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# Medicaid Can Improve the Lives of Justice-Involved Individuals & Save Oklahoma Money

## Introduction

Prior to the Affordable Care Act (ACA), most 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 "Medicaid expansion" states (including Oklahoma as of July 2021) the vast majority of those incarcerated are eligible for Medicaid upon release, including an estimated 80 and 90 percent in New York and Colorado.[1] However, while incarcerated, 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 corrections facilities are obligated by law to provide health care, this Medicaid exclusion means that the corrections system absorbs the overwhelming majority of health care costs for incarcerated people.

In Oklahoma, the health care situation for the justice-involved is dire. Oklahoma has the second highest incarceration rate in the nation, the prisons spend the least per person in health care nationally ($3,071 per person in 2007 and decreasing through 2011)[3] while Oklahoma's jails rank second worst in mortality (2 deaths per every 1,000 individuals)[4], and the state still spends $85.7 million on prison health care services.[5] These poor health care outcomes disproportionately impact individuals of color.

However, Oklahoma 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:

- Outline the dire nature of Oklahoma's health care services in corrections;
- Recommend solutions via Medicaid; and,
- Provide examples of other states leveraging Medicaid via the approaches listed above.

## Health Care in Corrections in Oklahoma

Across both prisons and jails, health care costs and quality are bleak in Oklahoma. The Department of Corrections (DOC) provides medical and dental services to more than 21,000 individuals in state prisons[6] and Oklahoma's county jails, where two out of every three were individuals being detained pretrial, were responsible for health care services for almost 13,000 people across the state in 2015.[7] Downstream racial health disparities are occurring because justice-involved individuals have less access to health care in Oklahoma and therefore more complex care needs. Oklahoma also disproportionately incarcerates individuals of color compared with their white counterparts. Black Oklahomans are incarcerated at a rate 4.5 times higher than white Oklahomans.[8]

Key drivers of health care costs and mortality in jails and prisons nationally include chronic conditions and behavioral health issues. Between 2009 and 2019, 148 individuals died in Oklahoma's 11 largest county jails with illness and suicide being the cause of half and a quarter of the deaths, respectively.[9] The high rate of suicide highlights a huge problem with the state's jails being able to provide individuals with mental health care. Hepatitis C is also a main driver of health spending in state prisons, with the Oklahoma Legislature budgeting $9.2 million for this area of medical care in Fiscal Year 2022.[10] 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 non-incarcerated U.S. population.[11]

Additionally, at least one in four individuals who go to jail will be arrested again within the same year.[12] Individuals who experience recidivism are often dealing with poverty, mental illness, and substance use disorders; these problems only worsen with incarceration. These serious health issues also lead to increased emergency department utilization, inducing a higher cost burden for both health systems and the state. Community-based interventions that support transitions of care have been shown to reduce health care utilization, recidivism, and lead to cost savings.[13] For individuals with serious behavioral health issues in particular, ensuring a seamless transition back into their communities is essential.

The COVID-19 pandemic has further endangered the health of this population. Currently, Oklahoma ranks 15th in the nation for the greatest number of COVID-19 cases in its state prison, reporting at least 7,455 positive cases and 56 deaths, despite the state's relatively small population.[14] Although the coronavirus can take an unpredictable course, it is expected that many of those affected by COVID-19 will require continued, long-term health care. The pandemic provides a unique opportunity for the state to adopt and sustain policy solutions through Medicaid that support the transition out of incarceration for individuals – an approach that can improve Oklahoma's overall health, safety, and state budget.

# Policy Solutions

Oklahoma's decision to expand Medicaid to low-income adults provides opportunities for the state and county governments to lessen correctional administrative burdens, reduce state and county expenditures, and improve health outcomes. More specifically, Oklahoma 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:** Data sharing between the Department of Corrections (DOC) and the Oklahoma Health Care Authority (OHCA) 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.

### STATE SPOTLIGHT: ARIZONA

Arizona is a model state for rapid, two-way data sharing.[15] For example, the Pima County Sheriff's Department sends data to Medicaid multiple times daily 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:

A. Implement Medicaid Suspension. Depending on state policy, Medicaid coverage is either terminated or suspended (paused). While technically a Medicaid termination state, Oklahoma de-activates individuals' Medicaid coverage when they are admitted into a jail or prison setting, with the option of coverage being reinstated upon notification of release. During incarceration, the state only can bill the federal Medicaid program for some inpatient services. Oklahoma should instead implement a suspension policy so individuals' Medicaid enrollment is simply paused during their incarceration and then (automatically) restarted once released. As outlined in the Families USA publication, Why States Should Suspend Medicaid for People during Incarceration, this practice will limit gaps in coverage and decrease administrative burden on behalf of both the individuals and the state, who will have to process fewer new applications.

### STATE SPOTLIGHT: ARKANSAS

Arkansas operates a time-limited Medicaid suspension procedure for incarcerated individuals for up to 12 months from their initial Medicaid approval or latest renewal.[16] Through administrative mechanisms, states with Medicaid suspension policies, such as Arkansas, are able to re-activate a Medicaid case for selected inpatient hospital services of 24 hours or more. In Arkansas, an individual's Medicaid enrollment is re-instated on a temporary basis when receiving medical treatment away from a jail or prison setting if the treatment is initiated within that 12-month period. This Medicaid re-instatement is in effect between an individual's hospital admittance and discharge, when their case is re-suspended.

B. On-site Enrollment Assisters. Oklahoma should have Medicaid enrollment assisters located in jails and prisons to help eligible justice-involved individuals sign up for Medicaid prior to reentry into their community. Justice-involved individuals experience higher hospitalization and mortality rates following release from incarceration than non-justice-involved individuals.[17] On-site enrollment assisters' efforts can help lessen these stark disparities by preventing coverage gaps and reducing the barriers to accessing needed care. Oklahoma can draw down federal funding at an increased Federal Medical Assistance Percentage (FMAP) of 75 percent to fund on-site enrollment assisters.[18] This increased FMAP funding requires approval from CMS through submission of an Advanced Planning Document.[19]

C. Design, Development, Installation, or Enhancement of Eligibility Systems: In addition to the 75 percent FMAP Oklahoma could draw down in federal funding for on-site enrollment assisters, the state should draw down federal Medicaid

funds for upgrading Medicaid eligibility systems. Specifically, a 90 percent FMAP is available for the design, development, installation, or enhancement of eligibility determination systems as well as a 75 percent FMAP for maintenance and operations of those systems.[20]

## 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.

A. Provide Justice-Involved Individuals with 30-Day Pre-release Care. Access to medical care provided through Medicaid in the month prior to release from jail or prison can establish continuity of care and care linkages following their release. A few federal policies could provide Oklahoma with the needed authorities to offer justice-involved individuals comprehensive health care services. The SUPPORT Act, Public Law No: 115-271, was signed into law in October 2018 and stipulates that CMS must issue guidance on improving health care transitions for justice-involved individuals, including the provision of Medicaid services 30 days prior to release.[21] 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 pre-release and post-release services to justice-involved individuals. After passing the House of Representatives in May 2020, this legislation has been reintroduced and may be included in upcoming legislative packages.[22]

### 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.[23] Illinois has become a model 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.[24] In just three years after Cook County's jail-based Medicaid application project began in 2013, 15,000 individuals had gained Medicaid coverage.[25] This process was made possible through coordinated collaboration between the Cook County Health and Hospitals System, the Cook County Sheriff's Office, and TASC.

B. 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 towards institutions, such as health providers and plans, these peers can help ensure better transitions of care. Evidence shows that community-based programs like Transition Clinic Networks, 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 services, scheduling and accompanying people to appointments, providing advice on securing housing and employment, and generally serving as a trusted advocate.[26] 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 percent fewer hospital emergency department visits, for an estimated savings of $912 per person in the first year of the program.[27]

## STATE SPOTLIGHT: NORTH CAROLINA

North Carolina has incorporated a Transitions Aftercare Network (TAN) to assist with community reentry.[28] 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 as they leave incarceration and return to their communities. Those who have completed certain pre-release programs can apply to receive a mentor through TAN, and when matched, they receive encouragement and guidance from a trained mentor.[29]

C. Managed Care In-Reach: Managed care as recently attempted would likely not have beneficial impacts on the state of Oklahoma. However, if Oklahoma moves towards implementation of managed care, care coordination for the justice-involved population is still possible. States can use their managed care contracts to require "in-reach" or pre-release planning. This work involves a provider, often a social worker or nurse, meeting with an individual prior to release to assess them on a number of dimensions. This assessment can include a review of their 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 their 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 (MPRE)[31] required that eligible justice-involved individuals enroll into Medicaid approximately 90 days prior to their release and select a managed care plan. The MCO was required to assess the 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 pre-release assessment, a care plan, and post-release provider appointments were established.[32] Between November 2014 and March 2018 approximately 22,000 people participated in the MPRE program and those individuals had higher utilization rates post-release for mental health and SUD 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 the MPRE program as it is an expectation MCOs will continue MPRE through a separate contract for individuals in state facilities with two or more identified risk factors.[35] Oklahoma could implement a similar reform without implementing managed care. While individuals could not enroll 90 days before release, the state Medicaid agency could provide case management and care coordination for enrollees. 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 non-formerly incarcerated staff members. This structure reduced Ohio's corrections budget; increasing Medicaid's role with reentry has reduced the budget by $20 million.[36]

## Conclusion

Oklahoma and its counties could improve the lives of thousands of individuals and save millions of dollars if they better leveraged the Medicaid program to improve data sharing across state agencies, streamline enrollment into Medicaid, and ease transitions of care upon release from incarceration.

# Endnotes


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