Medicaid Funding Opportunities for People with Behavioral Health Disorders in the Criminal Justice System

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Presentation

- Behavioral Health Needs of People Involved in the Criminal Justice System
- Opportunities for Criminal Justice Systems to Connect People to Coverage and Services
- System Implementation Considerations
- Questions?
High Rates of Substance Use Disorders

- Alcohol use disorder (Includes alcohol abuse and dependence)
  - Household: 2%
  - Jail: 47%
  - State Prison: 44%

- Drug use disorder (Includes drug abuse and dependence)
  - Household: 8%
  - Jail: 54%
  - State Prison: 53%

Source: Abrams & Teplin (2010)
High Rates Serious Mental Illness and Co-Occurring Substance Use Disorders in CJ Populations

**General Population**
- **95%** Serious Mental Illness
- **5%** No Serious Mental Illness

**Jail Population**
- **83%** Serious Mental Illness
- **17%** No Serious Mental Illness
- **72%** Co-Occurring Substance Use Disorder
- **28%** No Co-Occurring Substance Use Disorder
Not all Mental Illnesses are Alike: Mental Illness in the General Population

- Diagnosable mental disorders: 16%
- Serious mental disorders: 5%
- Severe mental disorders: 2.5%
Not all Substance Use Disorders are Alike

The Substance Abuse Continuum

- Social Use
- Heavy Use
- Hazardous Use
- Problem Use
- Abuse

Abstention → Dependence
Quadrant Model – Co-Occurring Treatment Framework

- **Quadrant I**: Low Severity - Alcohol and other drug abuse
  - Locus of care: Primary health care settings

- **Quadrant II**: Low Severity - Mental Illness
  - Locus of care: Mental health system

- **Quadrant III**: High Severity - Alcohol and other drug abuse
  - Locus of care: Substance abuse system

- **Quadrant IV**: High Severity - Mental Illness
  - Locus of care: State hospitals, jails/prisons, emergency rooms, etc.
Individuals with behavioral health disorders may:

- Frustrate police officers and information gathering
- Remain silent due to paranoia or depression
- Provide incoherent/nonsensical responses
- Hinder prompt disposition of cases
- Try court officers patience with behaviors
- Be disruptive
- Return again and again
- Be difficult to engage
- Have difficulty following instructions
- Receive repeated infractions

Source: Adapted from “Persons with Mental Disorders in the Courts,” Managing Cases Involving Persons with Mental Disabilities at National Judicial College (Hon. Stephanie Rhoades)
Most people with mental disorders are not violent, and most people who are violent are not mentally ill.

People with psychiatric diagnoses with a co-occurring substance use disorder or untreated symptoms of psychosis have an increased risk of violence.
States and Localities Spend Billions on Health Care for Justice-Involved

- State prisons and local jails must provide health care to inmates, accounting for a significant proportion of total corrections spending
  - 22.8% of CA corrections spending ($2.1 billion) was for adult inmate health care in FY 2010-2011
  - 15% of OH corrections spending ($225 million) was for health care in 2010

- Estimates suggest some $7 to $10 billion is spent on correctional health care annually.
Uninsured: Criminal Justice Population

- Individuals with criminal justice involvement are more likely than the general population to be uninsured at reentry – 68 to 90 percent\(^1,2\) versus 16 percent of the general population\(^3\)

### Health Coverage following Prison Release
Urban Institute Study, 2008

- **Uninsured**: 78% (2-3 Months), 68% (8-10 Months)
- **Medicaid**: 5%, 8%
- **Medicare**: 2%, 1%
- **VA Health Benefits**: 3%, 3%
- **Private Insurance**: 6%, 12%
- **Other**: 6%, 6%
Coverage Can Improve Health Outcomes

- An analysis of the coverage expansion in MA post-2006 showed a significant decrease in all cause mortality.¹

- A 2012 JAMA study of state expansions of Medicaid in Arizona, Maine, and New York prior to the ACA found a significant association with:
  - Reduced mortality
  - Fewer delays in accessing care
  - Better self-reported health status¹

A 30% reduction in risk of death for an individual gaining health coverage

![Individual Risk of Death Chart]

- [Pre-Expansion](#)
- [Post-Expansion](#)
Health Coverage and Public Safety

- In a 2006 study, individuals with SMI who were enrolled in Medicaid upon release from jail in King County, WA:
  - Accessed mental health services at higher rates
  - Had 16% fewer arrests
  - Spent more time in the community

- Evidence-based substance abuse treatment can lower rates of both subsequent substance abuse and recidivism

Evidence-Based Programs and Practices for Mental Health Treatment

- Assertive Community Treatment
- Illness Management and Recovery
- Integrated Mental Health and Substance Abuse Services
- Supported Employment
- Psychopharmacology
- Cognitive Behavioral Therapy
- Motivational Enhancement Therapy
Evidence-Based Programs and Practices for Substance Abuse Treatment

- Modified Therapeutic Community (MTC)
- Cognitive Behavioral Therapy (CBT)
- Motivational Enhancement Therapy
- Contingency Management Interventions
- Pharmacotherapy (i.e., Medication Assisted Treatments)
- Relapse Prevention Therapy
- Behavioral Couples Therapy
Process of Recovery

PHASE 1: Stabilization
- Stabilization of active substance use or acute psychiatric symptoms

PHASE 2: Engagement/Motivational Enhancement
- Engagement in treatment
- Contemplation, Preparation, Persuasion

PHASE 3: Prolonged Stabilization
- Active treatment, Maintenance, Relapse Prevention

PHASE 4: Recovery & Rehabilitation
- Continued sobriety and stability
- One year - ongoing
An Expanding Population Under Correctional Supervision

7 MILLION AND COUNTING

Led by probation, the correctional population has tripled in 25 years.

NOTE: Due to offenders with dual status, the sum of these four correctional categories slightly overstates the total correctional population.

Incarceration Declining in Many States

Prison Population Percentage Change, 2010-2012

Source: BJS, Prisoners in 2011 and Prisoners in 2012: Advance Counts
Excludes three states that did not report 2010 data
Inmates Confined in Local Jails at Midyear and Percent Change in the Jail Population, 2000-2013

Vulnerable Time for Individuals Returning to the Community

- Most people released from jail and prison recidivate
  - 30% of individuals released from state prisons will be rearrested in the first six months following their release.
  - Within 3 yrs, the percentage increases to two-thirds.

- Elevated health risks following release
  - Higher risk of drug use.
  - A 12-fold increased risk of death in the first two weeks after release.
Increase in Covered Population Under ACA

- Majority of criminal justice involved population newly eligible for health coverage either through:
  - Medicaid; or
  - publicly subsidized health insurance coverage.

- A 2012 *Health Affairs* article assigned expected income and estimated that of the 700,000 federal and state prison inmates released each year:
  - 34% of prison inmates are likely *enroll* in Medicaid
  - 24% are likely to *enroll* in Marketplace coverage

1. Alison Evans Cuellar and Jehanzeb Cheema. (2012). As roughly 700,000 prisoners are released annually, about half will gain health coverage and care under federal laws. *Health Affairs* 31:5, 931-38.
Affordable Care Act extended the protections offered by the Mental Health Parity and Addiction Equity Act of 2008 to new plan types:

- Insured, individual and small group plans
- Coverage for the newly eligible under Medicaid, known as alternative benefit plans

This means Medicaid and Marketplace plans must now cover EHB – including MH and SU – and must do so in a manner no more restrictive than medical/surgical coverage.
Opportunities for Criminal Justice Systems to Connect People to Coverage and Services
Recommendations to Increase Connections to Health Coverage and Services

• Enrolling individuals involved in the CJ system in health coverage
  • Make eligibility determinations a standard component of services
  • Forge a strong working relationship with the state Medicaid agency and the Marketplace
  • Identify strategy to sustain staff time needed to assist with enrollments
Identifying and Enrolling Eligible People in Health Coverage

Increased enrollment in health coverage leads to:

- Enhanced opportunities for the appropriate diversion of individuals to mental health and/or substance abuse treatment
- Reduced corrections spending on qualifying inpatient medical care of more than 24 hours for Medicaid eligible inmates
- Improved access to and continuity of health care upon release
- Decreased burden on local and state-funded health services
- Better health outcomes and reductions in recidivism
Make eligibility determinations for health coverage a standard component of intake and reentry processes

- Forge a strong working relationship with the state Medicaid agency and the Marketplace

- Identify strategy to sustain staff time needed to assist with enrollments
  - Dedicated staff for processing applications (to identify eligible people; to process applications pre-release)
The Sequential Intercept Model of the Criminal Justice System (see figure 2) was developed by Mark R. Munetz, MD, and Patricia A. Griffin, PhD, for the GAINS Center for Behavioral Health & Justice Transformation, funded by the Center for Mental Health Services within the Substance Abuse and Mental Health Services Administration (SAMHSA). The model was used originally to map connections between the criminal justice and mental health systems. NIC modified the model to illustrate ACA enrollment opportunities (see figure 3).

As shown in figure 3, the NIC Sample Decision Points Map divides the justice system into five "intercepts" or decision points where individuals will have contact with health and justice personnel who can connect them with coverage:

- **Intercept 1**: Law Enforcement/Emergency Services
- **Intercept 2**: Pre-Arraignment & Court Hearings
- **Intercept 3**: Jails/Courts
- **Intercept 4**: Prisons/Jails Reentry
- **Intercept 5**: Community Corrections
Massachusetts

- DOC incorporated enrollment into reentry planning
- Dedicated enrollment specialists

California

- Expanding existing efforts to identify and enroll those eligible for Medicaid
- Increasing number of full-time staff working in state’s prisons to complete pre-release applications
- Pre-release applications completed using state Marketplace
Why suspend vs. terminate?

- Increased access to care upon reentry—continuity of care
- Terminating benefits is counterproductive and undercuts investment made in health care services in jail and prison
- Significant financial savings
- CMS encourages states to suspend
Medicaid Suspension in Action: State Case Examples

**Ohio**
- Suspends Medicaid for a period of one year under a legislative mandate – Reinstatement of Medicaid for Public Institution Recipients (ROMPIRS)
- About 51,000 prison inmates; 45% serve less than one year

**New York**
- Suspends Medicaid enrollment indefinitely. Per §3661(a), New York State Social Services Law:

  “To the extent permitted by federal law, the time during which such person is an inmate shall not be included in any calculation of when the person must recertify his or her eligibility for medical assistance in accordance with this article.”
Billing for Medicaid for Inmate Inpatient Care

- Medicaid exclusion on coverage for inmates does not apply to community-based inpatient care lasting 24 hours+
  - Saves state money by billing Medicaid for allowable inpatient services
  - Often results in savings due to Medicaid reimbursement rates being lower than those negotiated by corrections departments
2009 audit identified potential for savings and resulted in passage of a 2010 law directing the DOC to develop protocols to capture savings.

**Savings between 2011 and 2013:**

- More than $34 million on a total of nearly 2,000 eligible hospitalizations.
- Average savings per hospitalization were $18,000.
- More Medicaid eligible inmates than anticipated: 51%.
KY Projects Savings on Inmate Inpatient Care

- Estimated impact of Medicaid expansion on corrections spending on inpatient medical care for inmates in KY\(^1\)

![Chart showing corrections savings on inpatient medical care from SFY 2014 to SFY 2021.](chart.png)
MI Projects Savings on Inpatient and Community Based Care

- Estimated impact of Medicaid expansion on corrections spending on health services for inmates, parolees and for reentry substance use treatment services in Michigan

$24.2 Million in Savings on Corrections Health Care Spending: FY 2013-2014

- Inpatient Care: $12,579,500
- Reentry Services and Programming: $3,566,600
- Substance Abuse Testing and Treatment: $8,066,100
Discharge planning should address health care literacy and assist individuals in connecting to appropriate community health care providers.

Massachusetts

- DOC employs medical discharge planners who meet inmates with mental health diagnoses prior to reentry to arrange outpatient appointments with community providers.
- Also provides training on how to appropriately access health services through the M/caid program as part of reentry planning for all inmates.
Improving Care Coordination – Health Homes

- Enhance coordination of physical health, mental health and substance use care and enhance linkages to community services and supports to improve health outcomes for high-cost patients with chronic conditions.
- Open to all states
- Increased federal match (90/10) for first two years of health home demo
New York State Medicaid Health Home

- Open to Medicaid-eligible individuals with multiple chronic condition, serious mental illness, substance abuse

- Identification of eligible enrollees is done using a predictive algorithm assessing risk of hospitalization, nursing home placement and/or death, but referrals can be made by other agencies, including prisons and jails

- Evaluation metrics will assess criminal justice impact, e.g. recidivism rates of health home enrollees
Pursuing Financial Opportunities

- Supplanting corrections-funded mental and substance use services provided to parolees with those funded by Medicaid or private coverage

- Billing Medicaid for allowable community-based inpatient care for individuals who are incarcerated
System Implementation Considerations
Some System Implementation Considerations

- Availability of treatment associated with good outcomes for people who are CJ-involved?
- Provider capacity and network adequacy
- Plans’ compliance with parity requirements
- Potential mismatch between covered services and expectations of judges/prosecutors
  - Exclusions on coverage of court-mandated treatment or treatment that is a condition of probation/parole
- Information sharing
Resources
Services and Supports Associated with Good Public Health and Safety Outcomes

- For a more comprehensive list, see “A Checklist for Implementing Evidence-Based Practices and Programs for Justice-Involved Adults with Behavioral Health Disorders”

Medicaid and Financing Health Care for Individuals Involved with the Criminal Justice System

People in prisons and jails often have complex and costly health care needs, and states and local governments currently pay almost the entirety of these individuals’ health care costs. In addition, it is estimated that as many as 70% to 90% percent of the approximately 10 million individuals released from prison or jail each year are uninsured. Lack of health insurance is associated with increased morbidity and mortality, and the high rate of unemployment among individuals involved with the criminal justice system is compounded by rates of mental illness, substance use disorders, infectious disease, and chronic health conditions that are as much as seven times higher than rates in the general population.

When an individual returns to the community after incarceration, disruptions in the continuity of medical care have been shown to increase rates of reincarceration and lead to poorer and more costly health outcomes. Research shows that the first few weeks after release from incarceration are the most critical in terms of connecting people to treatment. Reentry into the community is a vulnerable time, marked by difficulties adjusting, increased drug use, and a 12-fold increase in the risk of death in the first two weeks after release. For many, the failure to provide a link to healthcare coverage and services upon release results in needless, potentially months-long gaps in their access to health care. If they access care at all, these individuals often rely upon hospital emergency room services, shifting much of the cost burden to hospitals and state, county, and city agencies.

This failure to link individuals involved with the criminal justice system to health coverage and services has resulted in dramatically higher health care costs for state and local governments, as well as the uninsured. Total state and local spending on uncompensated care for the uninsured reached $172 billion in 2008. Individuals involved with the criminal justice system, who make up as much as one-third of the uninsured population, can be expected to account for a significant portion of this spending. Furthermore, elevated recidivism rates, which are associated with a lack of access to health care for individuals with mental illnesses or substance use disorders, contribute to the burden of state and local corrections spending.

The appropriate use of federal Medicaid dollars to help pay for health care provided to this population can save states and localities money, in addition to minimizing health and public safety concerns associated with recidivism following incarceration. However, opportunities to maximize and maintain Medicaid enrollment for eligible individuals in this population, and especially to make use of Medicaid to finance certain types of care provided to those who are incarcerated, have been largely underutilized by states.

Historically, adults who do not have dependent children or do not meet disability criteria have not been eligible for Medicaid, which has limited the extent to which the program has funded services for people involved with the criminal justice system. Under the Affordable Care Act (ACA), a significant portion of the justice-involved population will gain eligibility for Medicaid coverage for the first time. Some will qualify for federally subsidized health insurance plans offered through the state health insurance exchanges, and others may qualify for Medicaid expansion.
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Thank you

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