A Society of General Internal Medicine Position Statement on Expanding Medicaid Coverage to Incarcerated Individuals, 2025

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Incarceration, Health, and Justice Interest Group and Health Policy Committee and the Society of General Internal Medicine

The United States incarcerates more of its citizens than any other country in the world, and a substantial body of literature finds that carceral settings confer detrimental health effects.[1] Minoritized and marginalized populations, especially people who are Black, Latino, or of Indigenous heritage, are overrepresented in our nation's prisons and jails, a legacy of racism and structural violence in our criminal legal system.[2] The prevalence of a range of diseases, including chronic medical conditions, infectious diseases, mental health and substance use disorders, are higher in incarcerated populations than the general population.[3] The transition home after release from incarceration is a particularly high-risk period for poor health outcomes, as individuals transition from carceral healthcare services to community healthcare providers. This period is commonly marked with a disruption in health insurance and medication access.[4-6] People in reentry often face competing basic needs such as housing, food and physical safety.[7] Return to the community after release from incarceration is associated with high risk of hospitalization[8] and mortality.[9] Addressing health disparities conferred by the United States' criminal legal system and mass incarceration is therefore a crucial part of achieving health equity and reducing healthcare and criminal justice expenditures in our country.[10]

Through the Medicaid Inmate Exclusion Policy (MIEP), incarcerated individuals lose access to state-sponsored Medicaid health insurance[11]. This can lead to major barriers in healthcare access throughout incarceration and during times of community re-entry, contributing to the high risk of negative health outcomes during this vulnerable period.[12] Ensuring intact health insurance coverage upon release can improve health outcomes and reduce recidivism[13]. Furthermore, the MIEP contributes to partitioning of carceral health systems from the community health system, creating second-tier systems outside of standard oversight and accountability such as the Centers for Medicare & Medicaid Services (CMS). Evidence suggests that without such oversight, the provision of carceral health services is highly variable and most often, sub-standard when compared to that provided by non-carceral health systems.[14]

The Society of General Internal Medicine, in an effort to reduce health disparities to care for marginalized populations, supports efforts which increase access to standard medical care for patients who are incarcerated and approaching release through the expansion of Medicaid eligibility to people in jails and prisons. This is in alignment with the American Medical Association (AMA), American College of Physicians (ACP), American Academy of Family Physicians (AAFP), American College of Obstetrics and Gynecology (ACOG), American Academy of Pediatrics (AAP), and American Psychiatric Association (APA), and in line with current CMS guidance.

In summary, the Society of General Internal Medicine acknowledges that:

- The federal Medicaid Inmate Exclusion Policy (MIEP) obstructs the ability for individuals to obtain and maintain health insurance coverage during and after incarceration events.
- Moreover, by severing funding and oversight from the Centers for Medicare & Medicaid Services (CMS), the MIEP creates siloed systems of community versus carceral health care, with no current mechanism to provide oversight of carceral health systems.
- Transitioning between fragmented healthcare systems undermines continuous access to healthcare at times of community re-entry with well-documented negative impacts on health outcomes.
- Evidence shows Medicaid access for individuals with criminal legal involvement can improve health outcomes, reduce recidivism, and mitigate health disparities.

The Society of General Internal Medicine advocates:

- For Congress to repeal the “inmate exclusion” within the 1965 Social Security Act that bars the use of federal Medicaid matching funds from covering healthcare services in jails and prisons.
- For state Medicaid programs to apply for a Medicaid 1115 waiver to support access to health insurance for those re-entering the community, as encouraged by CMS.
- Advocates for greater collaboration between Medicaid and correctional health programs to increase access to medications included in the state’s Medicaid formulary and bolster oversight and assurance of quality of care.
- Encourages SGIM members to be actively involved in planning state programs for these services with the following components:
    - **Funding should start no less than 90 days prior to expected release** to maximize this transitional time period. This should, when possible, include pretrial individuals. Because pretrial detentions typically last fewer than 90 days and have uncertain release dates, such individuals should have presumptive eligibility for pre-release benefits from the start of their detention (unless or until it is determined that their length of stay will be longer than 90 days, in which case their pre-release benefits can be suspended and deferred until a later date)
    - **Eligibility criteria should be broad**, such that all individuals expected to need care shortly after release are covered. At a minimum, any patient with a chronic medical condition, behavioral health condition (including substance use disorder), pregnant or postpartum, cognitive impairment. or mobility impairment.
    - **Covered services should be as broad as allowable under the state’s Medicaid program**, with a particular focus on non-physician services including case

management and community health worker coverage, behavioral health treatment, and medications to treat substance use disorder. Coverage of telehealth services may improve access to care, especially for patients in need of subspecialty care.

References

1. Wildeman C, Wang EA. Mass incarceration, public health, and widening inequality in the USA. *The Lancet*. 2017;389(10077):1464-1474. doi:https://doi.org/10.1016/S0140-6736(17)30259-3
2. Bailey ZD, Feldman JM, Bassett MT. How Structural Racism Works — Racist Policies as a Root Cause of U.S. Racial Health Inequities. *New England Journal of Medicine*. 2020;384(8):768-773. doi:10.1056/NEJMms2025396
3. Binswanger IA, Krueger PM, Steiner JF. Prevalence of chronic medical conditions among jail and prison inmates in the USA compared with the general population. *J Epidemiol Community Health*. Nov 2009;63(11):912-9. doi:10.1136/jech.2009.090662
4. Wang EA, Western B, Berwick DM. COVID-19, Decarceration, and the Role of Clinicians, Health Systems, and Payers: A Report From the National Academy of Sciences, Engineering, and Medicine. *JAMA*. 2020;doi:10.1001/jama.2020.22109
5. Nowotny KM, Kuptsevych-Timmer A. Health and justice: framing incarceration as a social determinant of health for Black men in the United States. *Sociology Compass*. 2018;12(3):e12566. Accessed 30 Oct 2021.
6. Wang EA, Wang Y, Krumholz HM. A high risk of hospitalization following release from correctional facilities in Medicare beneficiaries: a retrospective matched cohort study, 2002 to 2010. *JAMA Intern Med*. Sep 23 2013;173(17):1621-8. doi:10.1001/jamainternmed.2013.9008
7. Aminawung JA, Harvey TD, Smart J, et al. Formerly Incarcerated Community Health Workers Engaging Individuals Returning From Incarceration Into Primary Care: Results From the Transition Clinic Network. *Front Public Health*. 2021;9:681128. doi:10.3389/fpubh.2021.681128 PMC8376286,
8. Frank JW, Linder JA, Becker WC, Fiellin DA, Wang EA. Increased hospital and emergency department utilization by individuals with recent criminal justice involvement: results of a national survey. *J Gen Intern Med*. 2014;29(9):1226-33. doi:10.1007/s11606-014-2877-y PMC4139534, Accessed Sep.
9. Spaulding AC, Seals RM, McCallum VA, Perez SD, Brzozowski AK, Steenland NK. Prisoner Survival Inside and Outside of the Institution: Implications for Health-Care Planning. *American Journal of Epidemiology*. 2011;173(5):479-487. doi:10.1093/aje/kwq422 Accessed 30 Oct 2021.
10. Wang EA, Shavit S. For Health Equity, We Must End Mass Incarceration. *Jama*. Jul 3 2023;330(1):15-16. doi:10.1001/jama.2023.8206
11. Social Security Act Amendments of 1965. Pub L No. 97, 42 USC §1396d April 9 1965.
12. Khatri UG, Winkelman TNA. Strengthening the Medicaid Reentry Act - Supporting the Health of People Who Are Incarcerated. *N Engl J Med*. Apr 21 2022;386(16):1488-1490. doi:10.1056/NEJMp2119571
13. Badaracco N, Burns M, Dague L. The Effects of Medicaid Coverage on Post-Incarceration Employment and Recidivism. *Health Serv Res*. Sep 2021;56(Suppl 2):24-5. doi: 10.1111/1475-6773.13752. Epub 2021 Sep 15.
14. Alsan M, Yang CS, Jolin JR, Tu L, Rich JD. Health Care in U.S. Correctional Facilities - A Limited and Threatened Constitutional Right. *N Engl J Med*. Mar 2 2023;388(9):847-852. doi:10.1056/NEJMms2211252