Gap Analysis On Post-Incarceration Health Care and Housing Linkage

For People from Historically Marginalized Groups/Identities with HIV

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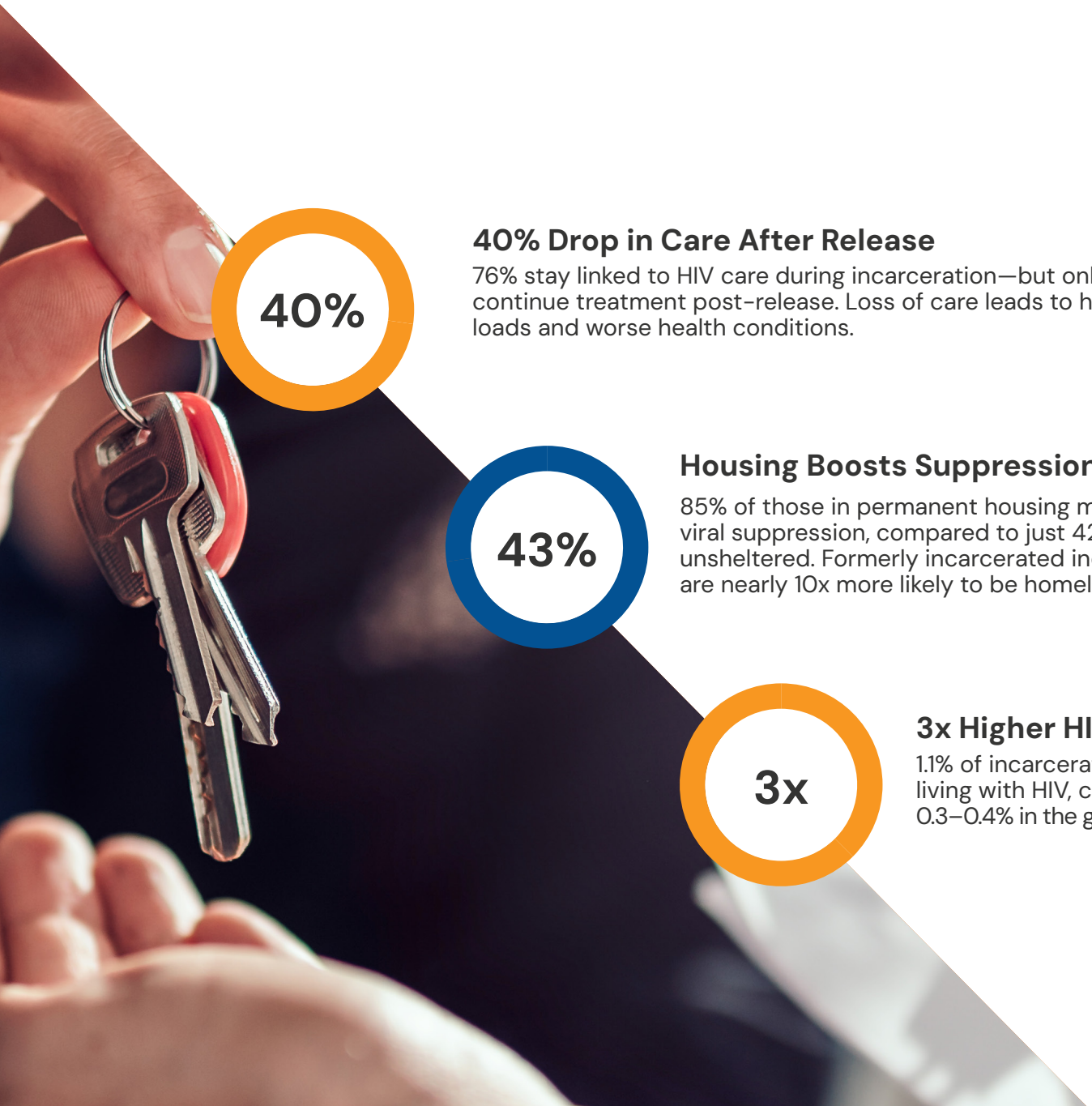
Introduction

The rate of HIV prevalence in the incarcerated population was estimated at 1.1%, compared to a 0.3%-0.4% rate among the general population.[1] It is estimated that approximately 22% of people who have HIV when they enter jail or prison are unaware of their status upon entry.[1] For many of these individuals, testing and treatment provided in carceral settings may be their first encounter with HIV care. However, despite the effort to provide HIV care and access to treatment within carceral settings, there continue to be barriers to accessing antiretroviral medications, appropriate counseling, and linkages to care during incarceration.[1] Nevertheless, various Departments of Corrections report significant improvements in virologic suppression in individuals from entry to release, where on average 76% of individuals maintain linkage to care during incarceration, but only 36% report continued linkage to care post-release from incarceration.[1]



40%

40% Drop in Care After Release

76% stay linked to HIV care during incarceration—but only 36% continue treatment post-release. Loss of care leads to higher viral loads and worse health conditions.

43%

Housing Boosts Suppression by 43%

85% of those in permanent housing maintain viral suppression, compared to just 42% of those unsheltered. Formerly incarcerated individuals are nearly 10x more likely to be homeless.

3x

3x Higher HIV Prevalence

1.1% of incarcerated people are living with HIV, compared to 0.3–0.4% in the general population.

Lower rates of linkage to care following release from incarceration can lead to decreased virologic suppression and declining health. Upon discharge from incarceration, many individuals face challenges finding and maintaining linkage to care and housing stability, both of which have been shown to have a significant impact on viral load and transmission rates. Analysis demonstrates a strong association between housing and virologic suppression rates, with one study showing that individuals living in permanent housing had 85% virologic suppression rates vs. 42% for those living unsheltered and 59% for those living in shelter.[2]

Unfortunately, formerly incarcerated individuals are almost 10 times more likely to experience homelessness than the general population, with those exiting jail less likely to have pre-release service coordination and support compared with those exiting prisons.[3]

Additionally, it is estimated that nearly 80% of those incarcerated with HIV also have substance use disorders, and many have additional co-occurring illnesses, including mental health disorders and other complex health care needs.[7] Homelessness following release from a carceral setting significantly increases the likelihood of recidivism, increased viral load, decreased care retention, worsening health outcomes, relapse to substance use and other poor indicators of health and well-being.[4] Therefore, linkage to housing in the first weeks post-release is vital for the health and safety of both the individual and the community.

Programs like the Housing Opportunities for Persons With AIDS (HOPWA) and Ryan White HIV/AIDS Program (RWHAP) can provide individuals with HIV who are exiting carceral systems with supportive housing and supportive services that can be a critical foundation for their continuation of care. Enrollment in Medicaid is also a crucial first step in ensuring individuals can be quickly connected to community-based medical providers following their release from incarceration.

85%

virologic suppression rates
for individuals living in permanent housing

This resource is intended to support health centers in identifying some important components to effective programming for HIV+ individuals leaving carceral settings to ensure smooth linkage to care and housing following discharge.

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Linkage to Care

Linkage to Care is defined as the timely and individualized process of connecting a client from one service system to another. In this context, effective linkage is evidenced by individuals receiving an initial outpatient appointment with a community-based medical provider who has medication-prescribing authority, and can provide:

1. Appropriate medical care including comprehensive physical and medical history.
2. Baseline lab testing for CD4 count and viral load, and ongoing HIV care.
3. Referrals to support services needed to improve both health and quality of life.
4. Client-centered care that is seamlessly accessed post-release.

Eligibility Requirements for Housing Opportunities for Persons With AIDS (HOPWA) Program:

- Individual and families in which the household has at least one (1) person diagnosed with HIV/AIDS.
- Total household income is 80% of Area Median Income or less.

See Full Requirements →

Eligibility Requirements for Ryan White HIV/AIDS Program:

- Medically diagnosed with HIV/AIDS
- Total household income meets the requirements for low-income
- Proof of residency

See Full Requirements →

Connection to Medicaid

Coverage Post-Incarceration

Individuals who are enrolled in state Medicaid programs and who are then incarcerated for more than one month will have their health care coverage suspended by the state.[6] Suspended coverage is turned off during incarceration but can be reinstated once the individual proves release to the state. As of January 2026, states will be required to suspend coverage and cannot terminate coverage.

Even when coverage is only suspended and not terminated, the burden falls on the released person to follow their state's processes for reinstating Medicaid health insurance coverage. Without healthcare coverage, access to care including doctors' appointments, prescription drugs, Home and Community Based Services (HCBS) and other benefits is very limited. Easing the process of accessing coverage can promote critical continuity of care for individuals following their return to their communities.

1. **Medicaid Suspension:**
   Individuals who are incarcerated for more than one month will have their state Medicaid coverage suspended.

2. **Upon Release:**
   The burden falls on the released person to follow their state's processes for reinstating Medicaid health insurance coverage.

3. **Reinstatement Support:**
   Easing the process of accessing coverage can promote critical continuity of care.

Connection to Medicaid (continued)

Role of Managed Care Organizations

After their Medicaid coverage is started, members are assigned to Managed Care Organizations (MCOs). This can take days or months and varies from state to state, depending upon the state's processes for MCO assignment. Depending on the state, and so long as eligibility criteria are met, individuals may be deemed eligible for retroactive eligibility, allowing provision of services up to 90 days prior to the date they present to the state to enroll. Once enrolled with the state, the individual can select an MCO or is assigned one by the state if a choice is not made. The length of time before an MCO assignment occurs and when coverage under the state's Fee for Service (FFS) System begins varies from state to state; however, until they are connected to an MCO, people often cannot access many services that are only offered via the MCO. Use of an In Lieu of Services strategy for post-carceral services is limited, as MCOs will commonly not be assigned a member until at least one month post-release.[7] Once an MCO assignment is made, the person is commonly eligible for care coordination and other community services, but continuity of care is broken. It is important to note that oftentimes, MCOs will not receive patient medical records from the carceral medical provider and will rely on the patient for information and documentation regarding diagnoses, medications, and important medical history.

Reentry Waivers

Recognizing the many barriers to continuity of care faced by returning community members, the Centers for Medicare & Medicaid Services (CMS) has approved 19 states for reentry waivers, with an additional five states also requesting this flexibility.[8] States with approved reentry waivers can offer a number of Medicaid-funded services up to 90 days prior to release from a carceral setting.[9] Services include case management, behavioral health services, Medications for Opioid Use Disorder (MOUD), screening for non-medical services needs and additional services as requested by the state in the waiver.[10] All states at this time also cover a 30 days' supply of all medications upon release, to address the continuity of care issues described above. California was the first state approved for such a waiver and is active in implementing these services with their carceral systems partners at this time.[11]

Example Program: Project Start PLUS[12]

Launched in 2009 and evaluated by the Bridging Group in 2014-2015, this program focuses on linkage to care and risk reduction for people living with HIV who are returning to the community after incarceration. The program is structured around six one-on-one sessions. Two take place pre-release within 60 days of discharge, and four take place post-release from prison or jail.[13]

The two pre-release sessions focus on discharge planning inclusive of linkage to care; enrolling in insurance including AIDS Drug Assistance Program (ADAP), a program of RWHAP that provides HIV medications to low-income individuals with limited or no health insurance coverage, and/or Medicaid; obtaining medical files, and identifying all necessary medications. Using a strengths-based and person-centered approach, pre-release utilizes individualized goal sheets to identify risk behaviors and risk of reincarceration and to make plans to address these.

Post-release sessions begin with a first meeting that takes place within 48 hours of release and is held at a community medical provider location. These four sessions also ensure all necessary medications have been obtained, continue to provide ongoing referrals to other social services, provide person-centered resources and materials, deliver HIV risk reduction education and coordinate with other supports as needed. Throughout the post-release sessions, individualized plans including goal sheets are continually revisited to ensure programming remains person-centered.

Key support provided in each session

- Necessary medications have been obtained
- Continue to provide ongoing referrals to other social services
- Provide person-centered resources and materials
- Deliver HIV risk reduction education
- Coordinate with other supports as needed

Example Program: Transitions Clinic Network[14]

While not specifically tailored to those living with HIV, the Transitions Clinic Network (TCN) Model was created to facilitate the transition from incarceration to community for chronically ill individuals. It was first launched in 2006 at the San Francisco Department of Health's Southeast Health Center and has since expanded to include 48 community-based primary care programs in 14 states and Puerto Rico. The majority (21) of programs remain in California.

The model is person-centered and based on the use of community health centers as the primary care medical home and safety net for patients, from which referrals to other social services can be made. Central to the model is the consideration of people who have lived experience of incarceration as Community Health Workers (CHWs) and members of the integrated medical team. Each program is based within a safety net community health center that is most often located in areas disproportionately impacted by incarceration.

Programs are focused on providing person-centered care in close partnership with local reentry and social services organizations. A cost assessment of the program conducted in 2022 concluded that the 12-month TCN program overall saved participating states money, due to its cost neutrality in terms of its Medicaid investments, and its reduction in criminal legal system costs.[14]

How It Works:

Person-Centered Re-Entry Care

- Focused on **chronically ill individuals returning from incarceration**
- Based in **community health centers** that serve as medical homes and referral hubs
- Employs Community Health Workers with **lived experience of incarceration**
- A 2022 analysis found the program **saved states money through Medicaid cost neutrality and reduced legal system costs**

Recommendations & Next Steps for Health Centers

1 Integrate Peers into the Care Team

Incorporate peers as part of an integrated care team to support individuals through the critical transition from incarceration back into the community.

2 Start Discharge Planning Early

Begin programming prior to discharge, with discharge planning initiated 60 to 90 days before release. Ensure planning is comprehensive and includes necessary paperwork for releasing medical records, continuing medications, and beginning the benefits enrollment process, including Medicaid.

3 Provide Navigation and Accompaniment Services

In addition to case management, include navigation and accompaniment services to support participants in attending appointments and engaging with care in community settings.

4 Prioritize Early Medicaid Enrollment

Enroll individuals in Medicaid as early as possible—pre-release when operating in states that have received a Reentry Waiver.

5 Use Evidence-Based Practices to Reduce Risk

Utilize Medications for Opioid Use Disorder (MOUD), peer recovery specialists, risk planning, person-centered tools, and other evidence-based practices to reduce risk of relapse for those with co-occurring substance use disorders.

6 Ensure Continuity of Care

Maintain continuity of care before and after release. Whenever possible, ensure the same team works with the individual throughout their entire programming for seamless support.

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