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Charting the Road to Coverage

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Medicaid Expansion and Criminal Justice Costs: Pre-Expansion Studies and Emerging Practices Point Toward Opportunities for States

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Results in brief

With states still in the early stages of Medicaid expansion, many are beginning to consider the potential role that Medicaid may play in tackling pressing criminal justice challenges, including reducing criminal justice spending and health care costs associated with treating individuals during incarceration and after release from prison and jail. These efforts take on added importance in light of the recently announced efforts of leading law enforcement officials to reduce incarceration rates.

Box 1: Law Enforcement Leaders Join in National Effort to End Mass Incarceration

One hundred thirty law enforcement officials representing all 50 states and Washington, D.C. recently launched the coalition, "Law Enforcement Leaders to Reduce Crime and Incarceration" to strengthen public safety and decrease the number of individuals imprisoned throughout the country. One of the group's four top policy priorities includes increasing alternatives to arrest and prosecution, with a focus on mental health and drug treatment. The coalition urges, "Policies within police departments and prosecutor offices should divert people with mental health and drug addiction issues away from arrest, prosecution, and imprisonment, and instead into proper treatment."[1]

[1] Law Enforcement Leaders to Reduce Crime and Incarceration, "130 Top Police Chiefs and Prosecutors Urge End to Mass Incarceration," (October 2015).

While the clearest and most immediate source of savings is Medicaid reimbursement for inpatient care provided to inmates in the community—Colorado, Michigan, and Ohio have already seen savings of $5 to $13 million a year—a large body of research conducted prior to the Affordable Care Act (ACA) provides promising approaches to reducing state spending by helping low-income adults avoid incarceration and re-incarceration, particularly through substance abuse treatment and mental health services. These pre-Medicaid

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expansion studies suggest that states that expand Medicaid have additional opportunities to better manage individuals during their incarceration and post-release. Potential savings from such initiatives include reductions in state and local criminal justice spending, as well as reductions in emergency department visits and hospitalizations.

States that expand Medicaid may experience savings in their criminal justice and social services budgets as a result of coverage for low-income adults through three key mechanisms:

1) Direct savings from Medicaid reimbursement for the inpatient care provided to inmates in the community;
2) Reductions in re-incarceration rates as a result of treatment upon release; and
3) Reductions in new entrants to jail and prison.

By expanding Medicaid, states may be able to harness significant resources to address persistent criminal justice issues, including the opiate epidemic and the incarceration of people with severe mental illness who could more effectively be served in the community. Medicaid expansion represents an important new tool available to states and localities that, in combination with other initiatives and resources, offers the opportunity for progress on these complex and multi-layered social problems.

Introduction

This report is the fourth in a series prepared by the Robert Wood Johnson Foundation's *State Health Reform Assistance Network* exploring the fiscal implications of Medicaid expansion. The first two reports explored state budget savings and revenue gains associated with expansion; the third examined the impact on uncompensated care spending and related state budget implications. This paper, in addition to cataloging early budget savings that expansion states are realizing, examines state experiences prior to expansion, focusing on state savings associated with providing health care services and social support to justice-involved individuals through state-funded programs. It also highlights some of the new approaches being adopted by states with Medicaid expansion to connect justice-involved individuals to coverage and care. These emerging best practices suggest considerable opportunities for states to implement similar initiatives with the support of additional resources through Medicaid expansion.

Medicaid's role for justice-involved individuals

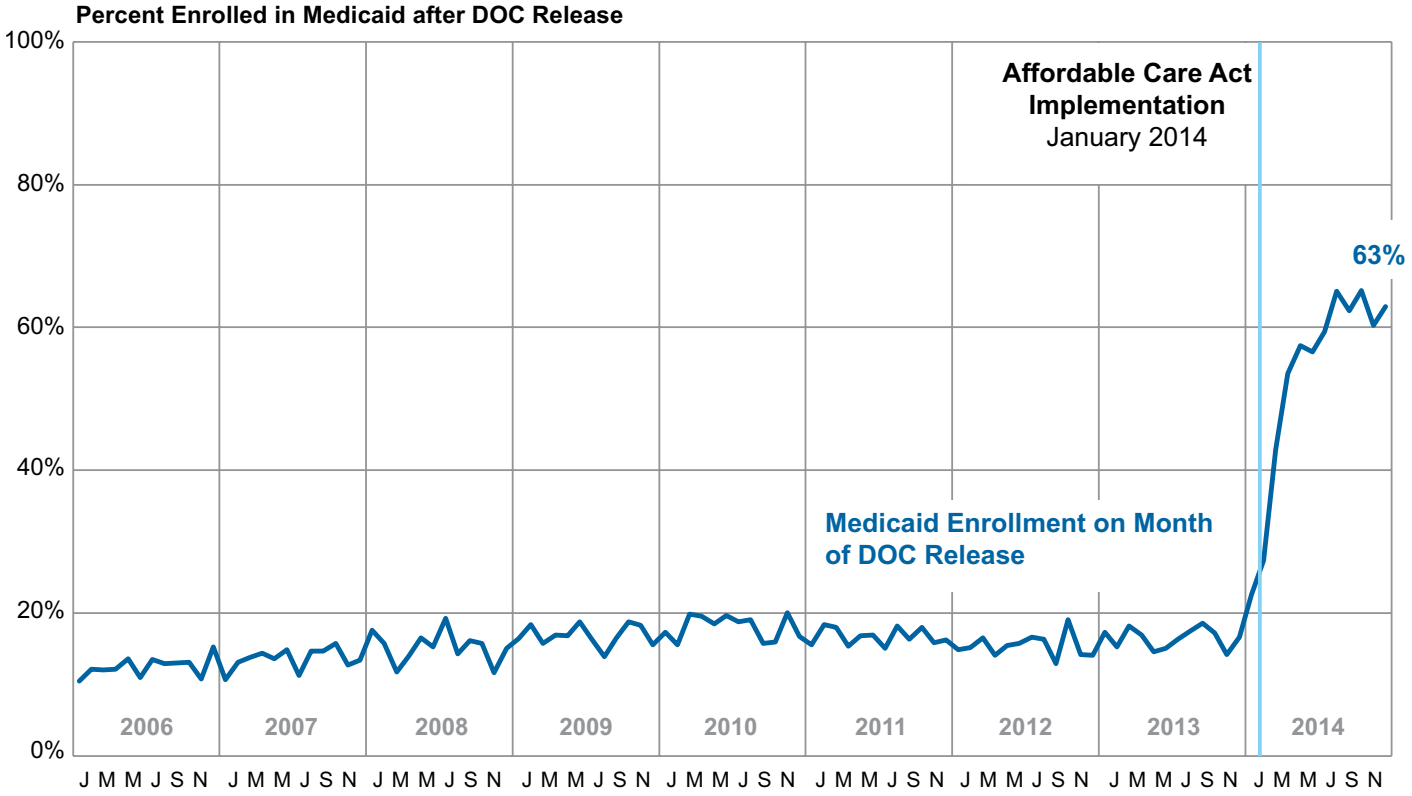
States and localities are responsible for financing the health care provided to people who are incarcerated. Under a long-standing federal rule, known as the "inmate exclusion," Medicaid is banned from financing the care of anyone committed to a jail, prison, detention center, or other penal facility. The one exception is that Medicaid can pay for services provided during an inpatient stay of at least 24 hours in a medical institution outside the prison or jail. In addition, because all inmates reside in the community prior to incarceration and nearly all are released back into the community, Medicaid can play a cost-saving role by providing services, such as treatment for mental illness and substance abuse, that reduce the risk of initial incarceration, as well as by providing care after release that improves their health, stabilizes them, and reduces recidivism.

Until passage of the ACA, Medicaid generally did not cover low-income adults without children, leaving out most incarcerated individuals and many of those at risk of incarceration.[1] Now, however, low-income adults up to 138 percent of the federal poverty level (FPL) are eligible for Medicaid in expansion states. National estimates indicate that approximately 60 percent of inmates have income below 138 percent FPL prior to incarceration.[2] However, some states are finding that the vast majority of those incarcerated are eligible for Medicaid. New York state and Colorado, for example, estimated that 80 and 90 percent of their prison populations, respectively, were eligible for Medicaid.[3]

The potential of Medicaid expansion to increase enrollment in coverage among the justice-involved population is illustrated in Figure 1 from the Washington State Department of Corrections. Prior to Medicaid expansion, less than 20 percent of inmates were enrolled in Medicaid upon release from a correctional facility, which means nearly all were left without coverage—but less than a year after expansion, more than 60 percent secured coverage.[4]

FIGURE 1. MEDICAID ENROLLMENT FOLLOWING RELEASE FROM DOC CORRECTIONAL FACILITY

Washington State Department of Corrections Releases, Calendar Year 2006 Through 2014



Fiscal impact of Medicaid expansion

States that expand Medicaid will experience savings in their criminal justice and social services budgets by substituting federal Medicaid funds for state funding for inpatient hospitalizations of incarcerated individuals. In addition, over the longer-term, states may be able to save by keeping individuals from re-entering jail and preventing incarceration for new entrants.[5] The savings related to reducing re-incarceration and keeping people out of jail and prison derive in large part from the health profile of justice-involved individuals. Substance use disorders and mental health problems are a major issue for this population:

- Fifty-six percent of state prisoners, 45 percent of federal prisoners, and 64 percent of jail inmates are affected by a mental health problem.[6]
- Two-thirds meet the medical criteria for substance abuse addiction.[7]
- Incarcerated individuals also have high rates of communicable and chronic diseases, such as HIV/AIDS, hepatitis C, elevated blood pressure, heart disease, and diabetes.[8]
- The 4.2 percent of the U.S. adults who have a recent criminal justice history are responsible for an estimated 7.2 percent of hospital expenditures and 8.5 percent of emergency department expenditures.[9]

The Medicaid expansion population is eligible to receive coverage for a broad range of treatments for mental illness, substance use disorders, and chronic and communicable diseases.

Box 2: Ohio Governor John Kasich on the Role of Medicaid Expansion in Reducing Recidivism

Officials in Ohio have cited the potential role of Medicaid expansion in reducing recidivism and criminal justice spending. In discussing his decision to expand Medicaid, Ohio Governor John Kasich explained:

"I had an opportunity to bring resources back to Ohio to do what? To treat the mentally ill. Ten thousand of them sit in our prisons. It costs $22,500 a year to keep them in prison. I'd rather get them their medication so they could lead a decent life.

Secondly, we are rehabbing the drug-addicted. Eighty percent of the people in our prisons have addictions or problems. We now treat them in the prisons, release them in the community, and the recidivism rate is 10 percent (…)."[1]

In addition, the chief of Ohio's prisons, Gary Mohr, has also voiced the positive effect of Medicaid expansion on recidivism rates stating, "[Enrolling inmates in Medicaid] is aligned with our mission to reduce recidivism. I believe it will reduce the number of people returning to prison. Our investment is in communities, not prison."[2]

[1] *TIME*, "Transcript: Read the Full Text of the Primetime Republican Debate," (August 2015).

[2] *Columbus Dispatch*, "State Pushes Medicaid Sign-ups for Inmates," (July 2015).

1. COVERAGE OF INPATIENT HOSPITALIZATIONS FOR INMATES

The most immediate source of criminal justice savings for states with expansion is the opportunity to claim federal Medicaid matching funds for the cost of care for 24 hours or more in a community medical institution. For states to accrue these savings, they must establish eligibility for inmates during incarceration,[10] but block the program from reimbursing for any services except appropriate inpatient care. States estimating or already experiencing Medicaid expansion savings associated with coverage of inmates' inpatient care include:

Savings Associated With Coverage of Inmates' Inpatient Care	
Ohio	$10.3 million (FY 2014)[1]
Kentucky	$16.4 million (FY 2014-2015)[2]
Michigan	$19.2 million (FY 2014-2015)[3]
Colorado	$10.0 million (FY 2014-2015)[4]
Washington	$2.1 million (FY 2014-2015)[5]
Arkansas	$2.75 million (FY 2015)[6]

[1] Community Oriented Correctional Health Services, "Medicaid Coverage for Jail Inmate's Inpatient Hospitalizations," (March/April 2015).
[2-6] Robert Wood Johnson Foundation, "States Expanding Medicaid See Significant Budget Savings and Revenue Gains," (April 2015).

Other states, such as Mississippi, North Carolina, and Louisiana, have also reported savings from using Medicaid to pay for inpatient care for the small subset of their inmate population that is eligible for Medicaid despite the decision not to expand.[11,12] This might include individuals with disability-based Medicaid who have not yet lost their Supplemental Security Income due to incarceration, pregnant women, and young adults covered under Medicaid's categories for children. These states would experience more significant savings if they covered low-income adults up to 138 percent of the FPL.

2. IMPROVING COMMUNITY-BASED CARE AND REDUCING RE-INCARCERATION

Pre-expansion research suggests that justice-involved individuals enrolled in Medicaid upon release from jail or prison may be more likely to remain stable in the community. The most relevant study on this point was conducted prior to the ACA on inmates with severe mental illness in two Washington state counties, finding 16 percent fewer detentions in the 12-month period after release when inmates were enrolled in Medicaid.[13] (The study was possible because even prior to Medicaid expansion, some inmates could qualify for Medicaid based on disability.) Other pre-ACA studies have produced similar findings, although they typically are based on individuals receiving care and social services through pilot projects rather than linked directly to Medicaid coverage.[14,15]

Since expansion, states have been doing more to connect former inmates to care, even prior to release. For example, Ohio is leveraging a strong partnership between the Ohio Department of Medicaid and the Department of Rehabilitation and

Correction to enroll inmates in Medicaid in advance of their release date and to assist them in selecting a Medicaid managed care plan in a county in which they expect to reside upon their release. Ohio's contract with managed care plans requires the plans to facilitate and manage transitions of care from the prison to the community for high-need inmates, including those with HIV, hepatitis C, serious mental illness, a history of substance use disorder, or multiple chronic conditions. The managed care plan initiates care management about 15 to 30 days prior to release beginning with a review of clinical information, engagement with the inmate about 7 to 14 days prior to discharge via a video conference, and development of a transition plan that documents services and supports that have been arranged for the inmate in the community. Each inmate is released with a copy of the Medicaid ID card and, if high-need, a copy of the transition plan with a scheduled follow up contact by a managed care plan care manager.

Box 3: Spotlight on Cook County, Illinois

"I have the highest level of confidence that [Medicaid expansion] will either keep them from coming back or extend out the period of time before they come back." – Cook County Sheriff, Tom Dart[1]

Cook County, Illinois, which operates the largest jail in the country, is at the forefront of strategically using the state's Medicaid expansion to improve care for justice-involved individuals. As part of a collaboration between the Cook County Health and Hospital System (CCHHS), the Cook County Sheriff's Office, and Treatment Alternatives for Safe Communities (TASC)—a local nonprofit that works with the justice-involved—detainees are screened and can receive help applying for Medicaid upon intake at the Cook County Jail. From April 2013 through April 2014, more than 10,000 applications initiated at the Cook County Jail were approved for coverage.[2] Once enrolled in Medicaid, an individual can choose to join or is otherwise auto-enrolled into one of approximately 15 managed care plans, including CountyCare, CCHHS's Medicaid managed care health plan.

By enrolling detainees during the intake process, the initiative ensures eligible detainees have health coverage upon or soon after release. This promotes continuity of care for these individuals, especially those with chronic conditions, once they are back in their communities. CCHHS has also contracted with TASC to provide linkage programs to help connect individuals recently released from detention with not only health care providers, but with other services and resources. Through this program, CCHHS hopes to protect the health of the justice-involved individuals and ultimately reduce recidivism by addressing underlying socioeconomic determinants of health (and crime), like homelessness and food insecurity, for this vulnerable population.

[1] *MSNBC*, "Jails Are Signing Up Inmates for Obamacare," (March 2015).

[2] Interview with Kathy Chan, Director of Policy Cook County Health & Hospitals System, (July 2015).

A particularly robust source of potential savings may accrue from inmates with substance use disorders who are able to receive long-acting medications—which can be financed by Medicaid for eligible, low-income adults—that reduce or block cravings for alcohol and drugs.

- In one study of a three-year pilot program for newly-released inmates, only two of 83 patients on a prescription medication for their substance use disorder used illegal drugs or alcohol.[16]
- A separate eight-week study of opioid-dependent inmates found that 38 percent of individuals receiving such medication relapsed, compared to 88 percent of persons receiving no treatment.[17]

Connecting individuals with behavioral health needs to health care providers can be the first step in securing the treatment they need to remain stable and residing safely in the community. By expanding Medicaid, states have more resources to finance crisis centers, such as those outlined in Box 4, which can help reduce the extent to which individuals with severe mental illness end up in the emergency room or incarcerated.

Box 4: Reducing Law Enforcement Hours Wasted in Emergency Rooms

Law enforcement officials often must spend hours driving people with severe mental illness to the emergency room and waiting until they are admitted or medically cleared. Some communities have tackled the situation by establishing community-based crisis care centers that offer an alternative site where law enforcement officials can drop people in crisis. In Bexar County, Texas, for example, a community-based crisis center that co-locates physical health services with mental health services was able to provide a single point of entry for both psychiatric evaluation and medical clearance. Prior to the center's opening, law enforcement officers waited between 12 and 14 hours at the local emergency room. After the center opened, the wait time for law enforcement officers at the crisis center was only 60 to 65 minutes.[1] In states that expand, Medicaid can be used to help finance the cost of these community-based crisis services for eligible individuals.

For a review of other innovative efforts to reduce the health and criminal justice costs of "high utilizers" with severe mental health issues, see Council of State Governments Justice Center, "Collaborative Law Enforcement, Health, and Community Mental Health Strategies in the Care and Emergency Room Diversion of People with Mental Illnesses: Principles and Promising Practices," (2010).

Bear County, Texas

12–14 hours
Law enforcement officers' wait time at the local emergency room for medical clearance, screening, and psychiatric evaluation

60–65 minutes
Law enforcement officers' wait time at a local crisis care center for medical clearance, screening, and psychiatric evaluation

[1] Leon Evans, Kathryn Jones, Aaron Diaz, and Gilbert Gonzales. "Integration, Restoration and Transformation: A Systems Overview." Presentation for the National Association of Counties Conference, "Restore the Partnership for Community Corrections, Reentry, Reinvestment and Public Safety." (January 2010).

3. REDUCTIONS IN NEW ENTRANTS TO JAIL AND PRISON

Many people are incarcerated for minor, non-violent offenses due to a mental health issue or substance use disorder. They may engage in petty theft to support a habit or be arrested under public nuisance laws. States that provide effective behavioral health treatment can reduce arrest rates. Washington state, for example, found that after it used state funds to provide three different groups of low-income adults with alcohol and drug treatment, arrests declined by 17 percent, 18 percent, and 33 percent, respectively.[18] This reduction in arrests saved local law enforcement, jails, courts, state corrections agencies, and crime victims $9,000 to $18,000 for each person treated, for a total of $275 million.[19] The study was conducted prior to implementation of the ACA, and Washington state now covers these individuals with Medicaid matching funds as a result of its expansion. Expansion states may be able to achieve comparable savings, and, if they pursue such initiatives, they can use federal Medicaid dollars to finance the cost of the care that is provided.

FIGURE 2: SAVINGS FROM DECREASED ARRESTS DUE TO ALCOHOL/DRUG TREATMENT

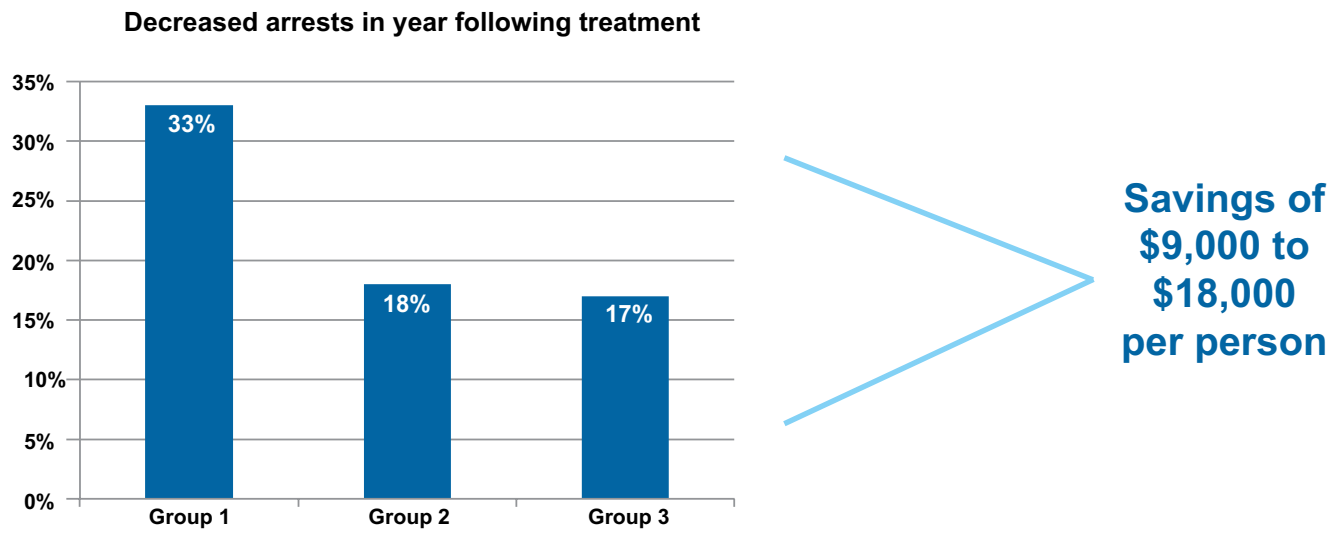


Figure produced by Manatt Health based upon findings from Washington State Department of Social and Health Services Research and Data Analysis Division, *Chemical Dependency Treatment, Public Safety: Implications for arrest rates, victims and community protection* (February 2009).

Increasingly, states and localities are using mental health and drug courts to divert the justice-involved population from incarceration. By agreeing to participate and continue with treatment under the supervision of the court, individuals can avoid incarceration. As illustrated by Box 5, these initiatives have proven to be cost-effective in many jurisdictions and result in improved outcomes for justice-involved individuals. Medicaid can finance the cost of the mental health and substance use disorder treatment required of Medicaid-eligible individuals served by these courts.[20]

Note, however, that most of these studies contain caveats about the importance of tailoring treatment and services to an appropriate population, as well as ensuring the treatment meets evidence-based standards. Expansion states exploring the role of Medicaid in financing the health care costs associated with drug and mental health courts on behalf of eligible individuals will want to carefully review the specific approach being taken by criminal justice officials.

Box 5: Significant Savings from Drug and Mental Health Courts

If a state expands Medicaid, it can use the funds to finance much of the cost of providing services to eligible individuals in drug or mental health courts. In many jurisdictions, these courts have been cost-effective by reducing health care and criminal justice spending.

- Over the course of two years, the Pennsylvania Mental Health Court decreased both average mental health services costs and jail costs, with the most significant savings from individuals with severe psychiatric illnesses staying out of jail and the hospital.[1]
- New York City jail diversion programs saved an average of $7,038 per person.[2]
- A Massachusetts jail diversion program with 200 participants saved an estimated $1.3 million in episodic emergency health services (e.g., ER visits, ambulance transportation) and jail expenditures.[3]
- Jail diversion program Project Link in Rochester, NY, generated savings of $39,518 per person and the Thresholds Jail Program in Chicago resulted in $18,873 of savings per person.[4]

[1] RAND Corporation, "Justice, Treatment, and Cost: An Evaluation of the Fiscal Impact of Allegheny County Mental Health Court," (2007).

[2] U.S. Department of Health and Human Services, Substance Abuse and Mental Health Administration, "Assessment of the Cost-Effectiveness of New York's Jail Diversion Program," (2002).

[3] VERA Institute of Justice, "Treatment Alternatives to Incarceration for People with Mental Health Needs in the Criminal Justice System: The Cost-Savings Implications," (February 2013).

[4] Psychiatric Services, "Forensic Assertive Community Treatment: Preventing Incarceration of Adults With Severe Mental Illness," (2004).

Conclusion

States with Medicaid expansion—and those considering expansion—have a potentially significant opportunity to improve and manage the care provided to low-income adults involved with the criminal justice system. With Medicaid expansion still being relatively new, states have much to learn about the best way to use expansion as a tool in larger efforts to tackle criminal justice issues. Pre-expansion research and the early experiences of expansion states suggest that in the long run, expansion may be able to contribute to reductions in incarceration and recidivism, and improve the health and stability of the justice-involved population while generating savings for state and local governments.

Acknowledgments

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End notes

[1] If they were parents, they could not qualify as such because they were not living with and caring for their child while in jail or prison. Similarly, individuals enrolled in Medicaid based on time prior to incarceration were suspended from their disability payments while incarcerated, and so they also lost Medicaid eligibility.

[2] Doris J. James, U.S. Department of Justice, Office of Justice Programs, "Special Report: Profile of Jail Inmates, 2000," (July 2004).

[3] U.S. Government Accountability Office, "Medicaid: Information on Inmate Eligibility and Federal Costs for Allowable Services," (September 2014). Like other Medicaid beneficiaries, incarcerated individuals must meet all eligibility criteria in order to qualify for Medicaid, including citizenship or immigration requirements and the requirement to provide a Social Security Number. As a result, inmates can still be ineligible for Medicaid even though they have no income.

[4] David Mancuso, Robert Hughes, Medicaid enrollment information drawn from Provider One via the Integrated Client Databases. Inmate release data is drawn from the Department of Corrections OMNI system (Analysis in Progress), Washington State Department of Social and Health Services, Research and Data Analysis Division (2015): p1.

[5] VERA Institute of Justice, "Treatment Alternatives to Incarceration for People with Mental Health Needs in the Criminal Justice System: The Cost-Savings Implications," (February 2013).

[6] US Department of Justice, Office of Justice Programs, "Mental Health Problems of Prison and Jail Inmates: Bureau of Justice Statistics Special Report No. NCJ 213600," (2006).

[7] National Center on Addiction and Substance Abuse at Columbia University, "Behind Bars II: Substance Abuse and America's Prison Population," (February 2010).

[8] U.S. Department of Justice, "Medical Problems of State and Federal Prisoners and Jail Inmates, 2011–12," (February 2015).

[9] Division of General Internal Medicine, University of Colorado School of Medicine, "Increased hospital and emergency department utilization by individuals with recent criminal justice involvement: results of a national survey," (September 2014).

[10] Alternatively, a state could seek to use hospital presumptive eligibility to quickly enroll any inmates in need of services from a medical institution, but, it generally is considered preferable to have the inmate enrolled in coverage prior to requiring care in a medical institution.

[11] Pew Charitable Trusts, "Managing Prison Health Care Spending," (October 2013).

[12] Pew Charitable Trusts, "States Missing Out on Millions in Medicaid for Prisoners," (June 2013).

[13] Psychiatric Services, "Medicaid enrollment and mental health service use following release of jail detainees with severe mental illness," (2006).

[14] Journal of Criminal Justice, "Assessing the effectiveness of mental health courts: A quantitative analysis," (2011).

[15] Corporation for Supportive Housing, "Frequent Users Service Enhancement Initiative (FUSE) – New York, New York," (2009).

[16] Washington Post, "Breaking good: Vivitrol, a new drug given as a monthly shot, is helping addicts stay clean," (March 13, 2015).

[17] Addiction, "Opioid treatment at release from jail using extended-release naltrexone: A pilot proof-of-concept randomized effectiveness trial," (2015).

[18] Washington State Department of Social and Health Services Research and Data Analysis Division, Chemical Dependency Treatment, Public Safety: Implications for arrest rates, victims, and community protection, (February 2009).

[19] This total savings number includes savings to crime victims. By Manatt calculations, savings specific to the Washington state criminal justice system total $100 million.

[20] Depending on how they are structured, Medicaid may be able to finance some of the costs associated with operating drug and mental health courts, including the cost of behavioral health assessments and targeted case management services provided to individuals as they move through the court system.