United States Government Accountability Office

Report to Congressional Committees

February 2023

# BUREAU OF PRISONS

# Assessment of Health Care Reentry Policies and Procedures Needed

GAO-23-105610

# GAO Highlights

Highlights of GAO-23-105610, a report to congressional committees

February 2023

# BUREAU OF PRISONS

## Assessment of Health Care Reentry Policies and Procedures Needed

## Why GAO Did This Study

BOP is responsible for the custody and care of federal inmates in BOP-managed facilities, which included almost 145,000 individuals as of December 2022. Inmates releasing from BOP custody—over 35,000 in 2021—may face challenges re-entering society, including accessing health care.

The joint explanatory statement accompanying the Consolidated Appropriations Act, 2021 includes a provision for GAO to review inmate health care, including enrollment in Medicaid upon release from prison. Among other things, this report examines BOP policies and procedures to facilitate inmates' enrollment in Medicaid or other health coverage and continuity of care upon release.

GAO reviewed BOP documentation on inmate reentry assistance. GAO also interviewed BOP officials, including those from two BOP facilities selected, in part, for variation in facility type, size, and region of the country. In addition, GAO reviewed BOP's approach against federal internal control standards.

## What GAO Recommends

GAO recommends that BOP assess the effectiveness of its reentry policies and procedures for facilitating inmate enrollment in health coverage and helping ensure continuity of care. BOP concurred with the recommendation.

## What GAO Found

Federal law requires the Federal Bureau of Prisons (BOP) to establish reentry planning procedures to help inmates apply for federal and state benefits upon release, such as Medicaid. BOP policies and procedures direct its facilities to target assistance with health coverage enrollment and continuity of care to the 3 percent of inmates BOP has designated as having greater health needs. This includes assisting with Medicaid and other benefit applications and arranging follow-up care upon release. For the remaining 97 percent of inmates who are generally healthy, BOP directs its facilities and Residential Reentry Centers to provide relatively limited health care reentry assistance.

**Bureau of Prisons (BOP) Health Care Reentry Assistance**

| Inmates with greater health needs *(e.g., HIV/AIDS, cancer treatment)* | Inmates with no or limited health needs *(e.g., medication-controlled diabetes)* |
|---|---|
| • Facility staff provides information on health coverage options<br>• Social worker assists with application for disability benefits, which confers Medicaid eligibility in most states<br>• Social worker may assist with application for Medicaid or other health coverage<br>• Social worker identifies community health care resources and may arrange for care, such as placement in a nursing home | • Facility staff provides information on health coverage options<br>• For certain inmates, social worker may assist with application for health coverage or arrange care appointments in community<br>• Case managers provide information on health coverage options and may connect inmates with community organizations for further assistance<br>• Reentry center provides phone/internet access to assist with application for health coverage |

**Reentry assistance provided at:**

BOP facility

BOP-contracted Residential Reentry Center

Source: GAO analysis of BOP policies and procedures. | GAO-23-105610

GAO found that BOP has not assessed the effectiveness of its health care reentry policies and procedures, including the targeting of assistance by inmate health needs and what assistance is provided. This is inconsistent with federal internal control standards, which recommend agencies periodically reassess policies and procedures for continued effectiveness. BOP collects some information that could support an assessment, such as documentation from social workers' reentry efforts, but it is not using this information and has no plans to do so. By assessing effectiveness, BOP would have a better understanding of whether or not its approach is assisting inmates during the reentry process with their health care coverage and continuity of care needs, and whether changes are needed.

View GAO-23-105610. For more information, contact Carolyn L. Yocom at (202) 512-7114 or yocomc@gao.gov, or Gretta L. Goodwin at (202) 512-8777 or goodwing@gao.gov.

# Contents

## Abbreviations

BOP Federal Bureau of Prisons
CMS Centers for Medicare & Medicaid Services
HHS Department of Health and Human Services
RRC Residential Reentry Center

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February 27, 2023

The Honorable Jeanne Shaheen
Chair
The Honorable Jerry Moran
Ranking Member
Subcommittee on Commerce, Justice, Science and Related Agencies
Committee on Appropriations
United States Senate

The Honorable Hal Rogers
Chair
The Honorable Matt Cartwright
Ranking Member
Subcommittee on Commerce, Justice, Science and Related Agencies
Committee on Appropriations
House of Representatives

Over 35,000 individuals were released from the Federal Bureau of Prisons' (BOP) custody in 2021.[1] Former inmates may face challenges re-entering society, including accessing health care, and these challenges can sometimes lead to re-arrest and a return to custody. According to research, inmates are often in poorer health and in greater need of health care than the general U.S. population. This is due, in part, to higher rates of chronic and infectious diseases, as well as serious mental illnesses and substance use disorders.[2] Research also suggests that access to health care coverage and continuity of care following incarceration

[1]See Federal Bureau of Prisons, "BOP Statistics: Inmate Release Numbers" (Oct. 2022), accessed Nov. 23, 2022, https://www.bop.gov/about/statistics/statistics_inmate_releases.jsp. Number does not include individuals released to the custody of another jurisdiction, such as a state, or those released for detention or deportation by U.S. Immigration and Customs Enforcement.

[2]See Congressional Research Service, *Medicaid and Incarcerated Individuals,* IF11830 (May 12, 2021); Medicaid and CHIP Payment and Access Commission, *"Medicaid and the Criminal Justice System"* (Washington, D.C.: July 2018); and Camhi, Natasha, Dan Mistak, Vikki Wachino, "Medicaid's Evolving Role in Advancing the Health of People Involved in the Justice System," *The Commonwealth Fund* (Nov. 18, 2020).

reduces the potential for re-arrest, particularly among individuals with substance use disorders.[3]

BOP, within the Department of Justice, is responsible for the custody and care of federal inmates in BOP-managed facilities, which included almost 145,000 individuals as of December 2022. As part of its mission, BOP provides programming during inmates' sentences to ensure they have the skills necessary to succeed upon release and to help inmates prepare for reentry by, for example, providing assistance obtaining identification.[4] Federal law requires BOP to establish reentry planning procedures that help inmates apply for federal and state benefits upon release, such as Medicaid, the federal-state health financing program that covered an estimated 79 million Americans in fiscal year 2022.[5] Medicaid eligibility and enrollment policies can vary state to state, which may affect inmate enrollment in the program.

The joint explanatory statement accompanying the Consolidated Appropriations Act, 2021 includes a provision for GAO to review inmate health care, including inmate enrollment in Medicaid upon release from prison.[6] In this report, we

1. examine BOP policies and procedures to facilitate inmates' enrollment in Medicaid or other health coverage, and help ensure continuity of care upon release; and
2. describe selected states' policies and procedures for enrolling federal inmates in Medicaid prior to or upon release.

To examine BOP policies and procedures to facilitate inmates' enrollment in Medicaid or other health coverage, and continuity of care upon release,

[3]See Aslim G. Erkmen et al., "The Effect of Public Health Insurance on Criminal Recidivism," *Journal of Policy Analysis and Management*, vol. 41, no. 1 (2021): 45-91; and Benjamin A. Howell et al., "Evaluation of Changes in U.S. Health Insurance Coverage for Individuals With Criminal Legal Involvement in Medicaid Expansion and Nonexpansion States, 2010 to 2017," *JAMA Health Forum* (Apr. 8, 2022).

[4]For our review of BOP processes in place to help ensure that inmates leave BOP custody with identification, see GAO, *Bureau of Prisons: Opportunities Exist to Better Assist Incarcerated People with Obtaining ID Documents Prior to Release*, GAO-23-105302 (Washington, D.C.: Dec. 7, 2022).

[5]18 U.S.C. § 4042(a)(6)(A).

[6]116 Cong. Rec. H7938 (daily ed. Dec. 21, 2020) (statement submitted by Rep. Nita Lowey), regarding the Consolidated Appropriations Act, 2021, Pub. L. No. 116-260, 134 Stat. 1182 (2020).

we reviewed BOP documentation, including program statements, staff guidelines, and a staff orientation manual. To examine how these policies and procedures are implemented at BOP facilities, we interviewed BOP officials, including social workers, from BOP's central office and two BOP facilities: the Federal Correctional Complex in Victorville, California (in BOP's Western region), and the Federal Medical Center in Lexington, Kentucky (in BOP's Mid-Atlantic region). We selected these facilities for variation in facility type, inmate gender, region, and because these facilities had inmate populations that were among BOP's largest at the time of our review. The information obtained from officials at these facilities is not generalizable to all BOP facilities, but provided illustrative examples and context for how these policies and procedures are implemented at BOP facilities. We also reviewed information on health care reentry planning in inmate medical records, such as notes from BOP clinician encounters with inmates.

To examine how BOP reentry policies and procedures are implemented at Residential Reentry Centers (RRC), which contract with BOP to confine inmates outside of a prison environment prior to release from BOP custody, we interviewed officials based in Residential Reentry Management field offices that have RRC oversight responsibilities from the two BOP regions in our scope (Western and Mid-Atlantic). In addition, we reviewed statements of work governing RRC contractual responsibilities. We assessed BOP's policies and procedures against federal internal control standards.[7]

To describe selected states' policies and procedures for enrolling federal inmates in Medicaid prior to or upon release, we reviewed enrollment policies for and interviewed officials from a nongeneralizable selection of six state Medicaid programs: California, Illinois, Kentucky, New Jersey, Texas, and West Virginia. We selected each for geographic variation and differences in program eligibility, such as whether the state expanded Medicaid eligibility as allowed under the Patient Protection and Affordable

[7]18 U.S.C. § 4042(a)(6)(A); Internal control is any process effected by an entity's management that provides reasonable assurance that the entity's objectives will be achieved. For this review, we assessed BOP's health care reentry policies and procedures against the federal internal control standard directing management to periodically review policies, procedures, and related control activities for continued relevance and effectiveness in achieving the entity's objectives or addressing related risks. See GAO, *Standards for Internal Control in the Federal Government,* GAO-14-704G (Washington, D.C.: Sept. 10, 2014).

Care Act.[8] We also reviewed guidance and technical assistance documentation from the Centers for Medicare & Medicaid Services (CMS), the Department of Health and Human Services (HHS) agency that oversees the Medicaid program. For example, we reviewed a state health official letter the agency published to aid states in facilitating access to covered Medicaid services for individuals transitioning from incarceration, and interviewed CMS officials to understand how the guidance applies to enrollment of federal inmates in Medicaid.[9] We also discussed with CMS officials any planned federal guidance or technical assistance to states.

We conducted this performance audit from December 2021 to February 2023 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

# Background

## BOP Inmate Confinement and Reentry

BOP must consider a variety of factors to determine the most appropriate facility in which to confine an inmate, including an inmate's programmatic needs (such as education and work programs); the level of security an inmate requires; and medical and behavioral health care needs.[10] Based on those factors, BOP is required to confine inmates in facilities as close to an inmate's primary residence as possible, and to the extent practicable, within 500 driving miles.[11] This may result in BOP confining inmates in facilities located outside of their home states.

[8]Under the Patient Protection and Affordable Care Act, states may opt to expand their Medicaid programs to cover nonelderly, nonpregnant adults who are not eligible for Medicare, and whose income does not exceed 133 percent of the federal poverty level beginning January 1, 2014. Pub. L. No. 111-148, § 2001,124 Stat. 119, 271 (2010), as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (2010).

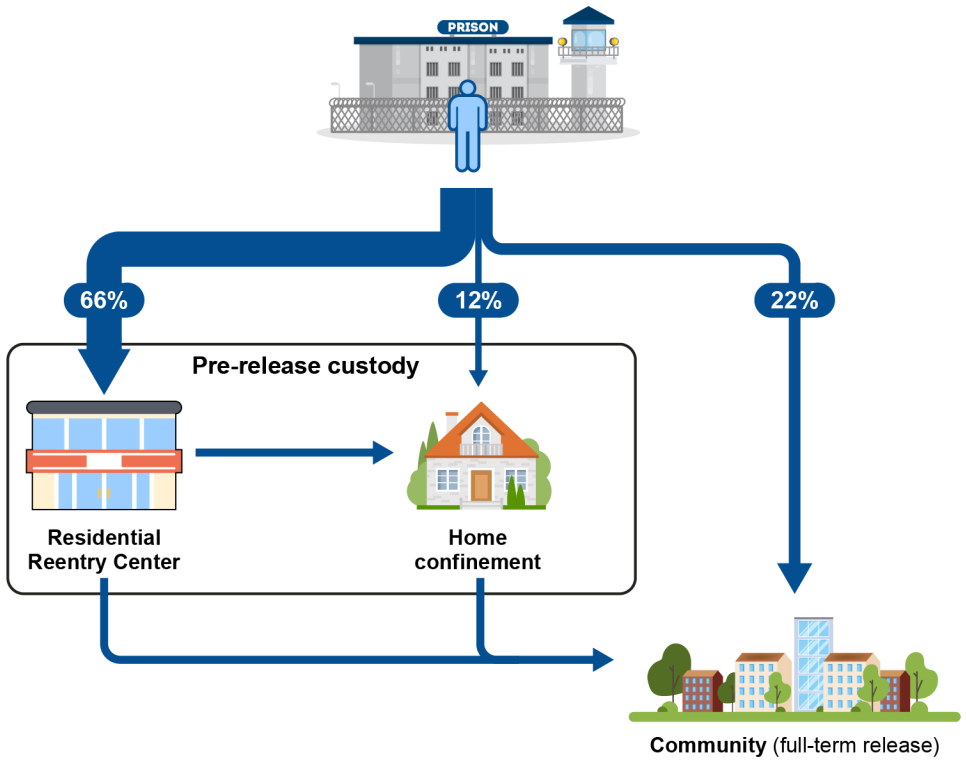
[9]See Centers for Medicare & Medicaid Services, *SHO # 16-007 RE: To facilitate successful re-entry for individuals transitioning from incarceration to their communities* (Baltimore, Md.: Apr. 28, 2016).

[10]18 U.S.C. § 3621(b).

[11]18 U.S.C. § 3621(b).

BOP is also responsible for preparing inmates to reenter the community. Inmates can reenter the community directly from a BOP facility—which BOP refers to as a full-term release—or with a period of pre-release custody either as a resident in an RRC or under home confinement, which is determined, in part, by a court during sentencing. (See fig. 1.) BOP's reentry assistance takes place at BOP facilities and in RRCs, which are overseen by field offices within BOP's Residential Reentry Management Branch.

**Figure 1: Reentry Pathways for Inmates Leaving a Federal Bureau of Prisons' (BOP) Facility, and Percent of Inmates Designated to Each Pathway, 2021**




Source: GAO review of BOP information; artinspiring/stock.adobe.com. | GAO-23-105610

Note: The "community" reentry pathway, which BOP refers to as full-term release, can include an individual moving to a family home, a nursing home, or a behavioral health group home, among others.

The location of an inmate's RRC placement is determined, in part, by the sentencing district where an inmate was found to have committed a crime, though a variety of factors may affect the placement, such as

availability of community-based treatment options. Some inmates may be placed in RRCs outside of their home states.[12]

BOP's reentry assistance is a multidisciplinary effort with facility social workers, among other BOP staff, playing an important role in health care reentry assistance provided to inmates. (See table 1.)

**Table 1: Bureau of Prisons (BOP) Staff Duties Related to Inmate Reentry Planning**

| Staff member | Duties |
|---|---|
| Facility social worker | Facility social workers are assigned to a specific facility or complex and provide clinical social work services, including assistance with reentry efforts. Facility social workers are also tasked with identifying inmates that are near their reentry date and providing health care reentry assistance. |
| Regional social worker | Regional social workers serve as a resource for facility social workers to consult on reentry assistance efforts and other social work services. In cases where a BOP facility does not have a social worker position, the regional social worker may perform the duties of a facility social worker, including assisting with reentry efforts. |
| Psychologist | Psychologists create documentation describing the behavioral health needs of inmates at the time of reentry. These documents serve as referrals to social workers and other BOP staff. |
| Reentry affairs coordinator | Reentry affairs coordinators are responsible for facilitating reentry initiatives at BOP facilities and providing reentry resources to inmates. For example, reentry affairs coordinators may determine the types of materials, such as information on community resources, provided during release programming. |
| Residential Reentry Center case manager | Residential Reentry Center case managers are responsible for coordinating reentry programming and providing reentry assistance to inmates designated to placement in a Residential Reentry Center or home confinement. |
| Unit team | The unit team includes BOP facility case managers, unit managers, correctional counselors, and unit secretaries who are jointly responsible for programming to meet inmate needs. For example, the unit team may assist social workers with developing inmate release plans, which include information on coordination of community care. |

Source: GAO analysis of BOP information. | GAO-23-105610

## Inmate Health Needs

As part of its duties, BOP provides health care services to inmates in its facilities.[13] BOP uses an electronic medical records system to document each inmate's medical history, as well as clinical encounters and medications prescribed while in a BOP facility, among other things. BOP also generally pays for health care services RRC residents receive. BOP health systems specialists approve and coordinate medical care for RRC

[12]In addition, RRC staff assess an inmate's reentry needs and determine suitability of the placement.

[13]BOP contracts with health care providers in the community for services the bureau does not provide in its facilities.

residents and community treatment specialists do so for behavioral health care.[14]

After an inmate's arrival to a BOP facility, BOP clinical staff identify the inmate's immediate and long-term medical and behavioral health needs and assign the inmate a care level (1, 2, 3, or 4). The intensity of care required increases with each care level. For example, inmates designated as care level 1 are generally considered healthy, while inmates designated as care level 4 have advanced disease states requiring frequent and specialized medical care. (See table 2.)

**Table 2: Medical and Mental Health Care Levels of Bureau of Prisons (BOP) Inmates, as of July 2022**

| Care level designation | Description | Percentage of inmates at medical care level[a] | Percentage of inmates at mental health care level[a, b] |
|---|---|---|---|
| Care level 1 | Generally healthy, under 70 years of age; may have some limited medical needs requiring clinician evaluation and monitoring such as mild asthma or diet-controlled diabetes. No need for regular behavioral health services. | 70 | 97 |
| Care level 2 | Stable condition(s), requiring monthly to every 6 months clinician evaluation, such as emphysema or medication-controlled diabetes. Routine outpatient behavioral health care required on an ongoing basis and/or brief, crisis-oriented behavioral health care required. | 27 | 2 |
| Care level 3 | Conditions requiring frequent outpatient clinical contacts, and/or some assistance with activities of daily living. Conditions include advanced HIV/AIDS or end-stage liver disease. Require enhanced outpatient behavioral health care, such as weekly interventions, or placement in a residential treatment program. | 2 | <1 |
| Care level 4 | Severely impaired; may require daily nursing care, such as patients with cancer in active treatment, dialysis, quadriplegia, and those undergoing or recovering from major surgery. Require acute care in a psychiatric hospital. | 1 | <1 |

Source: GAO analysis of BOP data. | GAO-23-105610

[a]Percentages do not include inmates under an initial care level designation—known as a screen level—which is administratively assigned by BOP's Designation and Sentence Computation Center before inmate arrival at a BOP institution. After an inmate's arrival at a BOP facility, a BOP physician can reassign the inmate's care level as needed. According to BOP officials, an inmate's care level is typically reassigned or confirmed within 14 days after arrival at a facility.

[b]BOP also includes behavioral health conditions, such as substance use disorder, when assigning mental health care levels.

[14]According to BOP officials, BOP does not cover health care expenses for all inmates housed in RRCs because some inmates receive care through employer-provided insurance or other means.

Care level is one factor that determines the facility where an inmate is confined and the reentry assistance an inmate requires prior to release. Each BOP facility includes a health services unit that provides medical and dental health care services to inmates in BOP custody, as well as a psychology services department that provides behavioral health care services. BOP also operates seven Federal Medical Centers to provide more advanced health services to inmates with end-stage disease states, such as those requiring dialysis or cancer treatment.[15]

## Medicaid and Inmates

Medicaid is a federal-state health care financing program serving low-income and medically needy Americans. Medicaid eligibility criteria and enrollment processes vary by state. While Medicaid generally cannot cover the cost of services for incarcerated individuals, states can enroll eligible individuals in Medicaid during incarceration and place eligibility or benefits in a suspended status.[16] For individuals enrolled in Medicaid prior to incarceration, states can also allow those individuals to remain enrolled, but have their eligibility or benefits suspended rather than terminated upon incarceration.[17] However, those inmates would be subject to annual eligibility redeterminations during incarceration.[18] In those cases, it may be challenging for federal inmates to maintain Medicaid enrollment during incarceration, given the majority of BOP inmates' sentences are over 5 years.[19]

[15]BOP's Federal Medical Centers are in Butner, North Carolina; Carswell, Texas; Fort Worth, Texas; Devens, Massachusetts; Lexington, Kentucky; Rochester, Minnesota; and Springfield, Missouri (named the Medical Center for Federal Prisoners).

[16]Medicaid cannot cover services provided to inmates of a public institution except when they are inpatients in a medical institution. 42 U.S.C. § 1396d(a)(A). See also Centers for Medicare & Medicaid Services, *SHO # 16-007 RE: To facilitate successful re-entry for individuals transitioning from incarceration to their communities,* (Baltimore, Md.: Apr. 28, 2016); Centers for Medicare & Medicaid Services, *SMD # 21-002 RE: Implementation of At-Risk Youth Medicaid Protections for Inmates of Public Institutions*, (Baltimore, Md.: Jan. 19, 2021).

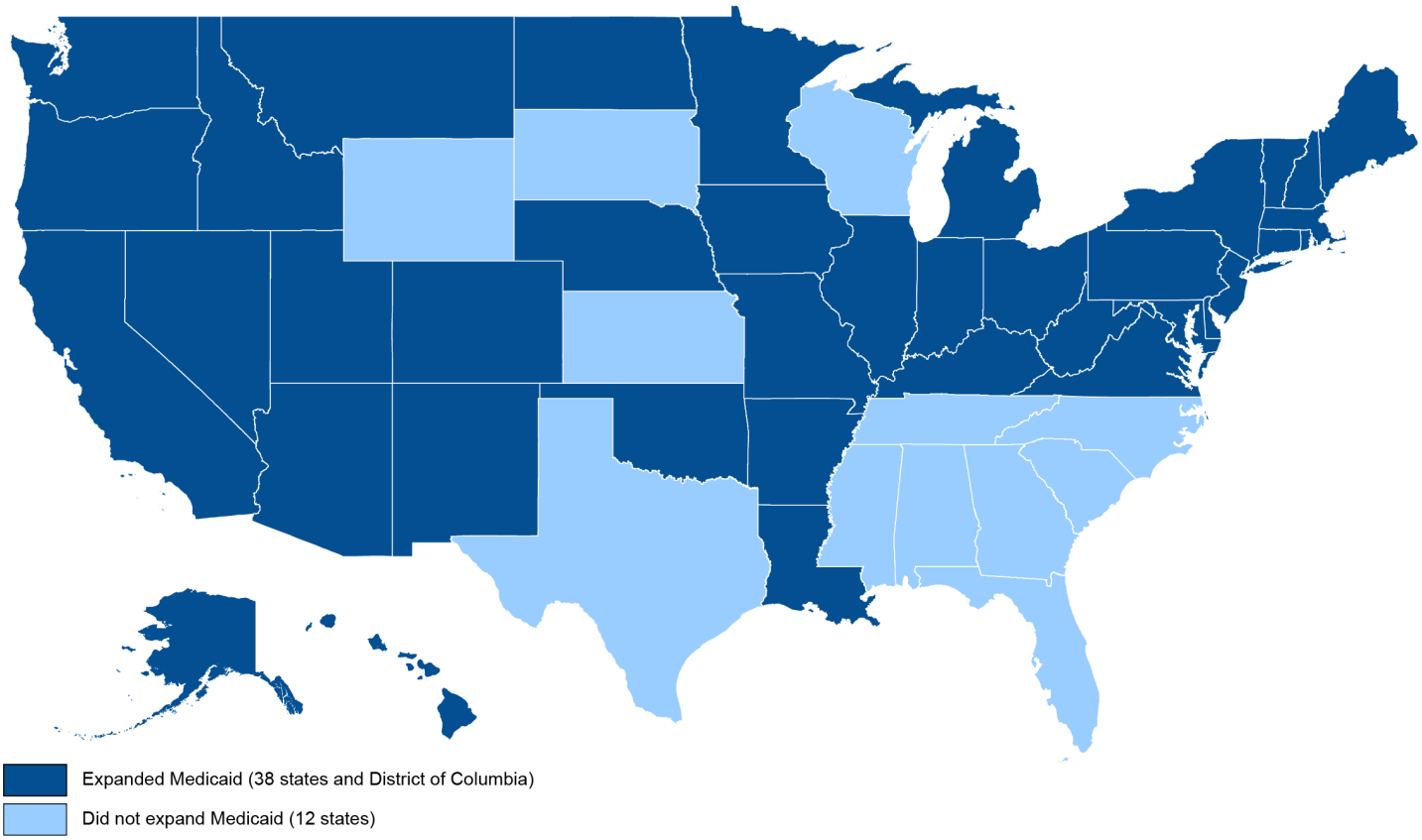
[17]According to CMS guidance, states may suspend an inmate's Medicaid benefits, but maintain the inmate's enrollment, so that benefits can be more quickly reinstated upon release from incarceration, or in the case of those incarcerated in state prisons or local jails, for coverage of certain inpatient hospitalizations.

[18]42 C.F.R. § 435.916. CMS officials told us that states do not have to conduct periodic renewals for eligibility suspensions for certain juveniles. See SUPPORT for Patients and Communities Act, Pub. L. No. 115-271, § 1001, 132 Stat. 3894, 3900 (2018).

[19]As of October 2022, over 78 percent of federal inmates were serving sentences over 5 years and less than 2 percent of inmates had a sentence of less than one year.

Former inmates leaving BOP custody may fall under different Medicaid eligibility categories, based on each state's eligibility rules. Reentering inmates may be eligible as part of the low-income adult eligibility group in the 38 states and District of Columbia that as of December 2022 had chosen to expand eligibility to this population as allowed under the Patient Protection and Affordable Care Act. (See fig. 2.) Reentering inmates may also be eligible on the basis of disability or other factors regardless of whether the state expanded Medicaid.

**Figure 2: State Adoption of Medicaid Expansion, as of December 2022**




Source: Centers for Medicare & Medicaid Services. | GAO-23-105610

Note: In November 2022, South Dakota voters approved a measure to expand Medicaid in the state, but as of December 2022 the state had not yet sought approval from the Centers for Medicare & Medicaid Services to amend its state Medicaid plan to implement the expansion.

While CMS has provided guidance to states on enrolling reentering inmates in Medicaid, states have considerable discretion in administering

their Medicaid programs, including around eligibility, enrollment, and service delivery.

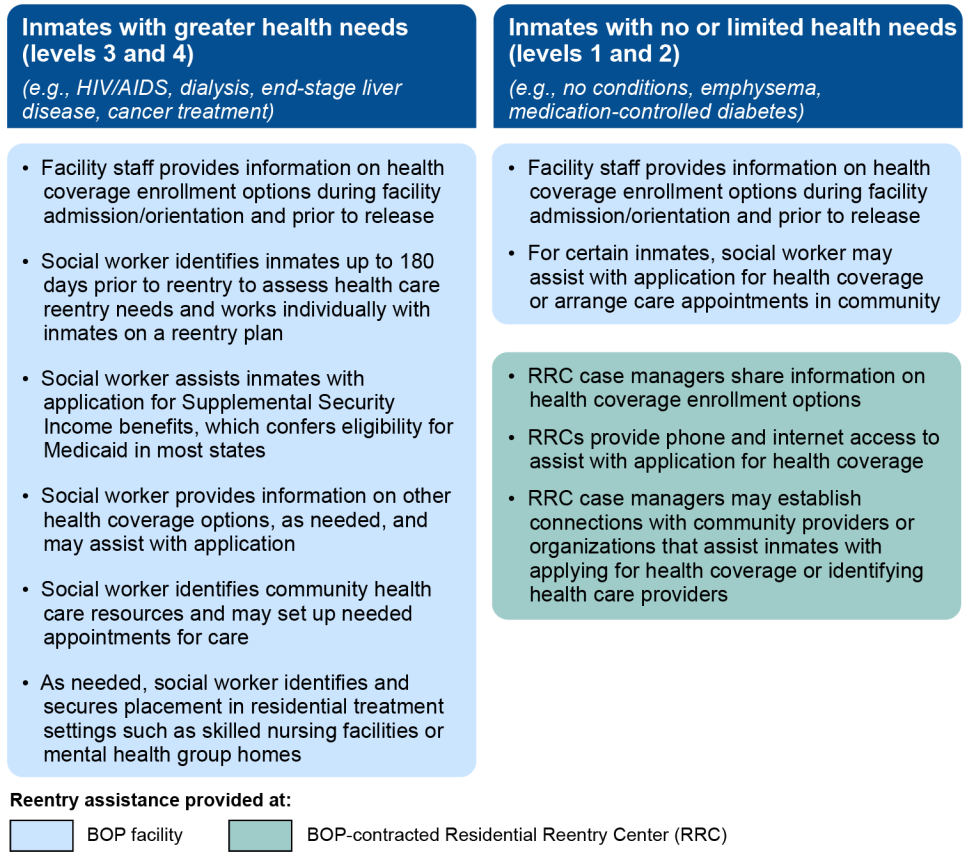
## BOP Targets Health Care Reentry Assistance, but Has Not Assessed the Effectiveness of its Approach

BOP provides individualized health care reentry assistance to the relatively small proportion of inmates it has designated as having greater health needs. Under BOP policies and procedures, BOP facilities generally provide more limited assistance to inmates designated as having no or limited health needs. BOP has not assessed the effectiveness of its overall approach—including the targeting of assistance and what assistance is provided—and has no plans to do so.

### BOP Targets Health Coverage Enrollment and Continuity of Care Assistance to Inmates Designated as Having Greater Health Needs

BOP policies and procedures direct facilities to target health coverage enrollment and continuity of care assistance to inmates designated as having greater health needs; specifically, the approximately 3 percent of inmates that BOP assigns to care levels 3 and 4. BOP directs social workers in facilities to assist these inmates with completing applications for health care coverage and to coordinate care in the community upon release from BOP custody. For the approximately 97 percent of inmates designated as having no or limited health needs (care levels 1 and 2), BOP policies and procedures establish more limited inmate reentry assistance. This assistance is provided in facilities and in RRCs, where assistance is based on RRC contract requirements. (See fig. 3.)

**Figure 3: Bureau of Prisons (BOP) Assistance with Health Care Coverage Enrollment and Continuity of Care, by Inmate Care Level Designation**




Source: GAO analysis of BOP policies and procedures. | GAO-23-105610

Notes: Information displayed reflects BOP policies and procedures; however, implementation may vary across BOP facilities. BOP assigns each inmate to a specific care level ranging from care level 1 to care level 4, with severity of health care needs increasing with care level designation. Inmates with greater health needs are generally not referred to RRCs because RRCs typically have minimal medical capabilities. Other BOP staff, such as psychologists and other medical professionals, consult with social workers to inform reentry plans.

While preparing inmates designated as having greater health needs for release from BOP custody, BOP procedures direct social workers to tailor their assistance to an inmate's individual circumstances and the type of health coverage for which the inmate may be eligible. For instance, BOP social workers we interviewed from the two selected facilities in our review explained that they first determine whether an inmate may be eligible for Supplemental Security Income benefits, which confers Medicaid eligibility in most states and automatically triggers enrollment in

some states.[20] BOP social workers also told us they may assess eligibility for other federal coverage or services including through the Medicare program, the Indian Health Service, and the Department of Veterans Affairs.

**Reentry pathways from Bureau of Prisons (BOP) facilities**

- Pre-release custody: inmate has a period of confinement at home or in a BOP-contracted Residential Reentry Center, also known as a halfway house.
- Directly to the community: inmate is released from BOP custody to the community, referred to as a full-term release.

Source: GAO review of BOP information. | GAO-23-105610

In the case of Supplemental Security Income and veterans' benefits, BOP social workers can leverage existing memoranda of understanding that BOP has entered into with the Social Security Administration and Department of Veterans Affairs, respectively, to facilitate inmate enrollment. For example, BOP's memorandum of understanding with the Social Security Administration permits inmates to apply for Supplemental Security Income benefits up to 180 days prior to release and, according to BOP officials, inmates releasing to home confinement or directly to the community (under a full-term release) can receive conditional approval while still incarcerated. This allows inmates to receive these benefits soon after release from BOP custody. A social worker we interviewed at one facility said she generally does not find out if an inmate is approved for benefits before the inmate leaves the facility. According to BOP procedures, for inmates not eligible for the Supplemental Security Income program or in states where inmates must apply for Medicaid coverage separately, BOP social workers assist inmates with applying for Medicaid.

BOP social workers told us the level of effort required to coordinate continuity of care for inmates designated as having greater health needs varies based on the type of care an inmate needs after release. According to BOP procedures, for inmates releasing directly to the community, social workers contact providers in the community on behalf of inmates, including making arrangements for any specialized medical or behavioral health care services. For example, one social worker reported that for an inmate undergoing dialysis, the social worker will set up the inmate's initial appointments in the community to ensure that dialysis care continues after the inmate leaves BOP custody. If an inmate requires a wheelchair, oxygen tank, or other equipment, the social worker said it is

[20]Supplemental Security Income is a federal assistance program administered by the Social Security Administration that provides cash benefits for certain individuals who are over 65, blind, or have a disability, and who have limited resources (i.e., assets) and income. In 41 states and the District of Columbia, enrollment in the program leads to automatic eligibility for Medicaid and, in some states (33 states and the District of Columbia), results in automatic enrollment in Medicaid, according to information from the Social Security Administration.

routine to work with an equipment supplier to ensure the inmate has the necessary equipment upon release.

Social workers we spoke with also said that for inmates releasing directly to the community, they will arrange for placement in a nursing home, a behavioral health group home, or other facility depending on an inmate's needs.[21] BOP regional social workers that we interviewed told us that, given staffing vacancies across several BOP facilities, it can be necessary to take on the responsibilities of a facility social worker to provide reentry assistance to inmates with greater health needs. In doing so, a regional social worker told us it was not atypical to place calls with up to 30 resources per inmate to meet continuity of care needs. The regional social worker explained that this is particularly true when attempting to place an inmate in a nursing home.

Social workers we interviewed also reported they develop release plans for inmates with greater health needs, which include information on resources in the inmate's community, upcoming medical or behavioral health appointments, health coverage options, and prescription medications (see text box).

**Example of Social Worker Release Planning for Inmate with Greater Health Needs**

One release plan we reviewed detailed social worker efforts to facilitate continuity of care for an inmate undergoing cancer treatment. According to the plan, the inmate recently completed cancer treatment while in BOP custody and needed follow-up care with a community oncologist after release. Over a period of 4 months prior to the inmate's release, the social worker identified and contacted a cancer center in the inmate's community, scheduled the inmate's first appointment, and transferred relevant medical records. The social worker also assisted the inmate with application for Supplemental Security Income, including facilitating a disability interview for the inmate with the Social Security Administration.

Source: GAO review of Federal Bureau of Prisons (BOP) documentation. | GAO-23-105610

For inmates designated as having no or limited health needs, BOP has generally delegated health care reentry assistance responsibilities to RRCs. Under their contracts with BOP, RRCs are required to provide the following to both residents (those serving a period of confinement within an RRC) and individuals under home confinement within an RRC's jurisdiction:

[21]BOP officials said that social workers collaborate with facility clinicians as needed to identify the most appropriate placement; for example, psychologists to identify behavioral health-related placements.

1. Information on applying for health coverage.
2. Access to phone and internet as needed to complete applications for health coverage.
3. The opportunity to access medical care and treatment while a resident of the RRC.

RRCs are also required to have case managers work with a resident within 10 days of arriving to develop an individual program plan, which includes discussing health care needs and health coverage. The case manager is then required to meet with the resident on a bi-weekly basis to assess progress on the plan. In examples of individual program plans for two RRC residents, both plans indicated that the case managers had asked the residents about their progress in enrolling in health coverage. While not required to do so, RRCs may also partner with local clinics or community-based organizations to provide residents with application assistance, according to BOP officials. Residents are responsible for independently arranging any care they may need after release from the RRC and BOP custody.

BOP officials told us that, in addition to assistance provided by RRCs, BOP health systems specialists and community treatment specialists have responsibilities that may help ensure continuity of care during pre-release custody. Officials said that health systems specialists coordinate with RRC case managers on health care services residents may need. Community treatment specialists are responsible for coordinating care, such as treatment for substance use disorders.

## BOP Has Not Assessed the Effectiveness of Its Health Care Reentry Policies and Procedures

BOP has not assessed the effectiveness of its health care reentry policies and procedures, and has no plans to do so. BOP collects or has access to some information that could be used to assess outcomes from its health care reentry assistance efforts, but BOP has not used this information to assess the effectiveness of those policies and procedures. For example:

- **Outcomes from social worker assistance:** According to BOP officials, social workers document the application for and enrollment in health coverage in an inmate's medical record. For example, notes in one medical record we reviewed documented social worker assistance with an inmate's application for Supplemental Security Income and with determining eligibility for veterans' benefits, as well as efforts to schedule follow-up care for the inmate with a community-based provider. While BOP currently does not have a mechanism to

review overall trends, enrollment numbers, or other outcomes using medical records, this may change. BOP officials said they are developing modifications to how staff enter certain information in BOP's medical records system that could allow for analysis of social worker assistance. This could include analysis of the health coverage options inmates applied for and the status of those applications. BOP officials reported that they anticipate these modifications will be completed in fiscal year 2024, but did not provide information on any planned analyses on the outcomes of social worker assistance.

- **Outcomes from RRC assistance:** Per contract requirements with BOP, RRCs must survey each resident upon exit to determine if the resident applied for health coverage, but BOP does not consistently collect or analyze this information.[22] RRCs are required to document residents' self-reported health coverage information in a tracking log. Although this information must be made available to BOP upon request, the bureau does not require its Residential Reentry Management field offices to collect the logs. Officials from the two Residential Reentry Management field offices we interviewed reported that their offices collect the tracking logs, with one office beginning in July 2022. However, neither office analyzes or otherwise uses the information in the logs. Officials from BOP's central office said they also do not use this information.

We asked BOP officials why the bureau does not have plans to assess its health care reentry policies and procedures, including why the bureau has not used available information to assess outcomes. Officials told us this was due to resource limitations and limitations in BOP's ability to collect health care information on individuals once they have left BOP custody. Officials referred to other efforts underway to better understand the health of inmates in BOP custody, such as BOP's recently established Population and Correctional Health Branch, staffed by BOP clinicians and an epidemiologist, whose mission includes studying population-level data on diseases and health risk factors affecting inmates, infection control,

[22]Contract requirements indicate that this effort, along with the requirement that RRCs provide residents with information on available health coverage options, was designed to assist residents with meeting the individual coverage mandate originally imposed by the Patient Protection and Affordable Care Act. The mandate, which took effect in 2014, required all Americans to obtain health coverage, whether through employer-sponsored health plans, individual health plans, or government-sponsored coverage, or pay a tax penalty. See generally 26 U.S.C. § 5000A. However, the penalties associated with this mandate were repealed in 2017. Pub. L. No. 115-97, § 11081(a), 131 Stat. 2054, 2092 (2017) (amending 26 U.S.C. § 5000A(c)). An official from a BOP Residential Reentry Management field office we interviewed reported that individuals under home confinement are also surveyed.

and improving the delivery of BOP health care services. Officials also referred to data collection and analysis efforts within BOP's Residential Reentry Management Branch to improve health care services delivered to RRC residents, including information on missed or rescheduled medical appointments, and staff resources needed for residents receiving medication-assisted treatment for substance use disorders. However, these efforts, while potentially valuable to BOP, will likely not provide the bureau with information on the effectiveness of its reentry-specific health care policies and procedures. For example, officials reported that the new branch will not collect information on outcomes or otherwise assess the effectiveness of BOP's health care reentry policies and procedures, including the targeting of assistance by inmate health needs and what assistance is provided.

BOP faces several challenges that could affect the effectiveness of BOP health care reentry efforts. These challenges further highlight the need for an assessment of BOP's current approach.

- **Social worker vacancies.** BOP has had broad challenges filling social worker positions throughout its facilities with almost 30 percent of facility social worker positions vacant as of May 2022. This mirrors challenges across the U.S. with workforce shortages for other clinician types.[23] Among BOP's seven Federal Medical Centers, where social workers assist with the reentry needs of BOP inmates designated as having greater health needs, we found that six reported social worker vacancies as of December 2022. For example, one facility reported three out of nine positions vacant, and another reported three out of six vacant. BOP officials reported that they continue to work to fill these vacancies—including recent hires across three medical centers in July, October, and December 2022—but officials reported that this

[23]For example, one study found that the total supply of registered nurses in the U.S. decreased from 2020 to 2021 by the largest amount in four decades. See D.I. Auerback et al., "A Worrisome Drop In The Number of Young Nurses," *Health Affairs Forefront* (Apr. 13, 2022).

is an ongoing challenge and there are some facilities that are difficult to staff.[24]

- **Variation in states' Medicaid eligibility and enrollment processes.** Officials from BOP's central office told us that BOP staff may struggle with navigating the different eligibility and enrollment processes of states' Medicaid programs. For example, social workers at one facility we interviewed noted they struggle with enrollment processes that not only vary at the state level, but can also vary at the county level. In addition, BOP does not have a communication or coordination mechanism with state Medicaid agencies or with CMS that might facilitate the application and enrollment process for reentering inmates. For example, social workers from one BOP facility said it can be difficult to find a contact person at state Medicaid agencies to help with questions. They reported that they were unable to finish the Medicaid application process for an inmate nearing release, because they could not identify a contact. As a result, facility staff had to coordinate with U.S. Probation and Pretrial Services to continue the application process after the inmate was released from BOP custody.[25] Officials from BOP's central office told us that BOP does not coordinate with state Medicaid agencies, such as establishing memoranda of understanding, in part, because there are too many individual Medicaid offices and Medicaid policy varies by state.
- **Community barriers to continuity of care.** Social workers we interviewed from one facility and from one BOP region reported that they sometimes face barriers coordinating community-based follow-up care for inmates releasing directly to the community because of social stigmas. Specifically, they said they have been denied inmate placement in nursing homes due to the nature of an inmate's crime.

[24]Although not addressing social worker shortages, BOP has made some efforts to improve staffing in federal prisons in response to our prior recommendations. In February 2021, we recommended that the Director of BOP develop and implement a plan for analyzing data to help identify and address the causes and potential impacts of staffing challenges on staff and inmates. BOP concurred and hired a contractor to assist with implementing the recommendation. In August 2022, BOP reported some progress in that the contractor had developed an automated staffing tool; however, BOP also reported that the focus was on correctional services positions and not on other types of staff, including social workers. See GAO, *Bureau of Prisons: Opportunities Exist to Better Analyze Staffing Data and Improve Employee Wellness Programs,* GAO-21-123 (Washington, D.C.: Feb. 24, 2021).

[25]If required by a federal court, inmates may have to serve a term of supervised release after being released from BOP custody during which they generally remain under the custody of U.S. Probation and Pretrial Services.

For example, a social worker who manages follow-up care for inmates from a BOP medical center said, regardless of care needs, it is difficult to place inmates convicted of sex crimes in nursing homes, because many nursing homes will not accept sex offenders. In addition, BOP social workers reported they sometimes face challenges scheduling follow-up care with providers for inmates who are likely eligible for Medicaid and whose applications have been submitted, but have not yet been enrolled. The social workers said providers may be unwilling to schedule appointments until an inmate is enrolled and coverage is active.

BOP is required to establish reentry planning procedures to help inmates apply for federal and state benefits upon release, such as Medicaid.[26] Although BOP has established health care reentry policies and procedures, including those to help inmates apply for Medicaid and other health coverage, as well as to facilitate continuity of care upon release, the bureau has not assessed whether these policies and procedures are effective. Standards for Internal Control in the Federal Government recommends that agencies periodically assess policies and procedures for continued effectiveness in achieving objectives and addressing related risks.[27] In the absence of an assessment, the bureau has no means to tell whether its health care policies and procedures are in fact assisting inmates in applying for health coverage and positioning inmates to continue needed care when released to the community.

## Selected States Generally Accepted Federal Inmates' Medicaid Applications, but Residency Requirements May Delay Enrollment

Officials from all six states in our review noted they rarely receive applications from federal inmates and, therefore, had little experience with enrolling federal inmates in their Medicaid programs. Further, these officials noted they did not have Medicaid enrollment policies and procedures specific to federal inmates. Officials from five of our selected states—California, Illinois, Kentucky, New Jersey, and West Virginia—told us that federal inmates nearing release could apply for Medicaid benefits under their states' general enrollment policies. These states would assess an inmate's Medicaid eligibility and, if determined eligible, the state would enroll the inmate. Officials from Kentucky explained that after enrolling an inmate, the state would suspend coverage until release from BOP custody. Officials from Texas told us the state would accept and process

[26]18 U.S.C. § 4042(a)(6)(A).

[27]See GAO-14-704G.

applications from federal inmates, but if an inmate was still incarcerated during the eligibility assessment, the state would deny the application.[28]

**General Steps of Medicaid Enrollment Process**

Enrollment in Medicaid includes the following:

- individual submits application;
- state determines whether application can be accepted for further processing;
- state determines eligibility based on factors such as residency, household size, age, income and disability;
- state proceeds with or denies enrollment; and
- state activates coverage.

Source: GAO review of federal guidance. | GAO-23-105610

Federal inmates in custody outside of their home states who are applying for Medicaid may face additional enrollment challenges, particularly with state residency requirements, which could delay enrollment. CMS guidance notes that states can process inmates' applications prior to release and recommends states accept "intent to reside" in meeting residency requirements.[29] Further, states may not deny Medicaid eligibility because an individual has not resided in the state for a particular time period.[30] Officials from five of the selected states said that "intent to reside" meets the states' residency requirements, and these states generally accept an applicant's attestation of residency. In situations where selected states question applicants' attestation of residency, state officials noted that applicants can prove their residency by providing documents that indicate a state address, such as state-issued identification, among others.[31] Officials from one selected state—Illinois—said the state does not accept an "intent to reside" in the state to meet the residency requirements for the state's Medicaid program.

In practice, states' residency requirements may result in challenges for federal inmates attempting to enroll in Medicaid coverage prior to their release.[32] BOP social workers reported that the biggest challenge they face in facilitating enrollment for federal inmates nearing reentry is that some state Medicaid offices will only accept applications if an individual is currently residing in the state. These social workers told us that while

[28]CMS officials confirmed that incarceration is not a Medicaid eligibility exclusion. They told us the agency plans to meet with Texas to gain a better understanding of the state's eligibility and enrollment policies and procedures, and will provide technical assistance to help the state come into compliance with requirements as needed.

[29]Under these circumstances, the date of the individual's arrival in the state would be the effective date of eligibility. 42 C.F.R. § 435.403 (2021); Centers for Medicare & Medicaid Services, *SHO # 16-007 RE: To facilitate successful re-entry for individuals transitioning from incarceration to their communities,* (Baltimore, Md.: Apr. 28, 2016).

[30]42 C.F.R. § 435.403(j) (2021).

[31]Other generally accepted documentation to prove residency includes property, income, or other tax forms or receipts; utility bills; leases; or rent payment records.

[32]Disabled inmates who enroll in the Supplemental Security Income program may be automatically eligible for Medicaid without a separate application process and, therefore, may not face the same residency requirement challenges as inmates who apply for Medicaid separately.

most reentering inmates are eligible based on income and can technically apply while incarcerated, they had varying success with enrollment. These social workers attributed this to differing implementation of state eligibility policy by state and county administrators.[33]

Medicaid officials in all six selected states told us they were not coordinating or exchanging information with BOP to facilitate Medicaid enrollment for federal inmates.[34] Officials from New Jersey reported they had previously communicated with a BOP facility regarding Medicaid coverage for federal inmates releasing to the state, but this ad hoc coordination ended several years ago. CMS has provided guidance to states on ways to coordinate with corrections agencies and allowable enrollment practices for inmates applying for Medicaid coverage (see text box).

**Examples of Enrollment Practices Highlighted in Centers for Medicare & Medicaid Services (CMS) Guidance and Training Documents**

In guidance to states, CMS highlighted the following strategies states may use to better facilitate enrollment for those transitioning from jail or prison:

- accepting attestation of anticipated future residency to meet residency requirements;
- working cooperatively with corrections facilities, including the Federal Bureau of Prisons, to coordinate enrollment for inmates applying for Medicaid outside of the state in which they are incarcerated; and
- identifying a point person in the Medicaid agency and a point person in each jail or prison to coordinate logistics of processing inmates' applications.

Source: GAO review of CMS documentation. | GAO-23-105610

Between June 2020 to November 2022, at least 13 states, including four of our selected states, had submitted proposals for CMS approval—known as Medicaid section 1115 demonstrations—to implement policies

[33]Some state Medicaid programs process applications through the state's central Medicaid office; other states process applications at the county level.

[34]By contrast, officials from five of our six selected states described coordination with their state's department of corrections to enroll inmates in Medicaid. For example, New Jersey's Department of Corrections is required to assist each inmate with completing and submitting a Medicaid application to the state Department of Human Services at least 30 days prior to an inmate's release from incarceration. N.J. Stat. Ann. § 30:1B-6.16(a) (West 2021). Illinois' Department of Corrections is required to give state inmates the opportunity to apply for Medicaid and other health coverage 45 days prior to release. 730 Ill. Comp. Stat. Ann. 5 / 3-14-1(f)(1) (West 2022).

to assist inmates transitioning from prison, among other changes.[35] These proposed policies often target certain populations, such as individuals with substance use disorders, and seek to extend Medicaid coverage from 30 to 90 days prior to release.[36] In January 2023, CMS approved California's proposal, the first approval of this type of proposal, which provided coverage of a limited set of services for certain inmates up to 90 days prior to release.[37] In its approval letter, CMS signaled its intent to encourage other states to implement such reentry strategies using section 1115 demonstrations.

A federal report and forthcoming related guidance may prove helpful as states consider future policy actions.[38] Specifically:

- In January 2023, HHS issued a report to Congress on best practices identified by a stakeholder group it convened in August 2021 for health care related transitions for inmates of public institutions to the community.[39] The report highlighted a number of promising practices to connect inmates to Medicaid, including suspension, rather than termination, of Medicaid coverage upon incarceration, data sharing across Medicaid agencies and correctional institutions to automate

[35]Under section 1115 of the Social Security Act, the Secretary of Health and Human Services may waive certain federal Medicaid requirements and approve expenditures that would not otherwise be eligible for federal Medicaid matching funds for experimental, pilot, or demonstration projects that in the Secretary's judgment are likely to promote Medicaid objectives. CMS oversees Medicaid section 1115 demonstrations and has approved states' use of demonstrations for a variety of purposes. 42 U.S.C. § 1315(a).

[36]While the states' proposals generally focus on state and local inmates, CMS officials told us the agency has worked with at least one state to revise the state proposal to include federal inmates.

[37]Federal inmates were not included in California's proposal to provide Medicaid coverage prior to release.

[38]This report and guidance are mandated by the SUPPORT for Patients and Communities Act. Pub. L. No 115-271, § 5032, 132 Stat. 3894, 3965–66 (2018).

[39]Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, *Health Care Transitions for Individuals Returning to the Community from a Public Institution: Promising Practices Identified by the Medicaid Reentry Stakeholder Group* (January 2023). According to the Federal Register notice establishing the stakeholder group, the group was to include non-federal members, such as state Medicaid agencies and representatives from local and state prison systems, and federal members, including designees from BOP. "Notice of Establishment of the Medicaid Reentry Stakeholder Group and Request for Nominations," 85 Fed. Reg. 61,957 (Oct. 23, 2020).

suspension and reinstatement of coverage, and pre-release application assistance, among others.[40]

- CMS is required to issue guidance on a section 1115 demonstration opportunity for health care related transitions for inmates of public institutions to the community that relate to the best practices the stakeholder group identified. According to the HHS report, stakeholders noted that key considerations for demonstration design should include the scope of the benefits provided pre-release, who would be eligible, the length of time for pre-release coverage for services, and strategies for addressing social supports, among others. CMS officials told us they were targeting issuance in early 2023.

The HHS report and associated CMS guidance will offer best practices, and CMS intends that the guidance will describe the types of policies states can pursue through section 1115 demonstrations. CMS officials told us the agency is not seeking nor does it have the authority to require state Medicaid agencies to implement these practices.

## Conclusions

Congress has recognized the importance of connecting former inmates with government programs, such as Medicaid, that can reduce or eliminate gaps in health care coverage that inmates may face upon release. As such, federal law directs BOP to help inmates enroll in these programs upon release. BOP has taken steps to do so and to facilitate continuity of care, targeting individualized assistance to the 3 percent of its inmate population with the greatest health needs. However, the bureau has not taken the additional step of assessing the effectiveness of its overall approach. Because BOP has not assessed the effectiveness of its approach—including the targeting of assistance and what assistance is provided—the bureau lacks assurance that the approach best suits the reentry needs of its inmate population. This is particularly problematic given staffing and other challenges BOP faces that may limit the effectiveness of its approach. By using available information as part of an assessment of its policies and procedures, BOP would have a better understanding of whether or not its approach is assisting inmates during the reentry process with their health care coverage and continuity of care needs, and whether changes are needed.

[40]The report also includes promising practices for connecting inmates to other types of health coverage, such as Medicare, and for ensuring continuity of care. For example, the report highlighted promising practices for facilitating connection to health care, including substance use disorder treatment and medication supports, among others.

## Recommendation for Executive Action

The Director of BOP should assess the effectiveness of the bureau's policies and procedures for facilitating enrollment in Medicaid or other health care coverage for inmates nearing reentry, and for helping ensure continuity of care upon release from BOP custody. (Recommendation 1)

## Agency Comments

We provided a draft of this report to DOJ and HHS for review and comment. In its comments, reproduced in appendix 1, BOP concurred with our recommendation and provided technical comments, which we incorporated as appropriate. HHS also provided technical comments, which we incorporated as appropriate.

We are sending copies of this report to the appropriate congressional committees, the Attorney General, the Secretary of Health and Human Services, and other interested parties. In addition, the report is available at no charge on the GAO website at https://www.gao.gov.

If you or your staff have any questions about this report, please contact Carolyn L. Yocom at (202) 512-7114 or YocomC@gao.gov, or Gretta L. Goodwin at (202) 512-8777 or GoodwinG@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff who made key contributions to this report are listed in appendix II.

Carolyn L. Yocom
Director, Health Care

Gretta L. Goodwin
Director, Homeland Security and Justice

# Appendix I: Comments from the U.S. Department of Justice

U.S. Department of Justice

Federal Bureau of Prisons

*Office of the Director* *Washington, DC 20534*

February 2, 2023

Ms. Gretta L. Goodwin
Director
Homeland Security and Justice
Government Accountability Office
441 G Street, NW
Washington, DC 20548

Dear Ms. Goodwin,

The Bureau of Prisons (BOP) appreciates the opportunity to review and comment on the Government Accountability Office's (GAO's) draft report entitled Bureau of Prisons: Assessment of Health Care Reentry Policies and Procedures Needed (GAO-23-105610). The BOP offers the following comments regarding the recommendation.

**Recommendation 1:** The Director of the BOP should assess the effectiveness of the Bureau's policies and procedures for facilitating enrollment in Medicaid or other health care coverage for inmates nearing reentry and for helping ensure continuity of care upon release from BOP custody.

**BOP Response:** The BOP concurs with recommendation 1. The BOP will continue to evaluate the policies and procedures for inmate health care coverage enrollment.

Thank you for the opportunity to comment on this report. We look forward to GAO closing the recommendation that the BOP has agreed to address.

Sincerely,

Colette S. Peters
Director

# Appendix II: GAO Contacts and Staff Acknowledgments

## GAO Contacts

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## Staff Acknowledgments

In addition to the contacts listed above, the following individuals made significant contributions to this report:

Susan Barnidge (Assistant Director); Joy Booth (Assistant Director); Ramsey Asaly (Analyst-in-Charge); Emily Bippus; Sonia Chakrabarty; Billy Commons, III; Elizabeth Dretsch; Eric Hauswirth; Drew Long; Sarah Prokop; and Haley Samuel-Jakubos.