MEDICAID COVERAGE FOR INDIVIDUALS IN JAIL PENDING DISPOSITION

OPPORTUNITIES FOR IMPROVED HEALTH AND HEALTH CARE AT LOWER COSTS

MARSHA REGENSTEIN, PhD
JADE CHRISTIE-MAPLES

Department of Health Policy
School of Public Health and Health Services
George Washington University

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Executive Summary

The Patient Protection and Affordable Care Act (ACA) provides an unprecedented opportunity for millions of poor men and women to obtain insurance coverage to address their substantial acute, chronic, physical and behavioral health care needs. The ACA raises Medicaid eligibility levels to 133 percent of poverty, thereby enabling adults with or without children to qualify for coverage. A substantial percentage of the newly eligible population will be jail-involved individuals – people who have had interactions with the legal system over the course of a year, including as an inmate at a county or city jail. Many of these individuals are in jail pending disposition; they have not been convicted of a crime but are nevertheless held as an inmate, often because they do not have the resources to satisfy bail requirements. Under current rules, individuals in jail pending disposition are ineligible for Medicaid services. They may enroll in the program but their status as an inmate results in their being ineligible for benefits.

The ACA explicitly allows incarcerated individuals pending disposition to be classified as qualified to enroll in and receive services from health plans participating in state health insurance exchanges if they otherwise qualify for such coverage. Furthermore, individuals who satisfy bail requirements and are released into the community pending disposition will be eligible for Medicaid under the ACA if they meet income and other program requirements. This leaves a group of high need, low-income and vulnerable individuals left out of comprehensive health coverage because of their place of residence.

This paper describes the jail population and offers 10 reasons why individuals in jail pending disposition should be eligible for Medicaid coverage. Covering individuals pending disposition through Medicaid:

1. Targets a highly vulnerable group of poor adults with substantial physical, mental health and substance abuse needs
2. Fulfills the spirit of the Affordable Care Act by increasing access to comprehensive coverage
3. Advances equity
4. Provides health insurance for a disproportionately chronically ill population
5. Increases integration and coordination of care by reducing gaps in health care
6. Positions jails as potential enrollment catchment areas for vulnerable populations
7. Reduces health system, Social Security Supplemental Security Income, and criminal justice costs
8. Provides access to health care at very low cost to states
9. Advances public health and social stability
10. Improves quality of care and data monitoring

Introduction

Jails have become holding places for some of the nation's most vulnerable people. The United States has the highest incarceration rate in the world, with the jail population growing at a faster pace than the prison population.[1] Jails continue to swell with new arrests and lower diversion rates, even while crime statistics have stayed relatively flat. In 2012, more than 10 million people will spend time in jail.[2] Most jail inmates are incarcerated for relatively short periods of time;[3] one count put the average length of stay at 17.5 days.[4] Jails are a costly proposition and take their toll on individuals, counties and communities. A 2004 estimate put the cost of jails to local governments at $97 billion.[1]

About two-thirds of the jail population are held *pending disposition*, meaning that they are detained prior to trial and have not been convicted of a crime. For most of these individuals, their confinement is much more a result of an inability to post bail rather than a need to be separated from the community.

As a group, inmates are likely to be poor, male, and often in need of health services. Most (90 percent) are uninsured.[5] With the passage of the Patient Protection and Affordable Care Act (ACA) of 2010, the United States reverses decades of health policy that has left poor adult men out of the most likely and accessible sources of coverage. When its provisions are fully enacted in 2014, ACA will enable four to six million of the 10 million individuals who are jailed over the course of a year to gain access to health insurance through Medicaid.[6] This represents approximately one-third of the newly insured Medicaid population.[7]

By enabling poor adult men to enroll in coverage, the ACA Medicaid expansions target precisely the groups in greatest need of a stable, high-quality and comprehensive source of care. A significant portion of these individuals have substantial medical, mental health and substance abuse issues that can lead to frequent interactions with the criminal justice system. However, current federal rules preclude these individuals from obtaining Medicaid coverage while in custody even if they otherwise qualify for Medicaid. This leaves states, counties or other localities responsible for the cost of care delivered to jail inmates even if their charges are pending disposition.

Enrolling inmates pending disposition into Medicaid has the potential to transform the way that some of our country's most vulnerable residents access and receive health services. Medicaid coverage would offer the opportunity for individuals in jail to receive a comprehensive set of physical, mental health, substance abuse, care coordination and other supportive services. The benefits of this approach accrue to both states and localities, which currently shoulder the burden of health care costs for these individuals. In turn, jails offer an unprecedented opportunity to bring millions of vulnerable individuals into a system of care with the potential to dramatically reduce overall health care costs for what is currently one of the neediest and costliest groups of individuals to the health care system.

Background

The Supreme Court decision in *NFIB v. Sebelius* affirmed the ACA's broad constitutionality but found that the Secretary of Health and Human Services cannot enforce the Medicaid expansion as a mandate.[8] Consequently, states may choose not to expand Medicaid and retain their current Medicaid program and federal matching dollars.[9] Beginning in 2014, Medicaid expansion states will extend eligibility to adults without dependents up to 133 percent of poverty, with the federal government assuming 100 percent of the matching costs for new enrollees for 3 years, then reducing to a 90 percent match by 2020. States will continue to receive their current federal match for enrollees already eligible for Medicaid prior to the ACA expansion. Not surprisingly, substantial debate has already followed the Supreme Court ruling in terms of interpretations of Medicaid policy for expansion and non-expansion states. The Congressional Budget Office and the Joint Commission on Taxation estimated that 3 million fewer children and adults will gain coverage over the next decade as a result of the Supreme Court decision and its anticipated effects on states' willingness to expand their Medicaid programs.[10] Nevertheless, historical trends with Medicaid and the State Children's Health Insurance Program (CHIP) indicate that full uptake of major state/federal partnerships may take some time. All 50 states and the District of Columbia participate in both Medicaid and CHIP, although only six states initially signed on for Medicaid and only eight participated in CHIP in its first year.[11]

Viewed more optimistically, the decision in *NFIB v. Sebelius* enables all states and the District of Columbia to move forward with a Medicaid expansion and consequently the opportunity for an influx of billions of additional dollars from the federal government. Such a widespread expansion will likely more than double the population of working-age adults receiving Medicaid and enable many previously ineligible poor and low-income childless adults to enroll in the program.[12] This will also result in better health outcomes. Expanding Medicaid provides direct benefits in terms of reduced mortality, fewer cost-related delays in care, and higher self-reported health status, especially for older non-elderly adults (ages 35-64), nonwhites, and residents of poorer counties.[13]

In states that elect to implement the Medicaid expansion, low-income non-disabled adults will have new access to services that could help reduce serious mental health and substance abuse issues as well as recidivism rates. Under current rules, however, when individuals are detained in local jails, they are not eligible to receive benefits. This is due to the "inmate exception" which precludes federal financial participation (FFP) funding for medical care provided to individuals who are inmates in a public institution.[14] In most states, people who enter jail with Medicaid coverage run the risk of disenrollment from the program, despite federal guidance requiring that Medicaid coverage (if not linked to Supplemental Security Income) only be suspended, not terminated, as a result of their incarceration.[15] Yet studies have shown that individuals who have Medicaid coverage upon release have reduced recidivism rates and the time between offenses is longer.[16] Several states including Florida, New York, Oregon, Minnesota and North Carolina suspend rather than terminate benefits, a practice that is likely to result in fewer obstacles to accessing needed health services.[17]

Securing and maintaining insurance coverage before, during and after incarceration is critical to jail populations and their ability to obtain services to address the multitude of physical, mental health and substance use disorder challenges they face. Disruptions in coverage have a direct impact on former inmates' ability to access care when they rejoin their communities. A study of jail inmates with serious mental illness in King County, Washington, and Pinellas County, Florida, who entered jail with Medicaid coverage found that, upon release, having Medicaid resulted in better access to community mental health services and greater use of services, compared to those released to the community without Medicaid coverage.[18-19] Notably, individuals released from jail with Medicaid coverage had on average 16 percent fewer subsequent detentions.[18] In King County, those released with Medicaid were 60 percent more likely to get mental health services than those who no longer had Medicaid; in Pinellas County, inmates released with Medicaid were 30 percent more likely to access services. The study also found that relatively small percentages of severely mentally ill individuals who came into jail with Medicaid had coverage terminated; only about 3 percent of these jail detentions resulted in loss of benefits, primarily because inmates were in jail for such short periods of time.[20] Anecdotal evidence suggests, however, that loss of Medicaid is a common occurrence for individuals in jail longer than 30-day periods.[15]

For most people in jail, maintenance of current Medicaid coverage has been a moot point since the majority of these individuals did not meet eligibility requirements. Fortunately, the landscape in terms of coverage is changing for Medicaid as well as private health insurance, with profound implications for jail populations pending disposition. The ACA explicitly allows incarcerated individuals pending disposition to be classified as qualified to enroll in and receive services from health plans participating in state health insurance exchanges.[16] States have been slow to pay attention to this important feature of health reform, with so many other complex issues to address as they roll out their health insurance exchange provisions and products. As the exchanges evolve, however, we are likely to see a variety of care delivery options for this vulnerable group of jail inmates.

ACA opened the door to a new conceptualization of certain groups of individuals who are being held in jails while not having been convicted of a crime. Beginning in 2014, individuals who are involved with the jail system will have realistic options when it comes to public and private health coverage. About half of the people who are detained in jail each year are released back to their communities within 24-72 hours, generally under their own recognizance, with or without some sort of bail arrangement. If the jail-involved individual has the means to meet the bail requirements, that individual – who is also pending disposition – leaves the jail environment. Jail-involved individuals who are pending disposition in a community setting, who are not held within a jail institution, will not be precluded from enrolling in Medicaid and receiving Medicaid services if they otherwise qualify for the program. Alternatively, if an individual remains jailed pending disposition and exceeds the income limits for Medicaid under the ACA expansions, that individual may be deemed eligible to enroll in a private health insurance plan through the state health insurance exchange.

This will leave just one group of jail-involved individuals who are pending disposition out of any coverage option: the jail-involved population pending disposition who, but for incarceration, would qualify for Medicaid under the ACA expansions. This exclusion is short-

sighted and inconsistent with other health reform provisions, which seek to aggressively reach out to the most vulnerable individuals and bring them into Medicaid and other health insurance plans.

Ten Reasons Why Individuals in Jail Pending Disposition should be Covered by Medicaid

Medicaid coverage of inmates pending disposition is a necessary and appropriate next step from a variety of different perspectives. Below we explore ten reasons for including inmates pending disposition in the Medicaid program.

1. Covering Individuals in Jail Pending Disposition Targets a Highly Vulnerable Group of Poor Adults with Substantial Physical, Mental Health and Substance Abuse Needs

It is difficult to identify a more appropriate group for coverage under the ACA than individuals in jail pending disposition. This is because of the health needs of the population, the extent to which they would benefit from coverage and care coordination, and the lack of access to health services that have characterized their lives. Jail populations have long been recognized as one of the costliest and most vulnerable groups of individuals. A substantial segment of the population who enter county jails is poor and suffers from serious medical conditions, mental illness and/or substance abuse dependency.[15,21] Jail-involved populations suffer from higher rates of chronic medical conditions including hypertension, diabetes, asthma, hepatitis B and C, tuberculosis, HIV/AIDS and sexually transmitted illnesses compared to the general population,[22] and these conditions have been found to be in more advanced stages in age-adjusted comparisons.[23] Individuals with a history of incarceration are 40 percent more likely to suffer from any general health condition and 30 percent more likely to suffer from multiple medical conditions than those without such history.[24] They are four to six times more likely to have HIV/AIDS and 17 times more likely to have tuberculosis compared to the general population.[25] Traditionally, medical care in jails has targeted communicable diseases. However, the increasing rates of chronic conditions are leading to a shift in health care needs among the population.[24] Prior to arrest, 80 percent of individuals with chronic conditions have not received treatment for their illnesses in the community, and all too frequently, treatment of these conditions does not continue upon release because 90 percent of inmates are uninsured and lack access to care.[26]

Among the most striking characteristics of the jail-involved population is the prevalence of mental health disorders, including severe mental health conditions. Approximately two-thirds of individuals booked in local jails each year meet criteria for mental illness at the time of booking or during the twelve months prior to their arrest.[27] Rates of serious mental illness are extremely high compared to rates in the general public; about 15 percent of men and nearly one-third of women in jail have a serious mental illness.[28] Mental health disorders such as depression, schizophrenia and bipolar disorder are prevalent among the jail population.[29] In addition, 22 percent of jail inmates suffer from some form of learning disorder, including dyslexia and attention deficit disorder.[30] The Department of Justice estimated in 2006 that 15 percent of jail inmates have two or more cognitive impairments. [30] In fact, jails and prisons are the largest institutions to house individuals with mental illness in the United States. [23] These

conditions often go untreated, increasing the likelihood of incarceration, rates of recidivism and costing an estimated $79 billion in lost productivity.[31] Although many individuals who suffer from serious mental illness (SMI) depend on entitlement programs for access to care, the majority of inmates with these conditions do not have Medicaid coverage at booking.[32]

In addition to high rates of mental illness, a large portion of the population struggles with chemical dependence. Addiction is a major indicator of criminal justice involvement, as more than 50 percent of the jail population meets criteria for drug dependence or abuse under the Diagnostic and Statistical Manual of Mental Disorders.[33] Treatment for these conditions remains inconsistent, however, and as few as 15 percent of eligible inmates receive treatment for their condition while in jail. For example, despite the availability of methadone and Suboxone for the treatment of opioid addiction, many facilities forgo or discontinue treatment of inmates upon entry, leaving them in withdrawal and substantially increasing their chances of relapsing on heroin and their risk of overdose upon release.[34] Additionally, recently released inmates experience high rates of drug related homicide and suicide.[35] Comorbidity of substance use and mental illness is common among the jail-involved population, as individuals who do not have access to traditional treatment endeavor to self-medicate their conditions. A number of counties have developed reentry programs that work to increase Medicaid coverage of individuals with serious mental illness and/or substance use issues at the time of release and help this population connect to providers within their community.[32]

Given their poorer health and greater likelihood of having mental health and substance use problems, many jail-involved individuals face difficulties finding and maintaining employment. Homelessness is a risk factor that increases the likelihood of arrest. More than 15 percent of the jail population are homeless at some point during the year prior to their arrest, a rate 7 to 11 times higher than the general population.[36] When an inmate reenters the community, basic needs including access to housing, a source of income and adequate food supplies often take precedent over continuation of medical care.[37] Post-release, many inmates also have difficulty reestablishing connections with family and social networks. As most jails do not offer discharge planning, inmates often lack the tools necessary to locate these critical resources. Since the passage of the Deficit Reduction Act (DRA) in 2005, Medicaid and Social Security program application requirements have become much stricter, especially in terms of identity and citizenship documentation. Many individuals cycling through the justice system do not have access to their social security cards, birth certificates, pay stubs and other forms of personal identification and proof of income. Without proper identification, a permanent address, and adequate support services, gaining timely and adequate health and social services can become an insurmountable challenge.[38]

2. Covering Individuals in Jail Pending Disposition Fulfills the Spirit of the Affordable Care Act by Increasing Access to Comprehensive Coverage

The primary goal of the 2010 Patient Protection and Affordable Care Act is to improve Americans' access to health care in the United States by moving toward universal coverage. Denying Medicaid coverage to inmates pending disposition fundamentally contravenes the spirit of the law. Enrolling the jail-involved population in Medicaid would fulfill the law's intent to

increase health coverage for low-income and at-risk population and facilitate their ability to obtain comprehensive care. Moreover, such a policy change would enable states to target the very populations who need coverage the most.

The ACA requires that Americans obtain "minimal essential coverage" through either an employer-sponsored or individual health plan, a government program such as Medicaid, Medicare Part A, the Children's Health Insurance Program (CHIP), veterans' program, or other coverage approved by the federal government.[39] In addition, the ACA explicitly targets enrollment of low-income and vulnerable Americans into coverage by encouraging states to expand Medicaid eligibility to adults without dependents up to 133 percent of poverty. As a powerful incentive toward this goal, the federal government assumes nearly all of the costs for the newly insured, sending states a powerful message that broad coverage is the overarching goal of the legislation. The ACA requires states to identify and enroll vulnerable and underserved populations who qualify for Medicaid or the Children's Health Insurance Program (CHIP).[40] Clearly, the legislation is designed to eliminate barriers to obtaining health insurance for those individuals who have historically been unable to reap the benefits of health services.

Due to the inmate exception as interpreted under current Medicaid rules, low-income childless adults who are held in jail pending disposition are not considered eligible for Medicaid. Maintaining this policy would result in a lost opportunity to enroll a significant number of poor adults in Medicaid, which is the group that the law purports to help the most. Changing Medicaid's administrative rules to allow those who are held in jail pending disposition to enroll in Medicaid is consistent with the law's emphasis on coverage for low-income uninsured adults and would encourage states to target these populations as part of their expansion.

3. Covering Individuals in Jail Pending Disposition Advances Equity

Permitting inmates pending disposition to enroll in Medicaid will restore parity in the ACA's provisions and aid in establishing equity for historically disenfranchised populations. The ACA explicitly allows incarcerated individuals pending disposition to qualify for, enroll in and receive services from health plans participating in state health insurance exchanges.[41] Likewise, jail-involved individuals who obtain bail and are released awaiting adjudication will be eligible to enroll in Medicaid. However, currently there are no plans to allow inmates pending disposition to enroll in Medicaid when the optional expansions take effect in 2014. Harmonizing these policies would produce a more rational approach to coverage and advance equity for a group of individuals who are at high risk for experiencing health disparities and disparate provision of health care services.

Maintaining the current provision in the ACA will not only undermine the spirit of the law, but it will codify inequity in unprecedented ways. Left unchecked, these inconsistencies in policy will have the net result of leaving the most vulnerable of all jail-involved individuals, those who have not been convicted of a crime but are too poor to obtain bail, without access to health care coverage. Moreover, those left behind bars without coverage are disproportionately poor and members of racial and ethnic minority groups. At any given time, 12 percent of black males ages 25 to 29 are in jail.[42] In 2011, 38 percent of the incarcerated population was black,

despite only making up 13 percent of the general population.[43] The incarceration rate for Hispanic men is also extremely high; at 1,252 per 100,000 U.S. Latino residents, it is nearly three times the rate for white men.[44]

Rather than mandating that this high-risk and high-cost population be left out of the ACA's coverage options, every effort should be made to ensure that they obtain Medicaid coverage while in custody and retain those benefits after they are released. As a nation, the US is locking up young black men at disturbing rates. To single out this group to deny Medicaid benefits and the continuity of care that can accompany coverage is alarming from an equity perspective. It is wholly inconsistent with national policy, articulated by the US Department of Health and Human Services' Office of Minority Health in its National Partnership for Action to End Health Disparities, an initiative to combat health disparities and achieve health equity.[45] Allowing inmates pending disposition to enroll in Medicaid is a crucial step in reversing some of the most insidious disparities that currently plague the US health care system.

4) Covering Individuals in Jail Pending Disposition Provides Health Insurance for a Disproportionately Chronically Ill Population

The ACA explicitly includes provisions for enrolling and serving chronically ill populations into health care coverage. For example, health plans can no longer exclude people from enrolling because of a pre-existing condition, and section 2703 of the law provides two years of enhanced federal funding for "health homes" that serve Medicaid beneficiaries with chronic conditions.[46] These and other similar provisions regarding those with chronic conditions are necessary to ensure severely ill people can access critical health care services.

The majority of individuals involved in the justice system suffer from some sort of chronic health condition. About 8 in 10 men and 9 in 10 women in jail have at least one chronic health condition that requires some sort of management. These conditions include asthma, diabetes, hypertension, hepatitis and HIV/AIDS. At the time of admission, most have not received treatment for their conditions and they may or may not receive treatment for these conditions while in jail. Admission to jail provides an opportunity for one of the most vulnerable and sick populations in the United States to receive care for their conditions, many for the first time. Medicaid coverage in jail for individuals pending disposition would also increase the likelihood that provision of services is continuous when inmates reenter the community. Through Medicaid, jail health and community providers would be able to coordinate care and manage the chronic conditions of this population, often for the first time.

Despite being largely uninsured as a population, former inmates rely heavily on health services, especially emergency departments and hospitalization. More than 70 percent utilize some sort of health service in the 10 months following release, including 30 percent who visited the emergency room and 20 percent who were hospitalized.[47] Unmanaged and untreated conditions are more expensive. Enrollment in Medicaid, especially managed care, would allow the cost of care for this population to be controlled as their conditions are managed. Given the extent of poverty and serious chronic illness, mental health and substance dependency among the jail-involved population.[17,21] Medicaid coverage is essential to ensuring they have access to

crucial health care services. This access will not only reduce overall health system costs, but studies suggest it is also likely to have a positive impact on inmates' health outcomes and mortality. This is especially true for older non-elderly adults (ages 35-64), nonwhites, and residents of poorer counties.[13]

Rather than excluding inmates pending disposition from Medicaid, the federal government and states should actively target this population for inclusion in the program before, during and after incarceration. Such action would help eliminate disruptions in coverage for chronically ill individuals, which can be so damaging to continuity in care, and ease access to health care services.

5) Covering Individuals in Jail Pending Disposition Increases Integration and Coordination of Care by Reducing Gaps in Health Care

One of the ACA's major policy goals is to facilitate and encourage greater integration among health care providers and to coordinate care for low-income Americans. Denying Medicaid coverage to low-income jail-involved individuals who are awaiting disposition of their charges encourages the very opposite of the law's intent and in fact creates barriers to care coordination. Allowing this population to enroll in Medicaid would provide an unprecedented opportunity to assist jail-involved individuals in obtaining access to comprehensive services, and may contribute to decreased recidivism rates.[17]

As discussed earlier, a majority of the jail-involved population churns through the justice system with relatively short stays. A large percentage of this group is low-income, male, minority and uninsured. Additionally, they lack access to a stable source of care for their serious health needs. Currently, this population will be eligible to receive Medicaid under the new expansion, but only when they are not incarcerated. Given this population's high rate of churn in and out of jail, individuals who are enrolled in Medicaid will be at risk of losing their coverage when they are incarcerated if current policies favoring termination of coverage persist. This will make it difficult to obtain necessary physical, mental health and substance abuse services in the community after release. While these people may re-join programs post release, long waits for re-enrollment can create dangerous delays and discontinuities in care. Current re-enrollment processes frequently take up to three months, during which time former inmates may not be able to access the critical health care they need.[48]

Several studies have underscored the importance of having health coverage upon release. In Florida and Washington State, seriously mentally ill inmates who had Medicaid when they were released had better access to mental health care and higher utilization than those without coverage.[18,19] Additionally, those who were released from jail had fewer subsequent detentions.[18]

Permitting jail-involved individuals who are otherwise eligible for Medicaid to enroll in the program will help close a different type of "donut hole" – i.e., a coverage gap that in this case occurs while people pending disposition are incarcerated – and will make coverage consistent across different settings.

6) Covering Individuals in Jail Pending Disposition Positions Jails as Potential Enrollment Catchment Areas for Vulnerable Populations

Jails represent an excellent opportunity to identify individuals who qualify for Medicaid under the expansion and assist with their enrollment into the program. Millions of new Medicaid eligibles are among those who interact with the justice system at some point over the course of a year.[17,49] Since this population is likely to cycle in and out of jail with relatively short stays, jails may be the best catchment area to access the neediest and most costly health care users. Most will come to jail without any coverage, often lacking any stable relationships with the health care system.[26] Jails can serve a critical role in advancing health care for vulnerable populations by providing enrollment opportunities for individuals who will be eligible for public and private health insurance options under the ACA. In fact, county jail staff may represent the best chance to enroll this difficult to reach population because of their proximity to inmates pending disposition and their deep knowledge of the population.

Counties could be encouraged to facilitate Medicaid enrollment of inmates pending disposition by establishing out-stationed enrollment offices in jail facilities. Medicaid enrollment is typically reserved for local Medicaid offices and contracted community-based organizations and other groups that conduct outreach and enrollment for the state. However, states could designate jail facilities as out-stationed enrollment offices in the same way they designate hospitals, community health centers and other locations. In this way, Medicaid staff, or jail staff who are deputized or otherwise designated as representing the Medicaid program, could work with inmates to process program applications.

In addition, a new presumptive eligibility category could be created for inmates pending disposition, similar to the state option that already exists for pregnant women and children.[50] Like hospitals, community health centers, health departments, and schools, county and local jails could be included in the list of "qualified entities" that are permitted to make presumptive eligibility determinations. This would address inmates' potential lack of documentation required to complete a Medicaid application.[38] For example, newly arrested inmates pending disposition are unlikely to have certain paperwork (recent paystubs, bank statements, government issued identification) that are commonly required to file a new Medicaid enrollment. Creating a new presumptive eligibility category would allow Medicaid workers or jail staff to enroll inmates that appear to be eligible for Medicaid into the program, granting them immediate access to coverage for their health care needs, and would provide counties with a reimbursement stream for any covered services they deliver.

7) Covering Individuals in Jail Pending Disposition Reduces Health System, Social Security Supplemental Security Income, and Criminal Justice Costs

Jail populations are a costly group for the health care system. Since the vast majority of these individuals are uninsured,[5] many have not obtained necessary care for the serious chronic health, substance abuse and mental health conditions they face. In addition, they are more likely to obtain episodic care that is not managed or coordinated. Subsequently these unmet health care

needs grow more severe and costly when emergency and longer-term interventions are required. The Medicaid expansion scheduled to take effect in 2014 will provide unprecedented opportunities for the jail-involved population to access much needed care and is likely to yield significant cost savings in the short and long term.

The enhanced federal match available under the ACA's Medicaid expansion creates significant financial incentives for states to provide alcohol and drug treatment to individuals who are newly enrolled in Medicaid. Such coverage, combined with access to health services, should slow the progression of disease conditions that create disability.[21] Clients who receive these treatments have better health outcomes, require less medical care and therefore cost less than those who do not.

Several research studies have demonstrated the cost savings of providing Medicaid to low or very-low income childless adults. A study by Mancuso and Felver provides evidence of this phenomenon. Mancuso studied health care and criminal justice costs in Washington State since the implementation of expanded use of substance abuse treatment and related services in low-income adults with substance use disorders. The study's cost benefit analysis found that clients who forgo alcohol and drug treatment are more likely to experience accelerated progression of their health conditions and medical expenditures, and ultimately deteriorate until they qualify for SSI-related Medicaid coverage. Once this stage is reached, the client requires significantly higher contributions from General Fund-State Medicaid expenditures than do those who receive necessary care and avert a disabling condition. Mancuso compared estimated costs for two different client scenarios using Washington State Medicaid data and conservative forecasts of annual chronic disease treatments and General Fund costs over the period 2014-2020. One client scenario involved an individual who received alcohol and drug treatment and the other involved an individual without such treatment. The result was more than a 10-fold difference in the cost to the General Fund for the client who did not receive alcohol and/or drug treatment; the treated client's costs were $1,859 to the county General Fund, compared with $21,834 for a client who did not receive such care.[21]

In a similar study, Mancuso found that providing drug and alcohol treatment has other cost-cutting benefits as well.[12] For example, arrests declined significantly after clients obtained alcohol and/or drug treatment services. Specifically, among low-income adults who are currently ineligible for Medicaid – but who will likely qualify after the 2014 expansions are implemented – arrests declined by 17 percent relative to a comparison group that did not receive similar services. These declines accounted for $2.58 in overall criminal justice system and crime victim savings for every dollar of cost incurred by delivering alcohol and treatment to these non-Medicaid, low-income adults. As attractive as these savings appear, they represent only one portion of the savings that can be derived by providing evidence-based behavioral health services. For example, after estimating the monetary value of such items as improved employment, reduced health care costs and reduced crime-related costs, Mancuso estimated a $3.77 offset in overall benefits per dollar of treatment cost. The largest portion of these savings came from reduced health care costs. In Washington State alone, the potential savings from evidence-based treatment is estimated to be $416 million.

An earlier study in Washington State found that chemical dependence treatment was associated with average medical cost savings of $2,500 annually per person treated, regardless of whether or not the client obtained sobriety.[51] Other researchers also found that among those who received chemical dependency treatment, emergency room use was 35 percent lower than those who did not obtain care.[52]

8) Covering Individuals in Jail Pending Disposition through Medicaid Provides Access to Health Care at Very Low Cost to States

The Medicaid expansions represent a potential windfall for states seeking to cover larger numbers of their most vulnerable citizens. Under the optional Medicaid expansion set to take effect in 2014, the federal government will cover 100 percent of the cost for three years, and 90 percent thereafter. States will be responsible for only a fraction of the cost of providing health services for a potentially very expensive group of individuals in terms of their health care needs.

Enrolling inmates pending disposition into Medicaid offers a cost-effective method of caring for low-income, vulnerable Americans. After controlling for health status, it costs more than 20 percent less to cover low-income people in Medicaid than it does to cover them in private health insurance.[53,54] Lower overall costs in Medicaid per capita can be attributed to lower reimbursement rates and lower administrative costs than that of private insurers, as well as the out-of-pocket cost limitations set for public program beneficiaries that keep cost sharing lower than the private market. In fact, a study by the Center on Budget and Policy Priorities found that covering the uninsured population with Medicaid would save more than $800 per person compared to coverage through the private market.[54]

If inmates pending disposition are permitted to access health coverage while incarcerated, they will be more likely to maintain that coverage when they are returned to the community. Providing this coverage and assisting low-income individuals with obtaining coordinated health care services will ultimately result in increased benefits to vulnerable individuals and greater cost savings to states and the larger health care system. For example, North Carolina has developed the Inmate Medicaid Enrollment program that screens inmates for Medicaid eligibility and enrolls them wherever possible.[55] This allows the state to trigger Medicaid coverage in the event that an inmate is transferred to an external facility for health services for more than 24 hours. One estimate of cost savings through this program suggested the state could save over $178,000 per enrolled inmate and $2 billion in 2014.[56]

9) Covering Individuals in Jail Pending Disposition Advances Public Health and Social Stability

Maintaining strong and consistent relationships between the health care system and inmates before, during and after incarceration can have important benefits for communities and public health. Up to 19 percent of all HIV, 30 percent of hepatitis C and 15 percent of hepatitis B in the United States is accounted for in the jail and prison populations.[57] High rates of incarceration have been correlated with high rates of gonorrhea and Chlamydia within the

community.[58] Without proper health coverage, former inmates cannot afford the cost of the health care necessary to treat their infections, creating opportunities for these infections to spread to others in the community. Some research suggests that "separational concurrency," where an individual will seek new partnerships if their existing partner is frequently incarcerated, contributes to the spread of STIs from the high-risk jail population to the community.[59] High incarceration rates have also been correlated with increasing rates of teen pregnancy,[42] which may indicate insufficient social supports in the community to promote healthy sexual behavior.

More than 30 percent of individuals that interact with the justice system each year suffer from a mental health condition.[60] At the time of arrest, it is unlikely they have been receiving treatment for their mental illness. People with mental illness are more likely to return to jail; 65 percent of individuals in jail who suffer from mental illness have been sentenced previously.[1] The stress of being in jail can further debilitate individuals with mental illness and increase their likelihood of hurting themselves or others. Only 60 percent of individuals with mental illness receive treatment for their condition while in jail,[61] and this treatment may stop completely upon reentry into the community because individuals do not have access to sufficient services. Upon release, individuals may receive enough medication for two weeks or less.[1] If an inmate reentering the community cannot immediately access the services they need, their ability to manage a mental health problem diminishes rapidly and their relapse puts them and the people around them at risk. Medicaid coverage during incarceration could increase the opportunity for receiving appropriate behavioral health services in jail and accessing behavioral services in the community after incarceration.

Addiction also plays a large part in the lives of the jail-involved population. Fifty-three percent of individuals who enter jail struggle with some form of addiction.[1] If inmates do not receive appropriate services and treatment, they may experience symptoms of withdrawal or face increased risk of overdose upon release. Lack of access to rehabilitative services upon release also increases the likelihood that former inmates will continue substance abuse and other dangerous (and illegal) activities upon return to the community. Evidence indicates that investment in drug treatment may result in overall cost savings. A study of such investments in the state of Washington estimated that one dollar spent on drug treatment produced $18.52 in positive benefits for the community.[62] Enrollment in Medicaid would enable former inmates to access stable and consistent mental health and substance abuse services, infection control interventions, chronic disease management, and other services, with derivative benefits for other residents in their communities.

10) Covering Individuals in Jail Pending Disposition Improves Quality of Care and Data Monitoring

Improving quality within jail environments is an important policy and public health objective. Jails are not, by design or mission, health care organizations; nevertheless, they are required to provide health services while inmates are in their custody. Some jails are working to provide adequate services to their inmate populations but many others provide substandard, inadequate and poor quality health care, regardless of the acute, chronic, psychosocial or behavioral health needs of those under their care.

A number of legal challenges have chronicled the abysmal conditions of jails and the effects of neglect, slow response, inadequately trained health professionals, and overall poor quality on jail-involved individuals. A recent example illustrates the neglect that routinely occurs, at great personal and system expense to the individual and the county. A 2011 case in Lee County, Florida, resulted in a $1.2 million award for the plaintiff, whose untreated staph infection, despite repeated pleas from the plaintiff to address the mounting symptoms and complications, caused permanent disability. This case also stands as just one example of a preventable disabling condition that will entail a lifetime of SSI payments and associated costs in lost work years. The decision was upheld on appeal from the US District Court for the Middle District of Florida in September 2012.[63] Another example involves the largest county jail system in the country, LA County, which for years has been the subject of investigations regarding crowding, safety and other health-related conditions for inmates. A 2008 report on mental health issues in LA County jails addressed health care specifically for inmates pending disposition, who despite a dire need for mental health services, did not receive necessary treatments, leaving them substantially more vulnerable to harm from others or themselves.[64]

Implementing policy change to allow inmates pending disposition to receive Medicaid services would transform the quality of health care provided to extremely vulnerable individuals. Health care for inmates is highly variable, with no consistent standards of care across cities or counties that currently are responsible for jail health. Bringing inmates pending disposition into Medicaid would result in a uniform set of quality standards that are consistent with other Medicaid beneficiaries in state Medicaid programs. It would also raise the visibility of health care delivery for this forgotten population with substantial, costly and treatable health conditions.

Providers who participate in the Medicaid program are required to adhere to a set of rules and standards aimed at increasing the quality of health care for beneficiaries. They must undergo credentialing processes that evaluate qualifications and practice history, including completed education, training, residency, licensure and certification in physicians' specialty areas.[65] In addition, the Medicaid program requires reporting of the Health Care Effectiveness Data and Information Set (HEDIS). HEDIS data allows states to make "apples to apples" comparisons of plan quality and set high performance standards in managed care contracts. These measures evaluate effectiveness of care, access and availability of care, experience of care and utilization.[66]

In large part because of Medicaid credentialing and reporting requirements, quality of health care should improve as jail-involved individuals enroll in Medicaid. As health programs for Medicaid covered populations meet requirements for measurable quality and improvement goals, care in jails can, for the first time, be compared with other Medicaid populations within jail environments and also in the community. Additionally, raising the visibility and comparability of jail populations will facilitate research and analysis of quality of care for these vulnerable individuals. Due to the data reporting requirements imposed on Medicaid providers, researchers and policy makers will have access to jails' quality measures. This should result in greater accountability on the part of health professionals who provide health services to inmates.

Conclusion

The ACA's Medicaid expansion provision offers an unprecedented opportunity to extend health insurance coverage to very low-income adults, many of whom have significant medical and behavioral health issues that make them particularly susceptible to criminal justice involvement. Current federal law precludes these individuals from obtaining Medicaid coverage while in custody pending disposition, even if they otherwise qualify for Medicaid. The result is a group of individuals who have not been convicted of a crime, yet are excluded from a comprehensive health program based on their place of residence.

Jail inmates pending disposition are an extremely costly, high-need, and vulnerable group who can benefit enormously from Medicaid coverage. As an added benefit, coverage of jail inmates pending disposition should yield significant savings to communities and local governments. States should consider all possible options to expand coverage to this population. Although not without its challenges, extending coverage to this highly vulnerable population would result in significant cost savings for states and counties along with commensurate quality-of-life benefits to millions of individuals who have been left out of reliable access to health care and stronger social structures for the communities in which they live.

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