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Medicaid Can Improve the Lives of Justice-Involved Individuals and Save Nebraska Money

Introduction

Prior to the Affordable Care Act (ACA), many individuals leaving prison or jail were not eligible for Medicaid because coverage was not available to most childless low-income adults. The ACA changed this dynamic, and for states that expanded Medicaid coverage (including Nebraska since October 2020), the vast majority of those incarcerated are eligible for Medicaid upon release, including an estimated 80% in New York and 90% in Colorado.[1] However, the federal "inmate exclusion" bans Medicaid payment for services provided to individuals of public institutions unless the individual is treated in a hospital or other medical institution outside the prison or jail for 24 hours or more.[2] Since correctional facilities are obligated by law to provide health care, this Medicaid exclusion means that state-funded correctional systems absorb the lion's share of health care costs for incarcerated people.

In Nebraska, the health care situation for the justice-involved has recently become quite dire. In fiscal year 2015, Nebraska's state prisons ranked sixth in the nation in health care spending by paying $8,583 per person.[3] However, in March 2019, Nebraska state correctional facilities were at 160% capacity, and the state's Diagnostic and Evaluation Center was at a staggering 336% capacity.[4,5] By 2020, the state had the second most overcrowded state correctional system.[6] This overcrowding has resulted in poor health care outcomes that disproportionately impact individuals of color.

However, Nebraska could improve the lives of thousands of individuals and save millions of dollars by more effectively leveraging the Medicaid program to share data, streamline enrollment, and support transitions of care.

In this paper, we will:

1. Outline the dire nature of Nebraska's health care services in correctional facilities.
2. Recommend solutions that take advantage of the Medicaid program.
3. Provide examples of other states leveraging Medicaid with the approaches listed above.

Health care in corrections in Nebraska

The Nebraska Department of Correctional Services (NDCS) oversees and provides health care services to over 5,100 individuals in state prisons and 3,300 people in local jails.[7] Nebraskans of color are incarcerated at higher rates than their white counterparts. The state has the eighth-highest Black-to-white and Latino-to-white incarceration differentials at 8.9 and 2.0, respectively.[8] As justice-involved individuals have more complex care needs than the general public, the disparate racial and ethnic incarceration rates in turn create downstream health disparities.

Key drivers of health care costs, disparities, and mortality in jails and prisons nationally include chronic conditions and behavioral health issues. In addition to experiencing high rates of substance use disorders and severe mental health needs, individuals in prison and jail are three to five times more likely to meet the threshold for serious psychological distress than adults in the nonincarcerated U.S. population.[9] In Nebraska, 56% of incarcerated people have a mental illness, including 16% with a serious mental illness.[10] These health outcomes are made worse by Nebraska's severe shortage of mental and behavioral health care providers, which included 36 behavioral health staffing vacancies in the state's correctional system as of March 2020.[11] More specifically, these behavioral health care provider vacancies doubled from June 2019 to June 2020 and remained through the end of the fiscal year.[12] Additionally, the Nebraska Advisory Committee to the U.S. Commission on Civil Rights released a report titled "Civil Rights, Prisons, and Mental Health," which asserts the state in general has limited or no programming that is "culturally specific, trauma informed, and serves the limited English proficient population."[13] This is the behavioral health care landscape a formerly incarcerated person may be released into after surviving the incarceration setting and its potentially limited behavioral health workforce and traumatic environment.

Additionally, at least 1 in 4 individuals who go to jail will be arrested again within the same year.[14] Individuals who experience recidivism are often dealing with poverty, mental illness and substance use disorders, problems that only worsen with incarceration. These serious health issues also lead to increased emergency department utilization, inducing a higher cost burden

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for both health systems and the state. Community-based interventions that support transitions of care have been shown to significantly reduce health care utilization and recidivism, and lead to cost savings.[15] For individuals with serious behavioral health issues, ensuring a seamless transition back into their communities is essential for their health as well as preventing recidivism.

The challenges facing Nebraska's incarcerated population were significant even before the pandemic, but COVID-19 has taken a devastating toll and disproportionately impacted this population. Since the beginning of the pandemic in Nebraska, the COVID-19 case rate has been 210.9 people per every 1,000 incarcerated individuals, and 14 incarcerated people have died from COVID-19.[16] Although the coronavirus can take an unpredictable course, it is expected that many of those affected by COVID-19 will require continued, longitudinal health care, including after release from incarceration. The pandemic's scale and wide-ranging impacts on every industry yielded greater understanding of our system's gaps, and now the state has a unique opportunity to adopt and sustain policy solutions through Medicaid that support the transition out of incarceration for individuals — an approach that can improve Nebraska's overall health, safety, and state budget.

Policy solutions

Nebraska's decision to expand Medicaid addresses many of the health care access concerns in the correctional system, but there are more opportunities to lessen correctional administrative burdens, reduce state expenditures, and improve health outcomes. More specifically, Nebraska and its counties can leverage Medicaid funds to achieve these goals by: improving data-sharing across state agencies, streamlining enrollment into Medicaid, and easing transitions of care upon release from incarceration.

1. **Data-sharing:** Implement rapid data-sharing to facilitate seamless care transitions. Currently, NDCS notifies the Nebraska Department of Health and Human Services (DHHS) to renew suspended Medicaid benefits upon an incarcerated individual's release. Rapid data-sharing between NDCS and DHHS on jail or prison discharges and Medicaid enrollment eligibility will help prevent justice-involved individuals from experiencing gaps in coverage upon their release. Seamless transitions should consist of two-way, real-time communications that involve all necessary stakeholders related to an individuals' clinical, coverage, and justice concerns.[17]

State spotlight: Arizona

Arizona is a model state for rapid, two-way data-sharing.[18] For example, the Pima County Sheriff's Department sends data to Medicaid multiple times a day on justice-involved individuals' different statuses within the county's jail system. The Arizona Health Care Cost Containment System (AHCCCS) also sends a daily file notifying managed care organizations and regional behavioral health authorities of justice-involved individuals placed on Medicaid suspension. Upon release, the AHCCCS uses secure file transfers to automatically lift those Medicaid suspensions as people enter their communities.

2. **Streamlined enrollment:** Adopt best practices for streamlined Medicaid enrollment.

   - On-site enrollment assistors. Currently, social work staff in Nebraska assist incarcerated individuals with Medicaid applications. However, this in-person expert assistance is only available to those who the state has identified as having "priority needs." Other incarcerated people only receive educational information, which may not be culturally appropriate or centered on their specific needs. Additionally, applications are not adjudicated until release. Under this proposed solution, Medicaid enrollment counselors located in jails and prisons help all eligible justice-involved individuals sign up for Medicaid prior to reentry into their community.
   - Data shows justice-involved individuals experience higher hospitalization and mortality rates following release from incarceration than individuals who are not involved with the justice system.[19] On-site enrollment assistors' efforts can help lessen these stark disparities. To prevent coverage gaps and barriers, states like Nebraska can fund on-site enrollment assistors by drawing down federal funding at an increased Federal Medical Assistance Percentage (FMAP) of 75%. This increased FMAP funding requires approval from the federal Centers for Medicare & Medicaid Services through submission of an advanced planning document.[20]
   - Design, development, installation, or enhancement of eligibility systems. In addition to the 75% FMAP in federal funding for on-site enrollment assistors, the state could draw down federal Medicaid funds for upgrading Medicaid eligibility systems. Specifically, a 90% FMAP is available for the design, development, installation, or enhancement of eligibility determination systems as well as a 75% FMAP for maintenance and operations of those systems.[21]

Failure to prepare an individual for parole may cost the state $35,000 to $40,000 per person per year.

3. **Transitions of care:** Help individuals — before release — assess needs, establish relationships with care providers, transition medical records, set up care, and build linkages to employment, housing, or enrollment into other public programs to help keep people healthy, safe, and productive after release. While Nebraska does provide individuals being paroled with a reentry workbook with prompts on medication access and health insurance, the 2016 annual report from the Office of the Inspector General of the Nebraska Correctional System found that failure to prepare an individual for parole may cost the state $35,000 to $40,000 per person per year if there are delays in the final programming or treatment necessary for parole to be granted.[22]

   - **Thirty-day prerelease care for justice-involved individuals.** Access to medical care provided through Medicaid in the month prior to release from jail or prison establishes continuity of care for justice-involved individuals once they are released. A few federal policies provide Nebraska with the needed authorities to offer justice-involved individuals comprehensive health care services. The SUPPORT for Patients and Communities Act, Public Law No: 115-271, was signed into law in October 2018 and stipulates that the federal Centers for Medicare & Medicaid Services must issue guidance on improving health care transitions for justice-involved individuals, including the provision of Medicaid services 30 days prior to release.[23] States can submit Section 1115 waivers for approval of these services, as Utah did in June 2020. Additionally, the Medicaid Reentry Act of 2021, H.R.955 and S.285, would allow Medicaid to provide prerelease and post-release services to justice-involved individuals. After passing the U.S. House of Representatives in May 2020, this legislation has been reintroduced and may be included in upcoming legislative packages.[24] Finally, the American Rescue Plan included $350 billion in flexible funding for state, local, territorial and tribal governments to address COVID-19, and those funds could be invested in reentry services. The Build Back Better Act, as currently written, allows for Medicaid medical assistance during the 30-day prerelease period[25,26]

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State spotlight: Illinois

Before Medicaid expansion, nine out of 10 people who entered jail lacked health insurance, even though justice-involved populations have high rates of substance use disorders, mental health conditions, and chronic medical issues.[27] Illinois is a model state in expanding Medicaid to justice-involved individuals through policy implementation and the coordinated efforts of the nonprofit organization Treatment Alternatives for Safe Communities (TASC). In 2013, the Illinois General Assembly passed House Bill 1046, allowing incarcerated individuals to apply for Medicaid over 30 days before their release from prison or jail to ensure their coverage would be effective immediately upon their release.[28] In just three years after Cook County's jail-based Medicaid application project began in 2013, 15,000 individuals had gained Medicaid coverage.[29] This process was made possible through coordinated collaboration among the Cook County Health and Hospitals System, the Cook County Sheriff's Office, and TASC.

- **Managed care in-reach:** States can use their managed care contracts, like Nebraska's Heritage Health, to require "in-reach" or prerelease planning. This work involves a patient navigator, often a social worker or nurse, meeting with an individual prior to release to assess that person's specific needs, including a review of the individual's physical and behavioral health status, medication usage, and planned housing and employment status. This information is used to develop a care plan for use upon the individual's release. An important product from this process is ensuring that the individual is enrolled in Medicaid, has an adequate supply of medication (often 30 days), is linked up with a provider, and has a place to live upon release.[30]

State spotlight: Ohio

Ohio's Medicaid Pre-Release Enrollment Program (MPRE)[31] requires that eligible justice-involved individuals enroll into Medicaid approximately 90 days prior to their release and select a managed care plan. The managed care organization was required to assess an individual's needs and identify a primary care provider. All recently released, enrolled individuals were required to receive care coordination, while higher-risk individuals received a prerelease assessment and a care plan, and post-release provider appointments were established.[32] Between November 2014 and March 2018 approximately 22,000 people participated in MPRE, and those individuals had higher utilization rates post-release for mental health and substance use disorder services than people who gained Medicaid enrollment via other programs.[33, 34] Recently, the Ohio State University released a request for proposal to evaluate the program for 2021, although the latest procurement does not include MPRE as it is an expectation managed care organizations will continue MPRE through a separate contract for individuals in state facilities with two or more identified risk factors.[35]

One aspect of MPRE that yielded significant benefits related to reduced cost and recidivism was the incorporation of peer-to-peer Medicaid guides. These volunteers were often formerly incarcerated individuals who educated their peers about the enrollment assistance. They also provided staff assistance throughout the entirety of the enrollment process and served as their peers' point of contact for any follow-up Medicaid or managed care questions. Evidence shows that the incorporation of peer-to-peer groups within this process led to improved mental and physical health among justice-involved individuals, as they were more likely to trust peers over staff members who had not been incarcerated. Increasing Medicaid's role with reentry has reduced Ohio's corrections budget by $20 million.[36]

› **Community-based in-reach:** States can pursue a peer-based approach that draws on individuals' lived experience to provide assistance. Peers who were previously incarcerated themselves can be an important component of care delivery teams for justice-involved individuals. Since many soon-to-be-released individuals often retain deep-seated mistrust toward institutions, such as state workers, health care providers, and plans, these trusted peers can help ensure better transitions of care. Evidence shows that community-based programs — like the Transitions Clinic Network, which uses a community health worker model embedded in the primary care setting — contribute significantly to reduced recidivism rates and health care costs. In this model, the community health workers

provide a wide range of services before and after release from incarceration. These services can include: making referrals to physical and behavioral health care services, scheduling and accompanying people to appointments, providing advice on securing housing and employment, and generally serving as a trusted advocate.[37] Analyses of this community-based intervention showed it played a role in reducing recidivism rates, increasing individual engagement with health care services, leading to improved health outcomes, and lowering the rates of emergency department utilization. In fact, individuals in this program had 50% fewer hospital emergency department visits, for an estimated savings of $912 per person in the first year of the program.[38]

State spotlight: North Carolina

North Carolina's Formerly Incarcerated Transition (FIT) Program is a collaboration among the University of North Carolina Department of Family Medicine, the North Carolina Department of Public Safety, the North Carolina Community Health Center Association, Federally Qualified Health Centers, county departments of public health, community-based reentry organizations, and local reentry councils.[39] This program is modeled after the evidence-based Transitions Clinic Network model, which has shown significant positive outcomes for both reduced cost and recidivism.

In addition to the FIT Program, North Carolina also has incorporated a Transitional Aftercare Network (TAN) to assist with community reentry.[40] This North Carolina Department of Public Safety initiative partners with community organizations to provide evidence-based practices of mentorship for justice-involved individuals. TAN trains individuals, agencies, faith-based organizations, and community organizations to mentor these individuals.

Conclusion

Nebraska and its counties have a number of policy avenues to improve the lives of thousands of justice-involved individuals and save millions of dollars. The Medicaid program can be better leveraged to improve data-sharing across state agencies, streamline enrollment into Medicaid, and ease transitions of care upon release from incarceration. These savings could in turn be invested in the correctional system's behavioral health workforce and strategies to equitably decrease overcrowding. As the threat of COVID-19 has lessened, although it still remains, now is an opportune time for Nebraska to pass legislation directing Medicaid to be better utilized in the justice system to protect the health and lives of justice-involved Nebraskans.

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