



**U.S. Department of Health and Human Services
Assistant Secretary for Planning and Evaluation
Office of Disability, Aging and Long-Term Care Policy**

AGING, REENTRY, AND HEALTH COVERAGE:

BARRIERS TO MEDICARE AND MEDICAID FOR OLDER REENTRANTS

March 2018

Office of the Assistant Secretary for Planning and Evaluation

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Aging, Reentry, and Health Coverage: Barriers to Medicare and Medicaid for Older Reentrants

Issue Paper

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ACRONYMS

The following acronyms are mentioned in this report and/or appendix.

ACA	Affordable Care Act
ART	Antiretroviral Therapy
BJS	Bureau of Justice Statistics
BOP	Bureau of Prisons
CHW	Community Health Worker
CMHP	Criminal Mental Health Project
CMS	Centers for Medicare & Medicaid Services
DOJ	U.S. Department of Justice
DUA	Data Use Agreement
ESRD	End Stage Renal Disease
FPL	Federal Poverty Level
FY	Fiscal Year
GEP	General Enrollment Period
HBV	Hepatitis B Virus
HCV	Hepatitis C Virus
HIV	Human Immunodeficiency Virus
ICPSR	Interuniversity Consortium for Political and Social Research
IEP	Initial Enrollment Period
MCO	Managed Care
NCRP	National Corrections Report Program
NIS	National Inmate Survey
NSDUH	National Survey on Drug Use and Health
QMB	Qualified Medicare Beneficiary
ResDAC	Research Data Assistance Center
SAMHSA	Substance Abuse and Mental Health Services Administration
SIFCF	Survey of Inmates in Federal Correctional Facilities
SILJ	Survey of Inmates in Local Jails
SISCF	Survey of Inmates in State Correctional Facilities
SLMB	Specified Low-Income Medicare Beneficiary
SMI	Serious Mental Illness
SOAR	SSI/SSDI Outreach, Access, and Recovery program
SPI	Survey of Prison Inmates
SSA	U.S. Social Security Administration
SSDI	Social Security Disability Insurance
SSI	Supplemental Security Income

TASC

Treatment Alternatives for Safe Communities

VA
VJO

U.S. Department of Veterans Affairs
Veterans Justice Outreach program

EXECUTIVE SUMMARY

Linkage to health coverage upon release from prison or jail is a critical aspect of the reentry process that may promote greater personal stability and productivity, as well as better care coordination in the community health care system and subsequent reductions in state expenditures. This paper examines operational and legal or regulatory barriers to enrollment in Medicare and Medicaid among elderly reentrants, and discusses promising correctional and community-based strategies for enrolling them in health coverage. The paper also identifies key gaps in current understanding and outlines an analytic plan to help address these gaps and inform future policy directions. Key findings include:

- **Elderly individuals make up an increasing proportion of the incarcerated population in the United States.** There were approximately 156,000 state and federal prisoners aged 55 and older at yearend 2015, comprising nearly 11 percent of the total prison population; this is a significant increase from 1995, when prisoners 55 and older totaled 32,600 and comprised 3 percent of the prison population.[1,2,3] This number is projected to grow to more than 400,000 by 2030, comprising over 30 percent of the estimated total prison population.[4] Between 2003 and 2013, growth among individuals aged 55 and older accounted for the majority of overall growth in the state prison population.[5]
- **Older incarcerated individuals are a unique subset of the overall incarcerated population and have high physical and behavioral health needs compared to both their contemporaries in the community and their younger, incarcerated counterparts.** This includes high prevalence of infectious diseases, chronic conditions, disabilities, and cognitive impairments.
 - Compared with both younger incarcerated individuals and older individuals in the community, older incarcerated individuals have substantially higher rates of high blood pressure, diabetes, and pulmonary disease.[6]
 - Older incarcerated persons report higher rates of physical disabilities than their younger incarcerated counterparts. Compared to those ages 18-24, individuals 50 and older in prisons and jails are 13-15 times more likely to report an ambulatory disability, six times more likely to report a hearing disability, and 4-5 times more likely to report a vision disability.[7]
 - A study of incarcerated persons aged 55 and older found that 40 percent had cognitive impairments, higher than the rate found among older non-incarcerated individuals.[8]
 - Rates of mental health issues among older incarcerated persons are lower than those among younger state and federal prisoners, but are nevertheless substantial, with 40 percent of state prisoners 55 years of age or older and 52 percent of jail inmates 55 years of age or older reporting a mental health condition.[9]
- **Medical parole and compassionate or geriatric release are not widely used at the state or federal level.** Although some form of early release law is in place federally and in 47 states, laws vary widely by jurisdiction and are infrequently used for the release of elderly prisoners. Lack of systematic outreach to potentially eligible individuals, a written application that may prove challenging for older adults, a lack

of universal decision making guidance for applying federal and state laws, and a limited number of appropriate locations to which to release eligible individuals appear to limit the use of such policies.

- **In states that expanded Medicaid eligibility, many elderly reentrants qualify for Medicaid coverage.** Elderly reentrants in non-expansion states have fewer options, but may qualify for Medicaid through Supplemental Security Income (SSI), or may qualify for Medicare or other insurance options.
- **Elderly reentrants face legal and regulatory barriers to eligibility, as well as operational and logistical barriers to enrollment among those eligible for coverage.** These include challenges around documentation of disability needed for SSI/Social Security Disability Insurance (SSDI); limited pathways to eligibility for non-disabled individuals; lack of sufficient qualifying work history for Medicare Part A and SSDI; inability to meet enrollment deadlines while incarcerated; limited communication between criminal justice, public benefits, and health care systems; and challenges presented by unstable housing, lack of transportation, functional and cognitive impairment, low literacy, and distrust of institutions and public benefits.

Targeted enrollment strategies can help to address these barriers and promote linkage to health coverage and care for older reentrants. Promising strategies include individualized assistance with the SSI/SSDI application process, use of community health workers (CHWs) and peer navigators, communication and data sharing between correctional and public benefits systems, training of prison and jail staff to support applications, and targeted approaches for subpopulations of elderly reentrants such as veterans.

Despite these preliminary findings, there is a need for a stronger research base to support the development of strategies for linking this population to health coverage and care. Key gaps in current understanding include estimation of the potential eligibility for Medicaid, Medicare, or other relevant sources of health coverage (e.g., TRICARE) among aging reentrants, and identification of qualitative or quantitative factors that influence health coverage or care outcomes among aging reentrants. Proposed analytic strategies for addressing several of these gaps are discussed in depth in the analysis plan section of this report, with the aim of building an empirical foundation to inform future policy.

1. DEMOGRAPHIC TRENDS IN THE AGING REENTERING POPULATION

1.1. Trends in the United States Prison Population

The past several decades have been marked by a well-documented rise in the number of incarcerated individuals in the United States. The Bureau of Justice Statistics (BJS) reported that at the end of 2014, 2.2 million adults were incarcerated in state or federal prisons and local jails, and an additional 4.7 million adults were supervised in the community on probation or parole.[10] Although the incarcerated population has remained stable since 2007, the decades prior were marked by explosive growth; from 1972 to 2007, the rate of United States residents incarcerated in prisons and jails per 100,000 population more than quadrupled.[11] The current United States incarceration rate is among the highest in the world.[12]

The justice-involved population of the United States is affected by overall demographic trends, including an ongoing shift towards an older population. The National Institute of Corrections defines incarcerated persons age 50 and older as “elderly” or “aging,” and BJS typically uses age 55 and older. Although these are both lower age thresholds than are used among the general population, evidence supports accelerated physiological aging as a result of factors such as substance abuse and inadequate access to health care before incarceration, and stress during incarceration.[2,13]

BJS data show that from 1995 to 2015, the number of state and federal prisoners 55 years of age or older grew nearly five-fold, from 32,600 (3 percent of the total state and federal prison population) to 156,000 in 2015 (11 percent of the total prison population);[1,3,14] this number is projected to grow to more than 400,000 by 2030 (30 percent of the estimated total prison population).[4] National Inmate Survey (NIS) data from 2011/2012 suggest an estimated 27,000 additional individuals age 55 and older in jail.[15] Since 2003, individuals 55 and older have been the fastest-growing segment of the state prison population.[5] Between 2003 and 2013, admission to state prison among individuals aged 55 and older increased by 82 percent, while state prison admissions *declined* among those less than 55. Growth in this older age group accounted for the majority of overall growth in the state prison population during this time frame, indicating that this rise is significantly reshaping the demographics of incarceration.[5]

Within this larger national shift, there is notable geographic variation in age-related trends among state prisoners. One case study of four state prison populations (New York, California, North Carolina, and South Carolina) found that from 2002 to 2012, the average age of the incarcerated population increased steadily in all four states; however, in New York and California the proportion of the youngest groups (age 18–29) has remained stable, whereas in North Carolina and South Carolina there have been dramatic reductions in the size of these groups.[16] National Corrections Reporting Program (NCRP) data show that in 2009, the proportion of incarcerated persons aged 55 years or older ranged from 4.2 percent to 9.9 percent, with the highest proportion in Oregon and the lowest in Connecticut.[14]

1.2. Factors Driving Growth of the Older Incarcerated Population

The factors that have driven overall growth in the older prison and jail populations over the past decade are not fully understood. Researchers point to longer sentences and greater time served, both of which may reflect mandatory minimum sentencing policies, as well as increased admissions among older individuals (especially ages 55-59) and more-limited use of parole.[5,17] Older individuals, as a result of their opportunity for longer criminal histories, may be especially vulnerable to enhanced sentences under “multiple strikes” laws.[5,14,18,19] However, there is little empirical evidence that sentencing policies of the 1980s and 1990s are primarily responsible for the older demographic shift; a California simulation analysis study concluded that “three strikes” laws in the state do not contribute to accelerated growth of the older incarcerated population.[20] Studies by Luallen and Kling and by Porter and colleagues used modeling to conclude that the aging of the prison population has largely been driven by the changing distribution of age at admission, with more admissions among an older cohort of individuals.[16,21]

Nationally representative data from the Survey of Inmates in State Correctional Facilities (SISCF) show that the majority of older incarcerated men are in prison for violent offenses, and many have had prior prison stays. Among a sample of 1,160 individuals aged 50 or older, 63.9 percent were convicted of a violent offense, 13.8 percent were convicted of a property offense, and 11.1 percent of a drug offense. Just over half of the sample had served a previous prison sentence (52.9 percent), and 3.6 percent were serving a life sentence.[22] In 1993, the percentage of state prisoners aged 55 and older admitted for violent offenses (including murder, manslaughter, rape, robbery, and assault) was 42 percent, which was the highest percentage of violent offense admissions among any age group.[5] Between 1993 and 2013, this percentage declined to 31 percent of admissions; however, the number of older individuals imprisoned for violent offenses increased by 3,500 due to the overall growth in the number of older admissions during this period. Similarly, although there was a 3 percent decline in the proportion of older offenders admitted for drug sentences between 2003 and 2013, the total number of admissions for drug crimes among older offenders increased by 1,700 because of an overall increase in admissions among this population.

1.3. Demographic Characteristics of Older Incarcerated Persons

The aging trend has affected both men and women in the prison population. Although men continue to significantly outnumber women in all forms of interaction with the criminal justice system, older individuals make up nearly the same share of the female and male prison populations. In 2011, older individuals (50 years and up) made up approximately 18 percent of women and 16.5 percent of men in prison.

Elderly individuals comprise a larger proportion of the non-Hispanic White prison population than they do any other racial group. However, as a result of disproportionate representation of African Americans in the incarcerated population generally, older African Americans comprise the overall largest percentage of the older prison population.[19]

2. HEALTH NEEDS OF THE AGING JUSTICE-INVOLVED POPULATION

2.1. Health Needs of Older Incarcerated Persons

Older incarcerated individuals have high health needs compared to both their contemporaries in the community and their younger, incarcerated counterparts, suggesting that their health status is shaped by both age and incarceration. Incarcerated individuals typically experience increased health problems (and greater associated health care costs) as they age.[23] Compared with both younger incarcerated individuals and older individuals in the community, older incarcerated individuals have substantially higher rates of high blood pressure, diabetes, and pulmonary disease.[6] A Texas study found that incarcerated persons 55 years of age and older used an average of 7.3 prescription medications, which is higher than for non-incarcerated Americans of the same age.[24]

The health effects of aging on the justice-involved population may be amplified by incarceration itself. Many older individuals in prison are serving sentences of 20 or more years, and those age 50 and above are more likely to have served at least 20 years in prison than their predecessors in previous decades.[25] Thus, elderly individuals reentering the community may have important health care needs not only because they are older, but also because they have spent lengthy amounts of time behind bars, whether in one stretch (e.g., a sentence of 20 or more years) or cumulatively (cycling in and out throughout adulthood). In addition to incarceration accelerating the aging process,[13] prior research has established that incarceration is a significant source of exposure for stress-related and infectious diseases.[26] It follows that the more years an individual spends behind bars, the greater the risk of exposure and the impact of accelerated aging.

As a result, older individuals are the largest consumers of health care within prisons and the most expensive subpopulation for correctional systems. A 2012 American Civil Liberties Union report found that individuals aged 50 and older cost American taxpayers an estimated \$68,270 per year to incarcerate. This is double the annual estimated cost for a state prisoner of average age.[25] A Bureau of Prisons (BOP) report found a smaller but still notable cost differential; in FY2013, individuals aged 50 and older incarcerated in BOP facilities cost 8 percent more on average to incarcerate than their younger counterparts.[17] This same report found that BOP institutions with the highest percentages of older inmates spent five times more per inmate on medical care, and eight times more on medications, than BOP institutions with the lowest percentages.

Compared to their contemporaries in the community, older incarcerated persons are significantly more likely to have infectious diseases or chronic conditions.[27] Based on data from the NIS and the National Survey on Drug Use and Health (NSDUH), compared with the general population, state and federal prisoners report significantly higher rates of infectious diseases, including tuberculosis, Hepatitis B and C (HBV, HCV), and other sexually transmitted infections.[28] HIV prevalence is estimated to be five times higher among the incarcerated than among the non-incarcerated population.[29] Because HIV is typically transmitted through injection or unprotected sex, individuals are also at elevated risk of additional comorbid conditions. Chronic conditions are also more prevalent among individuals incarcerated in jails and prisons, and one-quarter report multiple chronic conditions.[28] The most commonly reported chronic condition among incarcerated individuals is high blood pressure (30.02 percent), and other prevalent conditions include asthma, arthritis, heart-related problems, and diabetes, all of which are significantly more

prevalent among the incarcerated population compared with the general population[28] and likely even more prevalent among the older incarcerated population than the general incarcerated population. Kidney-related problems are also prevalent among incarcerated individuals,[28] which is notable due to the complexities and extremely high financial costs associated with providing dialysis within correctional settings.

Using nationally representative data from the SISCOF, Nowotny and colleagues examined health profiles of older incarcerated men to identify patterns of multi-morbidity across the domains of chronic medical conditions, substance-related diseases, impairments, and mental and behavioral health.[22] Latent class regression analyses identified four distinct groups of older incarcerated men: the relatively healthy (45.1 percent of the study sample), those with serious substance use and other behavioral health issues (23.4 percent), the chronically unhealthy with impairment and histories of violence or injury (23.6 percent), and the very unhealthy across all domains (7.9 percent). Each group had a unique demographic profile, and their composition also reflected racial disparities in health. For example:

- Those with the most serious substance abuse conditions were significantly younger than the healthy group (OR -0.89, $p > 0.001$), had significantly more episodes of prior incarceration, and included a higher proportion of Black men than any other group.
- The chronically unhealthy group had the highest mean age of any group (61.0 years), low rates of drug-related and alcohol-related diseases and mental health problems (suggesting that their poor health was largely due to the aging process), and included a higher proportion of White men than any other group.
- The very unhealthy group had the highest rate for all medical conditions except cancer, HIV/AIDS, and sexually transmitted infections, and also reported high rates of behavioral health conditions. Nearly one-third had experienced childhood physical or sexual assault, and one-third reported mental impairments.

Although the very unhealthy group made up just 7.9 percent of the overall sample, researchers noted that this group exemplified the highly complex and interconnected health needs of some older incarcerated men.

Nowotny and colleagues also found that veterans were overrepresented among the older incarcerated population. Thirty-nine percent of older male state prisoners reported veteran status, largely from the Vietnam War era, compared to just 10 percent of the overall state prison population according to BJS data.[22,30] Research suggests that these older veterans have poorer health status than older non-veterans. William and colleagues found that incarcerated veterans had higher rates of post-traumatic stress disorder, asthma, and hearing disabilities than non-veteran incarcerated individuals, but did not differ significantly for other disability and medical conditions.[31] In Nowotny and colleagues' analysis, veterans were overrepresented among very unhealthy older incarcerated men, suggesting that veterans are particularly likely to have multiple comorbid conditions that require intensive treatment and medical oversight.[22]

Trauma histories are also prevalent in the older incarcerated population; a study of state prison inmates aged 55 or older found that most participants (80 percent) reported childhood or adult trauma, including physical or sexual abuse.[32] Trauma is often compounded by extended exposure to the documented stresses of the prison environment, especially older adults who may fear dying in prison.[33] Rates of mental health issues among older incarcerated persons are substantial: 40 percent of state prisoners 55 years of

age or older and 52 percent of jail inmates 55 years of age or older report living with a mental health condition.[9] As is true in the general population, rates are higher among incarcerated women than incarcerated men, and incarcerated women have nearly twice the rate of co-occurring mental health and substance use disorders than their male counterparts.[9,34] The higher prevalence of mental health symptoms among individuals in jails than in prisons may be because local jails often serve as a temporary placement for people with mental health conditions before referral to an appropriate mental health facility, or because jails often do not provide sufficient time to diagnosis and provide medications to individuals displaying such symptoms. Substance use is another major concern among the incarcerated population, with approximately two-thirds of individuals in prison and jail meeting the medical criteria for substance use disorders; this rate is seven times higher than among the general population.[34]

2.1.1. Disabilities and Other Impairments in Older Incarcerated Persons

Disabilities are highly prevalent among the incarcerated population, with increasing prevalence among those over 50. Data from the 2011/2012 NIS found that across all ages, an estimated 32 percent of those incarcerated in state and federal prisons and 40 percent of those in jail report having at least one disability.[7] Among those age 50 and older, the prevalence was 44 percent and 60 percent, respectively.^a When compared with American Community Survey data on non-incarcerated individuals, those in prison were three times more likely and those in jail were four times more likely to report disability than the general population.[7] Women in prison are more likely than their male counterparts to report any disability. Co-occurring chronic conditions were common among prison and jail inmates reporting disabilities.

In addition, older incarcerated persons report higher rates of all disabilities than their younger counterparts, with the exception of cognitive impairments (which are equally likely to be reported among all age groups). Compared to those ages 18-24, individuals 50 and older in prisons and jails are 13-15 times more likely to report an ambulatory disability, six times more likely to report a hearing disability, and 4-5 times more likely to report a vision disability.[7] Among both prison and jail inmates, cognitive disability is the most commonly reported disability followed by ambulatory disability.^b A study of incarcerated persons aged 55 and older found that 40 percent had cognitive impairments, higher than the rate found among older non-incarcerated individuals.[8] Researchers have raised specific concern among the prevalence of dementia among older individuals and ethical and practical challenges associated with its management in correctional settings.[8]

2.2. Reentry and Access to Health Care

Given the known health needs of the aging incarcerated population, linkage to health care upon release is critical. Studies have found that during the early post-release period, reentering individuals experience significantly increased mortality, particularly from overdose, suicide, and homicide.[35,36] A recent study of more than 70,000 reentering persons found that death rates among released state prisoners were 3.6 times greater than the general population and ten times greater than the expected overdose death rate, with

^a In this survey, disability included hearing and vision impairment, cognitive impairment, ambulatory impairments, and difficulties with self-care or independent living.

^b BJS, which administered this survey, noted that prevalence estimates may be underestimates due to exclusion of individuals with serious cognitive impairments that prevented them from providing informed consent.

the risk of death particularly high in the first week after release.[37] These concerns are particularly acute because of the high prevalence of mental health and substance abuse issues among the incarcerated population, and because of psychiatric deinstitutionalization and a lack of treatment resources to receive reentering persons in many communities.[37,38]

Continuity of care for behavioral health treatment is an important part of improving and maintaining individuals' post-release health and well-being and reducing future recidivism. One study found that engagement in treatment for mental health conditions and substance abuse problems declined by up to 50 percent from the period before release to 8–10 months following release.[39] Incarcerated individuals with major psychiatric disorders are more likely than other incarcerated individuals to have a history of prior incarceration, which is indicative of a "revolving door" for individuals with behavioral health issues between the community and the criminal justice system.[40] Access to medication, counseling, and behavioral therapy has been found to correlate with decreased rates of criminal activity and recidivism among formerly incarcerated individuals.[41,42]

Similarly, the high prevalence of infectious diseases and chronic conditions among the older incarcerated population shapes health risks and health care needs upon return to the community. Continuity of care is an important aspect of treatment for chronic conditions, and has been associated with lower rates of inpatient hospitalization, emergency department visits, and complications among Medicare beneficiaries, as well as significantly reduced health care costs.[43] For HIV-positive individuals, consistent prison-based provision of antiretroviral therapy (ART) is associated with high rates of viral suppression and improved quality of life.[44,45,46] Several studies, however, have found that viral load typically increases significantly after incarceration, and rates of ART medication refill upon release are very low.[45,47,48] This has implications for not only the infected individual but also other community members, as studies have found increases in HIV transmission-risk behavior (needle sharing and unprotected sex) in the weeks after release.[49,50] Individuals who receive pre-release discharge planning were more likely to maintain continuity in ART. Although ART adherence has been most rigorously studied among the justice-involved population, it is likely that post-release medication adherence is a challenge for reentering persons with a variety of medical conditions.

Across the reentering population, increased uptake of health services during reentry is associated with not only improved health outcomes but lower rates of recidivism and improved outcomes around employment, housing, and family support.[39,51,52] However, health insurance coverage is a key determinant of access to health care in the community, and justice-involved individuals have historically had very low rates of insurance before and after incarceration. One 2005/2006 survey of individuals entering San Francisco county jails found that 90 percent lacked any form of health insurance.[53] Furthermore, another pre-Affordable Care Act (ACA) study found that 80 percent of individuals leaving Illinois jails were uninsured at 16 months following release.[52]

3. AGING AND EARLY RELEASE

3.1. Early Release Policies

Many older incarcerated individuals are potentially eligible for early release.[54] Early release laws, including provisions for medical parole and compassionate release (also referred to as geriatric release), were developed in response to correctional budget pressures and in the context of ethical and practical arguments about the presence of older adults in prisons. Since the size of a state's older incarcerated population is a major driver of correctional health care spending, and health care spending is a major driver of overall state correctional budgets, many states have considered early release as a potential cost saving strategy.[55,56] In addition, ethical and practical arguments have been made about the unfitness of prisons to meet the housing and medical needs of the aging or infirm, the presumed lower threat to public safety posed by aging or infirm persons, and humanitarian concerns related to death and dying in the prison setting.[56,57,58]

Some form of early release policy is in place in 47 states and in the federal BOP.[54,59] The criteria under which individuals may be eligible for either form of release vary by correctional system, and include being terminally ill or dying, physically incapacitated, or of advanced age ("geriatric"). In addition, early release mechanisms are sometimes used for incarcerated persons in need of constant medical care that cannot be provided within the correctional system.[54] Procedurally, early release typically takes the form of either medical parole (also referred to as discretionary parole) or compassionate release. Compassionate release determinations are made by the sentencing authority and represent a permanent adjustment to the original sentence.[59] Medical parole policies are administered by parole boards, and unlike those subject to compassionate release, individuals on medical parole remain under the supervision of the correctional system, which retains some responsibility for their medical care and will recall them to prison if they make a recovery.[60]

Specific early release laws vary widely by jurisdiction--particularly with regard to the categories of aging or infirm individuals who may be eligible. Table 1 shows early release policies by jurisdiction.

TABLE 1. Early Release Policies in the United States*	
Groups Eligible for Early Release	Applicable State or Jurisdiction
Terminally ill, physically incapacitated, or geriatric individuals	Alabama, Colorado, New Mexico, North Carolina, Oregon, South Carolina, Texas, Wyoming
Terminally ill or physically incapacitated individuals	Arizona, Arkansas, California, Connecticut, Florida, Hawaii, Idaho, Kansas, Kentucky, Louisiana, Maine, Mississippi, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New York, North Dakota, Oklahoma, Missouri, Rhode Island, Tennessee, Vermont
Terminally ill or geriatric individuals	South Dakota, Virginia, Wisconsin
Physically incapacitated individuals only	Alaska, Maryland, Michigan
Terminally ill individuals only	Minnesota, Ohio, West Virginia
Geriatric individuals only	Federal
Individuals who require outside medical care only	Delaware, Indiana, Utah, Washington
None	Illinois, Iowa, Massachusetts, Pennsylvania
* Demyan, A.L., <i>What's Compassion Got To Do With It? An Empirical Examination of Medical Release in California Prisons</i> . 2013, University of California, Irvine: Ann Arbor. p. 194.	

3.2. Early Release Implementation

Despite the widespread existence of various forms of early release and their potentially broad applicability (e.g., to all persons over a certain age in some correctional systems),[54] very few individuals are actually released under such mechanisms. Limited evidence exists on the risk of recidivism for individuals who are released via early release mechanisms and many potentially eligible individuals either are never considered for early release or are denied.[57,61]

3.2.1. Implementation of Federal Early Release Policy

Studies of compassionate release in the federal BOP system find extensive facility-level variation in compassionate release processes.[14,17,56] Although compassionate release decisions are made by the sentencing court, BOP wardens and regional directors exercise much discretion in selecting the petitions it sends forward to the court. One 2012 report indicated that BOP typically only forwarded the cases that BOP determined met the legal standard for “extraordinary and compelling” circumstances as well as other criteria related to public safety and public opinion.[14]

Overall, compassionate release is used very minimally by BOP.[17] During 2000-2011, wardens and regional directors approved and forwarded 444 requests for compassionate release to the sentencing court, and courts approved 60 percent of those requests. During the period since 1994 when the federal prison population has approximately doubled, the number of motions for compassionate release has increased very little.[14] The U.S. Department of Justice's (DOJ's) Office of the Inspector General indicated that a lack of consistent standards for inviting and considering compassionate release applications results in inconsistent decision making from institution to institution. These inconsistencies are evident with regard to:

- Whether or how individuals are informed of compassionate release policies and application processes.
- What standards are applied for life expectancy (e.g., no more than 6 months, no more than 12 months).
- Whether individuals may be considered for release on a non-medical basis.
- Whether timeliness standards apply and what they are (among institutions with timeliness standards, the standards for initial review range from 5 to 65 days, and review of appeal can take up to another 5 months).

In an effort to standardize the compassionate release review and approval process, the U.S. Sentencing Commission released new eligibility guidelines in 2016 for use by federal judges in compassionate release cases that have been advanced to the courts.[62] These guidelines are not mandatory, but they offer an important framework for BOP to consider in expanding use of compassionate release. Notably, the guidelines remove the requirement that an individual has a short-term “terminal” prognosis, which acknowledges the imprecision around forecasting lifespans and date of death. They also allow release of individuals with non-terminal but “debilitating” conditions such as advanced liver, heart, and lung disease, and dementia, all of which are enormously costly for prison health care systems. In addition, the guidelines allow older individuals with declining health to be eligible for release after serving 10 years or 75 percent of their sentence, whichever is shorter.

Compassionate release applications and decisions are very minimally documented by BOP; the agency only formally tracks applications that are approved by the relevant warden and regional director and forwarded for consideration, and applications that are denied and appealed. Among those tracked, DOJ’s Office of the Inspector General found that timeliness of application processing was of concern: in 13 percent of cases over a 6-year period, the subject of the application died before a final decision was reached.[17]

3.2.2. Implementation of State Early Release Policies

At the state level, early release provisions also appear to be infrequently exercised. Although systematic data on early release are also difficult to obtain at the state level, as they are not typically made available to the public, Williams and colleagues[59] found, for example, that:

- Colorado released three individuals under its early release policy from 2001 through 2008.
- Virginia released four individuals under its early release policy from 2001 through 2007.
- Oregon released no more than two individuals per year through 2009 under its early release policy.

Texas, one of the most active early release programs in the country, had released 170 persons through its medical parole program as of 2012.[60] Although a variety of eligible conditions are specified in the state’s early release policy, rates of medical parole approval for all criteria other than terminal illness were very low. For example, from 2007 through

2012, the approval rate for applications based on advanced age was 0.05 percent.[60] Demyan's[54] study of compassionate release and medical parole implementation in another large system, California, found a wide gap between the target populations described in state policy and the number and characteristics of those actually released under such provisions:

With only a 32.5 percent release rate, there are forces outside of the legislative arena preventing the use of this policy on a larger scale. These forces, particularly deciding bodies' susceptibility to stereotypes regarding offender characteristics and subsequent risk-averse action, have resulted in fewer than intended releases and the denials of many applicants for whom this policy was created...While medical release is often discussed in the context of the aging population, in California, the aging are not the ones benefitting from this policy. (p. 90)

3.2.3. Early Release Outcomes

Existing sources of data on early release implementation and outcomes are relatively scarce. This review did not identify any information on the number of older individuals who might be affected if existing early release laws were more fully implemented. Outcomes of early release implementation have been little studied, at least in part because complete data for a given jurisdiction are difficult to obtain. The potential for cost savings through early release has been one focal argument in favor of its use. However, BOP does not track cost data on eligible persons,[17,56] and our review did not identify any studies of cost outcomes at the state level.

The risk of recidivism, which has been used to argue in favor of compassionate release policies at the system level and against compassionate release implementation at the individual case level, is also little studied. DOJ's Office of the Inspector General found that, over a 6-year period, recidivism for individuals released under the federal compassionate release program was 3.5 percent, relative to an overall recidivism rate of up to 41 percent across the federal system.[17]

More research is needed to fully understand early release implementation processes and potential implementation outcomes. Early release implementation and outcomes might be examined using administrative data from state and federal systems (e.g., BJS's NCRP) to identify the number of older individuals who might be affected by proposed standardized early release guidelines designed to apply across correctional systems.[63]

3.2.4. Barriers to Early Release Implementation

Many barriers prevent broader implementation of existing early release policies. First, in many correctional facilities, no systematic outreach or education process exists to inform eligible individuals or their family members of the availability of such policies. Nor, within most institutions, does formal staff responsibility exist for making individuals or their families aware when a person might be eligible.

Second, facilities typically require a written application and complex application process, which may present a particular barriers to older individuals--whom experts suggest face greater literacy challenges and have less family member support during incarceration and release.[55,59] A case study in the Texas state correctional system found that applications submitted by medical staff were more likely to be approved than those submitted by incarcerated individuals or family members.[60]

Third, no standards exist in most jurisdictions for how decision makers are expected to apply legally specified criteria in making release decisions, nor for the timeliness of application processing.[17,56] In the absence of timeliness standards, decision making on early release applications may be so long delayed that it is made moot by the death of the applicant.[17] In the absence of standards for assessing eligibility based on legal criteria (and with no data to inform risk assessment), parole boards and sentencing administrators --as well as the facility administrators charged with forwarding early release applications to these decision makers--often focus more on concerns related to public safety and the perceived adequacy of the punishment than on determining whether an applicant meets legally defined eligibility criteria.[54,56,59,60,64] Without formal guidance on when to allow an application to proceed, these decision makers have little to no incentive to grant approval for release, and may err on the side of caution, rather than risk being held personally responsible for an individual's post-release offenses.[54] Denials of early release commonly reference the nature of the instant offense, rather than an assessment of whether the release criterion under which an application is being made has been met.[54,60]

Finally, the release of some individuals deemed eligible for early release is deferred due to a lack of available, medically appropriate placements for post-release care, such as nursing homes that will accept them.[55]

4. OVERVIEW OF HEALTH INSURANCE OPTIONS FOR THE AGING REENTERING POPULATION

Upon exit from prison or jail, older reentering individuals may be eligible for one or more health insurance options.

4.1. Medicaid

Medicaid has not historically played a central role in health coverage for justice-involved individuals, but with the passage of expanded Medicaid eligibility in 2010 in 31 states^c and the District of Columbia, it became an important insurance option for reentering individuals in some areas. In expansion states, nearly all individuals with incomes at or below 138 percent of the Federal Poverty Level (FPL) are eligible for Medicaid coverage, regardless of whether they meet categorical eligibility criteria. In these states, up to 15.1 million low-income adults are newly eligible for Medicaid coverage, including non-disabled adults with no dependent children who previously lacked a route to eligibility.[65] Although not part of the 2010 Medicaid expansion, Wisconsin also expanded Medicaid eligibility of childless adults with incomes of up to 100 percent of the FPL.[66] The DOJ estimates that over one-third of the newly eligible Medicaid population had past-year involvement with the criminal justice system.[67]

In non-expansion states, eligibility criteria vary, but individuals typically must be low-income *and* fall into one of the following groups: children; parents of dependent children; pregnant women; or blind, disabled, or elderly individuals.[68] Obtaining Supplemental Security Income (SSI) can serve as a path to Medicaid eligibility in most states, including many non-expansion states. In 32 states and the District of Columbia, receipt of SSI benefits allows for automatic Medicaid eligibility, an option made possible under Section 209(b) of the Social Security Amendments of 1972.[69] In these states, the SSI application doubles as an application for Medicaid, and receipt of both benefits starts simultaneously. In an additional seven states, the eligibility criteria for SSI and Medicaid are the same, but require separate applications. The remaining states have Medicaid eligibility criteria that do not necessarily align with SSI criteria.

The Centers for Medicare & Medicaid Services (CMS) has long held that individuals who meet eligibility criteria for Medicaid in their state of residence “may be enrolled in the program before, during, and after the time in which they are held” in a correctional facility.[70] However, Medicaid coverage cannot be used to pay for most health services delivered while incarcerated, with the exception of care delivered outside the correctional facility, such as at a hospital or nursing home, after the individual has been admitted for 24 hours or more.[71] In spring 2016, CMS issued a clarification that reversed previous policy prohibiting Medicaid coverage for individuals residing in community residential facilities under correctional supervision (i.e., halfway houses).[72] Medicaid benefits can now be provided to these residents as long as they have freedom of movement for work, community resources (e.g., library, grocery store), and health care treatment. Individuals on parole, probation, and under home confinement previously were eligible for Medicaid coverage; an additional estimated 96,000 individuals in halfway houses are newly eligible in Medicaid expansion states.[73] CMS guidance included clarification around Medicaid and

^c Optional state expansion of Medicaid eligibility was signed into law in 2010. Implementation began in 2014 in most states.

Medicare coverage of services for individuals released on medical or geriatric parole. Federal officials confirmed that to be eligible for coverage of services, individuals must be placed in medical institutions available to the public (and not specific to justice-involved individuals); must be free from physical restraint imposed solely for discipline reasons; and must be allowed to choose visitors, lock their unit (unless leaving the unit unlocked is necessary for medical reasons), and conduct private telephone calls.[74]

4.2. Medicare

Reentering individuals are eligible for Medicare coverage if they are age 65 or older, have End Stage Renal Disease (ESRD; permanent kidney failure requiring dialysis or transplant), or have disabilities and receive Social Security Disability Insurance (SSDI).[75] A beneficiary must wait 24 months after initial receipt of SSDI benefits before becoming eligible for Medicare.[76]

Medicare Part A is hospital insurance, which covers most medically necessary hospital, skilled nursing facility, home health, and hospice care. This is available premium-free to individuals 65 or older and their spouses who have worked and paid taxes under the Federal Insurance Contributions Act for at least 10 years, and who are eligible for (or currently receive) Social Security or Railroad Retirement Board retirement benefits.[75] Individuals under 65 can also receive premium-free Part A if they have received SSDI or Railroad Retirement Board disability benefits for at least 24 months, or if they have ESRD and meet certain eligibility requirements.[75]

Medicare Part B is medical insurance, which covers most medically necessary doctors' services, preventive care, outpatient services, durable medical equipment, laboratory tests, x-rays, mental health care, and some home health and ambulance services. Individuals pay a monthly premium for Part B, which is deducted from their Social Security, Railroad Retirement, or Civil Service Retirement check, if they receive these payments, or they are sent as a bill every 3 months if not.[75]

Medicare Part A coverage does not terminate automatically upon incarceration, while Part B typically does terminate because it is dependent on monthly premium payments that often go unpaid during incarceration. This is especially likely if premiums are being paid directly from an individual's Social Security benefits, which are terminated upon incarceration.[77] In 2016, CMS clarified that Medicare cannot be used to pay for medical items and services for individuals under arrest, incarcerated in prisons or jails, on supervised release or medical furlough, mandated to live in a halfway house or mental health facility, or mandated to live under home detention.[78] The exception to this policy is when: (1) state or local law requires that an individual repay the costs of certain services they receive while in custody; and (2) the state or local entity pursues the collection of amounts owed. Details around when these criteria are met remain open to debate, and it does not appear that Medicare financing for health care expenses for justice-involved individuals is used with any regularity among states.[79]

4.3. Dual Medicaid and Medicare

Some low-income individuals 65 and older, and younger individuals with qualifying disabilities, may qualify for both Medicare and Medicaid. These "dual eligibles" are among the sickest and poorest individuals covered by either program, and are more likely than

other Medicare beneficiaries to have mental health needs and to live in nursing homes. As of 2010, approximately 60 percent of dual eligibles were aged 65 and older, and more than 30 percent were younger persons with disabilities.[80] Low-income Medicare beneficiaries can qualify for Medicaid via different pathways, which subsequently affect the degree of coverage that Medicaid will provide. Most dual eligibles qualify for SSI, or have spent down all of their financial resources paying for health care and other long-term care; these individuals receive help with Medicare premiums, cost sharing obligations, and coverage of Medicaid benefits.[80] Qualified Medicare beneficiaries (QMBs) have incomes above the SSI cutoff but at the FPL, and they qualify for help with Medicare premiums and cost sharing. Specified Low-Income Medicare Beneficiaries (SLMBs) have income slightly above the FPL and qualify for Medicare premium assistance only.[80] Both the QMB and SLMB programs are considered Medicare Savings Programs, which provide an important pathway to subsidies for both Parts A and B; this is particularly important for individuals who do not have the required 10-year work history that qualifies them for premium-free Part A. Although precise estimates regarding how many justice-involved individuals are dually eligible for Medicare and Medicaid are not available, it is likely that many older reentrants have sufficiently low incomes and/or complex disabilities and chronic health conditions to qualify for both programs. Experts in this field have called for national and state policy research to determine the number of older justice-involved individuals who are dual eligible.[59]

4.4. TRICARE

Given the overrepresentation of veterans among the older incarcerated population, TRICARE--the health care program of the U.S. Department of Defense Military Health System--is another important insurance option for some older reentering individuals. TRICARE (formerly known as CHAMPUS) coverage is available to Uniformed Service members (including active duty and retired members of the Army, Air Force, Navy, Marine Corps, Coast Guard, Commissioned Corps of the U.S. Public Health Service, and Commissioned Corps of the National Oceanic and Atmospheric Association) and their families, National Guard/Reserve members and their families, survivors, former spouses, and Medal of Honor recipients and their families.[81] Individuals who are eligible for both TRICARE and Medicare can be dually covered under both plans; however, in most cases, eligible individuals must enroll in Medicare Part B in order to maintain TRICARE coverage. Although the U.S. Department of Veterans Affairs (VA) will not pay for medical care provided to incarcerated persons, TRICARE coverage is not terminated or suspended upon incarceration.[82]

4.5. Private Insurance

In addition to these public insurance programs, older reentering individuals can obtain private insurance plans through an employer or a spouse's employer, although this may not be offered if their employment is part-time or temporary.[83] Reentering individuals may also obtain insurance through the Health Insurance Marketplaces. Although individuals cannot purchase Marketplace plans while serving time in prison or jail (with the exception of those held pending disposition of charges), a special 60-day enrollment period begins upon their release into the community.[51] This provides a window for Marketplace enrollment for reentering individuals, outside of the typical annual open enrollment period.

4.6. Uninsurance

Many reentering individuals lack viable insurance options and will remain uninsured. This is particularly true in states that did not elect to expand Medicaid, where older reentering individuals have fewer options--particularly those who are male, non-disabled, non-veterans, and under 65 years of age.[51] Lack of insurance presents multiple barriers to accessing health care; however, uninsured individuals may access care through "safety net" providers, such as public hospitals, community clinics and health centers (including Federally Qualified Health Centers), and at hospital emergency departments. These providers may be limited in their ability to serve the uninsured due to limited resources, service capacity, and geographic reach. A discussion of legal, regulatory, and operational challenges that may serve as barriers to insurance enrollment for older reentering individuals follows.

5. LEGAL AND REGULATORY ELIGIBILITY CHALLENGES

The Medicaid and Medicare eligibility criteria outlined in Section 4 present both challenges and opportunities for connecting older individuals with health coverage following incarceration.

5.1. Medicaid

Legal and regulatory barriers to Medicaid eligibility differ significantly depending on whether the individual is reentering to a Medicaid expansion state. In these states, nearly all older individuals with incomes below 138 percent of the FPL are eligible for Medicaid. Justice-involved individuals are disproportionately low-income; a study of state and federal prisoners expected to be released within a year found that the estimated mean post-incarceration income for the sample was \$18,169 for state prisoners and \$23,763 for federal.[83] An earlier study in 2002 found that over 60 percent of jail inmates reported pre-arrest personal income that was below 138 percent of FPL at the time.[84,85] All of these estimates are based on conservative methods, and, notably, do not take into account the potential “wage penalty” reduction in income that individuals may face when seeking employment after incarceration. Therefore, the proportion of those reentering from prisons and jails who will qualify for Medicaid in expansion states is likely higher than estimated.[83]

In states that did not expand Medicaid eligibility, older reentrants face greater barriers to Medicaid coverage, as low income alone does not establish eligibility. In these states, older individuals who are non-disabled, or whose disabilities do not meet disability eligibility criteria set out by the U.S. Social Security Administration (SSA), have very few pathways to Medicaid coverage.

SSA is responsible for determining if an individual’s medical conditions qualify for SSI. While reentering individuals typically have higher-than-average health needs and cognitive and functional impairments, the SSA requires that individuals have a “severe” disability that has lasted--or is expected to last--at least 1 year or to result in death, prevents them from doing the work they did before, and prevents them from doing other work.[86] The burden is on the applicant to provide documentation of meeting these eligibility criteria.

To determine disability status, SSA established medical-vocational guidelines that take into account the applicant’s chronological age, in addition to his or her residual functional capacity (i.e., level of work intensity the applicant is capable of performing), education, and work experience. SSA guidelines state that, “*A person’s advancing age may limit the ability to adjust to other work...To determine the extent to which age affects a claimant’s ability to adjust to other work, consider advancing age to be an increasingly limiting factor in a claimant’s ability to make such an adjustment.*”[87] Applicants age 50 or older are designated as “closely approaching advanced age” (age 50-54) or “advanced age” (age 55 and older); these designations increase the likelihood of being approved for disability benefits. Older reentering individuals, especially those age 55 and older, may therefore have an easier time qualifying for disability-related SSI and subsequently Medicaid coverage.

Individuals who were insured through Medicaid based on their SSI benefits upon entry to prison or jail are at high risk of losing this coverage during incarceration. SSI payments are suspended initially upon incarceration and terminated after 12 months.[77] Termination of

these payments results in termination of Medicaid coverage, if that coverage was a result of the SSI benefits, and individuals must reapply for Medicaid upon release.

In all states, some immigrants are excluded from Medicaid coverage. Typically, undocumented immigrants and legal immigrants who have been in the United States for fewer than 5 years are not eligible for Medicaid.[88]^d A 2012 study estimated that 7 percent of soon-to-be-released state and federal prisoners (all ages) had been in the country for fewer than 5 years and would likely be ineligible for Medicaid.[83]

5.2. Medicare

Medicare eligibility presents challenges for older reentrants as well. Most significant to this population is the 10-year work history that is required to receive premium-free Part A coverage. Although data on work history among incarcerated and recently released individuals are difficult to obtain, it is highly probable that many older individuals leaving prisons and jails lack the required years of qualifying employment. Those who are released after serving multi-decade sentences, or who have cycled in and out of the criminal justice system throughout their lives, may not have spent sufficient time in the labor force to build a 10-year work history. Those who were incarcerated previously but returned to the community for a sufficient amount of time likely faced challenges to obtaining qualifying employment, including the stigma of a criminal conviction and the lack of appropriate job skills and educational qualifications.[89] A strong research base suggests employers are biased against individuals with prior criminal convictions; a survey of employers in four large United States cities found that 60 percent of employers reported that they would “definitely not” or “probably not” hire someone with an incarceration history.[90] Further, justice-involved individuals may have a history of temporary, part-time, or “off the books” employment that does not meet the Medicare work requirement.

If individuals obtain Medicare coverage through SSDI benefits, a qualifying work history is also required. To receive SSDI, an individual must be “insured for disability,” a standard that requires accumulation of a certain amount of Social Security work credits during a certain period. Work credits are based on total yearly wages or self-employment income; while the amount needed for a credit changes yearly (one credit required \$1,260 of wages or income in 2016), individuals can earn up to four credits per year.[91] The number of required credits increases with the age at which disability occurred, which may make qualifying more difficult for older reentering individuals. If an individual becomes disabled after reaching age 42, they require one credit for each calendar year between age 22 and the year before disability, within an upper limit of 40 work credits (or 10 years).[91] Workers over age 30 must have acquired 20 of these credits within the 10-year period before disability occurred.[91] This may disqualify from SSDI eligibility individuals who were incarcerated for all or part of the 10 years prior to their disability.

^d Certain groups are exempt from this 5-year waiting period, including refugees, asylum seekers, trafficking victims, and veterans and their families.

6. OPERATIONAL ENROLLMENT CHALLENGES

In addition to the legal and regulatory barriers that older individuals face to obtaining Medicaid and Medicare coverage after incarceration, numerous operational issues present challenges as well.

The Medicaid application is very complex when applying for disability-based Medicaid coverage that is *not* solely reliant on low-income status. These complexities may prove more challenging to navigate for older applicants, particularly those who are unfamiliar with technology or who have cognitive impairments.[92]

For Medicare, justice-involved individuals may face operational barriers to enrollment if they were incarcerated during their Initial Enrollment Period (IEP). This period includes the 3 months before an individual turns 65, the month of their birthday, and the three subsequent months. If eligible for premium-free Part A, an individual can sign up anytime during or after the IEP. However, Part B coverage and Part A coverage that is not premium-free must be obtained during the IEP; otherwise, the individual must pay a late enrollment penalty if they do enroll at a later date.[93] This penalty is in place for as long as the individual has coverage. Enrollment into Medicare during the IEP can be challenging for incarcerated individuals, particularly if assistance is not provided within prisons and jails, or if they are unaware of timing requirements around the IEP. Consequently, many older incarcerated individuals face late enrollment premium penalties when they try to enroll after release, which makes their Medicare coverage more expensive in years to come.[94] If an individual attempts to enroll in Medicare following release, they can only do so during the General Enrollment Period (GEP) from January 1 through March 31. If they are released after this period in a given year, they typically must wait for the new GEP to enroll.[94] Even when an individual does enroll during the GEP, Part B coverage does not begin until July 1.

As discussed previously, dual eligibles' Medicare premiums are typically paid for by Medicaid. Therefore, Medicare beneficiaries who receive a late enrollment penalty can have their full premiums--including the penalty--covered if they subsequently qualify for Medicaid coverage as well. However, enrollment as a dual eligible presents operational challenges for individuals who are not eligible for premium-free Part A, an issue that may disproportionately affect the older reentering population. To enroll as QMB or SLMB dual eligible, an individual must have Medicare Part A; however, individuals who are not exempt from premiums require the QMB benefit to pay the Part A premiums. CMS and SSA have sought to address this dilemma through the creation of a conditional enrollment process for Medicare Part A, through which an individual may apply for Medicare Part A on the condition that the state will pay the premium. In some states ("Part A Buy-in States"), this process is available at any time during the year; in others ("Part A Group Payer States"), the conditional enrollment process is only available during the IEP and the annual GEP. Older reentrants in Part A Group Payer states may therefore face significant delays in accessing QMB and SLMB benefits, depending on the timing of their release.[95]

For those individuals who are eligible for Medicaid only, the timing of the Medicaid application also presents special challenges, particularly for those reentering from jail who often have limited advance information about their expected dates of release. This hinders the ability of staff members to initiate the enrollment process prior to release, and can result in a coverage gap during reentry because benefits are not lined up ahead of time. Individuals who are enrolled in Medicaid during their incarceration who had their coverage suspended may face challenges lifting the suspension without an accurate release date.

Enrollment into SSI/SSDI disability entitlement programs--an important pathway to coverage for older reentering individuals--presents several operational challenges as well. Documentation of a qualifying diagnosis, and of the functional impairments to work that result from this diagnosis, is key to the eligibility process. However, functional impairments are often poorly documented by providers in prison and jail progress notes.[96] Additionally, when an individual is in a structured environment such a prison or jail, they may not demonstrate some functional impairments because they are not necessary for daily life.[96] Individuals applying for disability benefits also face challenges in accessing their medical records after release. A lack of coordinated databases and cross-agency access to such records impedes this process, and may also lead to interruption of treatment and duplication of services.[97] For older reentrants, cognitive impairments such as dementia or memory deficits can blur the lines between documented disabilities and functional impairments, which further complicates the eligibility assessment process.[96] Finally, as described earlier, individuals who obtain SSDI must wait another 2 years after these benefits begin to become eligible for Medicare. This Medicare waiting period may discourage some individuals from making the effort to apply for SSDI.

Older reentrants face several additional operational barriers to enrollment that are common across the benefits programs. Cognitive impairments can limit individuals' ability to navigate the enrollment processes and complete the required paperwork and application forms. Such impairments can be the result of various factors, including a history of traumatic brain injury, low educational attainment, nerve degenerative dementia processes, or substance abuse histories, and they can create what is known as "executive dysfunction." [98] This means that developing and executing a plan--something that is critical to the reentry process--will be more challenging for older reentering individuals. Even those without cognitive impairment may have trouble understanding reentry documents and instructions for benefits applications. Data from the 2003 National Assessment of Adult Literacy found that 21 percent of state and federal prisoners age 40 and older had below basic document literacy, defined as "knowledge and skills needed to search, comprehend, and use information from non-continuous texts." [99]^e An additional 37 percent scored at the basic document literacy level, which means they could read and understand information only in "simple" documents. Since applications for Medicaid and other benefits are notoriously complex, it follows that less than half of older incarcerated persons have the literacy skills required to understand and complete these forms. Physical impairments may impede enrollment as well; given the high prevalence of ambulatory disabilities among older incarcerated individuals, [7] traveling to SSA or Medicaid offices may be difficult.

Connecting older reentering individuals to Medicare and Medicaid coverage is further hindered by a lack of regular communication between the criminal justice, public benefits, and health care systems. In many instances, there is a lack of care coordination both upon entry to prison and jail and upon release. Community-based physicians are rarely notified that their patients have been incarcerated, and they lack a means of communicating with providers in prisons and jails; this can result in duplication of services, lack of medication continuity, and lack of appropriate treatment while incarcerated. [100] Upon release, most public benefits offices do not have data interfaces that allow them to access prison and jail medical records and other information that would assist in the benefits application process. The burden to obtain necessary documentation and communicate among agencies largely falls on the applicant, and doing so may be especially challenging for older individuals with disabilities, physical and cognitive impairments, and low literacy and health literacy.

^e Document examples included job applications, payroll forms, transportation schedules, maps, tables, and drug or food labels.

Reentering individuals without a fixed address or stable contact information face additional barriers to enrolling in benefits. Homeless individuals are eligible for receipt of Medicare, Medicaid, or SSI/SSDI benefits; however, a lack of stable contact information can hinder the process and cause delays or denials of applications if individuals do not receive notification to submit additional documents or take additional steps.[101] Documentation is a particular challenge among the reentering population, as many individuals lack identification cards, social security cards, or birth certificates.

Distrust of the medical system, and of authorities and systems in general, may be another challenge in linking older reentrants to health coverage. As discussed earlier, trauma histories are highly prevalent among incarcerated individuals, with 80 percent of those 55 or older reporting childhood or adult trauma in one study.[32,102] It is important to recognize that trauma is not necessarily the result of a single event, but is more commonly “prolonged and repeated... and may extend over years of a person’s life.”[103] Many justice-involved individuals enter prison or jail with social histories comprised of a complex interplay of traumatic events, including poverty, abuse, neglect, and other victimization.[102] The punitive and isolating nature of incarceration itself can act as a compounding traumatic experience, or a “re-traumatization.”[102] Individuals with trauma histories, and particularly childhood trauma, often develop a self-protective worldview that includes distrust of institutions and authority figures, particularly if those institutions reinforce hierarchies and confinement.[104] As a result, individuals may be disinclined to seek out public benefits and take the steps necessary to enroll in health coverage.[102,105,106] If individuals in prisons or jails are not given the medical treatment they need, or if their needs are met with skepticism, neglect, or disrespect, a distrust of medical systems may develop.[107]

Distrust of the medical system is higher among African Americans than among Whites, and higher among men than among women, and there is evidence that this lack of trust is a significant factor in the underutilization of health care services by justice-involved African American men.[107] Applying for Medicare or Medicaid coverage requires disclosure of personal and potentially sensitive information, as does meeting with a medical provider. Justice-involved individuals, particularly African American men, propelled by personal and historical distrust in medical systems, may avoid situations that require them to make themselves vulnerable and relinquish some degree of control of their personal information.[107] Frontline workers and administrators who work with the homeless population (another group of individuals with high distrust of public systems) have noted that it can take months or years to overcome this disengagement and build the trust necessary to enroll in health coverage.[101]

Older adults may also be challenged by social isolation. Isolation is a concern among all older adults in the United States and has been associated with a variety of risk factors and negative health outcomes.[108,109] The risk of isolation may be magnified if an individual has been in prison or jail for a long period, as incarceration tends to weaken social networks.[110] As a result, older reentering individuals may lack social connections that could be helpful in convincing them to enroll in health coverage or assisting them with the enrollment process.

Finally, it is important to acknowledge that health coverage is one of many competing needs that older individuals must navigate during the reentry process. Although health coverage and care are undeniably important, especially for high-risk, poor-health subpopulations of reentrants, so too are other priorities such as stable housing, employment, family reunification, and others.[111] The reentry process may further be shaped by physical and mental health problems, limited financial resources, and low levels of social support. These

factors all affect the degree to which an individual is willing and able to complete the steps necessary to enroll in coverage.

7. ENROLLMENT STRATEGIES

Given the known challenges to connecting the older reentering population with Medicare and Medicaid coverage, targeted enrollment strategies are key to encouraging linkage to coverage and care.

SSI and SSDI provide critical pathways to coverage, particularly in states where Medicaid eligibility criteria are narrower. Given this, the incarceration period is an important opportunity to document qualifying disability diagnoses. This may require specialized training and support for prison and jail providers that emphasizes the necessity of detailed and comprehensive medical notes regarding disability.

Upon release, the SSI/SSDI Outreach, Access, and Recovery program (SOAR), a project of the Substance Abuse and Mental Health Services Administration (SAMHSA), is a promising tool for connecting the older reentering individuals with Social Security benefits. SOAR was originally designed to connect people who are homeless or at risk of homelessness with SSA disability benefits, but is increasingly used to assist justice-involved populations as well.[112] SOAR-trained entitlement specialists work one-on-one with reentering individuals to help them determine whether they are eligible for benefits, access the documentation need to apply for benefits, complete their applications, and communicate with government agencies as necessary. Specialists can act as an applicant's official "representative," which allows them to communicate directly with Social Security and the Division of Disability Determination.[96]

This intensive, individualized approach has been successfully implemented in prison and jail settings; a study of five jails and four state prison systems found that under SOAR, approval rates for SSI applications averaged 70 percent or higher.[112] One such example is the Eleventh Judicial Circuit Criminal Mental Health Project (CMHP), established in 2000 in Miami-Dade County, Florida as a community diversion program for justice-involved individuals with serious mental illness (SMI). SOAR-trained staff members work with all CMHP participants to assess SSI/SSDI eligibility. From 2008 through 2013, 91 percent of individuals were approved in an average of 34 days, which is one-third of the 2012 national average waiting time.[112]

Similar programs have been implemented in Bergen and Mercer counties in New Jersey and in Fulton County in Georgia, with approvals ranging from 70 percent to 75 percent.[112] The SOAR program has also been utilized in prisons in New York, Michigan, Oklahoma, and Tennessee. In Oklahoma, individuals who were connected with SSI/SSDI through SOAR notably had a 41 percent lower 3-year recidivism rate than a comparison group of released individuals.[112] Although SOAR is a highly promising approach for a range of individuals across the criminal justice system, there is reason to believe that older adults--who likely have lower literacy levels, less experience with technology, and smaller social networks, as well as high prevalence of disabilities--are especially strong candidates for the program. Support from CHWs and peer navigators who have personal experience with reentry represents another potential strategy for engaging older reentering individuals in health care and coverage. The CHW and peer navigator models have been used in a variety of contexts to provide individualized support for reentering individuals, and offer services such as case management, health care system navigation, and assistance scheduling and attending appointments, as well as non-health-related support with housing, employment, and other needs.[113,114] Although their roles may vary, CHWs are generally viewed as "insiders" who may be more accessible and trustworthy than government employees, which makes them powerful potential allies in the reentry process.[114] For example, the

Transitions Clinic Network, a national network of clinics that serve individuals reentering from prison and jail, pairs all patients with a formerly incarcerated CHW.[113]

Another key strategy for connecting incarcerated individuals with coverage (across all ages) is the integration of public benefits eligibility assessments into prison and jail intake protocols. In Cook County, Illinois, the sheriff's office partnered with the county's Medicaid expansion plan (CountyCare) and a non-profit, Treatment Alternatives for Safe Communities (TASC), to screen all individuals entering Cook County Jail for CountyCare eligibility. For individuals determined to be eligible, TASC staff members use information collected at intake to validate identity and complete the application requirements onsite. A 2014 report found that there was a 94 percent CountyCare approval rate for these applications.[51] In 2012 and 2013, the State of Connecticut also implemented a jail intake-based process for Medicaid enrollment, building on their previous prison-based pre-release enrollment efforts.

Approaches to enrollment in jails and prisons must be uniquely tailored to each population, as jails and prisons serve fundamentally different roles in the criminal justice system and detained individuals have vastly different lengths of stays. Prisons are typically used for sentences of one year or longer, which allows for greater time to assess eligibility, identify needs, and complete the application process. In contrast, jails are typically used for pretrial detention, short sentences, and detention ending in transport to prison; rapid turnover and unpredictable release dates require quick, adaptable eligibility and application processes.[115]

For justice-involved individuals who are also military veterans, the Veterans Justice Outreach (VJO) Program can help make connections to coverage and care. The program, which operates through VA medical centers, was initiated in 2009 to "avoid the unnecessary criminalization of mental illness and extended incarceration among Veterans by ensuring that eligible, justice-involved Veterans have timely access to Veterans Health Administration services, as clinically indicated." [116] The VJO Program facilitates linkage to TRICARE by "reaching in" to criminal justice systems and pairing eligible incarcerated veterans with trained VJO specialists who provide outreach, assessment, case management, and assistance with application for VA benefits. The specialists focus on linkage to mental health and substance abuse services, when clinically indicated, as well as other supports and services.[117] In FY2015, the program served 46,500 veterans, nearly half of whom were over age 44.[118]

Proactive coordination between correctional and public benefits systems has enormous potential to improve enrollment among older reentrants. Communication between these systems is typically hindered by incompatible technology and a lack of data sharing protocols, but officials in Pima County, Arizona have bridged this technological divide by integrating local jail and Medicaid data systems. County officials instituted a policy to suspend--rather than terminate--Medicaid coverage for individuals entering jail, motivated by a goal of eliminating gaps in coverage for reentering individuals with immediate behavioral health and chronic health needs.[119] The suspension and reinstatement process requires frequent electronic data transfers between the local jail and the local Medicaid agency. The sheriff's department (which operates the jail) sends data related to admissions and releases, as well as personal identifying information for these individuals, 3-4 times a day. If an individual has been held for 24 hours, Medicaid coverage is suspended; since 60 percent of people are held less than 12 hours, this allows them to avoid the suspension process altogether.[119] If coverage is suspended, the Medicaid agency notifies the reporting jail, as well as the managed care organizations (MCOs) and regional behavioral health authorities that coordinate behavioral health care in the state. When the

individual is released, the sheriff's department sends the release data via secure file transfer protocol and the suspension is automatically lifted. Typically, individuals are reenrolled in the same MCO as prior to incarceration. This integration of data systems is also used to complete new Medicaid applications for individuals entering jail without coverage; jail staff complete electronic applications through Medicaid's online web tool, and the Medicaid agency automatically activates coverage for those who are eligible upon receipt of their release data.[119]

Finally, providers and other experts who work in this area emphasize the need for proactive efforts from public benefits programs to facilitate enrollment by older reentrants. Many current enrollment approaches rely on the applicant taking the initiative to seek help in applying for coverage. This can be a daunting ask for older individuals recently returned to their communities, most of whom have little understanding of how to navigate public systems and apply for benefits, and who are also faced with multiple competing needs and priorities. Proactive approaches can begin before the individual is released, by "reaching in" to prisons and jails and beginning the application process. Several states are exploring this option by applying to CMS for Medicaid waivers to cover post-release in-reach efforts; for example, Illinois has requested a waiver from Medicaid to cover behavioral health assessment in inmates' final 30 days before release.[120] They may also begin at the moment of release, through initiatives such as Stanford University's "Ride Home" program, in which reentrants are met at the prison gate upon release, assisted with basic needs, and driven to their preapproved halfway house placements. Once in the community, proactive outreach from Medicare, Medicaid, and Social Security agencies to community-based reentry service providers, and to older reentering individuals themselves through tailored messaging, can further assist in gaining coverage for this population.

8. ANALYSIS PLAN

8.1. Opportunities for Secondary Analysis

8.1.1. Gaps in the Literature

Existing data offer an opportunity to understand the health coverage and care needs of older reentrants more fully than is possible from the current research literature, and to close gaps in our understanding of this high-need subpopulation of justice-involved individuals. Prior work has documented the health needs and characteristics of various samples (mostly nationally representative) of prison and jail inmates aged 50 years and older. In particular, it has established the relatively high prevalence (compared to younger incarcerated persons or to similarly aged persons in the community) of disability, chronic medical conditions, infectious diseases, mental health conditions, trauma histories, and cognitive impairments in various prison and jail populations.

Prior work has also examined the criminal justice system experiences of older incarcerated persons, including the higher proportion (compared to the general incarcerated population) of older individuals who are incarcerated for violent offenses and serving long sentences, as well as the fact that almost all will eventually be released to the community. Finally, it has identified the proportion of incarcerated persons who are veterans and assessed differences in health-related need between veterans and non-veterans in the older incarcerated population.

However, older reentrants remain an understudied population, and substantial gaps in understanding limit the ability of researchers and policymakers to make actionable and well-targeted programmatic and policy recommendations. In particular, the literature identified by this review has not estimated potential eligibility for Medicaid, Medicare, or other relevant sources of health coverage (e.g., TRICARE) among aging reentrants. In addition, prior research on this population has generated a descriptive understanding of its demographic characteristics and health-related needs, but has not focused on identifying qualitative or quantitative factors that influence health coverage or care outcomes among aging reentrants. Both of these topics are critical to developing policy.

Representative data that could be useful in understanding the health care and coverage-related needs and experiences of older reentrants are collected and maintained by several federal agencies in the DOJ and U.S. Department of Health and Human Services. Except as noted, these data are publicly available, generally through the Interuniversity Consortium for Political and Social Research (ICPSR) at the University of Michigan.

8.1.2. Department of Justice Data Sources

The federal BJS collects and publishes administrative and survey data on persons involved with the criminal justice system, particularly those incarcerated in local jails and in federal and state prisons.

National Corrections Reporting Program (NCRP)

<https://www.bjs.gov/index.cfm?ty=dcdetail&iid=268>

NCRP is a compilation of administrative data from state departments of correction that includes information on prison admissions, prison releases, parole releases, and entries and

exits from post-release community supervision. BJS staff have suggested that NCRP data may be best suited for addressing research questions related to health coverage and health care among returning state prisoners.[121]

- *Eligibility-related variables:* age (at admission, release, parole completion), state.
- *Variables related to health needs:* sentence length, entity released to (including residential treatment, nursing home facility).

National Inmate Survey (NIS)

<http://www.icpsr.umich.edu/icpsrweb/NACJD/studies/35009>

NIS was designed to understand experiences of sexual victimization among individuals incarcerated in prisons and jails. NIS has been conducted three times to date, most recently with a total sample of 92,449 incarcerated adults (including 38,251 prison inmates, 52,926 jail inmates, 573 Immigration and Customs Enforcement detainees, 539 inmates in military facilities, and 160 inmates in Indian country facilities). Data are of high quality, but access is challenging; restricted files may only be analyzed onsite at the University of Michigan. NIS includes a wide range of constructs of interest related to physical and behavioral health, although these non-victimization-related data were only collected from 10 percent of the study sample (and due to survey time limits, item non-response may be higher among respondents who reported more physical or behavioral health issues). As a result, estimates related to chronic health conditions are particularly challenging; an analysis found that those who completed the physical and behavioral health subsection were systematically different than those who did not, making weight adjustments necessary when estimating national prevalence.[28]

- *Eligibility-related variables:* age category (45-54, 55+), state, veteran status, SMI, physical impairment.
- *Variables related to health needs:* various medical conditions, behavioral health services need and receipt.

Survey of Inmates in Local Jails (SILJ)

<https://www.bjs.gov/index.cfm?ty=dcdetail&iid=274>

SILJ generates nationally representative information on the individual characteristics of local jail populations. It has not been conducted since 2002. A redesigned SILJ is expected to be fielded around 2020.

- *Eligibility-related variables:* veteran status, pre-admission employment, pre-admission SSI receipt.
- *Variables related to health needs:* prescription drug use, behavioral health treatment history.

Survey of Inmates in State and Federal Correctional Facilities (SISCF/SIFCF)

<http://www.icpsr.umich.edu/icpsrweb/NACJD/studies/4572>

SISCF and SIFCF were designed to produce national statistics on state and federal prisoners using parallel questionnaires and data collection protocols.

- *Eligibility-related variables:* age, income, veteran status, SSI receipt, SMI, physical and mental impairment, “consider yourself to have a disability”.
- *Variables related to health needs:* various medical conditions, behavioral health services need and receipt, learning disabilities, special education receipt.

Survey of Prison Inmates (SPI)

SPI is the successor to SISCF/SIFCF, and is currently under way. Data from its initial implementation are being processed and are scheduled to be publicly archived by the end of 2017.

- *Eligibility-related variables:* age, state, veteran status, SMI, disability, income (and sources of income) during 30 days before arrest.
- *Variables related to health needs:* physical and behavioral health conditions, learning disability, special education receipt, physical and behavioral health treatment.

8.1.3. Additional Federal Data Sources

In addition to data maintained by BJS on individuals involved in the criminal justice system, agencies in the U.S. Department of Health and Human Services, as well as the SSA, maintain key sources of data on the general United States population that have relevance for understanding older reentrants, although none of them collects detailed information on incarceration experiences.

National Survey on Drug Use and Health (NSDUH)

<http://datafiles.samhsa.gov/study-series/national-survey-drug-use-and-health-nsduh-nid13517>

SAMHSA conducts NSDUH to generate national-level and state-level estimates on the use of tobacco, alcohol, and illicit drugs (including non-medical use of prescription drugs); the prevalence of mental health conditions; and experiences with behavioral health treatment.

- *Eligibility-related variables:* age category (45-54, 55+), veteran status, income, percent FPL, any past Medicaid or Medicare utilization.
- *Variables related to health needs:* uninsurance, cost barriers to treatment, behavioral health services need and receipt.

Social Security Administration (SSA) Data Sources

<https://www.ssa.gov/data/>

SSA maintains various data on the general population that are relevant for assessing Medicare, SSDI, and SSI eligibility. Among these are data on workforce participation (including earnings from and timing of formal employment), which are critical for estimating Medicare and SSDI eligibility and not readily available from other sources.

SSA allows public use of many data files, but the agency obtains workforce participation data from the U.S. Department of the Treasury and does not appear to make them available for research purposes outside the agency. Current data do not support determining what

proportion of incarcerated or reentering persons meet SSA eligibility criteria for workforce participation. SSA’s Office of the Actuary regularly conducts published and unpublished analyses to understand the eligible population, however, and these analyses (conducted by in-house actuarial staff without data sharing) could be a resource for future work in this area.

Centers for Medicare & Medicaid Services (CMS) Medicare Data Files

<https://www.resdac.org/cms-data/request/cms-data-request-center>

CMS collects and oversees extensive data on the population of Medicare beneficiaries and Medicare providers. This includes person-level data on beneficiary demographics, current address, eligibility category, dates of enrollment, and all medical claims (including information related to inpatient and outpatient service utilization, expenditures, diagnoses, procedures, and medications prescribed and filled). The Medicare enrollment database also includes variables that indicate if a beneficiary has ever been incarcerated and, if so, the start and end date of each incarceration episode. Incarceration data are limited to incarcerations occurring after a beneficiary was first enrolled in Medicare, and are only available from 2002 through present-day.

CMS provides numerous public-use datasets through the Research Data Assistance Center (ResDAC), including de-identified nationally representative data files related to beneficiary health status and access to care, and facility information. However, all files that provide identifiable person-level information (which is necessary for linkage with the incarceration variables in the Medicare enrollment database) can only be obtained through a research request process, which requires submission of a research protocol and a Data Use Agreement (DUA).

8.1.4. Summary of Available Data Sources

Table 2 summarizes available data sources, the constructs of interest that they contain, access parameters, and available years.

TABLE 2. Existing Data on Health Coverage and Health Needs among Older Reentrants					
Data Source	Criminal Justice Involvement	Health Care Utilization	Physical and Behavioral Health	Coverage Eligibility	Coverage Status
National Corrections Reporting Program	35 criminal justice variables. Detailed list is in the “NCRP” sheet.	Agency to which the individual was released (including health care facilities), facility where time was served (including hospitals and mental health institutions).	None	Age	None

Notes on access: Some variables from the 1991-2014 dataset are publicly available, but they are not relevant to this research. The individual datasets (latest 2014) are restricted use, and access can be applied for at <https://www.icpsr.umich.edu/rpxlogin>. Data have been collected annually beginning in 1983, and the latest available data are for 2014. The latest available codebook is for 2009 (which is the source from which variable information for this table is drawn).

TABLE 2 (continued)					
Data Source	Criminal Justice Involvement	Health Care Utilization	Physical and Behavioral Health	Coverage Eligibility	Coverage Status
National Inmate Survey	35 criminal justice variables. Detailed list is in the "NIS" sheet.	17 variables including prescription drug use, some measures of hospitalization and mental health treatment usage in prison/jail.	42 variables including detailed information about mental health conditions and disability status.	Age, military service	None
Notes on access: Datasets are all restricted use. More information on access parameters is available at http://www.icpsr.umich.edu/cgi-bin/file?comp=none&study=35009&ds=0&file_id=1177310&path=NACJD . The last available full dataset is for 2012.					
Survey of Inmates in State and Federal Correctional Facilities / Survey of Prison Inmates	>1000 variables including full criminal history and detailed information on offense types and time served.	17+ variables, mostly on utilization of mental health or substance abuse facilities.	51+ variables including numerous mental and physical health measures. (In the SPI, suicidality items and the mental health battery are replaced with the K6 Psychological Distress Scale. The SPI also has 2 additional variables related to learning challenges.)	Age, military service, income (including social security as income source), retirement status. (The SPI has added items on pre-incarceration health insurance and expectations for post-release VA coverage.)	None
Notes on access: Some of the variables of interest are restricted use. Access can be applied for at https://www.icpsr.umich.edu/rpxlogin . The most recent year for which data have been released is 2004. Data from the 2016 version of this survey, now referred to as SPI, are expected to be released by the end of 2017 as part of ICPSR's criminal justice data archive at https://www.icpsr.umich.edu/icpsrweb/ICPSR/studies?classification=ICPSR.XVII.E . The 2016 collection includes substantial revisions, particularly in the mental and physical health sections. However, most relevant constructs are maintained in the 2016 survey.					
Survey of Inmates in Local Jails	>500 variables. Includes detailed information about the incident for which they are in jail. Also includes criminal history. Selected examples are listed in the SILJ tab.	17+ variables, mostly on utilization of mental health or substance abuse facilities.	51+ variables including numerous mental and physical health measures.	Age, military service, income (including social security as income source)	None
Notes on access: Some of the variables of interest are restricted use. Access can be applied for at https://www.icpsr.umich.edu/rpxlogin . The most recent year for which data have been released is 2002.					

TABLE 2 (continued)					
Data Source	Criminal Justice Involvement	Health Care Utilization	Physical and Behavioral Health	Coverage Eligibility	Coverage Status
National Survey on Drug Use and Health	19 variables on parole, probation, and arrests. Also includes information on the type of crime.	75+ variables including information about treatment for substance use and mental health. Also includes hospital and ER visits from last year.	125+ variables covering mental and physical health and disability status.	Income, percent FPL, age	Type of insurance, unmet need due to lack of coverage, rationale for not having insurance
<p>Notes on access: Most variables are public use. Restricted use data currently not accessible (see http://datafiles.samhsa.gov/info/analyze-restricted-data-nid67). The public-use data only contain criminal justice variables and a few demographic variables. Age is not included. Data collection periods are not uniformly spaced. The most recent year for which data are available is 2015.</p>					
Medicare Data	3 variables that indicate if beneficiary was ever incarcerated during their Medicaid enrollment period, start date of incarceration, and end date of incarceration.	Full medical claims for inpatient and outpatient services. Includes information on diagnoses, procedures, and prescriptions.	Full medical claims for inpatient and outpatient services. Includes information on diagnoses, procedures, and prescriptions.	Current reason for Medicare entitlement (old age and survivor's insurance, disability, ESRD, 2 or more of the above)	Variables related to type of coverage as well as coverage start date and number of months per year that beneficiary had coverage,
<p>Notes on access: CMS makes identifiable data files available to certain stakeholders, including researchers, as allowed by federal laws and regulations as well as CMS policy. Requests for these data files require a research protocol and DUA, among other documents, and are reviewed by CMS's Privacy Board. More information on the research request process can be found at the ResDAC website (http://www.resdac.org).</p>					

8.1.5. Data Linking

BJS and the Census Bureau are collaborating on strategies for linking NCRP and census data behind the Census Bureau's firewall to better understand the experiences of reentering individuals. Linked data, which are only accessible to authorized federal staff, could support analyses related to employment, household income, and household structure among reentering individuals living in the community.[5]

8.1.6. Proposed Eligibility-Related and Health Need-Related Research Questions

As summarized in the literature review, prior research on health care and coverage for older reentrants has often made use of the secondary data sources discussed above. However, such data have not yet been fully leveraged for understanding health coverage eligibility and health-related needs in this population.

Understanding Benefits Eligibility

Proposed eligibility-related research questions and a brief summary of strategies for addressing them appear in Table 3. These questions and strategies are shown in descending order of their expected contribution to the field.

Addressing research questions 1-4 should be possible within single, existing data sources that are publicly available or obtainable. Where these research questions concern the incarcerated (as opposed to community-based) population, SPI (when released) is anticipated to be the best source of data on prison inmates. SILJ is anticipated to be the best source of data on jail inmates; however, these data are limited by their age (2002 is the most recent data collection).

TABLE 3. Addressing Eligibility-Related Research Questions		
Question	Data Source(s)	Statistical Approach
1. What proportion of justice-involved individuals* over 50 report military health benefits?	NSDUH	Frequency
2. Among individuals 55 years old and older who are incarcerated in prisons and jails**, how many have ever served in the United States Armed Forces? How many are currently serving? How many were dishonorably discharged?	NIS	Frequency
3. What proportion of justice-involved individuals* over 50 self-report current Medicaid coverage? Of those who do not, what proportion report that Medicaid paid for any of their care in the last 12 months?	NSDUH	Frequency
4. What proportion of justice-involved individuals* self-report current Medicare coverage? Of those who do not, what proportion report that Medicare paid for any of their care in the last 12 months?	NSDUH	Frequency
5. Among individuals 50–65 who are incarcerated in state prisons** in expansion states, how many are likely to meet Medicaid/SSI means tests?	NCRP with Census	Frequency
6. Among individuals 65+ who are incarcerated in prisons or jails**, how many are likely to meet the work threshold for Medicare eligibility? How many are likely to meet disability criteria for SSDI?	SSA with NCRP SSA with SPI SSA with SILJ	Frequencies in weighted data
* As operationalized here, “justice-involved individuals” would include those ever arrested and those who have been on probation or parole. (Individuals who have been on probation or parole are a subset of those who have ever been arrested, but probation/parole variables would be included for those with missing arrest data.)		
** As operationalized here, “individuals incarcerated in prisons or jails” would include a small number of individuals who will never be released (<5% of state prison samples).		

Addressing research question 5 could be possible using newly linked data developed in partnership between BJS and the Census Bureau. If authorized staff from either agency were interested in addressing this question, it appears that they could do so using combined data from NCRP (for incarceration status) and the American Community Survey (for state, household income, and assets). If neither agency is interested in that question, the next best approach could be to estimate the numbers of incarcerated persons who will be released to Medicaid expansion states, and use existing estimates of socioeconomic status

among justice-involved individuals to more roughly estimate the proportion of those persons who would meet Medicaid means tests. Finally, state-specific estimates for research question 5 may be available from state Medicaid agencies.

Addressing research question 6 (eligibility for Medicare) with any reliability is unlikely given the scope of existing datasets. Our inventory did not identify any dataset that included measures of lifetime workforce participation *and* of incarceration or reentry status, which would be needed to estimate the proportion of incarcerated or reentering persons who are likely to meet workforce participation requirements for Medicare or SSDI eligibility.^f However, subject matter experts suggested that statistical approaches that require making significant assumptions to enable estimation would be worthwhile, given the dearth of information on this question.[122,123,124] SSA has unpublished estimates of the proportion of individuals in the general population who have met Medicare eligibility criteria for workforce participation by age 62 and by age,[125] which might be statistically adjusted to estimate the proportion of reentering persons who meet those criteria. In addition, the federal BOP and state departments of correction that use electronic medical records may be able to estimate SSDI eligibility for their populations.

As shown in Table 4, for the last 5 years, approximately 93 percent of men in the general population have met Medicare workforce participation requirements as of age 62 and as of age 65.

TABLE 4. Men in General Population Who Meet Workforce Participation Threshold*		
Year	Work Participation Criterion Met, %	
	As of Age 62	Threshold As of Age 65
2011	93.3	93.9
2012	93.4	93.9
2013	93.3	93.6
2014	93.4	93.6
2015	93.8	93.6

SOURCE: Office of the Actuary, U.S. Social Security Administration, 2017.
 * Office of the Actuary, S.S.A., *Personal Communication*. 2017, Social Security Administration.

Research on employment challenges among reentering individuals finds that many experience serious pre-incarceration challenges with getting and keeping formal employment, and many rely heavily on sources of income outside the formal economy for pre-incarceration income.[126,127] It is generally expected--including among the experts interviewed for this study--that lifetime attachment to the formal workforce is lower among older reentering persons than in the general population. Yet reentering persons' lifetime employment histories have not been previously documented in a manner that maps well to the SSA eligibility criteria for workforce participation.

To understand the proportion of reentering persons who are likely to meet SSA criteria, SSA's demographic data on Social Security Area populations and data on older reentrants

^f To be eligible for Medicare Part A (which is provided at no cost to the insured), an individual needs 40 "covered quarters" of formal workforce participation, or at least one-quarter of formal work for each calendar year between the year s/he turns 21 and the year before s/he reaches age 62, dies, or becomes disabled (whichever is soonest). To be eligible for SSDI, an individual needs to have met Medicare workforce participation requirements *and* to have accumulated at least 20 "covered quarters" in the last 10 years.

from SPI could be used to construct a synthetic population, adjusted to resemble the older incarcerated population in terms of educational attainment, race, and (point-in-time) income from formal employment. Then, the proportion of that synthetic sample who meet SSA’s workforce participation criteria could be calculated.

In the context of a strong partnership with SSA, a similar approach might be explored for calculating likelihood of eligibility for SSDI disability benefits, adjusting based on measures of disability, medical condition, functional impairment, or a combination of these that are common across SSA and criminal justice system data. These data elements could be obtained from SPI for those incarcerated in prisons and SILJ for those incarcerated in jails, or (to overcome limitations associated with the age of SILJ data) could be obtained from NIS for both prison and jail populations.

Understanding Health Needs

In addition to understanding eligibility for health coverage in the older reentering population, understanding health and health care needs is crucial to inform appropriate benefits packages and outreach strategies. Proposed research questions related to health needs, and strategies for addressing these questions, appear in Table 5. These questions and strategies are shown in descending order of their expected contribution to the field.

Each of these approaches should be possible within single, existing data sources that are publicly available or obtainable.

TABLE 5. Addressing Health Need-Related Research Questions		
Question	Data Source(s)	Statistical Approach
1. How do the behavioral health treatment needs of justice-involved individuals* over 50 and over 65 compare to those of the general population?	NSDUH	2-sample t-test
2. Do physical or behavioral health conditions or disabilities predict whether older justice-involved individuals* report Medicaid, Medicare, or other sources of health coverage?	NSDUH	Multiple regression
3. How many individuals over 50 and over 65 who are incarcerated in prisons or jails** have been diagnosed with multiple chronic conditions (e.g., arthritis, hypertension, heart disease, depression)?	NIS	Frequency
4. Does receipt of mental health or substance abuse treatment in the last 12 months predict whether older justice-involved individuals* report Medicaid, Medicare, or other sources of health coverage?	NSDUH	Multiple regression
5. What is the prevalence of significant cognitive impairment among formerly incarcerated individuals who are enrolled in Medicare?	Medicare ICD9 data	Frequency
6. What is the prevalence of self-reported learning challenges among individuals over age 50 who are incarcerated in prisons or jails**?	SPI	Frequency
<p>* As operationalized here, “justice-involved individuals” would include those ever arrested and those who have been on probation or parole. (Individuals who have been on probation or parole are a subset of those who have ever been arrested, but probation/parole variables would be included for those with missing arrest data.)</p> <p>** As operationalized here, “individuals incarcerated in prisons or jails” would include a small number of individuals who will never be released (<5% of state prison samples).</p>		

Understanding Health Services Utilization

Although beyond the scope of this analysis plan, Medicare claims and enrollment files present several opportunities to explore post-release health care utilization and expenditure patterns. This could include understanding mental and behavioral health services receipt, mapping the facilities and clinics from which reentrants seek care, and identifying prescription medication access patterns among newly released beneficiaries. Such analyses could provide new insight into older reentrants' health needs and health care usage in the weeks and months immediately following release. However, they would be limited to the population of individuals who were enrolled in Medicare prior to incarceration.

Because Medicare data include updated address information for all beneficiaries, analyses could also be conducted to explore areas with a high concentration of justice-involved Medicare beneficiaries. The locations of potential health care and coverage resources for older adults could then be mapped relative to these population densities to inform resource gaps and needs for specialized assistance.

8.2. Opportunities for Primary Research

8.2.1. Gaps in Existing Data Sources

Although secondary analysis offers important opportunities to better understand older reentrants' coverage needs, the field remains limited by several gaps in existing data. They are:

- Prior studies using probabilistic samples that include older reentering individuals have focused on those still incarcerated in prisons or jails, as opposed to those who have returned to the community.
- Although such surveys often include some measures of health status and health services utilization, understanding health coverage status and consumers' engagement with coverage enrollment processes has not been a focus of research with this population.
- Although a few such surveys include a small number of items about income and employment experiences, they do not focus on capturing aspects of these constructs that are salient for assessing eligibility for health coverage or disability benefits (e.g., lifetime workforce participation, past 10-year workforce participation, household income, assets).

8.2.2. Primary Quantitative Research

Several options for primary, quantitative research would result in an improved ability to estimate eligibility for health coverage or disability benefits among older reentrants. The following primary research efforts would help to address existing data gaps #1 and #3 (described above).

- *Surveying reentering persons longitudinally, including during incarceration and in the community* using an instrument focused on assessing health coverage eligibility, need, and enrollment intentions, and enrollment. Respondents might be recruited as

a subsample from within an existing BJS data collection to facilitate linking this primary, longitudinal to other, existing data sources. This approach would be the most resource intensive (and subject to typical limitations associated with self-report data) but would also generate the most significant advances in the field relative to current understandings and data sources.

- *Adding a small number of eligibility-related survey items to representative, prison-based surveys* conducted by BJS. This approach would likely offer the best balance between data quality and cost; however, space in such surveys is already heavily sought after.
- *Identifying eligibility-related data elements collected in administrative data systems* by state departments of correction that have adapted their systems to collect such information. Availability and quality of state data on these constructs could be examined using a cross-state webform survey and single-state pilot prior to undertaking any cross-state analysis. This approach could likely be carried out with the fewest resources.

Each of these efforts would meaningfully expand current understandings; however, all three of them are likely to be more costly than pursuing secondary analysis or primary qualitative research approaches.

8.2.3. Primary Qualitative Research

A small, qualitative inquiry would offer the opportunity to better understand health coverage enrollment decisions and processes from the perspective of older reentrants. The following options would help to address existing data gap #2 (described above).

Conducting semi-structured interviews with correctional medical directors, correctional administrators, prison wardens, and reentry services coordinators on issues related to reentry and linkage to public benefits. This effort could consist of semi-structured interviews with stakeholders in several geographic regions, highlighting both innovative regional approaches and diverse perspectives. Interview topics would include:

- Health coverage eligibility barriers and strategies (including interagency data sharing and whether in-prison work contributes to Medicare work requirements).
- Existing correctional infrastructure for releasing older individuals (including compassionate release, discharge planning, and other correctional pre-release protocols or programs).
- Community-based infrastructure for receiving older reentering individuals.

Suggested locations and stakeholders are listed in Table 6.

TABLE 6. Suggested Interviewees for Qualitative Research		
	Corrections Systems	Reentry Services Providers
San Francisco County, CA	<ul style="list-style-type: none"> • San Francisco Sheriff's Department • Ali Riker (Director of Programs) • San Francisco Adult Probation Department • Karen Shain (Reentry Policy Planner) 	<ul style="list-style-type: none"> • Bayview Senior Services, Senior Ex-Offender Program • Dr. Frank Williams (Program Director) • Ceyante Pennix (Transitional Housing)
New York, NY	<ul style="list-style-type: none"> • New York State Division of Correctional Services • Yvonne Behan, ATI/Reentry Manager for Office of Probation and Correctional Alternatives • U.S. Department of Veterans Affairs • Jonathan Pollack, Health Care for Reentry Veterans Program, Albany VA 	<ul style="list-style-type: none"> • Osborne Association • Laura Roan, Health Services Specialist for Elder Reentry Initiative • Gabriel Ramirez, Director of Treatment Services for Reentry Wellness and Prevention Program
Cook County, IL	<ul style="list-style-type: none"> • Cook County Sheriff's Office • Nneka Jones Tapia (Executive Director of Cook County Department of Corrections) 	<ul style="list-style-type: none"> • Treatment Alternatives for Safe Communities • Maureen McDonnell (National Director for Healthcare Initiatives)

Statewide practices implemented by the Ohio Department of Rehabilitation and Correction, which include facilitating connections to Medicaid and (for the sickest reentering persons) a managed care case manager, might also be worth capturing as part of this inquiry.

Conducting semi-structured interviews on health coverage enrollment with older individuals within one month before and one month after release from prisons and jails. Such an effort could engage a venue-based sample of individuals served by correctional medical providers with an investment in this topic, and either follow those individuals through the release transition (more costly) or recruit other venue-based samples of individuals served in the community by health care safety net providers, shelters, and halfway houses (more vulnerable to bias, as it would miss those who do not connect to any services or supports).

Recruitment efforts would explicitly include individuals who present a variety of health needs, including mental/behavioral health, chronic illness, and disabilities. Interviews with these individuals before and after release would focus on:

- Health concerns and priorities.
- How health concerns and priorities fit within broader reentry plans, concerns, and priorities.
- Past health care utilization experiences (in and out of prison), perspectives on engagement with the health care system, and relative comfort/understanding regarding the health care system (including health literacy considerations).
- Past health coverage enrollment experiences, perspectives on health coverage enrollment processes, and relative comfort/understanding regarding health coverage

enrollment processes (including health and computer literacy considerations and any concerns about engagement with government systems).

- Acceptability of various health coverage and health care engagement strategies (e.g., pre-release enrollment, reentry case management, post-release medical appointments, parole officer involvement).
- What would motivate health coverage enrollment in the respondent's current situation and among others s/he knows in that situation.
- What would help to overcome health coverage enrollment challenges in the respondent's current situation and among others s/he knows in that situation.

Examining an innovative program model to support older reentering persons in connecting to health coverage and/or disability benefits after release. Such an effort could be done in partnership with Bayview Senior Services' Senior Ex-Offender Program in San Francisco. Data collection would include review of primary documents, including program plans, proposals, and outreach materials; semi-structured interviews with program administrators and with program staff who directly serve participants; and focus groups with program participants.

These activities would focus on documenting:

- Program design characteristics
- Fidelity or adaptation of program design
- Outreach and enrollment processes, challenges, and strategies for overcoming challenges
- Service delivery processes, challenges, and strategies for overcoming challenges
- Perceived strengths and weaknesses of applying program components and/or overall approach for engaging older reentering persons in health coverage and care
- Services or adaptations that would help to engage older reentering persons in health coverage and care.

Each of these efforts would meaningfully expand current understanding on this topic.

9. POLICY DIRECTIONS AND CONCLUSIONS

9.1. Promising Policy Areas

Further research is needed to inform the development of effective policy regarding aging reentering individuals (as outlined in Section 8). While recognizing the ongoing need to better understand health coverage eligibility among this population and the factors that influence their health coverage and care outcomes, this review also identified several emerging policy areas that may help to bridge the divide between older reentrants and health coverage and care.

Pre-release discharge planning has been associated with increased medication adherence, engagement with the medical system, connection to health coverage, and positive health outcomes among reentrants who are HIV-positive or have SMI.[53,128,129,130] Given the substantial costs associated with such planning, many states have limited their discharge planning efforts to these two groups, which include some members of the older reentering population. Targeted expansion of discharge planning to older individuals could help this particularly high-risk and high-cost group of reentrants connect to coverage and care.

There may be opportunities for greater use of early release policies to meet the needs of older justice-involved individuals and to reduce costs to correctional systems. The 2016 eligibility guidelines developed by the U.S. Sentencing Commission offer a suggested approach for compassionate release cases that have been advanced to the courts, and could provide an established framework to guide federal and state use of compassionate release for older and poor-health individuals.

Integration of screening for health coverage eligibility into prison and jail intake systems, as seen in Cook County and other jurisdictions, could allow for proactive and efficient eligibility assessment. Such assessment could include screening for veteran status, eligibility for TRICARE or other VA benefits, and eligibility for Medicaid, Medicare, and SSI/SSDI. The enrollment process for eligible individuals could be begun or completed during incarceration.

With the continuing growth of the aging incarcerated population, corrections systems may opt to shift attention to Medicare as another potential coverage option that may have cost savings implications for states. To support this shift, CMS could provide policy clarifications around Medicare and the justice-involved population, as they did for Medicaid in 2015, with a particular focus on eligibility and work history issues. It is likely that many older justice-involved individuals are dually eligible for both Medicare and Medicaid; a focus on enrollment of such individuals into both programs could provide them with more comprehensive health coverage, and would also benefit state governments through federal cost sharing.

Finally, increased coordination between criminal justice and public benefits could help promote consistent and efficient linkage to coverage for older reentering individuals. Leadership-level work could establish appropriate coordination between corrections and state and local Medicaid, Medicare, and Social Security offices and other benefits programs. Staffing for application assistance can draw on existing resources, such as correctional health care and social services staff and community organizations that work with older adults. Existing correctional staff could be trained in the SOAR process and begin providing documentation and application assistance to individuals in the months prior to their release. An agreement could be established with SSA such that an individual is approved for benefits

while still incarcerated, but payments are not activated until they are released. Corrections systems can also fund specific benefits navigator positions to help transition older adults to the community. The Pima County, Arizona initiative discussed in Section 7, as well as similar initiatives in Washington, Maryland, and California, are examples of work that can guide development of technological interfaces to promote cross-agency communication and coordinated enrollment approaches.

9.2. Conclusion

Reentry is a period of transition for all individuals leaving prison or jail and preparing for their lives after incarceration. With the significant growth in the aging incarcerated population over the last several decades (and an understanding that the vast majority of these individuals will return to their communities after serving their sentences) it may be important to examine the ways in which aging shapes the reentry process. Older reentering individuals have a variety of competing needs, which may include family reunification, housing, and employment--but linkage to health coverage is of the utmost importance to this population, and to the health of the communities to which they return.

Many of the barriers to enrollment in Medicare and Medicaid that older reentrants face are the same as those faced by their non-elderly counterparts, such as low literacy, distrust of public systems, lack of appropriate documentation, and challenges meeting eligibility criteria for Medicaid in non-expansion states. Age adds an additional layer of difficulty to these common enrollment challenges, from both a legal and regulatory perspective and an operational one. Legally, meeting the work history requirements for Medicare and SSDI is likely difficult for many older reentering individuals who have cycled in and out of the criminal justice system (or have served a long sentence continuously) and may not have spent enough time in the community to develop a sufficient work history. Operationally, older reentering individuals have high rates of physical and cognitive impairments and low levels of literacy and health literacy. All of these factors may limit their ability to navigate and complete the coverage enrollment process and engage the health care system.

Documentation of disability and functional impairment is key to establishing eligibility for SSI and SSDI following release, and SSI and SSDI eligibility are critical pathways to securing Medicaid and Medicare coverage, respectively. For some individuals, incarceration presents an opportunity to more clearly document disabilities and functional impairments because they are not under the influence of alcohol or other drugs. However, disability and functional impairments are often poorly documented by providers in prisons and jails. Even when documented, community-based health systems and benefits offices often struggle to obtain medical records of released individuals, which can lead to processing delays and denial of coverage.

Overall, enrollment into Medicare and Medicaid requires proactivity on the part of reentering individuals, all of whom are also faced with other competing priorities and needs. Initiatives that promote linkage to health coverage during reentry must also acknowledge the importance of meeting reentrants' basic needs during this period. Older individuals may be further limited in their ability and willingness to proactively initiate the benefits enrollment process for reasons related to impairments, lack of social support and assistance, trauma-driven distrust of public benefits, and beyond.

While compassionate release and medical parole are important yet possibly underutilized tools, they also present community safety net systems with the challenge of serving complex, expensive patients, without strong discharge planning or linkage to public

services. It may be useful to align the cost savings interests of correctional and community health systems so that powerful tools such as compassionate release can be used to the mutual benefit of these systems of care and their patients.

Finally, strategies for supporting older reentrants must recognize and address the disparities associated with disproportionate representation of certain populations in the criminal justice system. Veterans are overrepresented among the older incarcerated population, as are African Americans and low-income individuals. Addressing linkage to health care during reentry--in addition to access to comprehensive health care prior to and during incarceration--may serve as an important means to promote equity in access to health coverage and care among older adults, reduce the burden on state budgets, and improve public safety and population health in the broader community.

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APPENDIX A. CASE STUDY--CONNECTING OLDER REENTRANTS TO HEALTH COVERAGE AND PUBLIC BENEFITS: MIAMI-DADE COUNTY'S CRIMINAL MENTAL HEALTH PROJECT

Connecting Older Reentrants to Coverage and Care

Adults aged 55 and older represent a growing share of the incarcerated population; by 2030, they are predicted to comprise 30 percent of the incarcerated population.[1] Older incarcerated adults exhibit physical and behavioral health conditions and disabilities at much higher rates than both their non-incarcerated peers and younger incarcerated individuals. For this reason, common reentry hurdles (such as finding housing and employment) are compounded by the health-related and disability-related challenges many face upon return to their communities.[2]

The higher prevalence of infectious diseases, chronic medical conditions, disabilities, and cognitive impairments in this population means that older reentrants must find ways to meet their physical and behavioral health needs as part of the reentry process.[3] This can involve securing health coverage, connecting with community-based medical and behavioral health care, and attempting to ensure continuity for prescription drugs taken for chronic physical or mental health conditions. Those unable to work due to functional impairments (very common among incarcerated older adults; see "Health Needs of Older Reentrants," page A-4) must also identify sources of subsistence income to remain stable.

Few prisoner reentry programs, court diversion programs, or health coverage enrollment initiatives are tailored to the needs of older reentrants, yet older adults are likely to comprise an increasing proportion of those seeking such forms of assistance. This brief examines how one such program, Miami-Dade County's CMHP, meets the needs of older adults returning from incarceration.

Criminal Mental Health Project (CMHP): A Promising Approach

The CMHP is a mental health diversion initiative within the Eleventh Judicial Circuit of Florida in Miami-Dade County. The CMHP was established in 2000 as a coordinated, comprehensive program to divert non-violent misdemeanor defendants with SMI or co-occurring SMI and substance use disorders into community-based treatment and support services. A staff member offered the following explanation of CMHP's goals: *"As we help people to move toward community integration, we're hoping people can live good lives in the least restrictive setting, live successfully in the community, make the community safer, and improve their own health."* The CMHP is comprised of both pre-booking and post-booking jail diversion programs, the latter of which includes case management, connection to community-based service providers, and individual assistance applying for federal benefits. Services are delivered through a closely coordinated, team-based approach, with collaboration among a project director, lawyers, case managers, peer specialists, and entitlement specialists.

Miami-Dade County presents a challenging context for CMHP's work, as it has the highest percentage of residents with SMI among large United States communities, while Florida has one of the lowest national rankings for state funding for community mental health services.[4] Traditionally, the CMHP had very limited resources to assist reentrants with connection to housing, treatment, and other medical services upon release from jail. As

such, SSI/SSDI represented critical reentry resources for this population. These benefits continue to represent key pathways to Medicare and Medicaid for low-income individuals in Florida, as the state did not elect to expand Medicaid eligibility under the ACA. However, staff who attempted to assist their disabled clients in the SSI/SSDI process tended to experience a lengthy application process and very high rates of application denial.

SOAR Program Overview

Goal

- The primary goal of the SOAR program is to increase access to SSI/SSDI benefits for qualified individuals who have mental illness and are at risk of homelessness, including those returning to their communities from jails and hospitals.

Core Program Elements

- Individualized assistance with application completion and submission by trained SOAR case managers.
- Accelerated, high-approval rate process.
- Strategic planning with key community stakeholders, including SOAR team leads, the SSA and Disability Determination Services, housing and homeless service providers, and local hospital directors and medical records departments.
- Ongoing training and technical assistance (TA) provided by the SAMHSA SOAR Technical Assistance Center (<https://soarworks.prainc.com/>), including TA providers with expertise in implementing SOAR in criminal justice settings.

Training

- Case managers receive SOAR training to learn how to assist qualified individuals by completing and submitting a complete SSI/SSDI application packet.
- Training consists of 7 online classes, estimated at 20 hours total.
- The training includes a practice case component, which requires completion of a full sample application.

SOAR in Miami-Dade County

The SOAR model took root within the CMHP in 2006, after the project director, Cindy Schwartz, was invited to attend an in-person training event held by the SOAR Technical Assistance Center (see "SOAR Program Overview"). After training, she championed the SOAR approach in the CMHP, *"I came back totally engaged in this, and I told all my staff, 'This is going to be the best thing that ever happened to us [to] help the people we serve become more self-sufficient, get housing, and it'll help us maximize our limited resources so we can serve more people.'"* Despite the initial skepticism of other program staff and stakeholders, she began implementing the SOAR approach.

Now, CMHP's entitlement specialists provide full-time support for SSI/SSDI applications through the SOAR model. Staff attribute some of the SOAR initiative's success in Miami-Dade to the decision to hire dedicated entitlement specialists for this task. Dedicated staffing proved necessary when the case managers originally tasked with implementing SOAR struggled to prioritize labor-intensive SSI/SSDI applications against their clients' acute competing priorities in the post-release period. Ms. Schwartz explained, *"When people are coming out of jail, you have to first pay attention to their basic needs: where are they*

going to live, how are they going to get treatment, do they have medication....Once we learned this [SOAR] technique, we taught it to our case managers and said to go do it, but it took a longer period of time because they were still addressing the basic needs. [SOAR is] a lot of work. There's no easy button here." Dedicated entitlement specialists are a defining component of the Miami-Dade SOAR program, and a key factor to which staff attribute their high SSI/SSDI application acceptance rate.

Although the SOAR model is supported by SAMHSA and its technical assistance provider (PRA, Inc.), no federal funding stream is attached to the program. Many states and localities fund SOAR through SAMHSA's Cooperative Agreements to Benefit Homeless Individuals and Projects for Assistance in Transition from Homelessness funds, as well as state funds. In Miami-Dade County, SOAR implementation was supported by a Florida Reinvestment Grant, which funded three full-time entitlement specialists to assist jail diversion clients and other justice-involved individuals with SMI.

SOAR implementation also required partnership development with courts and corrections personnel, medical facilities, behavioral health inpatient programs, homeless and other community-based organizations, and local Social Security offices. Staff from SAMHSA's SOAR TA Center explained, *"Judge Steve Leifman and Cindy Schwartz developed a strong relationship with the local SSA [Social Security Administration] field office and Department of Disability Services... They were able to provide court staff, the public defender's office, State Attorney's office staff, family members of potential applicants, and all stakeholders who touch the lives of justice-involved people with information necessary to help them to understand how [SSI/SSDI] play a part in post release success and recovery."*

Health Needs of Older Reentrants

Older reentering individuals often have high physical and behavioral health needs, compared to both younger reentrants and older individuals with no justice system involvement.

- Older persons in prisons and jails report higher rates of physical disabilities than their younger incarcerated counterparts. Compared to those ages 18-24, individuals 50 and older are 13-15 times more likely to report an ambulatory disability, 6 times more likely to report a hearing disability, and 4-5 times more likely to report a vision disability.[6]
- A study of incarcerated persons aged 55 and older found that 71% reported a substance abuse problem. They had also been using their primary substance longer (a median of 43 years) compared to younger individuals.[7]
- A separate study of incarcerated persons aged 55 and older found that 40% had cognitive impairments, higher than the rate among older non-incarcerated individuals.[8]
- Self-reported rates of mental health issues among older incarcerated persons are lower than those among younger state and federal prisoners, but are nevertheless substantial, at 40% of state prisoners 55 years of age or older and 52% of jail inmates 55 years of age or older.[9]

Meeting the Needs of Older Reentrants

The CMHP program serves a diverse range of clients, including reentrants aged 50 years and older. Justice-involved individuals of this age are typically designated as "elderly" or "aging." This age threshold is lower than typically used among the general population due to

accelerated physiological aging that may result from factors such as substance abuse and inadequate access to health care before incarceration, and stress during incarceration.[5] Older reentrants are a uniquely high-needs population, with high prevalence of physical and behavioral health needs and comorbid health conditions. Linkage to health coverage is therefore a critical component of successful reentry following release from prison or jail and continued success beyond the reentry period.

Older reentrants are a heterogeneous population, and there are significant variations between those with and without SMI, those with histories of felony versus misdemeanor convictions, and other distinctions. However, staff at the CMHP and the SOAR Technical Assistance Center identified several common challenges of older reentering individuals that can also affect SSI/SSDI applications.

- **Older adults often have a history of cycling in and out of the criminal justice system, leading to fragmented and unconsolidated medical records.** Because medical records provide the foundation for the SSI/SSDI application, a lack of comprehensive records can result in insufficient documentation of disability and delays in application submission.
- **Older reentrants face very limited housing options.** SSI payments may not fully cover rent, particularly in areas with a higher cost of living. Some older reentrants require care in a nursing home, but Medicare provides nursing coverage only in very specific circumstances (up to 200 days total in a skilled nursing facility), and many nursing homes choose not to accept Medicaid. Staff also noted a lack of appropriate, affordable independent living placements for low-income older adults.
- **Older reentrants often have less family and social support than their younger counterparts.** Family members can provide entitlement specialists with a more complete picture of a client's daily activities and functional activity level. Without family, entitlement specialists often lack that information. Family members can also serve as representative payees for clients' social security payments, if SSA determines that the beneficiary is unable to adequately manage their own payments (often due to cognitive impairment, disability, or substance abuse). If a beneficiary requires a payee but has no willing individuals, SSA can designate an organization as the payee; however, this presents an additional hurdle to receipt of benefits.
- **Many older reentrants have longer histories of cumulative trauma and greater distrust of government systems and persons in authority positions.** As a result, they may be hesitant, unwilling, or unable to share personal information with entitlement specialists. Explained one such specialist, "*A lot of people at age 60 are not just going to open up and say, 'My psychotic symptoms get in the way of being able to concentrate.' You have to build up the rapport... There's that mentality of 'I've been through life,' and they're not willing to admit the situation they're in right now.*" Older reentrants sometimes struggle to communicate openly with staff members who are significantly younger than they are. Due to greater life experience, older reentrants may also be better able to "present well," projecting a facade that obscures their true impairments.
- **Compared to younger SSI/SSDI applicants, older applicants have had more years in which they could work.** Being older can present a catch-22 regarding SSI/SSDI work history requirements. It means that applicants must demonstrate more quarters of paid work than younger ones, which can be a problem for those who spent many of their hypothetical "working years" incarcerated. Yet those who

have, indeed, spent many years employed face an additional challenge in demonstrating that a more recent impairment prevents them from working. Explained one entitlement specialist, *"They will be held to the standard of, 'You did this work for 30 years, why can't you do it now?'"*

Promising CMHP Strategies for Serving Older Reentering Individuals

Despite the challenges inherent in working with older reentrants, staff at CMHP identified several promising strategies for serving this population.

Integrating the SOAR program into a larger CMHP has allowed the Miami-Dade team to collaboratively serve a broad range of clients. In particular, staff highlight the use of dedicated entitlement specialists (staff members whose primary job function is to assist clients with SOAR applications) as critical to the program's success. Ms. Schwartz emphasizes that after hiring a full-time entitlement specialist, and shifting this responsibility away from multi-function case managers, the program saw significant increases in application approval rates and decreases in approval time.

Peer specialists with personal experience in the criminal justice system played a crucial role in building trust and rapport with older reentrants. CMHP's peer specialists engage older reentrants by spending time with them in casual settings, such as parks or inexpensive restaurants. These individuals draw on their own life experiences to understand the needs of reentering individuals and to relate to them using language and conversation topics that build authentic connection and trust. Asked if he tells clients about his own experiences, one peer specialist explained, *"It does help, but it has to be the right place... They're also going through so much, they have to be in a place where they can hear that."*

Clear and respectful communication can be especially important when working with older reentrants. Staff noted that respect helps to build trust and rapport when staff members are younger than their clients. Simplicity, clarity, expectations management, and frequent status updates were seen as key by staff and their older clients alike. As one older client said of his SOAR entitlement specialist, *"She was all professional. They communicate and keep it simple, and I appreciate that. They talk to you; you're human."* Staff noted that communication must also be tailored to individual clients' illnesses, preferences, and needs. For example, many older reentrants would find direct instructions overly blunt and rude, whereas those with schizophrenia may need simple directives.

Strong writing skills are critical for assisting older reentrants with the SSI/SSDI application process. Given the precise and detailed requirements of SSI/SSDI and the limited time allocated to SSA application processing staff, applications must strike a balance between being concise and informative. Staff at the CMHP highlighted the importance of strong writing that focuses on the client's symptoms and functional impairments, and connects these impairments to their work capabilities. For clients receiving current treatment for their physical and behavioral health conditions, entitlement specialists often worked closely with their medical providers to obtain documentation of a client's expected level of functioning and capability to work if medical treatments were discontinued.

Connecting older adults with benefits requires strong partnerships with corrections staff, judges, medical and behavioral health facilities, homeless and other community-based organizations, and local Social Security offices. These relationships facilitate appropriate referrals to the SOAR program and an expedited application process for clients. Strong

relationships with providers accelerate delivery of medical records to entitlement specialists and increase providers' willingness to accept SOAR clients as patients. As one specialist explained, *"The initial relationships helped us to grow more relationships, and we'd actively leverage them to build new ones. We would ask, 'Here's what we did with this provider, would that work for you?'"* Staff also noted that coordination within the local Medicaid behavioral health managing entity helped to motivate and facilitate these connections.

When these strategies are in place, and the challenges of serving older individuals can be addressed, staff noted that older adults may actually demonstrate greater follow-through and more reliable program engagement than their younger counterparts. With greater life experience, and a longer time cycling through the criminal justice system, many appear ready for a change by the time they start working with CMHP staff. Explained one staff member, *"They're tired of living on the street, living from day-to-day, not knowing how to manage the next couple of weeks. It does get tiring for some."* One older client explained that with age comes a new perspective on reentry and program engagement: *"At my age, time for me is short. I don't want to throw it away. Time is beautiful. I'm out, clean, secure. Things are different now. I'm glad [the CMHP] found me."*

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