ISSUE PAPER

January 2011

Medicaid and Criminal Justice: The Need for Cross-System Collaboration Post Health Care Reform

Allison Hamblin, Stephen A. Somers, Sheree Neese-Todd and Roopa Mahadevan, Center for Health Care Strategies, Inc.

Perspective

This paper was written by the Center for Health Care Strategies (CHCS), a nonprofit health policy resource center dedicated to improving health care quality for low-income children and adults, people with chronic illnesses and disabilities, frail elders and racially and ethnically diverse populations experiencing disparities in care. For the past 15 years, CHCS has forged relationships at the state and national levels to promote more effective models for organizing, financing and delivering health care services for low-income beneficiaries. The organization has worked with nearly all 50 states, key federal agencies and other Medicaid stakeholders across the country to provide strategic policy advice and operational guidance on how to improve quality and control costs. Among its many ongoing programmatic activities, CHCS is engaged in efforts to help states plan for the significant expansion of Medicaid eligibility that begins in 2014.

Introduction

The Patient Protection and Affordable Care Act (ACA), passed in early 2010, has been celebrated (and vilified) in many ways that its sponsors could not easily have anticipated. Most national attention has been focused on the individual mandate, the new insurance exchanges and the sheer number of Americans (an estimated 32 million) who will gain access to publicly subsidized care. This paper sheds much-needed light on provisions of the bill that could change the lives of millions of low-income individuals who encounter the criminal justice system.

Among the more than 16 million people who will become eligible for Medicaid in 2014 by virtue of incomes at or below 133 percent of the federal poverty level (FPL), many have untreated mental illnesses and substance abuse that predispose them to repeat arrests. The prototypical participant in this cycle of recidivism is an underemployed, single male under age 30, who is arrested for possession of illegal substances, drunkenness or disorderly conduct. Because he cannot make bail, his second and third encounters with the local jail system are likely to lead to periods of incarceration during which minimal behavioral treatment services are available. And, up until now, the chances of his having had prior access to treatment in the community — as an uninsured, childless adult — have been next to nil.

The ACA could change all that. In extending Medicaid coverage to all Americans below 133 percent of FPL — $14,404 for a single adult — the legislation should lead to tremendous growth in the availability of Medicaid-financed, community-based mental health and substance abuse treatment services. States will be required to provide new enrollees with behavioral health benefits comparable to those offered to current Medicaid beneficiaries. From both a quality-of-care and a fiscal perspective, it will be in states' interest to do so, because without access to effective treatment, many of these individuals will be repeat users of emergency rooms and inpatient psychiatric services. And as of 2014, they will be doing so at Medicaid's expense.

Effective provision of community-based behavioral health services for the portion of the Medicaid expansion population — likely to be substantial — with criminal justice involvement will require significant collaboration among the broader health, social services and criminal justice systems. This paper brings into focus the opportunities inherent in the ACA for serving this population, and describes the challenges that state and local governments, health and social service providers, advocates and potential beneficiaries could encounter on the road to full and successful implementation of these aspects of the law in 2014.

COCHS
COMMUNITY ORIENTED CORRECTIONAL HEALTH SERVICES

Health Care Reform and Medicaid Eligibility

As a result of federal health care reform made law through the ACA in March 2010, Medicaid has become the foundation for universal health care coverage.[1] Based on expanded eligibility guidelines, Medicaid could well be serving upward of 80 million Americans — more than one-quarter of the U.S. population — each year after 2014.

Although some low-income parents will be newly eligible for Medicaid, the bulk of the expansion population will comprise childless adults. Prior to reform, states were not required to cover adults without children unless these individuals were otherwise eligible via disability status. Approximately 20 states had previously extended coverage voluntarily to some of their childless adults with state-only dollars, or under special Medicaid waivers.[2] Under the ACA, this coverage will expand dramatically, with up to 16 million becoming Medicaid-eligible.

As of April 1, 2010, states can provide Medicaid coverage for childless adults and receive regular federal matching payments without a special waiver.[3] Beginning on January 1, 2014, all states *must* provide coverage to this population up to 133 percent of FPL, with much higher federal matching payments than are available for existing Medicaid beneficiaries (100 percent in 2014-2016 in most states, phasing down to 90 percent by 2020).

Compared to the flexible waiver provisions some states use to cover childless adults, the Medicaid coverage requirements for this population in 2014 will be stricter, disallowing ceilings on enrollment, premiums for lower-income individuals and excessive cost-sharing with beneficiaries. For newly enrolled childless adults, Medicaid benefit packages must meet at least "benchmark" standards, which are somewhat lower than regular Medicaid requirements, but still relatively comprehensive. The current benefit package must include inpatient and outpatient hospital services, physician services, lab and X-ray and other services as designated by the Secretary of the Department of Health and Human Services (HHS). Beginning in 2014, benchmark coverage must also include prescription drugs, and mental health and substance abuse services.[4] Since the statutory language describing benchmark coverage is relatively general at this point, federal officials will undoubtedly provide more specific guidance for states on the type and level of coverage that will be required.

Profile of the Expansion Population

As 2014 approaches, better understanding of the health needs of newly eligible beneficiaries will enable states to: (1) design appropriate benefit packages and delivery systems; (2) allocate sufficient resources and set adequate payment rates; and (3) develop effective outreach and enrollment strategies. Below is a snapshot of the overlap between expansion and jail populations, followed by a discussion of the likely health needs of both groups.

Overlap Between Expansion and Jail Populations

The newly eligible Medicaid population of low-income childless adults will likely include a sizeable subset with criminal justice involvement. This assumption is supported by the following demographic characteristics, which are similar to those of jail-involved populations.[5]

- *Age and gender.* National survey data suggest that low-income childless adults are more likely to be male than female (61 percent versus 39 percent) and to be under age 35 (55 percent versus 45 percent).[6] Newly eligible men will be younger than newly eligible women, in large part because younger women are more likely to be already eligible for Medicaid by virtue of pregnancy or parenthood.

- *Race/ethnicity.* Racial and ethnic minority groups are likely to be overrepresented in the newly eligible population. The majority (53 percent) of uninsured childless adults with income at or below 133 percent of FPL report their race/ethnicity as non-white, with 19 percent identifying as black-only (non-Hispanic) and 26 percent identifying as Hispanic.[7]

- *Employment and education.* Almost half (45 percent) of the newly eligible population is expected to be unemployed (compared to below 10 percent of the general population).[8] Prior state experience suggests

even higher levels of potential unemployment; for example, when Oregon extended coverage to childless adults up to 100 percent of FPL, unemployment rates among the newly eligible were almost 60 percent.[9] Meanwhile, national surveys and state experiences suggest that approximately one-quarter of newly eligible individuals will not have finished high school (compared to 15 percent of the population at large).[10]

The experiences of states that have previously extended coverage to childless adults offer additional insights into the intersection between Medicaid expansion and jail populations. For example, Washington state found that 30 percent of very low-income childless adults (up to 38 percent of FPL) have recent jail involvement.[11] Although comparable data are not available for childless adults at higher income levels up to 133 percent of FPL, Washington's finding suggests that the jail-involved subset of the expansion population warrants attention by state and local policymakers.

Medicaid Eligibility and Incarceration

Providing adequate access to health services for the subset of the expansion population with jail involvement is complicated by the legal ramifications of incarceration for Medicaid eligibility. Federal law prohibits states from using federal Medicaid dollars to pay for health services provided to most individuals living in public institutions.[12] Nearly all states have polices terminating Medicaid eligibility upon incarceration, with the exception of a few states that opt for suspension.[13,14,15] Those states suspend eligibility at entry and reinstate eligibility at discharge. Federal matching dollars can be claimed for the administrative costs associated with suspension, as well as for eligibility determinations for individuals re-filing during or newly filing after their stays in public institutions.[16]

Overcoming the likely eligibility and enrollment lapses typical for this newly eligible, jail-involved population will require well-oiled administrative and data linkages among criminal justice and state Medicaid agencies. States will have greater incentive to gain coverage for these individuals to the extent that they can obtain federal funds at high match rates.

Health Needs of the Overall Expansion Population[17]

States that have previously extended Medicaid coverage to low-income childless adults can offer important insights on the potential physical and behavioral health needs of the expansion population. Beginning in 1994, Oregon extended coverage to all residents up to 100 percent of FPL through the Oregon Health Plan.[18] Similarly, since 2002, Maine has covered childless adults up to 100 percent of FPL under MaineCare, the state program for Medicaid and the Children's Health Insurance Program (CHIP). Following are lessons from these experiences that can shed light on the potential range and extent of health needs of the broad, newly eligible population.

■ *Self-reported health status.* In Oregon, newly covered childless adults reported significantly poorer health status than the overall U.S. population across physical health, mental health and disability domains.[19] Notably, the health status of childless adults was also significantly lower than that of newly covered parents in the state. In addition, more than one-third of newly covered childless adults reported that a disability prevented them from working.

■ *Health care service utilization.* In Oregon, childless adults had higher levels of annual health care service utilization than newly covered parents across all categories of service, including more than twice as many inpatient admissions, twice as many emergency room visits, more than three times as many mental health/substance abuse visits and 30 percent more evaluation and management visits.[20]

■ *Pent-up demand.* In Oregon, childless adults were significantly more likely than parents to cite the need to pay for a current medical condition (49 percent versus 25 percent) as the most important reason for having insurance.[21] And, whereas all beneficiaries newly eligible for coverage tended to use services most intensively during the initial month of eligibility, adults without children used proportionately more services in the first month compared to parents.

■ *Mental illness and substance abuse.* In Maine, mental health and substance abuse diagnoses accounted for four of the top 10, and nine of the top 20 most costly diagnoses among childless adults.[22] The likely prominence of behavioral health issues among the expansion population is further supported by data from Pennsylvania's General Assistance (GA) program, which covers low-income childless adults with mental illness and substance use prevalence rates of 53 percent and 36 percent, respectively.[23]

■ *High-cost populations.* In Maine, the top 5 percent of newly covered childless adults by cost accounted for 44 percent of total expenditures, and the top 10 percent accounted for 60 percent of expenditures.[24] This concentration of cost among a small subset of enrollees is consistent with broader Medicaid trends, and provides a compelling rationale for targeting intensive outreach and care management approaches to individuals with the highest need and potential for impact.

Health Needs of the Jail-Involved Subset

Washington state has unique abilities to link data between its state-funded health insurance and criminal justice programs. These integrated datasets allow for identification of the specific medical and behavioral health needs of beneficiaries with history of jail involvement, as presented below.[25] To note, these data represent the lowest-income subset of the expansion population (up to 38 percent of FPL) that currently qualifies for the state's GA program. By nature of their eligibility for this program, this subset's medical, mental illness and substance abuse needs are likely to be greater on average than those of the overall expansion population.

■ *Medical needs.* Low-income childless adults with prior criminal justice involvement in Washington clearly have medical needs. For example, 18 percent of jail-involved beneficiaries had diagnoses of cardiovascular disease, 5 percent had a diagnosis of diabetes and 15 percent had indications of pulmonary conditions, including chronic obstructive pulmonary disease and asthma.

■ *Mental illness and substance abuse.* Mental health and substance abuse needs in this population are substantial. Specifically, the Washington experience suggests that 53 percent of jail-involved, very low-income childless adults have indications of need for mental health treatment, including 20 percent with serious mental illness (SMI), 17 percent with anxiety disorders and 25 percent with indications of depression. Washington data also suggest that 79 percent of jail-involved, very low-income childless adults would need substance abuse treatment, compared with 42 percent of those with no history of jail involvement. Other studies have reported high prevalence rates of co-occurring (mental illness and substance abuse) disorders. For example, among jail-involved men and women with severe mental illness, 72 percent had a co-occurring substance use disorder.[26]

Taken together, these data suggest that the subset of the expansion population with jail involvement is likely to include many very low-income, non-working adults with chronic health needs and a very high prevalence of mental illness and substance abuse. These findings have broad implications, ranging from program budgeting to care management system design, suggesting both a need and an opportunity to help these beneficiaries better manage their illnesses, thereby improving health outcomes and reducing costs.

Recommendations for Delivery System Design for the Expansion Population

Medicaid Delivery Systems

Leveraging Existing Models

States that have previously extended Medicaid coverage to low-income, childless adults have generally done so using existing Medicaid care delivery models.[27] For example, in a review of 10 states with expanded coverage, the eight states that used capitated managed care organizations (MCOs) to deliver care in their overall Medicaid programs contracted with the same MCOs to serve their expansion populations. Similarly, the two states that employed a primary care case management (PCCM) approach in their regular

Medicaid programs also employed the PCCM model for childless adults.[28] It is thus reasonable to believe that after 2014, states will continue to leverage existing care delivery models to serve newly enrolled, childless adults.

However, given the complex medical and behavioral health needs that substantial subsets of the expansion population are likely to have — including the subset with jail involvement — states should carefully consider the ability of existing delivery system partners to serve this new population. States that have contracted with MCOs to serve only pregnant women and families, whose health needs are generally less complex, should not assume that these health plans have adequate care management capacity and provider networks to successfully manage populations with more complex needs. MCOs with experience serving adults with disabilities (beneficiaries receiving cash payments under Supplemental Security Income (SSI) or child welfare populations are more likely to have the resources and know-how to manage the complex subsets of the expansion population.

Assuring Continuity of Care During Eligibility Transitions

Some jail-involved, newly eligible Medicaid beneficiaries with incomes approaching 133 percent of FPL could fluctuate between Medicaid eligibility and eligibility for publicly subsidized private health insurance offered through newly created health insurance exchanges. To assure continuity of care for this subset of the population, Medicaid agencies are likely to consider contracting with health plans that will also participate in the exchanges, so these beneficiaries do not have to change plans if they lose Medicaid coverage. Likewise, it will be important to include requirements in managed care contracts to maintain continuity of care for those leaving and returning to Medicaid, to the extent possible. Such requirements could also be used to facilitate continuity of care for eligibility transitions related to incarceration.

Mental Health and Substance Abuse Treatment Benefits

The high prevalence of mental illness and substance abuse among the expansion population, particularly among the jail-involved subset, means that it will be critical for states to design and implement effective approaches to mental health and substance use treatment.

Medicaid Delivery Systems

State Medicaid agencies currently take several approaches to delivery of mental health and substance abuse services. The three dominant models of service delivery are: (1) comprehensive managed care, in which one MCO manages both physical and behavioral health benefits; (2) behavioral health "carve-outs," where mental health and substance abuse benefits are managed separately from physical health benefits by contracted behavioral health organizations (BHOs); and (3) fee-for-service, whereby mental health and substance abuse benefits are, again, carved out from the acute health care delivery system, but are unmanaged and paid for directly by the state to the provider. As of 2006, 26 states used a comprehensive MCO approach for some population subsets (e.g., non-SMI populations), 11 operated BHO carve-outs and 10 delivered mental health and substance abuse services via fee-for-service.[29]

Notably, within states, different delivery models are often employed for various subpopulations. The comprehensive managed care approach is most commonly used for children, pregnant women and low-income families, whereas BHO and fee-for-service models are predominant among complex and special needs populations, which tend to have a higher prevalence of mental health and substance abuse.[30] States almost always carve out behavioral health services for populations with SMI (Tennessee is the one notable exception).

Covered Benefits

There is a great deal of variation among states in the scope of coverage of behavioral health services in Medicaid, particularly with regard to substance abuse benefits. Table 1 lists commonly used services for mental health and substance abuse and the proportion of states that cover such services in their Medicaid programs (based on 2003 data).[31]

Table 1. Percentage of State Medicaid Agencies Covering Commonly Used Mental Health and Substance Abuse Services

	Inpatient Hospital	Outpatient Testing Treatment and Clinic Services	Extensive Outpatient Services	Rehabilitation	Targeted Case Management	Opioid Treatment	Residential Services	Crisis Services
Mental Health	100%	100%	88%	96%	96%	NA	59%	84%
Substance Abuse	78%	84%	49%	96%	25%	55%	29%	18%

Source: Abt Associates. "State Profiles of Mental Health and Substance Abuse Services in Medicaid." Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration: 2003.

Applicability of Parity

The substantial interstate and intrastate variation in the design of behavioral health care delivery systems and benefits has important implications for how these services are covered under the ACA. As noted, the ACA requires states to provide the expansion population with at least benchmark or benchmark-equivalent benefits, including "essential health benefits" (as of 2014) that explicitly include mental health and substance abuse services.

Therefore, all newly eligible Medicaid beneficiaries will have some level of mental health and substance abuse coverage, although the specific services covered will likely continue to vary by state. Furthermore, to the extent that these benefits are provided by a comprehensive MCO, they must be provided in parity with other medical benefits.[32] Where parity does apply, it would likely impact (and increase) inpatient and outpatient benefits, but would not likely affect residential treatment, since the latter is typically excluded from managed care contracts.[33] Similarly, parity would not affect other mental health and substance abuse services for which there is no comparable physical health service (e.g., opioid treatment). Meanwhile, parity is not likely to apply at all for beneficiaries receiving mental health and substance abuse benefits via fee-for-service or through a separate BHO.[34]

In sum, it is hard to predict which mental health and substance abuse services will be covered and how those services will be delivered to new beneficiaries under Medicaid expansion. It is safe to say, however, that variation will continue across states and among population subsets. That said, given the anticipated level of behavioral health needs of the expansion population overall and the jail-involved subset in particular, states will have to consider covering a wide range of mental health and substance abuse services to meet these individuals' treatment needs. As discussed further below, state experience suggests that the cost of such coverage may be recouped through reduced use of emergency room and other Medicaid-covered services, as well as through reductions in costs to the criminal justice system through reduced recidivism.

Treatment Capacity

The likelihood that many newly eligible adults who enroll in 2014 will have significant health needs has important implications for ensuring sufficient access to care. Based on the experience discussed above, states may expect high levels of demand for primary and specialty care services (e.g., mental health and substance abuse treatment), particularly in the initial months following enrollment.

For primary care, the ACA-authorized increase in provider payment rates to 100 percent of Medicare rates in 2013-2014 may help increase access in the initial expansion period.[35] However, if states revert to pre-2013 payment rates once enhanced federal funding ends in 2015, primary care access could become a more critical issue in the absence of other efforts to increase capacity. In recognition of this limited capacity, the ACA includes a number of provisions designed to stimulate workforce development in primary care; however, it will be many years before the impact of these investments is felt.[36]

The high prevalence of mental illness and substance use among the expansion population, particularly among the jail-involved subset, suggests that capacity issues may be even greater with regard to behavioral health treatment. Medicaid is a dominant national purchaser of mental health and substance abuse services, paying for 26 percent (more than $31 billion in 2003) of all such expenditures, and, as such, represents a primary source of funding for investments in system capacity.[37] With expansion, Medicaid's role in supporting the development of the community mental health and substance abuse delivery system could grow substantially.

Block grants will also likely continue to play a key role in supporting mental health/substance abuse treatment capacity. Notably, Mental Health Block Grants administered by the Substance Abuse and Mental Health Services Administration contribute more than $400 million annually to improving mental health service systems across the country.[38] States are also eligible to receive Substance Abuse Prevention and Treatment Block Grants, which fund substance abuse treatment and prevention services for a number of vulnerable populations through a variety of means. These grants totaled approximately $1.8 billion in 2009, and in many states represent a primary source of substance abuse funding.[39] Unlike Medicaid, which restricts spending to specific, approved services, block grants allow states considerable flexibility around service eligibility and type, and thus can be used to cover gaps in Medicaid reimbursement and to build the case for coverage of new services. For example, Michigan used block grant dollars to create a statewide network of "assertive community treatment teams" and subsequently qualified them for Medicaid reimbursement to support their ongoing operation.[40] Post health reform, such strategic blending of funding sources will be even more critical to ensuring sufficient mental health and substance abuse treatment capacity.

Many states report that the substance abuse treatment providers (and to a lesser extent the mental health providers) that typically serve jail-involved populations have limited overlap with current Medicaid provider networks (with the exception of hospital-based providers and methadone clinics).[41] State officials have explained this network divergence as stemming from:

- *Prohibitions related to credentialing:* For example, some Medicaid agencies do not recognize licensed clinical alcohol and drug counselors (master's level addictions specialists) as reimbursable service providers;

- *Restrictions on facility types:* Adult residential treatment settings are bound by the Medicaid "institution for mental disease" (IMD) exclusion that prohibits federal funding to all institutions of more than 16 beds;[42] and

- *Adequacy of Medicaid rates:* State criminal justice officials have suggested that their contracted substance abuse treatment providers generally perceive Medicaid reimbursement rates as too low to be of interest.

Accordingly, state Medicaid agencies should consider partnering with colleagues in state and local criminal justice systems to determine how to most effectively meet the demand for services among the jail-involved segment of the expansion population. For example, in states where Medicaid credentials differ from those for other payers, providers have begun to seek cross-licensure, with certain providers integrating substance abuse and mental health treatment within the same organization. In addition to addressing access issues, such co-location approaches also enhance opportunities to coordinate care for individuals with co-occurring mental health and substance abuse treatment needs.

Finally, it is worth noting that expansion of treatment capacity takes time. For example, when the Washington state legislature authorized substantial funding for substance abuse treatment expansion, it took several years to increase capacity to match.[43] Therefore, with the anticipation of a large influx of beneficiaries with substantial substance abuse treatment needs just a few years down the road, states need to begin planning for expanded treatment capacity as soon as they can. Importantly, a number of opportunities in the ACA can provide resources to support these investments. These include enhanced federal match for providing health homes services, grants to develop community health teams and the many new demonstrations that will be authorized by the newly created Center for Medicare and Medicaid Innovation. [44] As states prepare for 2014, these opportunities could help build the infrastructure that will be critical to managing care and controlling costs, particularly as state match kicks in as of 2017.

Effective Medicaid Purchasing Strategies to Promote Coordinated Care

As dominant purchasers of health care services, states have substantial power to set contractual standards with participating health plans and providers that drive toward desired levels of service quality, coordination and accountability. Along these lines, there is ample precedent for using contract requirements to ensure that providers coordinate care for individuals engaged in multiple state systems. For example, states are increasingly contracting with individual care management entities to coordinate care for children with complex behavioral health care needs across Medicaid, child welfare and juvenile justice systems.

Below are examples of contract requirements designed to address these goals, tailored for jail-involved beneficiaries with potentially co-occurring physical, mental health and/or substance abuse treatment needs:

- Comprehensive physical and behavioral health screening upon release/enrollment in Medicaid;

- Stratification and triage of services based on need, with targeting of services to priority populations and with varying intensity based on individual risk profiles (e.g., in-person versus telephonic care management, minimum contact frequency, etc.);

- Electronic data systems capable of sharing clinical and administrative data (e.g., health care service use) across physical and behavioral health providers, including case managers;

- Real-time notification of hospitalizations, emergency department and/or crisis visits among relevant physical, behavioral and criminal justice system partners;

- Clear designation of a health care home that is accountable for coordinating physical and behavioral health care and that capitalizes on opportunities for co-location and deeper collaboration;

- Engagement of consumers, including self-management education and involvement in care plan development, and recognition of the importance of maintaining existing provider relationships;

- Shared development of care plans addressing physical and behavioral health needs (available to both provider types electronically);

- Care coordination support to help beneficiaries access specialty, diagnostic and other community-based services;

- Sensitive and competent providers with adequate training, credentialing and support to appropriately deliver care and facilitate change in health behaviors;

- Use of evidenced-based and promising practices that can be tailored to meet the needs of individual patients and set clear expectations for providers; and

- Joint and standardized clinical and performance measures, treatment follow-up, and feedback mechanisms that are shared among providers.[45]

In addition to using contract requirements as a lever to promote high-quality, coordinated care, state Medicaid

agencies can use financial incentives to encourage delivery of specific services and to ensure that plans and providers focus on high-priority issues. For example, states can use pay-for-performance models to promote the use of evidence-based practices. Given the associated costs of providing care to medically complex populations, states that reward use of evidence-based treatments shown to be effective with jail-involved adults with behavioral health issues may have the greatest potential for improving long-term health outcomes and controlling costs.[46]

States can also use performance incentives to encourage cross-system collaboration. For example, Pennsylvania has developed performance incentives to encourage active coordination between MCOs and BHOs in managing the care of adults with SMI. To receive payment, the MCOs and BHOs must demonstrate collaboration on such activities as joint identification and risk stratification of the population, joint care plan development, real-time notification of hospitalizations and coordinated pharmacy management.[47]

Finally, Medicaid agencies can implement mechanisms for sharing savings from reductions in avoidable emergency and inpatient utilization across physical and behavioral health care delivery systems. By including savings from reduced recidivism into such gain-sharing models, Medicaid agencies could further support collaboration with criminal justice system partners.

Promoting Cross-System Collaboration

Rationale for Collaboration

Effective management of jail-involved members of the expansion population will require collaboration across multiple systems, including criminal justice, Medicaid and state and local agencies responsible for mental health and substance abuse services. This collaboration must extend to community-based providers across physical, behavioral health and other social services, and begin with coordinated outreach and enrollment of eligible Medicaid beneficiaries. Specifically, the criminal justice system could become a strategic partner to state Medicaid agencies for the purpose of facilitating enrollment of eligible individuals upon release from jail. For example, the streamlining of data between Medicaid and criminal justice entities could facilitate the rapid integration of eligible individuals exiting the criminal justice system into the Medicaid enrollment rolls.

Medicaid eligibility requirements include documentation of citizenship and identity; the National Crime Information Center gathers similar information on individuals entering jails. As part of its goal to simplify enrollment for newly eligible individuals, the ACA encourages Medicaid to perform electronic data matching with existing federal and state data sources to establish, update and verify eligibility. Using electronic verification provided by criminal justice entities can help Medicaid to complete the first important step in granting insurance coverage for jail-involved individuals.

Once eligible beneficiaries are enrolled, further cross-system collaboration is necessary to ensure: early identification of medical, mental health and substance abuse treatment needs; connections with appropriate community-based services; and appropriate monitoring and follow-up with criminal justice officials. One model for this comprehensive approach includes an independent organization (e.g., a specialized case management entity) that provides: crisis intervention services; physical, mental health and substance use assessments; referrals and treatment plans; and case coordination and status updates to justice partners. Adoption of this type of model would ensure access to appropriate care and the clinical collaboration needed to inform justice recommendations. Based upon discussions with officials in New Jersey, New York, Pennsylvania and Washington, cross-system collaboration is already occurring[48]:

- All four states have created cross-system and cross-agency task groups that aim to foster improved coordination of services for this population.

- In three states, criminal justice personnel have worked closely with local welfare and Medicaid agencies to ensure expedited re-enrollment for eligible individuals upon jail release.

■ One state has begun an initiative under which criminal justice officials, working with their state Medicaid agency, are seeking a waiver to fund a "recovery-oriented" substance abuse case management program.

■ In another state, criminal justice-sponsored programs identify people with SMI, fast-track their enrollment in Medicaid and facilitate subsequent linkages to a broader range of community-based services upon release.

■ Two states have launched pilot initiatives that provide case management services (funded by the criminal justice system) upon release from jail to individuals identified as frequent users of emergency room services.

These examples highlight important considerations for promoting effective, cross-system collaboration, including: joint identification of priority populations, coordinated efforts to facilitate (and maintain) Medicaid enrollment, early identification of treatment/service needs and coordinated case management with cross-system accountability. As illustrated herein, agencies can look to small-scale, targeted pilot projects to begin these relationships and build a strong foundation for more systemic coordination.

The Business Case for Medicaid

The expansion of Medicaid eligibility under the ACA creates new incentives for collaboration across public systems. As presented below, these incentives, coupled with the evidence on the medical and criminal justice cost offsets that can be generated by effective substance abuse treatment, make a compelling rationale for active outreach and engagement of newly eligible, jail-involved childless adults.

Financial incentives encourage prevention. First, it is important to note how the ACA markedly changes the financial incentives for state Medicaid agencies around the enrollment and management of childless adults. Prior to health care reform, many states that had previously expanded coverage to childless adults had done so through state-only funded initiatives such as GA programs. In this context, states had substantial financial incentives to support GA beneficiaries to apply for federal disability or SSI status to enable these individuals to transition from wholly state-funded coverage to Medicaid coverage at standard federal matching rates. Beginning in 2014, this calculus changes dramatically. With childless adults eligible for enhanced federal matching rates, beginning with 100 percent federal match and ratcheting down to 90 percent by 2020, states now have significant incentives to prevent the escalation of chronic conditions that might otherwise lead to disability. After 2014, if Medicaid expansion beneficiaries become eligible for SSI, states will lose the enhanced federal match. Table 2 below illustrates these incentives under health reform, suggesting a 10:1 financial advantage to states to prevent the attainment of disability status among newly covered, childless adults.[49] When annualized and applied to large numbers of beneficiaries, the incentives to invest in prevention could become quite powerful. Extending the example below, preventing 1,000 childless adults from reaching disability status would result in almost $5.5 million in annual savings to the state.

Table 2. Example of Financial Incentives to States Post Health Reform

Eligibility Group	Average Expenditure Per Member Per Month (PMPM)*	Federal Matching Rate	State Share
Childless Adult	$500	90%	$50 PMPM
SSI	$1000	50%**	$500 PMPM

* To note, PMPM rates for childless adults vs. SSI populations are illustrative examples based on the claims experience from numerous states.
** Federal matching rate for medical services for SSI populations will vary by state. Fifty percent is provided as an illustrative example.
Source: Example provided through personal conversation with David Mancuso, Senior Research Supervisor, Research and Data Analysis Division, Washington State Department of Social and Health Services.

Medical-cost offsets from substance abuse treatment. In addition to the financial incentives described above, evidence suggests a favorable cost-benefit ratio to states for providing access to needed substance abuse treatment services. A study in Washington state found that substance abuse treatment (where indicated) reduced emergency room costs by 35 percent.[50] This reduction alone, $154 per member per month (PMPM), almost completely offset the $162 PMPM average substance abuse treatment cost. Further, emergency room visits often lead to expensive hospitalizations, suggesting additional cost savings.

Consistent with these findings, a subsequent internal study in Washington state found that receipt of substance substance abuse treatment services among GA beneficiaries was associated with statistically significant overall medical cost savings, on the order of $2,500 annually annually per person treated.[51] Further studies have suggested that these savings can persist four years after treatment.[52] These findings are consistent with the notion notion that access to effective substance abuse treatment can prevent the escalation of other physical and mental health conditions, as well as prevent other behaviors that can lead to expensive health care service utilization (e.g., emergency room visits). To note, given that these studies focus on the lowest-income, higher-acuity subset of individuals who will be newly eligible for Medicaid Medicaid in 2014, one might expect cost offsets of a smaller magnitude and/or duration when applied to the broader expansion population. As with health care in general, prevention targeted to specific high-risk subsets is more likely to yield cost-benefit than broader prevention efforts.

The Business Case for the Criminal Justice System

The financial benefits of providing low-income adults with access to substance abuse treatment extend to the criminal justice system. Studies have documented significantly reduced risk of arrest following the receipt of substance abuse treatment: Rates of arrest are 21 percent to 33 percent lower compared with adults requiring but not receiving treatment.[53,54] Such reductions are associated with estimated financial savings to local law enforcement, jail, court and state corrections department costs of $5,000 to $10,000 per person treated.[55]

Policy Implications

Given the likely cost offsets in both medical and criminal justice expenditures, there is a strong business case for targeted state investments in substance abuse treatment capacity. The above analyses also highlight important considerations for policymakers attempting to bridge agency divides in preparation for 2014:

■ *Data integration across Medicaid, mental health, substance abuse and criminal justice agencies is critical to developing and sustaining a shared agenda.* By linking state databases to enable tracking of individual encounters across systems, policymakers can evaluate and demonstrate the impacts that each system has on the others. These analyses can be powerful levers to align incentives and marshal resources for mutual benefit. As referenced earlier, data integration would create synergies beyond these business case considerations, including more efficient eligibility determination and enrollment for jail-involved populations, early identification of treatment needs and increased rates of referral and connection to needed services.

■ *Privacy issues must be addressed to maximize the health benefits of cross-system collaboration.* Federal law currently prohibits the sharing of information related to substance abuse without consent, except in the case of medical emergency.[56] Although invaluable for protecting individual rights to privacy, this regulation imposes important restrictions on the ability of individual agencies or organizations to share information for the purposes of early identification, outreach, and enrollment in treatment/care management programs. Regulation reform that would extend the ability to share information related to substance abuse treatment needs across the various entities imbued with health care management responsibility would greatly facilitate effective engagement and recovery.

■ *Effort is needed to sustain "win-win" scenarios over the long term.* In anticipation of medical or criminal justice cost offsets associated with substance abuse treatment, legislators might reasonably reallocate state funds away from these services in order to support the expansion of substance abuse treatment capacity.

Although in line with optimizing public resource allocations, this approach can foster competition and resentment rather than collaboration across agencies. States should be aware of this risk and consider opportunities to maintain alignment of incentives over time. One such approach is use of gain-sharing mechanisms, through which savings accrued to one system are shared with another in recognition of their relationship and interdependence.

Conclusion

With all that needs to be done in preparation for Medicaid expansion in 2014, state policymakers are just beginning to think about the composition of the expansion population — including its range of health needs and the resulting implications for delivery system design and capacity. As Medicaid agencies continue these pursuits, they should bear in mind their increasing connection to counterparts in state and local criminal justice systems, as newly eligible beneficiaries will be crossing these lines in substantial numbers.

The high level of jail involvement anticipated among newly eligible populations and striking rates of substance abuse within this subset will demand unprecedented levels of cross-system collaboration among Medicaid, mental health and substance abuse agencies and criminal justice systems to: (1) facilitate Medicaid enrollment for eligible individuals; (2) enable early identification of treatment needs; (3) assure connections to appropriate community-based services; (4) allow for monitoring, follow-up and accountability across systems; and (5) provide the desired continuity of coverage and care that drove the passage of the ACA.

Given the unquestionable need for increased substance abuse treatment capacity to serve this population, system partners should begin planting the seeds for this investment sooner rather than later. High on the priority list should be alignment of information systems to allow linkage of individual records. Critical to documenting the alignment of financial incentives across systems, this linkage is key to motivating the joint investment in treatment infrastructure that will be required to improve the health and function of many of Medicaid's new beneficiaries.

References

[1] For more information on the Medicaid program, and related issues of administration, financing, eligibility and payment/delivery systems, see the following:

- The Kaiser Commission on Medicaid and the Uninsured. *Medicaid: A Primer, Key Information on Our Nation's Health Coverage Program for Low Income People,* June 2010, www.kff.org/medicaid/7334.cfm.
- Klees BS, Wolfe CJ and Curtis CA. "Brief Summaries of Medicare & Medicaid: Title XVIII and Title XIX of The Social Security Act." Prepared by Office of the Actuary Centers for Medicare & Medicaid Services Department of Health and Human Services, November 1, 2009.
- The Council of State Governments. "Medicaid 101: A Primer for State Legislators," January 2009.

[2] Kaiser Commission on Medicaid and the Uninsured. *Where Are States Today? Medicaid and State-Funded Coverage Eligibility Levels for Low-Income Adults,* December 2009, www.kff.org/medicaid/upload/7993.pdf.

[3] Mann C. State Medicaid Director Letter #10-005. "New Option for Coverage of Individuals under Medicaid," April 10, 2010.

[4] Kaiser Family Foundation. *Explaining Health Reform: Benefits and Cost-Sharing for Adult Medicaid Beneficiaries,* www.kff.org/healthreform/upload/8092.pdf, August 2010.

[5] Veysey BM. "The Intersection of Public Health and Public Safety in U.S. Jails: Implications and Opportunities of Federal Health Care Reform." Unpublished paper, 2010.

[6] Kaiser Family Foundation. *Expanding Medicaid under Health Reform: A Look at Adults at or Below 133% of Poverty,* www.kff.org/healthreform/8052.cfm, April 2010.

[7] ibid.

[8] U.S. Bureau of Labor Statistics. Data as of June 2010.

[9] Haber SG, Khatutsky G and Mitchell JB. "Covering Uninsured Adults Through Medicaid: Lessons from the Oregon Health Plan." *Health Care Financing Review*, 22 (2), Winter 2000.

[10] Kaiser Family Foundation. *Expanding Medicaid.* Also Haber SG, Khatutsky G and Mitchell JB.

[11] Data provided by the Washington State Department of Social and Health Services, Research and Data Analysis Division.

[12] According to 42 CFR § 435.1010, "public institution" means an institution that is the responsibility of a governmental unit or over which a governmental unit exercises administrative control. This

includes correctional facilities and state-licensed IMDs that are governed by Medicaid and SSA policies. According to 42 CFR § 435.1009, an IMD (Institution for Mental Disease) is defined as a facility of more than 16 beds that is primarily engaged in providing treatment services for individuals diagnosed with mental illness.

[13] Morrissey JP, Dalton KM, Steadman HJ, et al. "Assessing Gaps Between Policy and Practice in Medicaid Disenrollment of Jail Detainees with Severe Mental Iillness." *Psychiatric Services,* 57(6): 803–808, June 2006.

[14] Lackey C. "Final Results of State Medicaid Agencies Survey." Memorandum to Fred Osher, Director of Center for Behavioral Health, Justice and Public Safety. New York, NY: Council of State Governments, October 16, 2000.

[15] Bazelon Center for Mental Health Law. *Best Practices: Access to Benefits for Prisoners with Mental Illnesses,* http://www.bazelon.org/issues/criminalization/publications/bestpractices.pdf (accessed November 15, 2006).

[16] 42 CFR § 435.1001

[17] Portions of this section have been adapted from Somers S, Hamblin A, Verdier J and Byrd V. *Covering Low-Income Childless Adults in Medicaid: Experiences from Selected States,* www.chcs.org/publications3960/publications_show.htm?doc_id=1261143, August 2010.

[18] To note, Oregon subsequently limited this coverage and now uses a lottery.

[19] Haber SG, Khatutsky G and Mitchell JB.

[20] ibid.

[21] ibid.

[22] Anderson N and Gressani T. "MaineCare for Childless Adults Waiver Year 7 Annual Report, October 1, 2008 – September 30, 2009." Cutler Institute of Health & Social Policy, Muskie School of Public Service, University of Southern Maine, February 23, 2010.

[23] Analysis by the Office of Medical Assistance Programs, Department of Public Welfare, includes adults receiving cash assistance, based on paid FFS and encounter claims between 4/1/2008 and 3/31/2010 with the primary diagnosis code between 29000 and 30299 or between 30600 and 31399 for mental illness and primary diagnosis codes between 30300 and 30599 for substance use.

[24] Anderson and Gressani.

[25] Washington data provided by Department of Social and Health Services, Research and Data Analysis division. Data as of 2008-2009.

[26] National GAINS Center for People with Co-Occuring Disorders in the Justice System. "The Prevalence of Co-Occurring Mental Illness and Substance Use Disorders in Jails," a fact sheet. Delmar, NY: The National GAINS Center, 2001.

[27] For more detail, see Somers S, Hamblin A, Verdier J and Byrd V. *Covering Low-Income Childless Adults in Medicaid: Experiences from Selected States,* www.chcs.org/publications3960/publications_show.htm?doc_id=1261143, August 2010.

[28] For more information on primary care case management, see Kaiser Commission on Medicaid and the Uninsured, *Medicaid: A Primer.*

[29] Verdier J, Barrett A and Davis S. "Administration of Mental Health Services by Medicaid Agencies." DHHS Pub. No. (SMA) 07-4301. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2007.

[30] Rulin RB. "Fact Sheet: Medicaid and Health Plan Contracting for Behavioral Health Services; the Role of Carve-outs," Association for Community Affiliated Health Plans, August 2007.

[31] Abt Associates. "State Profiles of Mental Health and Substance Abuse Services in Medicaid." Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2003.

[32] As required under the Mental Health Parity and Addictions Equity Act.

[33] Rulin.

[34] To note, further CMS guidance on Medicaid implications of the Mental Health Parity and Addictions Equity Act is anticipated.

[35] States will receive 100 percent federal funding for the increased primary care payment rates in 2013-2014.

[36] For more detail on workforce provisions, see Title V of the ACA.

[37] Mark T et al. "National Expenditures for Mental Health Services and Substance Abuse Treatment, 1993–2003." SAMHSA Publication No. SMA 07-4227. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2007 (www.samhsa.gov/spendingestimates/SAMHSAFINAL9303.pdf).

[38] President's New Freedom Commission on Mental Health. *Major Federal Programs Supporting and Financing Mental Health Care,* www.mentalhealthcommission.gov/reports/Fedprograms_031003.doc, January 2003.

[39] National Association of State Alcohol and Drug Abuse Directors, Inc. "Fact Sheet: Substance Abuse Prevention and Treatment (SAPT) Block Grant," June 2009.

[40] Smith G et al. "Using Medicaid to Support Working Age Adults with Serious Mental Illnesses in the Community: A Handbook," Washington, D.C.: U.S. Department of Health and Human Services Office of the Assistant Secretary for Planning and Evaluation, January 2005.

[41] In some states, such as Washington, there is significant overlap between substance abuse providers serving jail-involved populations and those serving Medicaid beneficiaries, as facilitated by consistent license and certification arrangements.

[42] Draper DA, McHugh MC, Achman L and Kuo S. "Medicaid Financing of State and County Psychiatric Hospitals." DHHS Pub. No. (SMA) 03-3830. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2003.

[43] Personal communication with Alice Huber, Administrator,

Evaluation and Quality Assurance, Division of Behavioral Health and Recovery, Washington Department of Social and Health Services.

[44] See sections 2703, 3021 and 3502 of the ACA for complete descriptions of the health homes, Center for Medicare and Medicaid Innovation and community health teams provisions, respectively.

[45] Adapted from Bella M, Somers S and Llanos K. "Providing Behavioral Health Services to Medicaid Managed Care Enrollees: Options for Improving the Organization and Delivery of Services," Medicaid Institute at United Hospital Fund, June 2009.

[46] Freidmann P, Taxman F and Henderson C. "Evidence-Based Treatment Practices for Drug-Involved Adults in the Criminal Justice System." *Journal of Substance Abuse Treatment,* 32(3):267-277, April 2007.

[47] For more information, see www.chcs.org/publications3960/publications_show.htm?doc_id=1066660.

[48] Conversations took place in July 2010 and were confidential.

[49] Example provided through personal conversation with David Mancuso, Senior Research Supervisor, Research and Data Analysis Division, Washington State Department of Social and Health Services.

[50] Nordlund DJ, Mancuso D and Felver B. *Chemical Dependency Treatment Reduces Emergency Room Costs and Visits.* Washington State Department of Social and Health Services, Research and Data Analysis Division, July 2004, http://publications.rda.dshs.wa.gov/887/.

[51] Wickizer TM, Krupski A, Stark KD, et al. "The Effect of Substance Abuse Treatment on Medicaid Expenditures among General Assistance Welfare Clients in Washington State." *Milbank Quarterly,* 84(3), 555-576, 2006 (www.milbank.org/840304.html).

[52] Shah MF, Mancuso D, Yakup S and Felver B. *The Persistent Benefits of Providing Chemical Dependency Treatment to Low-Income Adults.* Washington State Department of Social and Health Services, Research and Data Analysis Division, November 2009, http://publications.rda.dshs.wa.gov/1397/.

[53] ibid.

[54] Mancuso D and Felver B. *Providing Chemical Dependency Treatment to Low-Income Adults Results in Significant Public Safety Benefits.* Washington State Department of Social and Health Services, Research and Data Analysis Division, February 2009, http://publications.rda.dshs.wa.gov/1372/.

[55] ibid.

[56] See 42 CFR Part 2, www.access.gpo.gov/nara/cfr/waisidx_02/42cfr2_02.html.