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BREAKING THE CYCLE: THE EXPANDING ROLE OF MEDICAID IN THE CRIMINAL-LEGAL SYSTEM

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AJ's STORY

AJ started using opioids after he found his parents' prescribed medication in the medicine cabinet. His parents were in the midst of a messy divorce, and just one pill got him through the daily grind of adolescence and family turmoil. No one seemed to notice. Before he graduated high school, he was already addicted. As a young adult, he was arrested and incarcerated for possession of a controlled substance. His early 20s were marked by varying levels of community supervision and short-term stays in the jail. Besides his wife, his addiction was one of his few constants.

As his family grew, AJ knew he wanted more for himself and his loved ones. Once his home state expanded Medicaid eligibility, he could finally afford high-quality substance use disorder treatment, particularly peer support programs and medication-assisted treatment which allowed him to work and care for his family without painful withdrawal. He was optimistic about the future and successful in his MAT program. Then, AJ was pulled over for a routine traffic stop—and his probation status and the unregistered gun in his car, landed him in the county jail.

The moment he was booked into jail, AJ lost his Medicaid coverage. He could no longer access the community-based programs that had supported his sobriety to this point, and the jail did not provide equivalent services. AJ was released after only a week but the wheels of government work slowly, so his Medicaid coverage was not fully reinstated for six weeks.

AJ was eager to restart treatment upon his release but without Medicaid coverage he could not afford his previous medication-assisted treatment or access peer support programs. He then relapsed after he lost the medical and emotional scaffolds that had allowed him to live and work with his addiction. AJ is now reenrolled in Medicaid and treatment programs, but his recovery journey has been irrevocably set back due to his laps in coverage.

Why did AJ face these challenges, even as his home state expanded Medicaid? The answer is because policymakers have long overlooked the jail as a place where people receive treatment—leading to the impossible task of finding consistent treatment while the carceral systems played a major role in his life. The treatment of the jails apart from the broader health systems is driven, in part, by a clause in the 1965 Social Security Act that strips people of their federal health insurance upon incarceration, even before they are convicted of a crime. There is, however, good news. Unprecedented changes to this policy could ensure access to high-quality healthcare in the community and behind the walls of the jail, fundamentally changing the relationship between community health systems and carceral systems. First, we must understand how the history of this law has shaped our current health and justice landscape.

BACKGROUND

There is an open secret in our criminal-legal systems: many people cycle in and out of correctional settings due to chronic underinvestment in and development of other safety net systems. Even as great gains have been made to improve access and integration of health and justice systems, staff within jails and prisons and many communities experience daily the consequences of our broken systems. Compared to the general population, individuals enter jails and prisons with higher rates of untreated chronic and infectious diseases, serious mental illness, and substance use disorders.[1] Once within the walls of the jail, correctional healthcare services are disconnected from community services, resulting in episodic healthcare that is siloed from other care settings and providers. It is no surprise, then, that people leaving incarceration are more likely to use hospital services and experience adverse health events than the general population— including a mortality rate 12 times higher than the general population.[2]

Interaction with criminal-legal systems results in additional hard ships: time in jail may lead to the loss of employment or housing, family relationships become strained by the limitations of reentry services, and chronic health needs not adequately met by correctional healthcare services create worsening conditions upon release. The loss of housing or inability to find employment exacerbates a bitter cycle of poverty and incarceration for the individual who is leaving incarceration, for their families, and for their communities. These challenges are compounded by the fact that individuals released from carceral settings now have arrest records that make their next engagement with justice systems have harsher penalties.

Correctional staff, policymakers at all levels of government, and research institutions are increasingly aware of the impacts of this cycle on individuals, communities, and the criminal- legal and healthcare systems. As a result, recent legislative and regulatory changes have been approved that have the potential to radically shift the relationship between health and justice systems by altering the role that Medicaid plays in correctional health and the entire criminal-legal system. COCHS has prepared nine briefs for the variety of stakeholders that engage with criminal-legal systems that can help them better understand the opportunities created by these changes and create closer alignment between health and safety systems.

These briefs will help both systems move away from the siloed systems that fail those who need behavioral health support and create the systems that can help people avoid incarceration.

To help all parties prepare for this opportunity, this white paper discusses:

- The roles that system failures play in the poverty-incarceration feedback loop;
- The history and impact of the Medicaid inmate of a public institution exclusion

(colloquially the "inmate exclusion");
- How unmet behavioral health needs are exacerbated by the inmate exclusion;
- Why reentry should be reframed as a health event; and
- The value of sharing data across healthcare and criminal-legal systems.

SYSTEM FAILURES

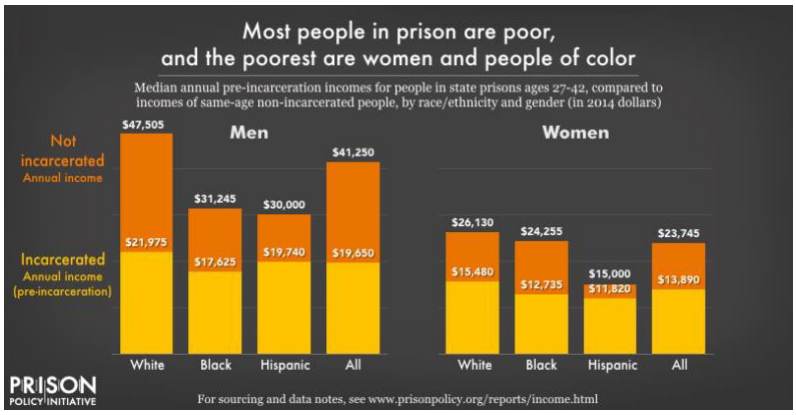
The United States' social safety net consists of a complex network of public programs that include education, housing and utility support, tax incentives, and healthcare coverage intended to alleviate financial pressures for low-income Americans. These programs have been shown to effectively reduce severity of poverty, disrupt cycles of generational poverty, and reduce the number of people living in poverty.[3] However, ostensibly cost-conscious state and federal policies have often resulted in an underfunded, understaffed public benefits system that is unable to meet the growing extent of poverty in the United States.

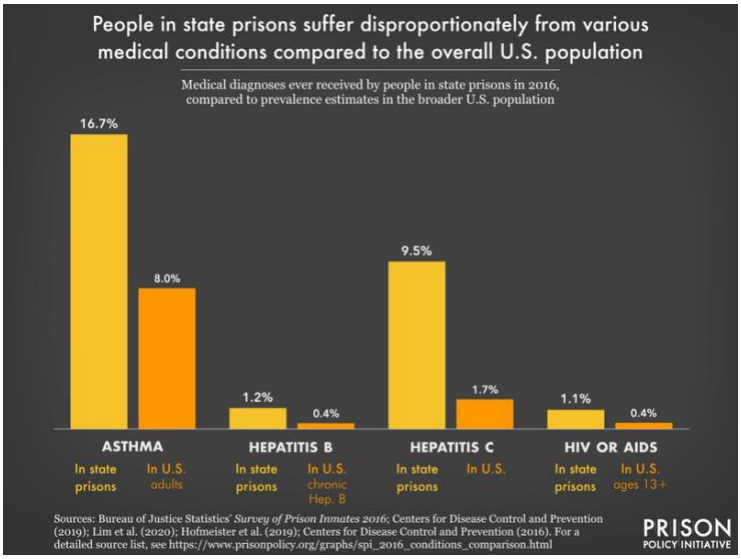
Healthcare safety net systems are stretched thin, and many people who slip through the net find themselves in the criminal-legal system. When people cannot find help for untreated mental health or substance use disorders, the criminal-legal systems often become tasked with warehousing and processing those who have been failed by chronically neglected community systems. The frontline of the criminal-legal system is the jail, and correctional settings end up playing the role of healthcare provider of last resort. No amount of jail-based healthcare could, or should, take the place of well-funded community programs with the potential for upstream prevention, but due to the failures to provide robust community behavioral health support, jails are consistently overpopulated by people with chronic and acute physical and behavioral health needs. Jails, too, are stretched to provide services beyond their capacity to the detriment of the incarcerated people, the staff, and the communities that both parties come from.

The relationship between these systems punishes marginalized communities the most. The United States' healthcare and criminal-legal systems both suffer from and reinforce existing inequities in low-income, often Black and brown, communities. Black Americans are especially poorly served by our healthcare systems and face worse outcomes than white Americans. Our country's history of slavery, Jim Crow, and policies that have disenfranchised Black Americans along with the present state of poverty, health, and incarceration creates a complex feedback loop in which poor health can lead to lower incomes all while poverty is systemically criminalized.[4] [5] In addition to continued advocacy for proper funding and support of the social safety net, both sectors must recognize the disparities their systems influence and act on opportunities to disrupt the feedback loop.

POVERTY, HEALTH, & INCARCERATION

Across the country, policymakers are attempting to resolve the health disparities that are faced by marginalized communities. While COVID-19 has highlighted gulfs in healthcare access and quality, marginalized communities have long faced dramatic health disparities, which drive higher rates of disease and premature mortality. Individuals are more likely to experience these disparities depending on whether they are low-income, rural, a sexual or gender minority, have previous involvement in the child welfare system, or are a minority racial or ethnic group. Poverty and incarceration compound these factors and can even be considered "fundamental causes" of health disparities.[6]





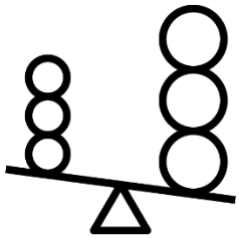
Without robust safety-net systems, the jail has been a significant way that unmet social needs are managed out of the view of the broader health systems. Management through carceral systems performs an insidious sleight of hand that changes conversations about health to conversations about "public safety" and leads to increased disparities for marginalized populations that become indexed to "crime" and often lead to further criminalization of unmet health needs, rather than expansion of health services. The separate siloes of health and criminal-legal systems mean that capturing the full impact of unmet health needs becomes a challenge.

These consequences of incarcerating people for unmet health needs subjects people to vastly different standards of care. While the community health systems exist within a tightly regulated structure, local jails do not have similar regulatory oversight. This lack of oversight drives challenges with aligning the care provided outside and inside of carceral settings. Once incarcerated, the correctional health system is held to a looser accountability structure than community-based healthcare. The voluntary accreditation system through the National Commission on Correctional Health Care

attempts to create standards to improve care, but the vast majority of jurisdictions do not seek accreditation. This has left each jail to develop its own set of standards and practices that are disconnected from healthcare quality measures, resulting in drastic variation across local jurisdictions with few opportunities to share data and insights into patient health.

Since people of color are more likely to experience poverty and negative outcomes across the social safety net, it is unsurprising they are also overly represented in the incarcerated population. In 2018, while Black people were 13 percent of the general population and white people were 60 percent of the general population, each demographic group represented 38 percent of the prison population.[7] Compounding disparities results in a justice-involved population that is much more likely to suffer from chronic health conditions and infectious diseases (such as hypertension, tuberculosis, diabetes, and hepatitis) than nonincarcerated individuals[8]. Justice-involved people also experience high rates of substance use disorders and have more severe mental health needs, but they cannot access integrated, community services.

In summary, disparate outcomes in health and social safety net systems drive disparate outcome in criminal-legal settings. Despite the connection between these systems, few inroads have been available for improving care and coordination across care settings. Attempts at creating more equitable health or criminal-legal systems without addressing the relationship between health and justice systems will fail to drive change. Rather, policy must be crafted in a way that can improve health wherever people receive it rather than allowing for blame to shift between health and justice partners.



MEDICAID'S INMATE OF A PUBLIC INSTITUTION EXCEPTION

Resolving the disparities in both health and criminal-legal systems requires a close look at policies that underly both systems. Calls for reforms of health and criminal-legal systems often fail to look at the way these systems interact and mutually reinforce poor outcomes. Medicaid, a central pillar of our safety net health system, has created new opportunities to improve the lives of justice-involved people. Medicaid is the health insurance program for low-income individuals or individuals who qualify based on certain health conditions. Because most people who are incarcerated are poor, nearly all are eligible for Medicaid. However, by law, Medicaid cannot cover services provided to people while they are in jail or prison, excluding inpatient hospital stays.

This prohibition, known as the **Medicaid inmate exclusion** ('inmate exclusion'), was established in the Social Security Act of 1965, in which Congress first authorized Medicaid. The original purpose of the inmate exclusion was to prevent cost-shifting from state and local governments to the federal

government. As a result, states and local governments are solely responsible for financing healthcare delivered to incarcerated people who are otherwise Medicaid eligible. As Medicaid has become a driver of change in community health systems, it has been barred from statute from reaching people at their most critical moment of need—before, during, and after incarcerated.

The inmate exclusion has resulted in multiple unanticipated barriers for justice-involved populations and the health systems they use:

1. **It disrupts access to healthcare:** The inmate exclusion creates discontinuities in care for Medicaid beneficiaries. Once individuals are detained, they fall under the inmate exclusion and may have their Medicaid coverage suspended or terminated even if they are never convicted of a crime. Detained individuals move from Medicaid coverage pre-incarceration to the correctional system, which is largely managed locally without oversight, and back to the Medicaid system upon release. Services, medications, and treatments are frequently interrupted by insufficient coordination between corrections providers and community providers.
2. **It exacerbates barriers to services that can prevent recidivism:** Medical, behavioral health, and social services have been shown to reduce recidivism rates by addressing the causes of many "nuisance arrests" (e.g., public intoxication, loitering). Reenrollment into Medicaid post-release can take weeks or months, with pharmacy benefits often taking even longer. While they wait to be reenrolled in Medicaid, most newly released individuals cannot access the healthcare services they need. These delays in access to services and benefits create a cycle of reincarceration.
3. **It drives individuals to plead guilty despite innocence:** For an individual who faces losing their health insurance and community healthcare, the consequences of the inmate exclusion can be a deciding factor when determining legal strategy, particularly for individuals who cannot meet the cost of bail. The risk of losing access to these benefits may increase the likelihood that an individual pleads guilty to a crime that they did not commit in order to maintain access to programs they use in the community by avoiding incarceration.

Momentum to address the inmate exclusion has driven some major changes in how this law operates. Leading policy and research organizations have highlighted the widespread impacts of the inmate exclusion and the importance of including Medicaid as a partner in criminal justice reform, including the American Medical Association; National Sheriffs' Association; the National Academies of Science, Engineering and Medicine; and Aspen Health Strategy Group.[9] [10] [11]

This growing understanding has created broad bipartisan political support to amend or repeal the inmate exclusion. In December of 2022, President Biden

signed into law the first statutory change to the inmate exclusion as a part of the Consolidated Appropriations Act of 2023. Section 5121 of the law will require states to allow eligible, sentenced beneficiaries to receive important screenings, diagnostic services, and referrals thirty days before release from a public institution and thirty days of targeted case management before and after release. Section 5122 of the law amends the Social Security Act to allow states to choose to allow incarcerated juveniles to maintain their Medicaid benefits as they await disposition of their charges, meaning community support and treatment can continue during incarceration.

While these federal changes do not go into effect until 2025, many states have proposed Medicaid waivers to expand prerelease Medicaid enrollment and mandate that Medicaid- covered services are provided while incarcerated. California received approval from the federal government for its request to allow for targeted Medicaid services 90 days before release from a jail, prison, or juvenile justice facility. This waiver will go into effect after certain benchmarks are met by the state to ensure a smooth transition into improved services for justice-involved people. The waiver will fundamentally change the relationship between community and correctional health systems—not to mention correctional operations.

In the short term, other jurisdictions will be awaiting approval of their Medicaid waivers or will be weighing how they can leverage the moment created by the recent statutory and regulatory changes. The remainder of this brief will highlight the ways that the healthcare and criminal justice sectors are burdened by the inmate exclusion and how increased collaboration can improve outcomes for their shared population and beyond. By exploring three key areas where health and justice systems have been frustrated by the silo created by the inmate exclusion, policymakers in both sectors will see how much more there is to gain by collaboration.

ISSUE: COMMUNITY BEHAVIORAL HEALTH CHALLENGES ARRIVE IN JAIL

The United States has a long history of challenges in creating a functioning behavioral health system. The horrors of over-institutionalization in the early 20th century led to the movement to deinstitutionalize mental health hospitals during the 1950s and 60s. The Community Mental Health Act of 1963 led to many people being released from state hospitals. The Mental Health Services Act of 1980 was passed to create and fund community alternatives to care. Unfortunately, the statute was repealed during President Reagan's administration without the creation of a replacement. Populations unable to afford private treatment were left without options—and jails became the default behavioral health provider for people in crisis. Unsurprisingly, the number of people incarcerated skyrocketed during this time. These deeply

connected events have resulted in high rates of homelessness, substance use disorders, and incarceration rates of individuals with untreated mental illness.[12] To this day, more than half of sentenced jail inmates met the criteria for drug dependence or abuse (compared to five percent of the general population) and were much more likely to meet the threshold for serious psychological distress than non-incarcerated adults.[13] [14] The inability to creating a functioning federal system for mental health shifted the burden to local correctional facilities.

With the passage of the Affordable Care Act and the Mental Health Parity and Equity Act, behavioral health in the community has had a major expansion. Unfortunately, the nascent community systems face similar challenges that local correctional facilities have been facing for years: staffing shortages. Correctional and community-based behavioral health systems are experiencing extreme workforce shortages that put both patients and providers at risk. A national mental health workforce shortage is widespread, with over 250,000 community behavioral health roles expected to be unfilled in the US by 2025.[15]

The inmate exclusion creates challenges for Medicaid-funded community providers to offer their services in jails. The inability for community providers to also practice in jails leads to competition for a small pool of qualified applicants. Correctional facilities typically cannot compete with community systems to hire qualified health staff. Simultaneously, prisons and jails struggle to maintain safe levels of correctional staffing due to low wages, traumatic work environments, and explosive growth in the number of incarcerated people.[16] [17] In absence of providers, correctional staff are then thrust into the role of behavioral health, physical health, and social worker in a high-stress jail environment. They must identify whether a person entering the jail is exhibiting signs of psychosis, suicidal ideation, a variety of drug-induced states, and a variety of physical health emergencies that might not be readily apparent but affect the health and safety of the individual and others in the facility.

The inmate exclusion, while not the originator of the behavioral health crisis in communities and jails, forestalls attempts for community and correctional systems to support one another in their efforts. By allowing Medicaid to pay for services on the inside and the outside, community providers could continue their care behind bars and eliminate the additional demand for health providers created by Medicaid funding limitations.

Besides mitigating the duplication of efforts and creating competition rather than cooperation in community and carceral settings, amending or repealing the policy could support improving health efforts in multiple ways:

- **Behavioral health integration:** In general, systemically integrating physical and behavioral healthcare across providers has been a federal policy priority, with multiple funding and operational opportunities in recent years. However, the inmate exclusion prohibits correctional healthcare from creating similar programs inside the walls of the jail. By removing the inmate exclusion, correctional health providers could leverage innovative delivery models and collaborate on the complex issues that incarcerated individuals face.

- **Continuity of care:** Continuity of care, a consistent and ongoing relationship between provider and patient, is beneficial for any patient, and is especially important for those with serious and persistent mental illness. Twenty percent of individuals enter incarceration having seen a community provider, but due to the inmate exclusion, they are prevented from continuing that treatment while behind bars. Without the inmate exclusion, individuals could maintain existing therapeutic relationships while incarcerated or even establish new ones that could persist upon reentry. Removing the inmate exclusion would allow those who have never received care from a community provider to initiate a relationship that could continue upon release.

- **Addressing behavioral health needs before release:** Unmet behavioral needs are often the root cause of incarceration, especially low-level misdemeanors like public drunkenness, disorderly conduct, and loitering. By beginning treatment during incarceration via Medicaid-reimbursable services and medications, jails could begin to provide individuals with the tools they need to leave incarceration and remain in their community.

ISSUE: LACK OF HEALTH-ORIENTED REENTRY PROGRAMS

Reentry is a pivotal and precarious health event on par with hospital discharge and other care transitions. Upon reentry, people have higher rates of physical and mental illness, homelessness, and overdose, which add to their difficulties gaining employment and accessing healthcare services.[18] [19] Despite the negative health outcomes associated with reentry, most reentry programs are under the purview of the criminal-legal system rather than healthcare. This can be partially attributed to the challenges with timely enrollment in Medicaid caused by the inmate exclusion which leads to unreliable funding for healthcare entities interested in serving people reentering the general population from jails and prisons.

There are two major implications of the current jail-based reentry system: financial and programmatic. Reliance on criminal-legal funding leaves reentry programs subject to the budgetary whims of local jurisdictions, limits the types of services provided, and negatively impacts the desired

programmatic and individual outcomes. This was illustrated in the early days of the COVID-19 pandemic when 75 percent of surveyed reentry programs were either stopped or shut down entirely.[20] Even now, many of those surveyed providers indicate that they still have not reached pre-pandemic levels of services. This drastic reduction of services happened at a time when the National Academies of Science, Engineering, and Medicine recommended decarceration as an essential tool for combating the pandemic.[21]

Programmatically, reentry programs are structured around desired criminal-legal outcomes rather than health and wellness. These programs tend to focus on individual life skills (e.g., job search, opening a bank account) and forgo services that have been shown to reduce recidivism (cognitive behavioral therapy, peer specialists).[22] Programs that incorporate therapeutic modalities have more in common with healthcare provision than many of the historic reentry programs that neglect the needs of reentering individuals. Community- based care management programs have experience in successful treatment modalities and have a long history of deploying (and funding) peers for logistical and emotional support for a wide range of diagnoses and conditions.

The good news is that states can use Medicaid 1115 waivers to fund reentry programs to improve outcomes and better align with existing healthcare infrastructure:

> **Example:** California's CalAIM program, recently approved by CMS, provides access to a set of Medicaid services 90 days before release from a jail, prison, or juvenile justice facility. As mentioned above, this is the first time a waiver of the inmate exclusion has been approved by the federal government. The program also provides access to enhanced care management (ECM) for people leaving incarceration as they navigate a variety of social service providers. ECM providers can access community support for their clients to help them pay first and last months' rent, receive support during substance use treatment, and have a helping hand throughout the reentry process. The program will also fund community providers to provide services to people while they are incarcerated—improving the quality of care and ensuring that formerly incarcerated people do not have to find their own provider.

ISSUE: DISCONNECTED INFORMATION SYSTEMS

The criminal-legal and healthcare sectors have disparate information infrastructures that limits the ability to share information across systems about individuals in their care. Both contain crucial data about individuals' medical history, providers, social networks, and goals that would be useful for all related providers. However, data-sharing mechanisms for these sectors to communicate about their overlapping clients do not exist, impeding continuity of care and long-term recovery.

Multiple federal acts have provided mandates and financial incentives to transition the country's healthcare system to electronic medical records, resulting in an 86 percent adoption rate of appropriate systems by hospitals and physicians.[23] [24] There has not been a similar federal push to incentivize jails and prisons to adopt modern electronic data management systems. In addition, jails are managed locally with financial and operational decisions left up to county sheriffs or other elected officials. As a result, jails may operate with outdated or analog paper systems limited to information that applies only to day-to-day operations.

This disparity prevents jails and prisons from sharing or receiving information electronically with healthcare providers. Without access to health records, incarcerated people cannot receive appropriate medical and behavioral health care while behind bars. There can be severe consequences if booking staff are unaware of one's health conditions or if they are at risk of drug withdrawal. On the other side, healthcare providers rarely receive records of treatment provided in jail that can inform care delivery once an individual is released.

Medicaid has the potential to revolutionize how criminal-legal and health systems can share data. If Medicaid-covered services were provided within the walls of the jail, institutions could leverage federal funding to update information management systems, or develop an electronic health record. Health Information Exchanges, data-sharing programs that allow patient information to be shared across healthcare organizations, could be supported through a variety of federal initiatives and could provide another valuable resource for jails to share data with healthcare partners.

There are successful collaborations in which jails and healthcare organizations were able to establish data-sharing agreements and communicate on the individual's behalf and more are on the way:

- The Camden Coalition established a data-sharing agreement with the county jail via its HIE, in which correctional health providers can view a limited medical history while Camden Coalition care teams are made aware of care delivered within the jail. The agreement ensures that sensitive information is securely stored and that shared patients are informed of and consent to information disclosure.

NEXT STEPS

The inmate exclusion has been a mistake. It burdens the health system, it burdens the criminal-legal systems, and it burdens the people who pass in and out of carceral facilities. Despite efforts to work around this archaic law, its presence remains a stumbling block for local jails, healthcare providers, those who are incarcerated, and anyone seeking to improve public health and

public safety. With the recent legislative and regulatory changes to how Medicaid operates with criminal-legal systems, the health care provide in carceral settings will be able to leverage the support of community providers, rather than operate independently.

COCHS worked with health and justice system partners as they navigated around the inmate exclusion. Now that there are clear pathways forward to meet the needs of justice-involved people, COCHS is excited to continue to improve connectivity between partners and shift the focus away from punitive systems towards systems that meet people wherever they are.

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