REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 2-I-16

Subject: Health Care while Incarcerated
(Resolution 118-A-16)

Presented by: Peter S. Lund, MD, Chair

Referred to: Reference Committee J
(Candace E. Keller, MD, Chair)

At the 2015 Interim Meeting, the House of Delegates adopted as amended Resolution 801 (Policy D-430.994), which asked that the American Medical Association (AMA) study mental health and health care for incarcerated juvenile and adult individuals and identify the best mental health and health care models for local, state and federal facilities.

At the 2016 Annual Meeting, the House of Delegates referred Resolution 118, "Addressing the Health and Health Care Access Issues of Incarcerated Individuals," submitted by the Minority Affairs Section. Resolution 118-A-16 asked that our AMA advocate for:

> (1) an adequate number of health care providers to address the medical and mental health needs of incarcerated individuals; and (2) an adequate number of primary care and mental health personnel to provide adequate health care treatment to civilly committed (designated to correctional institutions), incarcerated, or detained individuals; and (3) the reversal of the "inmate exclusion clause" such that detainees and inmates who are eligible for state and federally funded insurance programs in the community maintain their eligibility when they are pre-trial, detained up to one year, and within one year of release to improve health outcomes in this vulnerable population and decrease its burden of racial and ethnic health care disparities.

The Board of Trustees referred these items to the Council on Medical Service for a report back to the House of Delegates at the 2016 Interim Meeting. This report provides background on the criminal justice population; explains the role of the Affordable Care Act (ACA) Medicaid expansion in accessing health care for the criminal justice population; highlights quality health care and behavioral health care delivery models in the correctional system; summarizes AMA policy and activity; discusses avenues to provide quality health care to the incarcerated population; and presents policy recommendations.

BACKGROUND

Testimony on Resolution 118-A-16 urged the AMA to address barriers to health care access for the incarcerated population and suggested that the requested study review the provision of behavioral and physical health care throughout the full continuum of incarceration from intake to re-entry into the community. Testimony also requested that the study address the training of correctional facility staff on providing behavioral health care; the training of correctional facility staff on providing prenatal care, delivery support and postpartum care; and the use and interoperability of electronic health records (EHRs) in correctional facilities.

Approximately 2.3 million individuals are currently incarcerated, including 34,000 juveniles in the juvenile justice system and 5,200 juveniles in adult prisons or jails.[1, 2] An additional 4.7 million individuals are on probation.[3] The incarcerated population disproportionately consists of low-income, uninsured, adult men of color.[4, 5, 6] It is widely acknowledged that the incarcerated population has a higher rate of chronic diseases, mental health conditions, substance use disorders and contagious diseases than the general population.[7] Juveniles may also have additional issues impacting their health, such as more recent histories of physical abuse or assault, sexual abuse or assault, victimization by sex trafficking, emotional abuse, neglect, domestic violence, traumatic loss, community violence and school violence.[8]

In a 1976 landmark case, *Estelle v. Gamble*, the US Supreme Court established that the standard of pleading required for a prisoner to assert a denial of access to health care constitutes "cruel and unusual punishment," which is in violation of the US Constitution.[9] Nevertheless, not all correctional systems comply with providing timely, comprehensive or high quality health care to their inmates. Many studies analyzing health care provided in correctional institutions are limited and outdated.

AFFORDABLE CARE ACT MEDICAID EXPANSION

Section 1905 of the Social Security Act prohibits the use of Medicaid funds for the cost of any services provided to an "inmate of a public institution," except when the individual is a "patient in a medical institution."[10, 11] This policy is referred to as the "Medicaid Inmate Payment Exclusion." Given the historically low number of incarcerated individuals who qualified for Medicaid, some states have not enrolled their inmates in the program.

The ACA has provided states with the opportunity to expand Medicaid eligibility to low-income childless adults, which characterizes the majority of the incarcerated population. States that have expanded Medicaid may now have the opportunity to enroll many of their inmates in Medicaid, which pays for inpatient care if needed and may facilitate continuity of care upon release. Given the increased number of inmates who could benefit from Medicaid coverage, many expansion states are eager to enroll their detainees. However, some state laws prohibit the submission of Medicaid applications during incarceration; whereas others permit submission, but no earlier than 30 days before release from custody.

An Illinois state law (HB 1046) was enacted in 2014 allowing individuals to apply for Medicaid while incarcerated with coverage taking effect upon release. Cook County Jail in Chicago has enrolled at least 11,000 inmates since the law went into effect. The state of New York has submitted a waiver request to the Centers for Medicare & Medicaid Services (CMS) asking to use Medicaid funding to pay for coordination of care services during the 30 days prior to an inmate's release. The status of the waiver is pending.

CMS has advised states to consider Medicaid as a valuable resource for their incarcerated populations. In May 2004, CMS issued guidance to state Medicaid agencies to suspend, rather than terminate, Medicaid enrollment when individuals become incarcerated in order to facilitate re-entry into the community.[12] Not every state has followed this guidance, as the majority of states currently terminate instead of suspend Medicaid eligibility upon intake into a correctional system.[13]

In April 2016, CMS issued a letter to state health officials providing guidance on facilitating successful re-entry for individuals transitioning from incarceration into their communities.[14] The guidance specified that individuals on probation, parole or community release pending trial are

eligible for Medicaid as are individuals residing in corrections-related, supervised community residential facilities.

HEALTH CARE MODELS

Policy D-430.994 requested that the AMA identify the best mental health and health care models for local, state and federal correctional facilities. The National Commission on Correctional Heath Care (NCCHC) has developed standards for how health care services should be delivered in jails, prisons, and juvenile facilities as well as for mental health services and opioid treatment programs. Implementing the standards and becoming accredited ensures that systems, policies and procedures are in place to provide quality delivery models for jails, prisons, and juvenile facilities as well as for mental health services and opioid treatment programs. Following are examples of NCCHC accredited health care delivery models on the local and federal levels.

Local: Maricopa County Jail System, Phoenix, AZ

Maricopa County Jail System received the NCCHC's "Facility of the Year" award in 2015 for its efficiency, coordination, information-sharing and provision of quality team-based health care. Inmates are considered patients and receive a comprehensive health screening during the intake process to allow staff to provide continuity of care and make necessary referrals for mental health, substance use or acute care services. Each of the six NCCHC accredited jails in the system include an outpatient clinic staffed by board-certified physicians, psychiatrists and mental health professionals providing medical care and mental health services. An EHR system facilitates coordination of health care services. The correctional system provides classes for inmates on substance use, mental health coping strategies, health care, education, parenting and transitioning into the community.[15] Assistance is provided with enrolling in health care coverage through Medicaid or the federal marketplace. [16, 17, 18]

Federal: Federal Bureau of Prisons

The Federal Bureau of Prisons (FBP) is the nation's largest correctional system with 121 institutions housing approximately 200,000 inmates. The FBP is overseen by a national health care governing board and mental health clinical care committee and uses a primary care team-based model to ensure continuity of health care. Comprehensive clinical practice guidelines have been developed that define the scope of health care services for federal inmates, which the FBP has published for other correctional systems to emulate.[19] The FBP includes centers of excellence, a system-wide infection control program, inmate access to organ transplants, a preventive health care program, an EHR system, telehealth and telepsychiatry.[20]

BEHAVIORAL HEALTH CARE

In the vast majority (44) of states, more seriously mentally ill individuals are incarcerated than are receiving treatment in psychiatric hospitals.[21, 22] The health care professionals and services necessary to address these inmates' behavioral health care needs are often lacking with many inmates not receiving adequate care. Cook County Jail in Chicago has developed a program to provide quality behavioral health care to its inmates.

Cook County Jail, Chicago, IL

Chicago's Cook County Jail is often referred to as the nation's largest mental health facility with approximately 30 percent of the 9,000 daily detainees having a serious mental health diagnosis.

The executive director of the jail is a clinical psychologist. The correctional facility includes a mental health transition center that provides mental health care, psychoeducation, peer support and re-entry services. Ongoing treatment at the center is available once an inmate is released. [23] The Cook County Circuit Court has a countywide network of specialty courts that includes mental health and drug treatment courts to assist individuals who have committed non-violent, nonsexual felonies, and are more in need of health care treatment than incarceration. A team of professionals coordinate efforts between members of the court system and outside organizations to guarantee that participants receive intensive treatment, interventions and supervision. The program has succeeded in significantly reducing its participants' recidivism rates.

RELEVANT AMA POLICY

Notably, Council on Science and Public Health Report 8-A-16, "Juvenile Justice System Reform," established Policy H-60.919, which comprehensively outlines ways to transform the juvenile justice system to focus on preventing delinquency, rehabilitating justice-involved youth, providing access to health care, ensuring a safe environment and prohibiting discrimination. Of note, Policy H-60.919[7] encourages states to suspend rather than terminate Medicaid coverage following arrest and detention.

AMA policy supports access to mental health services, including an adequate supply of psychiatrists, appropriate payment for all services provided and adequate funding levels for public sector mental health services (Policies H-345.981, D-345.997, D-345.998, H-345.976 and H-345.980). AMA Policy H-345.981 further advocates that the diagnosis and treatment of mental illnesses should be tailored to age, gender, race, culture and other characteristics that shape a person's identity. The AMA encourages physicians to become more involved in pre-crisis intervention, treatment and integration of chronic mentally ill patients into the community in order to prevent unnecessary jail confinement (Policies H-345.995 and H-95.931).

The AMA urges state and local health departments to foster closer working relations between the criminal justice, medical, and public health systems to ensure continuity of health care services (Policies H-430.989 and H-60.919). The AMA believes that correctional and detention facilities should provide medical, psychiatric and substance use treatment that meets prevailing community standards, including appropriate referrals for ongoing care upon release from the correctional facility in order to prevent recidivism (Policies H-430.997, H-430.987, H-430.988, H-440.931 and H-430.994). The AMA advocates for the maintenance of essential mental health services at the state level to identify and refer individuals with significant mental illnesses for treatment in order to avoid repeated interactions with the law primarily as a result of untreated mental health conditions (Policy H-345.975). The AMA supports the accreditation standards developed by the National Commission on Correctional Heath Care (NCCHC) to improve the quality of physical and behavioral health care services to the incarcerated population and encourages all correctional systems to support NCCHC accreditation (Policy D-430.997).

As outlined in Policy H-60.986, the AMA encourages state and county medical societies to become involved in the provision of adolescent health care within correctional facilities and to work to ensure that these facilities meet minimum national accreditation standards for health care as established by the NCCHC. The AMA opposes the use of solitary confinement in juvenile correctional facilities (Policy H-60.922), advocates that juveniles receive comprehensive screening and treatment for sexually transmitted infections and sexual abuse (Policy D-60.994), and that safeguards be in place to protect prisoners from sexual misconduct and assault (Policy D-430.999).

A correctional facility should use the least restrictive restraints necessary for pregnant inmates. No restraints of any kind should be used when an inmate is in labor, delivering her baby or recuperating from the delivery unless the inmate poses a serious threat of harm to herself or others and cannot be reasonably contained by other means (Policy H-420.957).

AMA ACTIVITY

The AMA, as a supporting organization of the NCCHC, has a physician member as a liaison to the NCCHC. The NCCHC maintains standards on how to manage the delivery of behavioral and physical health care in correctional systems. The standards are the foundation of NCCHCs voluntary accreditation program for correctional facilities to demonstrate a commitment to delivering high quality health care. The NCCHC also offers a correctional health professional program, which certifies individuals working in the correctional system who demonstrate mastery of national standards. Advanced certifications can be obtained by behavioral health practitioners, physicians and registered nurses. In addition, the AMA has developed model state legislation advocating for states to study the physical and mental health care needs of detained and incarcerated youth, and prohibiting the shackling of pregnant prisoners.

DISCUSSION

The Council has highlighted local and federal examples of correctional systems that have been accredited by the NCCHC to serve as models for other systems to emulate. The Council recommends the reaffirmation of Policy D-430.997, which supports the accreditation standards developed by the NCCHC to improve the quality of physical and behavioral health care services to incarcerated individuals and encourages all correctional systems to support NCCHC accreditation.

The majority of individuals in the correctional system are low-income, uninsured and have multiple health conditions. The Council believes that access to and continuity of care is a priority for this population and recommends that our AMA advocate for adequate payment to health care providers, including primary care and mental health professionals, to encourage improved access to comprehensive physical and behavioral health care services to juveniles and adults throughout the incarceration process from intake to re-entry into the community.

In order to facilitate continuity of care for individuals transitioning between the correctional system and the community, the Council suggests that the AMA support partnerships and information sharing between correctional systems, community health systems and state insurance programs to provide access to a continuum of health care services for individuals in the correctional system. An avenue to share information could be the implementation of EHRs in correctional facilities.

The majority of inmates struggle with mental health conditions and substance use disorders.[24, 25] Some may be incarcerated due to crimes committed because of their illnesses and are in need of consistent health care rather than time in correctional facilities. Some may never have had health care except for while they were incarcerated. The Council suggests that the AMA encourage state Medicaid agencies to accept and process Medicaid applications from individuals who are incarcerated. State Medicaid agencies should work with their local departments of corrections, prisons, and jails to assist incarcerated individuals who may not have been enrolled in Medicaid at the time of their incarceration to apply and receive an eligibility determination for Medicaid.

Resolution 118-A-16 requested that our AMA advocate for the reversal of the “Medicaid Inmate Payment Exclusion” so that detainees can retain their Medicaid eligibility throughout the incarceration process. The Council cautions that advocating for the elimination of the exclusion

necessitates the redistribution of Medicaid funding and could have unintended consequences regarding the provision of care and payment to physicians. AMA Policy H-60.919[7] addresses continuity of Medicaid eligibility by encouraging states to suspend rather than terminate Medicaid coverage for juveniles following arrest and detention. Consistent with Policy H-60.919[7], which was adopted at the 2016 Annual Meeting, the Council believes that Medicaid eligibility for both juveniles and adults should be suspended rather than terminated during the entire incarceration process and that coverage should be reinstated when the individual transitions back into the community.

The Council recommends that Policy D-430.994 be rescinded, which requested the study that this report has accomplished.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 118-A-16 and that the remainder of the report be filed:

1. That our American Medical Association (AMA) reaffirm Policy D-430.997, which supports the accreditation standards developed by the National Commission on Correctional Heath Care (NCCHC) to improve the quality of physical and behavioral health care services to incarcerated individuals and encourages all correctional systems to support NCCHC accreditation. (Reaffirm HOD Policy)

2. That our AMA advocate for adequate payment to health care providers, including primary care, mental health, and addiction treatment professionals, to encourage improved access to comprehensive physical and behavioral health care services to juveniles and adults throughout the incarceration process from intake to re-entry into the community. (New HOD Policy)

3. That our AMA support partnerships and information sharing between correctional systems, community health systems and state insurance programs to provide access to a continuum of health care services for juveniles and adults in the correctional system. (New HOD Policy)

4. That our AMA advocate for necessary programs and staff training to address the distinctive health care needs of incarcerated women and adolescent females, including gynecological care and obstetrics care for pregnant and postpartum women. (New HOD Policy).

5. That our AMA encourage state Medicaid agencies to accept and process Medicaid applications from juveniles and adults who are incarcerated. (New HOD Policy)

6. That our AMA encourage state Medicaid agencies to work with their local departments of corrections, prisons, and jails to assist incarcerated juveniles and adults who may not have been enrolled in Medicaid at the time of their incarceration to apply and receive an eligibility determination for Medicaid. (New HOD Policy)

7. That our AMA encourage state Medicaid agencies to suspend rather than terminate Medicaid eligibility of juveniles and adults upon intake into the criminal justice system and throughout the incarceration process, and to reinstate coverage when the individual transitions back into the community. (New HOD Policy)

8. That our AMA urge the Centers for Medicare & Medicaid Services and state Medicaid agencies to provide Medicaid coverage for health care, care coordination activities and linkages

to care delivered to patients up to 30 days before the anticipated release from correctional facilities in order to help establish coverage effective upon release, assist with transition to care in the community, and help reduce recidivism. (New HOD Policy)

9. That our AMA rescind Policy D-430.994, which requested the study accomplished by this report. (Rescind HOD Policy)

Fiscal Note: Less than $500.

REFERENCES

[1] Peter Wagner and Bernadette Rabuy. Mass Incarceration: The Whole Pie 2016. Prison Policy Initiative. Available at: http://www.prisonpolicy.org/reports/pie2016.html
[2] Lauren Glaze, Danielle Kaeble, Todd Minton and Anastasios Tsoutis. Correctional Populations in the United State, 2014. Bureau of Justice Statistics Special Report. US Department of Justice. 2015. Available at: http://www.bjs.gov/index.cfm?ty=pbdetail&iid=5519
[3] *Ibid.*
[4] Kamala Mallik-Kane. Returning Home Illinois Policy Brief Health and Prisoner Reentry. Urban Institute. 2005. Available at: http://www.urban.org/research/publication/returning-home-illinois-policy-brief-health-and-prisoner-reentry
[5] Alexandra Gates, Samantha Artiga and Robin Rudowitz. Health Coverage and Care for the Adult Criminal Justice-Involved Population. The Kaiser Commission on Medicaid and the Uninsured. 2014. Available at: https://kaiserfamilyfoundation.files.wordpress.com/2014/09/8622-health-coverage-and-care-for-the-adult-criminal-justice-involved-population1.pdf
[6] Bureau of Justice Statistics. Annual Survey of Jails, Annual Survey of Parole, Annual Survey of Probation, Census of Jail Inmates & National Prisoner Statistics, 1980-2014. Available at: http://www.bjs.gov/index.cfm?ty=kfdetail&iid=487
[7] Alexandra Gates, Samantha Artiga and Robin Rudowitz. Health Coverage and Care for the Adult Criminal Justice Involved Population. The Kaiser Commission on Medicaid and the Uninsured. 2014. Available at:
[8] Carly B. Dierkhising et al. Trauma Histories Among Justice-Involved Youth: Findings from the National Child Traumatic Stress Network. European Journal of Psychotraumatol. 2013. Available at: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3714673/
[9] Estelle v. Gamble, 429 U.S. 97, 97 S. Ct. 285 (1976).
[10] Alexandra Gates, Samantha Artiga and Robin Rudowitz. Health Coverage and Care for the Adult Criminal Justice-Involved Population. The Kaiser Commission on Medicaid and the Uninsured. 2014. Available at: https://kaiserfamilyfoundation.files.wordpress.com/2014/09/8622-health-coverage-and-care-for-the-adult-criminal-justice-involved-population1.pdf
[11] 1905(a)(29) of the Social Security Act
[12] Department of Health and Human Services. Centers for Medicare and Medicaid Services. Letter issued to State Medicaid Directors: Ending Chronic Homelessness. 2004. Available at: https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Supports/Community-Living/Downloads/Ending-Chronic-Homelessness-SMD-Letter.pdf
[13] Catherine McKee, Sarah Somers, Samantha Artiga and Alexandra Gates. State Medicaid Eligibility Policies for Individuals Moving Into and Out of Incarceration. The Kaiser Commission on Medicaid and the Uninsured. 2015. Available at: http://files.kff.org/attachment/issue-brief-state-medicaid-eligibility-policies-for-individuals-moving-into-and-out-of-incarceration
[14] Department of Health and Human Services. Centers for Medicare and Medicaid Services. Letter issued to state health officials providing guidance on how to facilitate successful re-entry for individuals transitioning from incarceration to their communities. 2016. Available at: https://www.medicaid.gov/federal-policy-guidance/downloads/sho16007.pdf
[15] Maricopa County Sheriff's Office. Adult Programs. Available at: https://www.maricopa.gov/pdweb/docs/Adult_Programs_offered_for_PD_Oct_2014.pdf_v0_0_1.pdf
[16] Maricopa County Correctional Health: "Best in the Nation." 2015. Available at: http://www.maricopa.gov/pr_detail.aspx?releaseID=3037

[17] National Commission on Correctional Health Care. Looking Back – Moving Forward. 2015. Annual Report. Available at: http://www.ncchc.org/filebin/Publications/2015_NCCHC_Annual_Report.pdf
[18] State Reform. Opportunities for Enrolling Justice-Involved Individuals in Medicaid. 2015. Available at: https://www.statereforum.org/weekly-insight/enrolling-justice-involved-individuals-in-medicaid
[19] Federal Bureau of Prisons. Clinical Practice Guidelines. Available at: https://www.bop.gov/resources/health_care_mngmt.jsp
[20] National Commission on Correctional Health Care. Looking Back, Moving Forward. 2015 Annual Report. Available at: http://www.ncchc.org/filebin/Publications/2015_NCCHC_Annual_Report.pdf
[21] Fuller Torrey, Aaron Kennard, Don Eslinger, Richard Lamb and James Pavle. More Mentally Ill Persons Are in Jails and Prisons Than Hospitals: A Survey of the States. Treatment Advocacy Center and the National Sheriffs' Association. 2010. Available at: http://www.treatmentadvocacycenter.org/storage/documents/final_jails_v_hospitals_study.pdf
[22] Fuller Torrey, Mary Zdanowicz, Aaron Kennard, Richard Lamb, Donald Eslinger, Micheal Biasotti and Doris Fuller. The Treatment of Persons with Mental Illness in Prisons and Jails: A State Survey. Treatment Advocacy Center. 2014. Available at: http://s3.documentcloud.org/documents/1095566/persons-with-mental-illness-in-jails-and-prisons-2.pdf
[23] American's Largest Mental Hospital Is a Jail. The Atlantic. 2015. Available at: http://www.theatlantic.com/politics/archive/2015/06/americas-largest-mental-hospital-is-a-jail/395012/
[24] Bureau of Justice Statistics, US Department of Justice. Drug Use and Dependence, State and Federal Prisoners, 2004. 2006. Available at: http://www.bjs.gov/content/pub/pdf/dudsfp04.pdf
[25] James, D. and Glaze, L. Mental Health Problems of Prison and Jail Inmates. Bureau of Justice Statistics Special Report. US Department of Justice. 2006. Available at: http://www.bjs.gov/content/pub/pdf/mhppji.pdf