



Medicaid Expansion

and the Local Criminal Justice System

MICHAEL DuBOSE

In 2014, cities, counties, and States will have an unprecedented opportunity to reduce the costs associated with individuals involved in the justice system—from jail bed use to emergency room admissions to medical care—while improving public safety and public health. Medicaid expansion under national health reform will extend the prospect of health care coverage to an estimated 16 million newly eligible individuals, including the substantial population of nonviolent offenders with mental illness or chemical addiction who cycle in and out of local jails.



For counties and court systems, this is a costly, high-need group of individuals with complex health problems that frequently contribute to their criminal behavior.

Because the vast majority of this group is poor, most will qualify for Medicaid coverage under the Patient Protection and Affordable Care Act (PPACA) of 2010, the national health reform law. In addition, starting in 2014, the Federal government will pay 100 percent of billable Medicaid charges for newly eligible enrollees through 2017, decreasing to 90 percent by 2020.

Currently, States and localities bear almost all health care costs incurred within the criminal justice system. However, Medicaid expansion could shift a large share of such costs to the Federal government. For this to occur, counties and jails must be prepared to bill Medicaid. Moreover, State Medicaid authorities will need to define Medicaid benefit packages that best address the needs of the justice-involved population. They also must be alert to ways of improving care and health outcomes and containing costs across the health care and criminal justice systems.

This new approach under health care reform gives States and counties the opportunity to save money by making comprehensive health care services available to justice-involved populations. Medicaid expansion will support the delivery of community-based medical and mental health care, which can reduce the use of jail beds as well as other government costs. To prepare for Medicaid expansion, State legislators, county administrators, criminal justice leaders, the judiciary, and community advocates need to rethink the priorities of the criminal justice system to develop sound policies and regulations. Now is the time for States and localities to start planning and developing new policies to take advantage of this new opportunity.

Parity for Behavioral Health

There is reason to believe that there will be significant overlap between the newly covered Medicaid population and the jail population. Ninety percent of the 10 million Americans who pass through local and county jails each year have no health insurance of any kind (Wang et al., 2008). In addition, they are largely male and poor, a population that most States do not currently cover under Medicaid. When Washington State expanded Medicaid coverage to childless adults, 30 percent of very-low-income childless adults had had recent jail involvement. These data from the Washington State Department of Social and Health Services suggest that the jail-involved subset of the expansion population will also be substantial in many other States.

Another important aspect of Medicaid expansion is the establishment of parity for mental health and

chemical dependency treatment if the care is provided by a managed care organization. Parity means that health insurance benefits for mental illness and chemical dependency—defined in terms of lifetime or annual dollar limits—must be equivalent to those for physical illness. Under PPACA, for the first time, all newly eligible Medicaid beneficiaries will have some level of mental health and chemical dependency coverage, although specific benefits will probably vary by State and by type of provider agency.

These implications are potentially enormous. According to a 2006 study by the Bureau of Justice Statistics, 64 percent of people in jail have some form of mental illness (James & Glaze, 2006). For the first time, local jurisdictions will have both the resources and the motivation to connect such people with appropriate treatment to manage their conditions in the community. Access to mental health services could keep some people from reoffending, thereby lowering criminal justice costs.

Potential Effects

What kinds of results can local jurisdictions expect to see under Medicaid expansion? Again, Washington State's experience with providing treatment to chemically dependent, very-low-income childless adults demonstrated important benefits:

- Emergency room use among those who received treatment was 35 percent lower than among those who did not. The resulting savings almost completely offset the average costs of chemical dependency treatment (Nordlund, Mancuso, & Felver, 2004).
- Chemical dependency treatment was associated with average medical cost savings on the order of \$2,500 annually per person treated—regardless of whether the person achieved sobriety (Wickizer et al., 2006).
- Rates of rearrest were 21 to 33 percent lower in three groups treated for chemical dependency compared with other adults in need of but not receiving these treatments. This reduction in arrests saved local law enforcement, jails, courts, and State correction agencies an additional estimated \$5,000 to \$10,000 for each person treated. This reduction in crime also benefitted the public in terms of both public safety and reduced criminal justice costs (Mancuso & Felver, 2009; Shah, Mancuso, Yakup, & Felver, 2009).

In addition, the average annual income of people who received chemical dependency treatment increased by \$2,000 to \$3,000 in Washington State and in California, respectively (Ettner et al., 2009; Shah et al., 2009). Higher incomes mean more tax revenue and less need for public assistance.

The experience in Washington State indicates that the savings associated with chemical dependency treatment far outweigh its costs. Moreover, studies have suggested

that these benefits often persist for several years following chemical dependency treatment (Shah et al., 2009). Medicaid coverage for the jail population could lead to a wider use of health care services within the community, thereby improving continuity of care and the stability of justice-involved individuals. PPACA also encourages the creation of community-based *medical homes* that provide patients with timely, well-organized, and coordinated care as well as easier access to providers across a continuum of services. Better access to care within the community may in turn help reduce the burden placed on jails to provide health care services, particularly for acute care, chronic care, mental health treatment, and chemical dependency disorders.

Issues for Implementation

Medicaid expansion creates major incentives for additional partnerships between criminal justice and community health providers. A great deal is at stake: public health, public safety, and the more efficient use of public tax dollars. States and counties must address the following questions:

- How should a benefit package be designed to address the needs of justice-involved populations and maximize the positive effects of Medicaid expansion for local jurisdictions? How can local jurisdictions help inform the development of Medicaid benefit packages?
- How can we ensure that eligible detainees and offenders are enrolled in Medicaid? Where and when should enrollment take place? What role can jails play in enrolling eligible offenders in Medicaid?
- How can we design and implement more effective diversion programs that place detainees into appropriate treatment, including mental health and chemical dependency treatment?
- How can we promote access to treatment for those in need throughout the continuum from arrest to adjudication to release?
- Does the local provider community have the capacity to meet the needs of the newly expanded service population? If not, how can it be strengthened?
- How can local criminal justice and health care systems create effective mechanisms for sustained coordination and collaboration?
- What protocols are needed to achieve seamless continuity of care for offenders returning to the community? How (and how often) will the organizations involved exchange health information?

Even as we begin to address these questions, many factors remain outside our control. For example, Congress may amend PPACA or restrict Medicaid. Much depends on how Federal and State governments implement various provisions of the expansion of Medicaid.

The *inmate exception*, a Federal regulation prohibiting Federal Medicaid funds from being used to pay for services for incarcerated persons who are otherwise eligible for Medicaid (Blair, 2011), must also be considered. Because of the inmate exception, nearly all States opt to terminate Medicaid eligibility for incarcerated persons, so the offender must reapply for these services upon release. This process can take months, delaying access to much-needed medication and other treatment. Although this has been a cost-saving strategy for States in the past, the PPACA may change those incentives beginning in 2014.

Some have argued that the inmate exception does not or should not apply to pretrial detainees (Blair, 2011). Although PPACA does not explicitly address the inmate exception, it does specify that individuals who are held in jail “pending disposition of charges” are qualified to enroll in Medicaid or in State insurance exchanges. How this provision will interface with the inmate exception will depend on Federal and State regulations.

The First Steps

Community Oriented Correctional Health Services (COCHS), a nonprofit organization that builds partnerships between jails and community health care providers, has been taking a hard look at what needs to be done between now and 2014 to fully exploit the opportunities arising from Medicaid expansion. COCHS recognizes the tremendous challenges involved in leveraging the provisions of PPACA—not only for jail administrators and local criminal justice officials but also for community health providers and public health agencies.

It is crucial to create partnerships between local health care providers and the criminal justice system. These two systems need to learn how to work together, and they need to learn quickly. Although not easy, it can be done, as COCHS has learned from its experience working with several jurisdictions to connect the health care provided in jails with the health care provided in communities. There is a variety of strategies for achieving this connectivity, but the goal is always the same: to ensure that members of the justice-involved population can get the health care services they need, regardless of their criminal justice status and of whether they are in jail or in the community. Mental health courts provide one example of what can be accomplished when localities find ways to bridge the gap between the justice and health care sectors.

Regardless of how these various unresolved issues are decided, Medicaid expansion offers jails and counties a unique opportunity to improve access to health care for the jail population while reducing costs in the criminal justice and public health care sectors. The experience of Washington State indicates that a well-designed package of Medicaid services that addresses the needs of the criminal justice population can more than pay for itself

in terms of both improved public safety and reduced public expense. Ongoing dialogue and strong collaboration will be required to address the challenges and take advantage of this opportunity. Now is the time to begin that dialogue. ■

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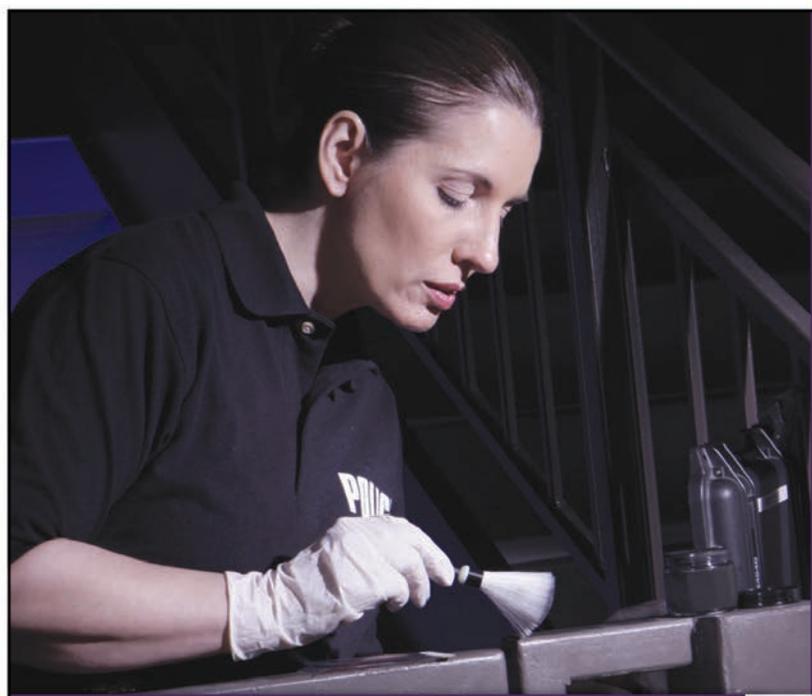
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Michael DuBose, is the Chief Executive Officer at Community Oriented Correctional Health Services (COCHS), a nonprofit organization that establishes partnerships between jails and community health care providers. In 2010, COCHS commissioned four papers that offer cutting-edge thinking on the implications for the criminal justice system of expanded eligibility for Medicaid and subsidized insurance to low-income, childless adults under the Patient Protection and Affordable Care Act. These papers may be downloaded at cochs.org/health_reform_conference_dc/papers. For more information on COCHS, visit cochs.org.



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