Using Medicaid Coverage to Improve Peer Support and Other Services for Incarcerated Persons With Mental Illness

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In this month's issue, Adams and Lincoln (1) report on a qualitative study of the barriers and facilitators to implementing peer support services for justice-involved persons with behavioral health conditions in Pennsylvania. As peer support services have spread from behavioral health to justice settings, there is much to appreciate about the potential benefits of forensic peer specialists (FPSs), who can span the boundaries of lived experiences both in behavioral health and justice settings. As the authors report, FPSs provide emotional support, assistance in goal setting and wellness-related activities, advocacy, and crisis support, and they facilitate group and community building in addition to vocational, housing, and benefits assistance. FPSs in Pennsylvania work with individuals 90 days before and on their release. Community re-entry from justice settings can be formidable, given the challenges of maintaining continuity of care, finding and paying for treatment, securing housing, and tending to other critical tasks of starting over.

A key barrier to sustainment of FPS services, the authors note, is lack of funding; Medicaid often ceases after 30 days of incarceration. In fact, many re-entry services are greatly hampered by the near universal lack of health insurance for incarcerated persons. Typically, start-up funding for such services comes from a grant or other special program, but the burden of sustaining services rests squarely on the budgets of chronically underfunded jails and prisons already struggling with the financial ramifications of the COVID-19 pandemic and opioid crisis. Outside of justice settings, peer support services are typically Medicaid reimbursable. This is not so in forensic settings, where reimbursement is expressly prohibited by the Inmate Exclusion Policy (IEP)—a provision similar to the Institutions for Mental Disease (IMD) Medicaid exclusion for psychiatric hospitals. Established in 1965, when Congress first authorized Medicaid, the IEP, like the IMD, is designed to prevent cost-shifting from state and local governments to the federal government. Federal rules prohibit states from billing Medicaid for any inmate care other than a hospital admission of 24 hours or more. Incarceration also cuts off Social Security and Disability Insurance payments.

Medicaid benefits cease after 30 days of detention even if the individual is only awaiting trial. The consequence is that states and local governments are solely responsible for financing health care delivered to detained and incarcerated people who previously qualified for Medicaid before they were incarcerated. While some states merely suspend Medicaid, 34 states terminate it outright until the individual is eligible to reapply. Therefore, the quality and quantity of services for incarcerated persons vary substantially depending on state and local resources. Under Medicaid expansion, absent the IEP, at least half of these health care expenses would be paid by the federal government and would lighten the extraordinary state burden of these services. Given that health care in jails and prisons is constitutionally guaranteed, does it make sense to let this right to treatment for medically complex, impoverished, and disproportionately minority populations vary inequitably depending on local resources?

Just as there is widespread advocacy to soften or end the IMD exclusion, so as to open up psychiatric beds to all Medicaid recipients, proposed legislation would facilitate Medicaid coverage for re-entry by limiting states to merely suspend and not terminate Medicaid, by reinstating Medicaid 30 days before release, and by covering substance use treatment while incarcerated. Some states have also applied for section 1115 Medicaid waivers to target justice-involved populations with complex health care needs. Utilizing federal block grants to support FPS services for incarcerated individuals is one resource that many states are not fully implementing. The most far-reaching–and sensible–federal proposal would eliminate the IEP altogether. All health care services for incarcerated individuals, including FPS services, would be far more sustainable with Medicaid coverage; would recalibrate the financing responsibilities assigned to local, state, and federal governments for health care of detainees; and would greatly facilitate continuity of care for these vulnerable individuals.

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Psychiatric Services 2021; 72:621–622; doi: 10.1176/appi.ps.72602

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