COVID-19, Decarceration, and the Role of Clinicians, Health Systems, and Payers
A Report From the National Academy of Sciences, Engineering, and Medicine

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The nation’s correctional facilities are deeply entangled with the coronavirus disease 2019 (COVID-19) pandemic.¹ The criminal justice policies that drove mass incarceration have created fertile ground for the pandemic. According to the COVID Prison Project, by August 2020, 90 of the largest 100 cluster outbreaks in the United States have occurred in prisons and jails.² Many correctional facilities are overcrowded and understaffed, and the high rates of incarceration among Black, Latino, and Native communities map closely with the demographic pattern of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) infections and COVID-19-related death.

Despite being a focal point of the pandemic and past respiratory outbreaks, correctional facilities have not consistently been included in pandemic planning or guidance. Unlike in nursing homes and other long-term care facilities, which were also sources of outbreaks, health care in prisons and jails has no mandatory independent quality oversight nor is it integrated with the community health systems. The consequences include variability and failures in pandemic management.

The health risks that converge in the US penal system make reducing the incarcerated population, otherwise labeled decarceration, an important and urgent strategy for mitigating virus transmission in prisons and jails. A new report from a consensus panel of the National Academy of Sciences, Engineering, and Medicine provides recommendations on decarceration.³ The committee recognized that the current public health response in corrections is insufficient and that reducing the size of the incarcerated population could help increase the penetration and effectiveness of standard prevention measures in jails and prisons, such as testing, quarantining, and medical isolation for those who remain.

Since the pandemic began, prison and jail populations have declined, which helped to limit the spread of the SARS-CoV-2 virus somewhat. Between January and August 2020, jail populations decreased by 22% (from 738 400 to 575 952), state prison populations decreased by only 4% (from 1 260 393 to 1 207 710), and federal Bureau of Prisons by only 10% (from 175 315 to 156 940 who applied from March through May 2020).⁴ Prisons have been difficult to decarcerate given legal barriers to “compassionate release,” which is a legal provision that varies by state but typically allows people with terminal illnesses, such as metastatic cancer and end-stage heart failure, to be released before their sentences have been served. A condition of release often includes a documentation of prognosis by a licensed physician for a person who has 6 months or less to live. Rarely used before the pandemic, compassionate release has been ineffective for distancing the most medically vulnerable individuals in prison from the risks of COVID-19. In the Bureau of Prisons, where compassionate release was used most widely, only 156 prisoners were released among the 10 940 who applied from March through May 2020.⁵

Clinicians, the health care system, and payers each have roles in helping to reduce the prison and jail population and to support formerly incarcerated people after release.

Clinicians
Compassionate release could be a lever for protecting many high-risk patients from harm, but compassionate release policies are not aligned with current medical and geriatric science about care at the end of life or vulnerabilities based on medical risk. Licensed clinicians can advocate to reform existing policies to include “life-limiting illness” or “debilitating conditions” rather than relying on prognostic certainty. Clinicians can also directly assist by providing medical attestations to the need for compassionate release of individual patients during COVID-19.

Correctional and Community Health Systems
Health systems should do more to meet the needs of released individuals and their families. A person leaving incarceration faces higher risks of hospitalization and death than does the general population. In a 2013 study involving 76 208 individuals released from Washington state prison and followed up for 10 years (1999-2009), the mortality rate was 737 deaths from all causes per 100 000 person-years, which was significantly higher than was the rate for the noninstitutionalized population after adjusting for age, sex, and race (standard mortality ratio, 3.61; 95% CI, 3.48-3.73).⁶ Before the pandemic, these elevated risks were related to overdose and other chronic conditions, including hepatitis C, cardiovascular disease, and cancer, conditions for which morbidity and mortality may be preventable by primary care.

Effective discharge planning by the correctional health system must consider both the baseline risk for hospitalizations and also how to prevent SARS-CoV-2 transmission. This involves COVID-19 testing prior to release and planning for access to community health care, noncongregate housing, food security, and basic material well-being. Discharge from corrections should include a 90-day supply of medications, appointments with primary care physicians, an internet-enabled phone (because engagement in primary care now requires telemedicine access), and a place to safely quarantine in the community.
People released from incarceration need reliable assistance to connect into the community health care system. For those navigating the extreme uncertainties and insecurity of prison and jail release, community health systems should accept new patients without government identification and soften restrictions for the need to connect first to an electronic health record portal to connect by video. Health systems can rely on proven strategies to maximize participation in health care after release, such as by hiring community health workers to work within the health system. Evidence shows that addressing the needs of newly released individuals can improve their engagement in primary care and reduce preventable hospitalizations and later contact with the criminal justice system.6

**Medicaid or Medicare and Payment**

Central to health care access is insurance. On any given day, the jail population includes more than 700,000 individuals, but more than 10 million people a year pass through jails. Approximately 6% of the jail population is 65 years or older. When Medicare or Medicaid beneficiaries are incarcerated, they are ineligible for the benefits because of their incarceration status. The Medicaid Inmate Exclusion Policy prohibits use of federal funds and services for medical care provided to “inmates of a public institution.” About two-thirds of the jail population are held before trial and most are unable to post bail to get released. Perversely, the law denies these health insurance benefits to those who are too poor to pay bail but for defendants with more resources who can pay for their release, their Medicaid or Medicare continues.

Under the Centers for Medicare & Medicaid Services (CMS) administrative rules, states can initiate programs or policies to support safe decarceration, including covering the costs of SARS-CoV-2 testing and related health needs prior to release and facilitating access to medications, primary care, substance use, and mental health treatment. Importantly, states can follow Social Security Administration rules and suspend (as opposed to fully terminate) Medicaid or Medicare benefits when a person is incarcerated, which ensures activation of coverage upon release. Suspension of these benefits also has financial benefits. States that have suspended Medicaid have been reimbursed for inpatient medical services for incarcerated individuals enrolled in Medicaid and have reported cost savings ranging from $3 million to $19 million per year.10

Medicaid coverage also could be expanded with waivers under Sections 1115 and 1135 of the Social Security Act. Some states are seeking waivers to expand the scope of services to incarcerated people during the COVID-19 emergency to cover testing or outpatient treatment, although CMS has not yet approved any waivers. In addition, wholesale expansion of Medicaid in the first 30 days prior to release could cover COVID-19 testing and also create a smoother transition to the community by covering medications and enabling referrals to community care.

Even in the 12 states that have not yet expanded Medicaid under the Affordable Care Act, coverage is available for COVID-19 testing and related services if the state takes up the optional eligibility group provided in the Families First Coronavirus Response Act of 2020. This pathway allows low-income adults in nonexpansion states, including incarcerated adults, to enroll in Medicaid. While the Inmate Exclusion Policy would continue to apply, this pathway could assist access to health care immediately upon release.

**Conclusions**

Decarceration in service of both public health and safer communities will require sustained engagement from clinicians, health systems, and Medicaid authorities. The actions the country takes now against COVID-19 are opportunities to put in motion longer-term improvements to correctional and community health and to advance health equity at large.

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**REFERENCES**


