2017 FORECAST
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Healthcare Services for Justice-Involved Individuals

THE BACKGROUND

States that expanded Medicaid gained two advantages in addressing adults involved with the criminal justice system.

+ Nearly all inmates who were inpatients of community hospitals and enrolled in Medicaid while in custody have had their inpatient costs covered by Medicaid federal financial participation (FFP) at 100 percent.

+ For the first time, most of the justice-involved population – largely low-income men – =gained access to coverage of the exceptionally high burden of chronic disease, mental illness, and substance use disorders (SUD) they bear. Diversion from incarceration, reductions in criminal recidivism and improvements in the continuity of medical, psychiatric, and SUD treatment were seen as important outcomes that would enhance public health and safety.

Expansion states and counties have worked with varying levels of intensity and success to enroll inmates into Medicaid. Less progress has been made in connecting formerly incarcerated persons (FIPs) to the medical, mental health, and prescription drug services they need. Challenges are so specific to local situations that replicable best practices have not yet emerged. However, important and encouraging successes have occurred. These exemplars typically build on progressive community mental health systems. Some Medicaid managed care organizations are also testing approaches to improve the continuity of care for FIPs.

New York and Illinois have requested through Medicaid waivers that some benefits be extended to inmates towards the end of incarceration, primarily to assure smooth transition to community providers and to cover long-acting drugs to treat addiction or psychosis. Neither waiver has been approved to date.

FORECAST

If the Medicaid expansion is rolled back or eliminated, the vast majority of FIPs will again be uninsured. The public health challenges of maintaining treatment for Hepatitis C, HIV/AIDS, and TB will re-emerge in the expansion states. Treatment for addictions will again become very rare, and many of the gains in the opioid epidemic will weaken or disappear. Persons with serious mental illness will be eligible for Medicaid only if they are determined to be disabled.

In a Medicaid block grant scenario, states may well determine who should and should not be eligible for Medicaid. Over time, block grants typically shrink, so a winnowing of services should also be expected. States that place high value on public health and/or treating addictions and high-risk populations may continue to extend Medicaid eligibility to FIPs, although the likelihood of continued broad coverage is unlikely. Other states will almost certainly determine that FIPs should not be eligible for Medicaid. It seems likely that we will see both approaches and wide variation among states.

In either case, the adult justice-involved population will almost certainly become a high-risk group in competition with many other high-risk groups for healthcare resources in every state. States will be forced to allocate a smaller pool of resources among many constituencies, and FIPs historically rank low.

This means fewer resources for the justice-involved, but it also creates a scenario in which any successful and replicable approaches to treat opioid addiction, increase psychotropic medication adherence, or address homelessness, for example, would be rapidly embraced.