

MEDICAID EXPANSION & CRIMINAL JUSTICE-INVOLVED POPULATIONS: OPPORTUNITIES FOR THE HEALTH CARE FOR THE HOMELESS COMMUNITY

POLICY & PRACTICE BRIEF

JANUARY 2013

Starting in 2014 (or earlier at state option), the Affordable Care Act will give states the option to expand Medicaid eligibility to most people earning at or below 138% of the federal poverty level. Those currently involved with the criminal justice system will benefit from this policy change because this group tends to be low income and uninsured, often experiences homelessness, and needs a wide range of health care services. This policy brief is intended to outline the changes in Medicaid eligibility affecting the criminal justice population, summarize the process improvements being made to enrollment, provide a brief overview of the health status of this population, and recommend steps the HCH community might take to maximize the opportunities afforded by the expansion of Medicaid to childless adults.

Introduction

Homeless health care providers and administrators within the criminal justice system share significant numbers of common patients, and also share important goals. These include wanting to see improved health status among patients, increased community safety, reduced recidivism and health care costs, and an increased capacity within the community to deliver needed health care services. The policy changes in Medicaid eligibility and enrollment made possible by the Affordable Care Act (ACA) bring new opportunities for bridging the dual systems that serve a high-needs population, and offer possibilities for stronger partnerships. This policy brief is intended to illustrate opportunities for the HCH community to engage the criminal justice community, and to outline the changes in Medicaid eligibility affecting the criminal justice population, the process improvements being made to enrollment, the health status of this population, and recommendations the HCH community might pursue as a result of these policy changes.

Homelessness is a common experience among incarcerated persons.

Among adults in jail, 15.3% had been homeless at some point in the year prior to incarceration, which is 7.5 to 11.3 times the estimate of homelessness among the U.S. adult population (1.36% to 2.03%).¹ In the state and federal prison population, this rate drops to 9%, with those homeless more likely to be incarcerated for a property crime, to have had previous criminal justice system involvement for both property and violent crimes, and to suffer from mental health and/or substance abuse problems.² Community health care providers who treat homeless populations often experience patients suddenly dropping out of care without notice, only to reappear weeks or months later to report having been in jail. During such transitions, medication regimens and treatment plans are disrupted, possibly with adverse health implications.

15% of adults in jail experienced homelessness in the year prior to detention — 7 to 11 times the rate of the general public.

Medicaid Eligibility: Provisions of the Law

One of the most important provisions of the Affordable Care Act is the option for states to expand Medicaid to most low-income people. Starting on January 1, 2014, Medicaid has a new eligibility category created for non-pregnant, non-disabled adults over age 19 and under age 65 earning at or below 133% of the federal poverty level (FPL), with a 5% income disregard, making the actual eligibility limit effectively 138% FPL.³ Using 2012 FPL guidelines, 138% FPL is equivalent to an individual earning \$15,000 per year (about \$25,500 for a family of three).^a

If all states expand Medicaid to all those earning below 138% FPL, an Urban Institute analysis found just over 15 million adults will be eligible to enroll (76% of them—11.5 million—are at or below 100% FPL).⁴ While the Supreme Court upheld the ACA, it determined the expansion of Medicaid would be a state option, rather than mandatory.⁵ At the same time, 4.3 million adults in the U.S. are currently eligible for Medicaid, but unenrolled.⁶ Because of state variance and past experiences with enrollment among eligible populations, the Congressional Budget Office (CBO) projects that *only seven million will enroll in the first year* (2014), and only 10 million two years after implementation (2016).⁷ Of those remaining uninsured after 2014, just over one-third are projected to be those eligible for Medicaid but un-enrolled (36.5%).⁸ These reports demonstrate that *eligibility does not automatically equate to enrollment*, hence the importance of all states maximizing the ACA's opportunities as well as ensuring strong outreach efforts.

Individuals experiencing homelessness are a key population that stands to gain from the Medicaid expansion. In 2011, Health Care for the Homeless (HCH) grantees delivered health care services to 825,295 patients, yet nearly two-thirds (62%) had no health insurance and only 28% were enrolled in Medicaid despite 90% having income under 100% of the FPL.⁹ Hence, the expansion of Medicaid is one of the most important provisions of the ACA for this low income population.

Medicaid Eligibility in the Criminal Justice Population

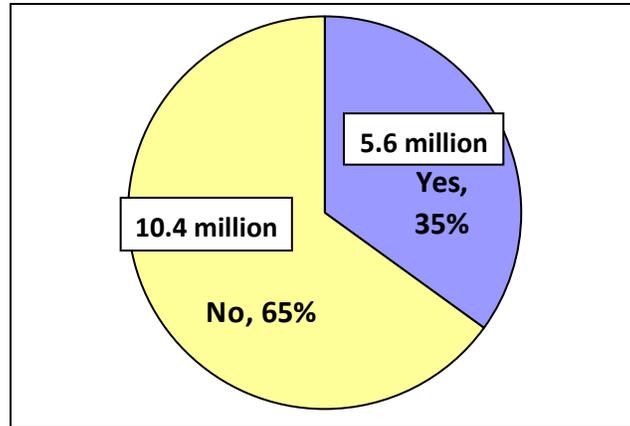
Nearly all (90%) of those entering local and county jails and detention centers are uninsured.¹⁰ One profile of jail inmates found 69% engaged in regular drug use, 60% earned less than 133% FPL in monthly income, and 29% were unemployed at the time of their arrest.¹¹ Those who are enrolled in Medicaid traditionally have that coverage terminated upon incarceration based on a federal law that prohibits Medicaid expenditures within correction environments. Federal guidance recommends suspension of benefits during incarceration, rather than termination;¹² this simplifies and accelerates resumption of Medicaid coverage upon discharge but many states do not follow these guidelines. While the criminal justice system has made more efforts to improve connections to health services as part of re-entry planning, especially for those serving longer terms in prison, language in the ACA has important implications for those incarcerated in jails and detention centers who make up larger numbers of

90% of those entering jail have no health insurance and 60% earned less than 133% FPL.

^a Note the ACA does not extend eligibility for Medicaid to those who are undocumented immigrants, or those legal residents who have been in the country less than five years.

individuals. Of those potentially eligible for Medicaid under the ACA, just over one-third (35%) have prior criminal justice involvement (see Figure 1).¹³

Figure 1. How Many of the Newly Medicaid Eligible have Prior Justice Involvement?



Source: Department of Justice, National Institute of Corrections, 2011. (Note the total number of people newly eligible in this graph was based on earlier estimates of 16 million.)

Jails and Detention Centers: At midyear 2010, there were nearly 750,000 individuals incarcerated in county and city jails in the U.S. on a single day; of these, 61.1% were awaiting court action on the current charge (e.g., the “pre-trial” population).¹⁴ In 2010, 12.9 million people were admitted to these types of facilities, making this a prime population to target for Medicaid enrollment and services upon release. This policy development offers a wide range of possibilities for increasing access to health care, improving the re-entry process, engaging criminal justice agencies in Medicaid enrollment, strengthening discharge plans, and participating in a host of other collaborative activities.

The size of the jurisdiction’s jail/detention center may affect the opportunities for intervention, since there is a wide range of average weekly turnover in this population (51.5% to 136.7%). Overall, smaller jails see greater turnover than larger jails (see Table 1) so the time needed for enrollment and other re-entry planning will need to be tailored based on the length of time an individual is incarcerated.

Table 1. Daily Census and Turnover Rate, Based on Size of Jail¹⁴

Jurisdiction Size	Average Daily Population	Weekly turnover rate
<50 inmates	21,875	136.7%
50-99	38,041	96.1%
100-249	87,508	80.6%
250-499	104,076	78.0%
500-999	121,611	61.1%
1,000+	375,442	51.5%
Total	748,553	64.9%

Prison and Community Corrections: Those released from prison are also likely to benefit from the expansion of Medicaid to childless adults starting in 2014. While there were 1.6 million men and women incarcerated in federal and state prisons in 2009, 730,000 were released that year (21% higher than releases in 2000).¹⁵ A recent study estimates **up to one-third (33.6%) of those released from prisons annually could enroll in Medicaid after the expansion becomes effective.**¹⁶ For the nearly 5 million people already involved in community corrections,^b most are on active supervision (which may require participation in some type of treatment).¹⁷ Hence, there are also opportunities for expanding Medicaid enrollment for those re-entering from prisons and/or those already in the community but still in need of services.

Medicaid Enrollment: An Improved Process

The new Medicaid enrollment guidelines make a number of changes that should make it much easier to enroll into the program compared to the current process.¹⁸ In general, the system is designed to enable individuals to apply on their own from any point of entry into the system (to include a home computer connection), though many of those in the HCH community applying for Medicaid will want/need assistance in doing so. Improvements include the following:

- *Modified adjusted gross income (MAGI):* Income is determined based on total received by household, with no asset tests allowed. For families who do not file taxes, “household” is defined as the applicant as well as any spouse and natural/adopted/step-children living with the applicant. In general, these guidelines follow those established for filing taxes under IRS rules.
- *Timeliness:* States are required to conduct eligibility determinations “promptly and without undue delay.” Of note, the Medicaid rule requires that determinations must not exceed 45 days for non-disabled applicants and 90 days for those seeking determination based on disability. States will be required to report on their performance in this regard.
- *Electronic verification of information:* States will be required to access a federal data hub that enables citizenship and identification information from the Social Security Administration (SSA) as well as wage information from the Internal Revenue Service (IRS) to be verified electronically. **This will include verifying a lack of income**, which is important for those clients who do not earn wages.
- *Residency:* The state of residence is where the individual is living and intends to reside (**including without a fixed address**). No paperwork need be produced to demonstrate “intent”—it is enough to self-attest residency and it is enough to use alternative addresses (e.g., housing program, HCH, etc.). There will also be a “no fixed address” option on the application.
- *Limited use of paper documentation:* Because personal information will be electronically verified, **use of paper documents is specifically prohibited** unless the electronic data is not compatible with the information provided by the applicant. This will largely negate the need for birth certificates, photo IDs, social security cards, paycheck stubs, utility bills, rental leases, or other “proof” needed to establish identity, income and residency—items particularly difficult to produce for homeless populations.

^b “Community corrections” refers to the supervision of criminal offenders in the resident population, as opposed to confining them to secure correctional facilities. The two main types of community corrections supervision are probation and parole.

- *Renewal process:* Renewals must occur **every 12 months (but not more frequently)** using an administrative renewal process that matches data electronically based on available information. States cannot require additional information from a beneficiary if eligibility can be determined with available information and data. States will **automatically re-enroll the beneficiary if there is no available information to disqualify them**, and states are required to send a notice to the individual that they have been re-enrolled, or that the state requires additional information.
- *Assistance:* States must provide assistance to any individual seeking help with an application or renewal in person, over the telephone, and online and in a manner that is accessible to individuals with disabilities or have limited English proficiency.

These improvements should make applying for Medicaid (and re-enrollment) much easier for both clients and those providers who are assisting them. Because an application can be submitted online with electronically verified information under the new system, staff working in jails and prisons now have a much greater opportunity to actively participate in the Medicaid enrollment process as part of re-entry standard operating procedures.

Health Status of the Criminal Justice Population

There is a wide body of literature focused on the health status of those involved with the criminal justice system that demonstrates poorer health compared to the general population, increased rates of chronic and infectious disease, and very high rates of behavioral health disorders.^{19, 20}

Chronic and infectious disease: One in-depth report on medical problems of jail inmates found about half of women (53%) and one third of men (35%) report a current medical problem; the most commonly reported conditions were arthritis (19%/12%, respectively), hypertension (14%/11%), asthma (19%/9%) and heart disease (9%/6%).²¹ One study conducted in Maryland jails found nearly 7% tested positive for HIV, while prevalence of hepatitis C reached nearly 30% and hepatitis B just over 25%.²² Overall, persons released from criminal justice venues (both jails and prisons) have been found in past studies to represent 17% of the total AIDS population, 13-19% of those with HIV, 12-16% of those with hepatitis B, 29-32% of those with hepatitis C, and 25% of those with TB.²³ These conditions pose important public health implications, as well as fiscal realities for criminal justice agencies responsible for providing needed health care.

Behavioral health: Behavioral health conditions are particularly prevalent in a criminal justice setting. One study found 64% of those in jail have some form of mental illness,²⁴ while another study found serious mental illnesses in nearly 15% of the men and 31% of the women, which is more than three to six times those rates found in the general population.²⁵ Other research has found 10-15% of those in state prisons also have severe mental illnesses.²⁶ The prevalence of substance use is even higher. More than two-thirds of jail inmates are dependent on or abused alcohol or drugs (with men and women having similar rates).²⁷ The rates of substance abuse among jail inmates can be as much as seven times that of the general public.²⁸ Among women, rates are particularly high in state prisons, with 60% estimated to be dependent on or abuse drugs.²⁹ Often, mental illness and substance abuse are co-occurring conditions in this population. In jails, an estimated 72% of individuals with serious mental illnesses have a substance use disorder.³⁰ In prisons, co-occurring disorder estimates range from 3 to 11% of the total incarcerated population.³¹ Clearly, addressing

mental health and substance use disorders must be a high priority for both community health care providers and the criminal justice system.

The ACA requires Medicaid coverage for the newly-covered populations (as well as coverage under all qualified health insurance plans) to include the following ten categories of services:³²

1. Ambulatory patient services
2. Emergency services
3. Hospitalization
4. Maternity and newborn care
5. Mental health and substance use disorder services, including behavioral health treatment
6. Prescription drugs
7. Rehabilitative and habilitative services and devices
8. Laboratory services
9. Preventive and wellness services and chronic disease management
10. Pediatric services, including oral and vision care.

Hence, for the first time, many of those who have criminal justice system involvement will have access to insurance that covers a wide range of health care services. Increasing the availability of ongoing community-based health care services has the potential to improve health and stabilize behavior, thereby decreasing the risks of (re)arrest and incarceration. It is possible that those who do enter the justice system could have improved health status, and those who leave could be better connected to community care that helps maintain stability after release. As one example, results from a Washington State study found rates of re-arrest were 21-33% lower in three groups treated for chemical dependency compared with other adults needing, but not receiving, treatment. This reduction saved \$5,000-\$10,000 for each person treated.³³

Nine Recommendations for the HCH Community

1. Meet with the administrator of your local jail/detention center to discuss the new Medicaid eligibility and enrollment provisions, and identify feasible actions that will better connect homeless clients to health services upon release.
2. Encourage jails and detention centers to implement protocols to screen incoming detainees for health insurance enrollment, and initiate applications for those leaving detention.
3. Incorporate exiting jail and prison populations into outreach and enrollment efforts.
4. Develop relationships with correctional programs to ensure Medicaid enrollment is a priority of both re-entry case managers and parole and probation officers.
5. Partner with jail and prison administrators to establish data links between community providers and the criminal justice system so important health information can be exchanged.
6. Coordinate health services for individuals prior to release (to include an advance visit while still retained, if possible).
7. In keeping with prior CMS guidance to states, illustrate to your state policy makers the benefits of suspending—rather than terminating—Medicaid benefits for those incarcerated (or in other public institutions).

8. Raise awareness among a broad range of policy makers about the health care needs of the criminal justice population, including their needs for behavioral health services, and the potential impact of health reform opportunities. Analyze how well current and proposed Medicaid benefits packages meet these needs, as well as the capacity of the provider networks to meet them.
9. Identify possible cost-savings that may create additional resources to be invested in areas related to outstanding health care and housing needs.

CONCLUSION

The Medicaid expansion to low-income childless adults in 2014 is a significant policy change that will now extend health insurance access to most of those involved with the criminal justice system. Because there is an overlap between that population and those who experience homelessness, the HCH community is a key stakeholder in ensuring that clients are enrolled in Medicaid, providing needed health services, and minimizing barriers to ongoing care. Criminal justice administrators and health care providers share goals related to reducing recidivism and improving health, especially for a population that has high rates of chronic and communicable disease, and is particularly in need of ongoing behavioral health services. The recommendations included in this policy brief are intended to increase awareness about the needs of a vulnerable group, to maximize the outreach and Medicaid enrollment levels, and identify opportunities where stronger connections to care are possible. While the implementation of a wide range of changes prompted by the Affordable Care Act (and other health reform initiatives) will focus on mainstream populations, it is vital that the health care needs of traditionally underserved, high needs groups are included in planning efforts as soon as possible to maximize the potential for better health.

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buy health insurance because they have an affordability exemption, 7.5% would qualify for subsidies in the Exchange, while 15.3% would be able to afford insurance without a subsidy.

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