MILLIMAN WHITE PAPER

Substance use disorder and justice-involved populations: Exploring rehabilitative policy options

Mary Pat Stemnock, JD
Jeremy Hoffman, JD
Jeremy Cunningham, FSA, MAAA

Milliman

Over the past 50 years, the prison population in the United States has risen from approximately 200,000 to over 1,400,000.[1] Far and away above any other crime, substance offenses have been the leading cause of incarceration in state and federal jails and prisons.[2] In response, states and the federal government have introduced, implemented, or promoted a number of rehabilitative policy options to encourage recovery and reduce recidivism.

According to the Federal Bureau of Prisons, nearly half of all federal inmates are incarcerated for drug offenses.[3] Studies on recidivism have shown that individuals convicted of a drug offense are much more likely than not to be convicted of another crime. A 2018 study from the U.S. Department of Justice found that 77% of individuals convicted of a drug offense were convicted of another offense within the next nine years.[4]

Many individuals in prison or jail who have a substance use disorder (SUD) struggle to receive treatment. However, there are rehabilitative policy options available to improve access to and options for care. In this paper, we discuss the current status of SUD treatment within jails and prisons as well as existing rehabilitative policies and programs that could improve treatment. We will also discuss the existing funding sources for SUD treatment within jails and prisons and the potential to expand funding and treatment.

Landscape of SUD and treatment within the criminal justice system

SUDs are highly prevalent among the justice-involved population. According to the National Center on Addiction and Substance Abuse, almost two-thirds of inmates (64.5%) meet the DSM-IV criteria for SUD.[5] In 2005, federal, state, and local governments spent $74 billion on law enforcement and judicial proceedings for substance-involved adult and juvenile offenders and less than 1% of that, $632 million, on prevention and treatment.[6]

Despite such high rates of SUD within jails and prisons, most jails and prisons currently offer little to no SUD treatment for their inmates. According to a 2010 study by the National Center on Addiction and Substance Abuse, only 11.2% of individuals received professional treatment while incarcerated. In the same study, nearly half of all medical directors for jails and prisons said they did not believe or did not know whether medication-assisted treatment (MAT) was appropriate for treating addiction and preferred drug-free detoxification.[7] Barriers to implementing effective, clinically proven treatment include perception, costs, and staff turnover.[8]

However, expanding treatment within jails and prisons could produce positive outcomes for both the state and the individual. The Office of National Drug Control Policy Research shows that every dollar spent on treating SUD saves $4 in healthcare costs and $7 in law enforcement and criminal justice costs.[9] Research also suggests that widespread, early, and continuous treatment could prevent or mitigate relapse, a driver of recidivism.[10]

Rehabilitative policy options

MEDICATION-ASSISTED TREATMENT (MAT)

One of the most effective treatment options for SUD is medication-assisted treatment (MAT). MAT is the use of medications to treat substance use disorder in combination with counseling and therapies.[11] In 2016, the National Commission on Correctional Health Care supported MAT as an effective treatment option for SUD within prisons and the Federal Bureau of Prisons correspondingly adopted new treatment options to offer MAT to its populations.[12] However, MAT is not widely offered to justice-involved individuals in the United States. A 2018 Pew Trusts survey estimated that fewer than 1% of institutions utilize MAT as a regular treatment model for SUD and instead utilize drug-free detoxification.[13] Studies have found that 55% of individuals who only use detoxification as a treatment method relapse within one month of being released from jail or prison.[14] That number grows to 90% as time goes on.[15] Research has shown that MAT is at least twice as effective as detoxification and other abstinence-based treatments.[16]

Several obstacles have prevented the widespread implementation of evidence-based treatment methods like MAT. The first and foremost concern is cost. With limited budgets and no additional funding from Medicaid, jails and prisons cannot afford the appropriate staff and resources to utilize evidence-based practices, on a wide scale, to treat SUD. These cost restraints also prevent jails and prisons from maintaining appropriate levels of staffing in order to meet evidence-based standards for care, therapy, and treatment.[17]

In addition to the cost of offering effective treatment, there are costs associated with providing treatment along a continuum based upon the unique needs of the individual with SUD. With increased prison populations, the greater need for SUD treatment, and the constant turnover among the prison population, the needs and volume along the continuum change regularly. While costs and changing variables help to explain the limitations for treatment in jails and prisons, research suggests that the cost of providing treatment is often mitigated through long-term savings and improved outcomes for the individual.[18] One such study found that longer enrollment in a MAT program was associated with a greater reduction in healthcare expenditures overall and produced greater savings compared to other addiction treatment options.[19]

Nonfinancial benefits of providing MAT have been shown as well. A study of the Washington State Department of Prisons found that formerly incarcerated individuals were 100 times more likely to die from an overdose compared to the general population.[20] However, when individuals are able to receive MAT while institutionalized, the rates of overdose and death are substantially lessened. For example, after Rhode Island expanded access to MAT within institutions, the rate of post-release overdose-related deaths decreased by 61%.[21]

DRUG COURTS

Drug courts are an alternative to jail or prison for low-level drug offenders. These courts are not a new phenomenon in the criminal justice system. Legal scholars trace their inception to the late 1980s, when unprecedented numbers of drug offenders began to enter the justice system.[22] Drug courts emphasize that SUD can be overcome with treatment and support.[23]

According to the National Drug Court Resource Center, while there are different types of drug courts, most programs offer clinical and case management services. Program participants must frequently appear in court and are randomly drug-tested throughout the program. Sanctions, including jail or prison time,[24] may be imposed for noncompliance. Successful completion of the program could result in dismissal or expungement of the criminal case.[25]

Today, every state has at least one drug treatment court[26]—but individuals who do not live in a county where a court is located may struggle to access such diversion opportunities. This can be particularly problematic for individuals in rural areas with high rates of SUD.[27]

Counties or states may be hesitant to adopt drug courts because of the costs. However, according to the Congressional Research Service, several studies have shown drug courts cost less than processing an offender through the traditional criminal justice system.[28] Additionally, the federal government and state and national organizations frequently offer grants for drug courts. For example, in 2020, the Bureau of Justice Assistance within the Department of Justice solicited applications for drug court funding with a focus on issues faced by rural communities. The solicitation estimated that a total of 96 awards were available for amounts up to $750,000.[29]

MEDICAID COVERAGE[30]

Access to healthcare for justice-involved individuals with SUD has been demonstrated to reduce the likelihood of relapse, decrease recidivism, and lower the rate of other drug-related illnesses.[31] A majority of incarcerated individuals are experiencing poverty and thus more likely to be eligible for social services such as Medicaid.[32] Thus, while Medicaid does not currently cover services provided to inmates, many states have made reconnecting individuals with coverage after release from jail or prison a priority.

During incarceration

Federal Medicaid funds cannot be used to pay for services for inmates of public institutions.[33] This policy is referred to as the Medicaid Inmate Exclusion.[34] The exclusion does not apply when an inmate is admitted to an off-site hospital or other qualifying medical institution for 24 hours or more or to individuals in the community on parole or probation.[35] However, the exclusion does apply if the individual was involuntarily admitted to a residential treatment facility in conjunction with incarceration or an Institution for Mental Diseases.[36]

Because this policy is a coverage exclusion, not an eligibility exclusion,[37] states can choose whether to terminate or suspend Medicaid coverage when a person is incarcerated. In states that suspend coverage, Medicaid benefits are “paused” either for the duration of the individual’s incarceration or for a shorter, predetermined period—called time-limited suspension. If a time-limited suspension policy is in place, coverage is terminated after the designated time period has elapsed.

If coverage is terminated outright or due to a time-limited suspension policy, then the individual loses their Medicaid coverage and is removed from the program. Generally, that individual will have to reapply for coverage upon release. Until recently, termination was the favored approach in many states. However, the number of states choosing to suspend coverage instead of terminating—and with federal affirmation of that decision—has increased significantly over the past several years.

As of 2019, 10 states still terminated coverage for individuals in jail, prison, or both.[38] One of those states, Wisconsin, changed its policy in October 2020. State officials said they believe suspending coverage will increase the likelihood of successful reentry.[39] Additionally, the Centers for Medicare and Medicaid Services (CMS) has stated that it encourages states to suspend coverage instead of terminating. In 2019, the SUPPORT Act prohibited the termination of coverage for individuals under the age of 21 and former foster children up to age 26.[40]

Upon release

While the exclusion policy remains the law, states must decide how—or whether—to reconnect individuals with Medicaid coverage upon release.[41] Several approaches to this issue have focused on making reenrollment easier. The Arizona Medicaid program has implemented a data exchange so that jails and prisons can quickly inform the state when an individual is in custody or has been released.[42] Other states contract with managed care organizations (MCOs) to conduct outreach and provide care coordination services to individuals approaching a release date.[43] By connecting with individuals before they are released, the MCO can ensure that they are enrolled as soon as possible upon reintegration into the community. Ohio conducted one such prerelease enrollment program and found that participants reported better access to care and health outcomes.[44]

There have also been multiple attempts in Congress to pass legislation allowing for states to activate Medicaid coverage up to 30 days prior to an individual being released from jail or prison. Known as the Medicaid Reentry Act,[45] it was most recently incorporated into the 2021 COVID-19 relief bill, the American Rescue Plan Act.[46] This language was ultimately removed by the Senate before the bill became law.[47]

Funding sources

FEDERAL FUNDS

President Biden has expressed support for alternatives to incarceration for individuals with mental health disorders.[48] As a presidential candidate, Biden proposed a grant program to incentivize states to shift from incarceration to prevention.[49] If a program mirrors the proposal that inspired it, the federal government would provide $20 billion of grant money to states that are able reduce their prison populations by 7% every three years. The hope is that over a 10-year period states will reduce their prison populations by 20%.[50] While the legislative priority of this proposal is unknown, if implemented, states could potentially use this money to expand access to drug courts and/or to SUD treatment, both in a jail setting or in the community. As previously discussed, SUD treatment has been shown to reduce relapse, one of the driving factors of recidivism.[51]

STATE GENERAL FUNDS

Providing SUD treatment to incarcerated individuals has received increased focus over the past several years at the local and state level. Nearly a dozen states have passed legislation to appropriate state general funds and/or have received grants to support SUD treatment.[52] However, despite increased attention and funding, most states do not have enough funding to meet the treatment needs of all who are incarcerated with SUD.[53]

To date, Rhode Island is the only state to screen every inmate for a SUD.[54] As mentioned in the previous section, Rhode Island has expanded access to MAT in institutions and offers all three types of drugs approved by the U.S. Food and Drug Administration (FDA) to treat opioid use disorder.[55] Upon implementation of the program, the state saw a significant decrease in overdose deaths.[56] The effort is backed by the state general fund and consists of a $2 million annual budget.

While Rhode Island may have been the first, other states are taking notice and implementing their own programs. At the time of this publication, nearly a dozen states have started to fund programs through state general fund appropriations rather than only through federal grants. The number of jails and prisons that offer evidence-based treatment options has also tripled in the past two years to 120 jails in 32 states and prison systems in 10 different states.[57]

MEDICAID WAIVERS

Some states, including New York, have proposed utilizing 1115 Medicaid waivers to activate coverage for high-risk inmates before they are released. According to its 2019 waiver application, the New York State Department of Health believes that providing Medicaid coverage to individuals while they are still incarcerated will increase the likelihood that they receive appropriate healthcare services like SUD treatment.[58] Waiving the Medicaid Inmate Exclusion Policy for SUD treatment would allow states to leverage their general funds by drawing down federal financial participation.

In late 2020, Kentucky submitted a Medicaid waiver requesting both the ability to provide SUD treatment to individuals while incarcerated and transition incarcerated individuals to a managed care organization 30 days before release.[59]

Kentucky has already undertaken many of the efforts discussed in this paper to connect incarcerated individuals with SUD services. In its waiver application, the state details the many programs and resources it has implemented without federal assistance, including drug courts and increasing available treatment slots from 300 to 3,000 without Medicaid funding. In 2021, the state will utilize software to link incarceration data with Medicaid data in a similar manner to Arizona. The state began a Reentry Pilot Program in 2018 with a four-member team (including Department of Corrections staff, parole officers, MCO coordinators, and/or community mental health personnel) to coordinate care for those reentering the community from two prisons. Another reentry program, the Community Reentry Coordination pilot program, supports incarcerated individuals with opioid use disorder (OUD) by providing MAT.

Despite these achievements, Kentucky hopes to utilize this waiver to expand existing services and assist more individuals. The eligibility group for Kentucky's waiver is incarcerated (Medicaid) members with incomes between 0% and 138% of the federal poverty level (FPL). While this includes both pretrial and convicted individuals, pretrial individuals must fulfill additional criteria (e.g., no felony convictions within the past 10 years).

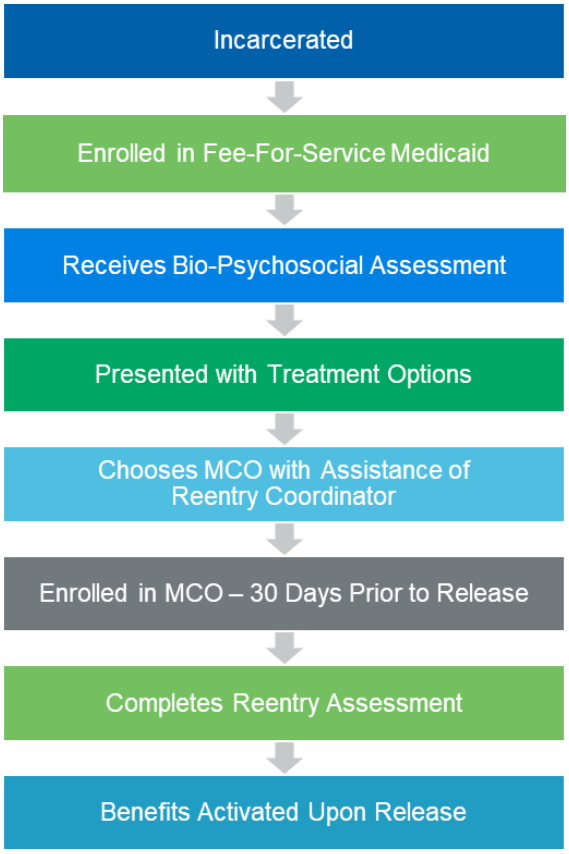
The state envisions that the member will go through the steps shown in Figure 1.

Benefits provided under the waiver are defined as:

- **SUD Treatment Services (SAP):** Provided to members with SUD diagnosis; meets American Society of Addiction Medicine (ASAM) level of care for treatment. Evidence-based services. Ten hours of clinical treatment a week that last for six months.
  - 5,300 slots proposed in the first year
- **SUD Recovery Services (SOAR):** For members who complete SAP. Minimum of seven hours a week of recovery services; up to 30 months.
  - 270 slots proposed in the first year
- **Medication management:** For members who meet qualifications for MAT. Medications prescribed by a qualified physician and administered as prescribed until release.
- **MCO Selection:** 30 days prior to anticipated release.

The waiver was submitted on November 24, 2020, and will need to be approved by CMS before it can be implemented. It remains to be seen how this waiver will interact with the federal Medicaid Inmate Exclusion Policy.

FIGURE 1: STEPS BEFORE RELEASE



Conclusion

As states and the federal government continue to battle against a proliferation of substance use disorder, one of the most effective tactics for both health outcomes for individuals and financial savings for states may be to increase access to treatment options for justice-involved individuals. Medication-assisted treatment, drug courts, and Medicaid coverage for incarcerated individuals are just some of the rehabilitative policy options available. Funding sources such as federal grants, state general funds, and federal participation provided through Medicaid waivers may be available to implement these important programs and services. If funding can be secured, such policies may play a role in breaking the costly cycle of relapse and recidivism.

CONTACT
Mary Pat Stemnock
MaryPat.Stemnock@milliman.com

Jeremy Hoffman
Jeremy.Hoffman@milliman.com

Jeremy Cunningham
Jeremy.Cunningham@milliman.com

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