for Medicaid, the Medicaid program plays a vital role in ensuring access to safe and affordable care.[12] The Medicaid Inmate Exclusion Policy creates a potential coverage gap for individuals after their release, if Medicaid is not immediately reinstated upon release. While prisons and jails are supposed to screen individuals for Medicaid eligibility before release to prevent coverage gaps, this rarely occurs in practice. One study found that only 28 percent of jails nationwide screen for Medicaid eligibility at release to ensure post-release coverage.[13] This disruption in Medicaid coverage through the Inmate Exclusion Policy, which prohibits use of Medicaid by incarcerated individuals, is likely a contributor to low insurance coverage rates among formerly incarcerated individuals who are eligible for Medicaid. In 2014, over 30% of nonelderly adults recently involved in the justice system were uninsured, compared to 15% of those with no involvement.[14]

Most Justice-Involved Individuals in North Carolina Likely Qualify for Medicaid Under Expansion

In the U.S., adults in poverty are three times more likely to be arrested than those who aren't, and individuals earning less than 150% of the federal poverty level are fifteen times more likely to be charged with a felony.[15] In 2014, incarcerated people had a median annual income of $19,185 prior to incarceration – 41% less than non-incarcerated people of similar ages.[16] In North Carolina, 30% of the prison population has a ninth grade education or less, and 99% have no more than a high school degree.[17] Additionally, a North Carolina Department of Correction survey found that 36% of people entering prison had been homeless at some point, and 7% had been homeless immediately before arrest.[18]

Moreover, regardless of their status prior to entering prison, individuals leaving prison are highly unlikely to be employed and therefore would meet financial criteria for Medicaid under expansion. Reentering individuals are likely to have had significant barriers to employment prior to incarceration; after incarceration these barriers may be expected to increase, particularly for those with a felony record or a long period away from society.

Ensuring Access to Medicaid Would Greatly Improve Outcomes for Justice-Involved Individuals

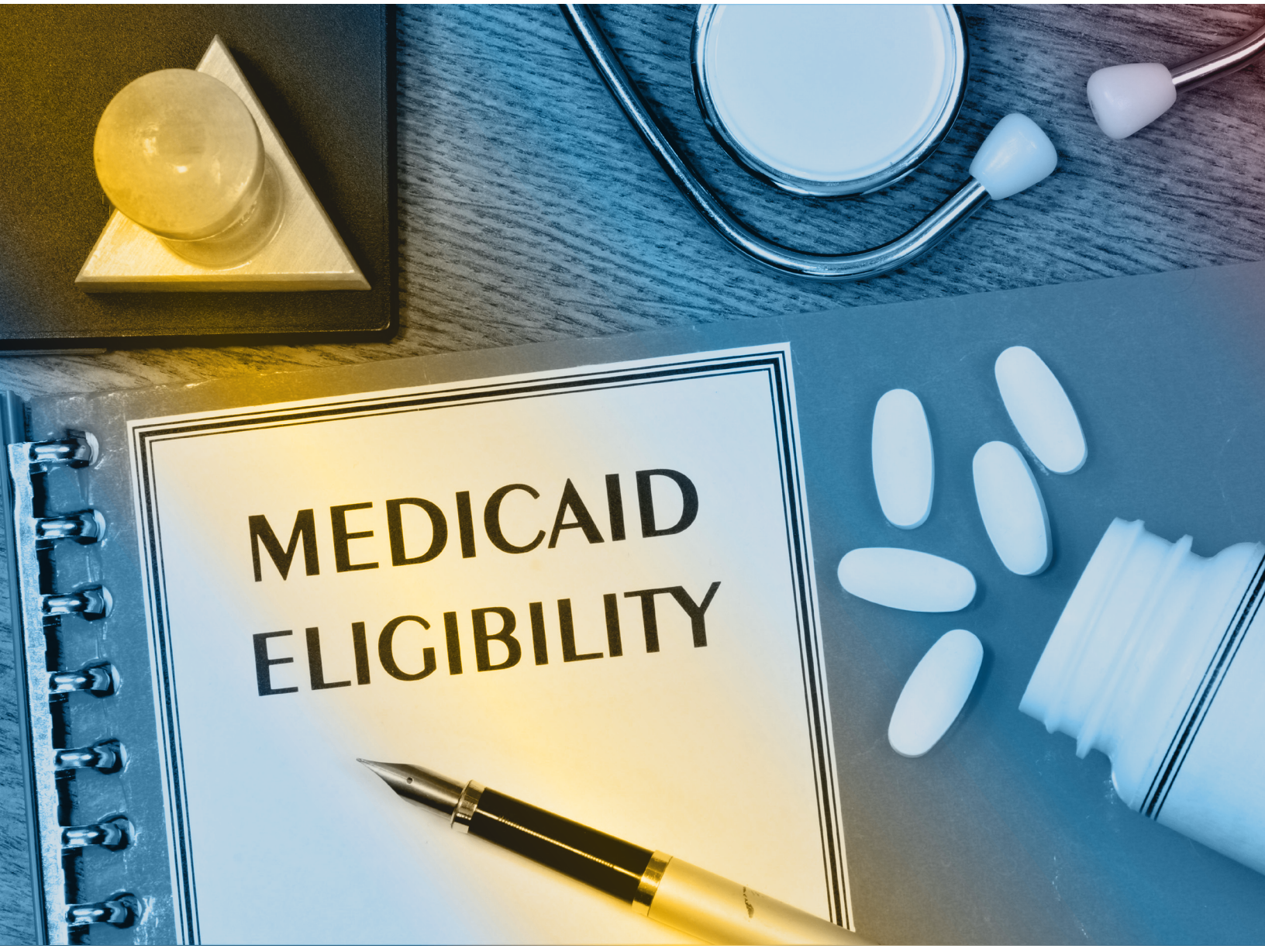
The first days and weeks of reentry are periods of heightened vulnerability for individuals leaving incarceration. Formerly incarcerated individuals face barriers to employment, housing, reconnecting with services, and reestablishing social connections.[19] Individuals released from incarceration face significantly higher risks for adverse health outcomes due to preexisting behavioral health and chronic medical conditions as well as the harmful impacts of incarceration. Structural barriers to healthcare and social determinants of wellbeing and healthcare amplify the impact of these risk factors. Compared with the general population aged 18-65, incarcerated adults have 1.2 times the odds of hypertension, 1.3 times the odds of asthma, 4.2 times the odds of hepatitis, and 4.8 times the odds of cervical cancer.[20] Incarcerated individuals also experience higher rates of mental illness. Approximately half of individuals in U.S. jails and over one-third of individuals in U.S. prisons have been diagnosed with a mental illness.[21] Additionally, an estimated 65 percent of all U.S. prisoners have a substance use disorder, with an additional 20 percent estimated to not meet the criteria for substance use disorder, but were under the influence of drugs or alcohol at the time of the offense.[22] Finally, emerging pandemic research illustrates that incarcerated populations are over 5.5 times more likely to become infected with COVID-19 than the general US population and face higher risk for serious infections and long-term symptoms.[23]

Individuals receiving treatment for chronic health conditions in jail or prison abruptly lose access to this care upon release, including people who receive medication for serious mental illness. Furthermore, reentering individuals face higher risks for worsened health, rehospitalization, and mortality than the general population.[24] One study found that in the first two weeks post-release, individuals re-entering society die at twelve times the rate of the general population, primarily of heart disease, drug overdose, homicide, and suicide.[25] These elevated risk factors make healthcare a vital priority for individuals leaving incarceration, especially those with chronic disease, serious mental illness, or substance use disorder.

Numerous studies demonstrate the beneficial effects of health insurance coverage on outcomes for justice-involved individuals. While recidivism is the most commonly used measure of post-incarceration outcomes, successful reentry hinges on much more than simply staying out of jail or prison. Research has demonstrated that access to healthcare is a important determinant of successful reentry, along with employment, stable

housing, and social support. For some individuals, including those with serious mental illness, a lack of healthcare can derail reentry efforts that could otherwise have been successful.

In other Medicaid expansion states, evidence shows significant decreases in drug arrests, violent offense arrests, and low-level offense arrests.[26] In Florida, research has shown that Medicaid eligibility for juveniles may decrease overall incarceration rates over time.[27] A 2022 study also determined that Medicaid expansion was associated with significant reductions in rearrests for individuals reentering the community.[28]



Recommendations

1. NC should follow the lead of other expansion states that have amended their Section 1115 waivers to facilitate access to community providers up to 90 days prior to release for incarcerated individuals and ensure continuity of care during reentry

Under the federal inmate exclusion policy, states cannot claim Medicaid reimbursement for medical expenses incurred by individuals during their incarceration.[29] For this reason, states must terminate or suspend Medicaid coverage for individuals incarcerated in jails or prisons either at admission or after a period of time (e.g., 30 days after admission).[30] If coverage is terminated, the individual must reapply after release, but if coverage is only suspended, coverage can be reinstated immediately upon release by state agencies. It is also important to note that the federal inmate exclusion policy does not prohibit *enrollment* in Medicaid during periods of incarceration; it only prohibits *billing* Medicaid for medical treatment during incarceration.[31] To facilitate continuous treatment for incarcerated individuals up to 90 days prior to release, many states have requested waivers under Section 1115 of the Social Security Act to modify the restrictions of the inmate exclusion policy. Section 1115 gives the US Secretary of Health and Human Services authority to approve alternative program designs to improve their program and evaluate approaches to better serve community members.[32] As of December 2022, at least six states had Section 1115 waivers requesting modifications to the federal inmate exclusion policy.[33] For instance, in California, inmates with complex healthcare needs (including substance use disorders and mental health disorders) can receive case management and medication from Medicaid for up to 90 days prior to release.[34] In Montana, incarcerated individuals with substance use disorder, serious mental illness, and serious emotional disability can receive some community-based clinical services, in-reach services, and 30-days of medication.[35]

Recommendation:

Amend NC's Section 1115 Waiver to allow incarcerated individuals to enroll and receive treatment under Medicaid up to 90 days prior to release, including case management services and institutional in-reach.

- Jails and prisons may need to amend policies to allow community providers to provide treatment in the institutions.

2. Local jails should share data with the state Medicaid agency, to avoid Medication terminations during incarceration

NC DPS and NC DHHS share data using a system known as NC FAST to facilitate Medicaid terminations and suspensions in prisons. DPS currently uses NC FAST for three primary purposes: i) suspension of Medicaid at intake; ii) enrollment in Medicaid if necessary for inpatient treatment; and iii) reinstatement of coverage upon release.[36] For local jails, the NC FAST system is not currently in place, meaning the only possible outcome for individuals with Medicaid entering jails is termination rather than suspension. There is also no consistent process to re-enroll these individuals in Medicaid after they are released from jail. Individuals incarcerated in jails are also not systematically screened for Medicaid eligibility prior to reentering communities.

Recommendation:

Fully implement NC FAST data sharing system between North Carolina jails and NC DHHS.

- Implementing NC FAST data sharing between jails and DHHS would facilitate Medicaid suspensions, rather than terminations, for individuals incarcerated in jails. If the individual is released from jail to the community, Medicaid could be reinstated without the need for an additional application.
- Individuals incarcerated in jails could also be easily screened for Medicaid eligibility for inpatient medical needs or to facilitate reentry into the community.

3. Reentry service providers need more resources to assist eligible incarcerated individuals with Medicaid enrollment and connection to community care providers

In 2017, the North Carolina Department of Public Safety updated its policies and procedures concerning case management for individuals incarcerated in its prisons.[37] According to policy, while an individual is in the prison admission process, a Case Analyst will complete a Risk/Needs Assessment (RNA). The RNA, which classifies justice-involved individuals by their risk of reoffending and subsequent needs within prison, is used to structure an individual's Case Plan. Each Case Plan, created by an Initial Case Manager after processing, recommends jobs, programs, activities, and services that would benefit inmates while in prison, although participation in these programs is not mandatory. A subsequent Case Manager will meet with inmates as needed to review their case plan and progress.

Nine months prior to release, every incarcerated individual must meet with their Case Manager at least once a month to discuss their transition plan and report their expected residence upon release. The transition

plan includes a residence plan, interventions and services within prison, interventions and services within the community where each individual will reside, and an employment plan. Upon release, individuals returning to community should have a prison-issued ID and social security card, and may have other identification documentation if case managers are able to secure them. However, in practice, case management often does not meet these expectations due to staffing shortages and a lack of adequate funding, leaving incarcerated individuals without the proper documentation or support needed to reenter their community.

Jails often do not have social workers within their facilities, relying on outside organizations and agencies to bridge service needs. While some counties, such as Durham County, offer education, vocational, and self-improvement programs, the extent of case management and variation among counties is unknown to the decentralized system and lack of statewide jail data.[38]

Because of limited resources, local and state non-profits and agencies are tasked with supporting previously incarcerated individuals with Medicaid enrollment and other reentry services.

Local reentry councils

Founded by statute in 2011, local reentry councils provide case management and coordinated support to individuals returning to communities after periods of incarceration, including assistance with Medicaid enrollment and connection to healthcare resources. As of 2018, there were fourteen local reentry councils serving twenty councils. While some local reentry councils have successfully connected individuals to services in their respective counties, others have failed and become defunct. Stakeholders report concerns about staffing capabilities, funding streams, and accountability metrics. Additionally, the capabilities and funding for local reentry councils vary across the state.

Non-profit support: NC FIT

NC FIT provides medical and reentry services to incarcerated individuals with chronic disease, mental illness, or substance use disorders.[39] Through a partnership with the UNC Division of Family Medicine, DPS, the NC Community Health Center Association, county departments of public health, local reentry councils, and other community-based organizations, NC FIT connected Community Health Workers (CHWs), whom have previous incarceration history, with individuals leaving prisons and jails. Participants may receive vouchers to cover medication costs if they are uninsured or referrals to evidence-based substance disorder treatments upon release.[40] Initial seed funding was provided by the NC Division of Public Health and is currently funded through DPS contracts and grants from the Duke Endowment.

CASE STUDY

Arizona

In Arizona, incarcerated individuals not previously enrolled in Medicaid can begin the application process up to 30 days prior to release.[41] The Arizona Medicaid program has dedicated staff members to process these applications to facilitate approvals prior to release. Additionally, some counties in Arizona implemented special enrollment efforts targeting formerly and currently incarcerated individuals.[42] Maricopa County placed health insurance navigators in probation centers and the county also provides Medicaid enrollment and health insurance education sessions to individuals with substance use disorders.[43]

CASE STUDY

New Mexico

In New Mexico, Medicaid managed care plans must provide care coordination services for individuals returning to communities after incarceration.[44] One managed care plan created an in-reach project with the local jail, providing care coordination services in the facility twice a week. The project reduced the recidivism rate from 57 percent to 16 percent among project participants and reduced emergency department use by 64 percent.

Recommendation:

Use the Medicaid expansion bonus funds provided by the federal government after the passage of expansion to support reentry services across the state.

- The resources available now to support reentry and Medicaid enrollment do not meet the current need. When Medicaid eligibility expands, the need will only expand, creating even more burden on already taxed resources.
- To meet this need, DAC should hire additional staff (e.g. social workers, case managers, navigators, and community health workers to assist with reentry planning, including Medicaid eligibility screening.
  - The current Case Manager and Case Plan system are well-positioned to assist with Medicaid enrollment, if provided with additional resources.
  - These additional social workers could ensure that each individual returning to communities from prison are screened for Medicaid eligibility prior to release.
    - Under current guidelines, there is no limitation to enrolling individuals in Medicaid while incarcerated.[45] Individuals can apply and be enrolled, with their status set to suspended until release or an inpatient stay of greater than 24 hours.
    - Universal screening and enrollment during incarceration would allow individuals to receive coverage immediately upon release.
    - Regardless, individuals should be screened for Medicaid eligibility and applications initiated at least 45 days prior to release to accommodate average application processing times.[46]

- State and local policymakers should consider funding for local reentry councils and non-profits to assist in Medicaid enrollment for formerly incarcerated individuals.
  - » Non-profits already serving justice-involved populations could leverage these relationships to increase enrollment in Medicaid and connect individuals to healthcare providers.
- Service providers working with formerly incarcerated individuals should receive additional training on the criminal legal system and Medicaid in order to better serve the needs of these individuals.

Recommendation:

Require Medicaid managed care plans to provide care coordination services in jails and prisons.

- Managed care plans could be required to designate a specific contact person for jails and prisons to answer Medicaid-related questions.
- The care coordinators could conduct outreach to newly eligible individuals in jails and prisons.
- Once an incarcerated individual enrolls in a Medicaid plan, the plan could be required to conduct in-reach sessions with the individual, assessing needs and connecting the individual with care providers in the community.

4. Individuals currently under community supervision also require support in enrolling in Medicaid

As of December 2020, 65,808 individuals were under probation and 13,419 were under parole, meaning 1.6 times more people are under community supervision than incarcerated in the state.[47] Despite gains after the passage of the ACA, individuals under community supervision are still uninsured at higher rates than the general population.[48] Other expansion states have implemented programs to facilitate Medicaid enrollment among individuals under community supervision. For instance, Connecticut has implemented universal Medicaid screening for individuals sentenced to probation.[49] Probation officers initiate applications and special eligibility workers process applications at the state Medicaid agency. Similarly, Massachusetts trains parole officers as certified application counselors so they can complete applications.

Recommendation:

Implement universal Medicaid screening for individuals sentenced to probation.

- Probation and parole officers should receive certified application counselor training to facilitate Medicaid enrollments.

5. Jail release forms should be standardized to remove barriers to receiving state identification cards

As part of the Medicaid application, individuals must provide documents verifying identity, such as a state-issued identification card or driver's license from the DMV.[50] Under current policy, DAC is required to assist individuals in obtaining a social security card prior to release, but not a state-issued identification card. It would be good practice for DAC to also assist individuals in obtaining identification from the DMV.[51] In theory, any individual leaving prison with an accessible driving record, social security number, and a prison release form can receive an identification card from the DMV.[52] For individuals leaving jails, there is no such process in place and jails do not follow a standard release form template. For this reason, individuals leaving jail may face additional barriers to successful enrollment in Medicaid.

Recommendation:

In partnership with local jails and the DMV, DAC or DHHS should create a standardized jail release form to ensure acceptance of the form when individuals apply for identification cards.

- Engage DMV and local jail stakeholders to ensure the process can be implemented effectively.

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