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UNDERSTANDING HEALTH REFORM AS JUSTICE REFORM: MEDICAID, CARE COORDINATION, AND COMMUNITY SUPERVISION

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Policymakers are becoming increasingly aware of the failure of mass incarceration and the need for substantive reevaluation of how justice system dollars are spent. Learning from successes and failures of state and local justice reform and reinvestment strategies, policymakers have a solid framework upon which to make coordinated changes in health and justice spending that will reduce mass incarceration and provide healthier and safer residents and communities.

Given the current focus on state and federal funding, timing is exceptionally good for states to make targeted reforms in health spending, combined with substantive reforms in probation and parole, in order to reduce mass incarceration and achieve better outcomes. These combined strategies will be especially impactful for people who are overrepresented in jails and prisons, including people with mental illness and people of color. We argue that mass incarceration can be significantly reduced through the abolishment of probation and parole paired with state and federal investment in social service programs (i.e. housing and education) and with community-based healthcare and programs powered by Medicaid expansion.

Probation and parole agencies today are not designed to meet the needs of people with complex health and behavioral health needs, a population overrepresented in jails and prisons. A Medicaid-funded community effort to provide care coordination would bridge a gap in healthcare provision for reentering people and increase individuals' ability to

manage life challenges and health conditions including mental illness and substance use disorder. "Care coordination" is a complex term that encompasses the full array of healthcare service activities across all systems of care, and encompasses a wide range of actions: organizing the care and management of patients, improving healthcare quality, and achieving cost savings (Prokop 2016). Then, drawing from our local knowledge of the Michigan health care and justice system, we will focus on the state parole system to show how Medicaid-funded care coordination can provide better justice and health outcomes for people exiting prison and jail.

People with chronic behavioral health conditions, such as serious mental illnesses or substance use disorders, are disproportionately incarcerated and re-incarcerated (Matejkowski and Ostermann 2015). Probation and parole agencies are often unequipped to support their needs. Community corrections thus contributes to the criminal justice entanglement of people with health problems. Efforts at diversion into community-based treatment are often hindered by the lack of funding to cover comprehensive treatment programs. However, carefully targeted health reform efforts can become justice reform: state Medicaid programs can tailor and fund specialty community-based care coordination and behavioral health programming for targeted populations. Furthermore, the reallocation of funds through Medicaid can significantly reduce the total costs related to incarceration.

In this paper, we will first describe how the United States' current community supervision system does not effectively serve people with chronic health conditions. Then, drawing from our local knowledge of the Michigan health care and justice systems, we will focus on the example of the state parole system to show how Medicaid-funded care coordination can provide better justice and health outcomes for people exiting prison and jail. Care coordination can disrupt punitive community supervision and prevent re-incarceration from parole violations. This intersection of health and justice holds the potential for smarter spending, better health outcomes, reduced incarceration, and fewer people with mental illness and substance use disorders under correctional control.

COMMUNITY SUPERVISION AND THE NEED FOR A NEW MODEL OF CARE

Community supervision, a collective term for probation and parole, is theoretically an alternative to incarceration, but in reality it has driven and helped sustain mass incarceration in the 21st century.

A staggering 4.5 million people are under community supervision in the United States, which is twice the number of people that are incapacitated through incarceration. A large community corrections population means large caseloads for probation and parole officers. Increasing caseloads paired with punitive correctional policy undermines the capacity of probation and parole officers to meet the treatment and health needs of people with chronic conditions and other social vulnerabilities.

Each year, an estimated 80 percent of people released from incarceration in the United States have a substance use disorder, mental health illness, or physical health condition—and people suffering from these conditions are significantly more likely to fatally overdose after release from prison or jails (Mistak 2019). Moreover, the prevalence of hepatitis C in the same populations is 10 times the rate found in the general population, and HIV is eight to nine times the rate of the general population (Goyer, Serafi, Bachrach, and Gould 2019). These health problems, coupled with unrealistic expectations for correctional compliance, significantly hinder opportunities for successful reintegration into community life. Ultimately, the lack of access to healthcare affects recidivism while undermining efforts to maintain or find employment, housing, family relationships, and sobriety (Mallik-Kane, Paddock and Jannetta 2018).

Community supervision was originally conceived as a progressive alternative to incarceration that allowed people to remain in their communities (probation) or reintegrate after incarceration (parole). During the 1980s and 90s, however, community supervision shifted from a casework model focused on rehabilitation toward a crime control model that relied on intensified surveillance and punishment ("trail 'em, nail 'em, and jail 'em") (Klingele 2013). The system incentivizes and often requires officers to funnel people back

EACH YEAR, AN ESTIMATED 80 PERCENT OF PEOPLE RELEASED FROM INCARCERATION IN THE UNITED STATES HAVE A SUBSTANCE USE DISORDER, MENTAL HEALTH ILLNESS, OR PHYSICAL HEALTH CONDITION.

to prison, rather than address and support their behavioral health needs or tackle the social conditions from which noncompliance may emerge. This shift in focus has not only increased the number of people supervised, but also has standardized the punishment of noncriminal conduct (e.g. staying out past curfew or missing parole appointments) (Doherty 2019). Practitioners in the field lament that probation and parole officers have been pushed away from their role as rehabilitative agents, and instead are immersed in a bureaucratic process focused on compliance. Neglecting to provide people under community corrections with valuable resources from a trusted case manager—like transitional housing, vocational training, health, and behavioral health services—is the ultimate failure of the supervision system.

People with mental illness and addiction are particularly vulnerable to probation and parole violations because symptoms from these diagnoses can negatively impact compliance. Navigating the demands of community corrections, while also battling a chronic health condition, searching for employment and housing, and meeting basic material needs, is essentially impossible (Phelps 2018). Community corrections officials recognize that people with behavioral health conditions need support, but that the system in which they work does not easily accommodate people's mistakes, related to their illnesses or not.

In recent years, scholars and practitioners have written about the detrimental effects of probation and parole and the need for fundamental reform (Horn 2001; Doherty 2016; Phelps 2018). Community supervision practitioners have partnered with scholars to call for a dramatic reduction in the number of people who are under community supervision and a greater focus on providing people with the help and resources they need to remain in their communities and thrive (for example, see the Executives Transforming Probation and Parole initiative)

(Muhammad 2019). Reformers have argued that community supervision has driven and helped sustain mass incarceration in the 21st century, which is why a model that can provide people with the care they need outside of parole and probation is necessary and long overdue (Williams, Schiraldi, and Bradner 2019). Reinventing and shrinking community supervision by drawing from Medicaid-funded care coordination models has the potential to contribute to significant reductions in incarceration, especially amongst a high-need population with physical and behavioral health conditions.

THE POWER OF MEDICAID TO EXPAND RESOURCES FOR JUSTICE REFORM

Expanding Medicaid is a key mechanism for providing health and social services that, when carefully targeted, can ultimately reduce the scope of the community supervision system. As of January 2020, thirty seven states and the District of Columbia have expanded Medicaid under the Affordable Care Act.[1]

In Medicaid expansion states like Colorado and New York, 80 to 90 percent of people exiting incarceration are eligible for Medicaid and can receive these critical behavioral health programs; in states that have not expanded Medicaid, eligibility for medical coverage and programs falls under 10 percent. Typically, in these non-Medicaid expansion states, Medicaid only covers low-income children, the elderly, pregnant women, and people with disabilities, thus leaving most of those who are living at or near poverty without healthcare after incarceration.

Medicaid is financed through a shared state and federal funding model, making it possible for states to access additional health resources. States that implement a Medicaid expansion program receive an enhanced federal Medicaid matching rate for their local dollars invested. In 2020, the federal match was 90 percent, which is generally much higher than the state's regular federal match rate (Goyer, Serafi, Bachrach, and Gould 2019). Expanding Medicaid coverage has provided new opportunities for states to establish care coordination services to people under supervision. All people returning to the community with income at or below 133 percent of the federal poverty level and who meet other federal citizenship requirements are eligible for these services (Goyer, Serafi, Bachrach, and Gould 2019; Howell, Kotonias, and Jannetta 2017).[2]

The continuity of treatment from the prison to the community is important in sustaining good health practices, particularly for

those with chronic conditions, while promoting a point of access to other social services. People with chronic conditions often receive consistent treatment in prison, but then face the challenge of continuing their care once they return to the community. Many expansion states are enrolling people in Medicaid before they are released from prison, which can support health immediately after incarceration. Mental illness and addiction are potent risk factors for re-incarceration. Care coordination available through Medicaid coverage will reduce the probability of returning to jail or prison for high-risk patients. A well-designed system of care can improve health and increase the likelihood of successful re-entry.

Although Medicaid is an opportunity for expanding the availability of care, having access to healthcare is not synonymous with receipt of care. As described below, the power of these resources is better harnessed when state Medicaid agencies partner with the justice system, community-based health providers, and people with direct experience in designing a program to make a significant difference in the health of people reentering by promoting their ability to obtain health services and improve well-being (Centers for Medicare and Medicaid Services 2018).

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INTEGRATED COMMUNITY-BASED PROGRAMS AS JUSTICE REFORM

MEETING THE NEEDS OF PEOPLE WITH HISTORIES OF INCARCERATION.

Most probation and parole systems do not address community and personal vulnerabilities like economic instability, lack of access to housing and educational opportunities, food insecurity, and other vulnerabilities captured by social determinants of health (SDOH) that are associated with a higher likelihood of incarceration and revocation. Additionally, healthcare management of behavioral health needs by probation and parole officers are inadequate and may also contribute to recidivism. A five-year study of communities implementing jail diversion programs, pre- and post-justice involvement, reports that people in Michigan with co-occurring substance use disorders were twice as likely to return to jail than people with mental illness and no addiction (Kubiak et al. 2019). Connecting reentry populations with appropriate post-release health services to manage chronic health conditions is challenging because managing health may be a low, or unattainable, priority for people dealing with various survival needs and SDOH. In designing models, researchers need to understand best practices and consider the experiences of the populations they are trying to target. Returning individuals' perceptions of health and healthcare in the reentry process remain insufficiently understood (Mallik-Kane et al. 2018).

As in Michigan, all states in the nation need to work through potential barriers of care coordination for people with chronic conditions and justice system involvement. Careful collaboration across different health and social service networks is needed to ensure individual success. Care coordination should be tailored to address an individual's healthcare needs. One particularly challenging barrier to care coordination involves securely sharing personal health information between the justice system and community-based healthcare staff, consistent with state and federal privacy laws. Quality care coordination is dependent on secure information sharing across health and justice community systems. Yet of ten Michigan communities with pilot diversion programs over five years, only four reported a close working relationship between parole, probation, and community behavioral health programs. A five year Michigan-based pilot diversion program found that only four of the ten programs reported a close working relationship between parole, probation, and community behavioral health programs,

and only 30 percent of jail discharges incorporated a behavioral health related discharge service (Kubiak et al. 2019).

While many barriers and challenges remain, Michigan's Departments of Corrections and Health and Human Services are successfully working in several areas to strengthen the likelihood of a person's success before, during, and after incarceration. Michigan efforts include promising practices in specialty reentry support and systems for people with mental illness and substance use disorders, as well as bold employment efforts such as Michigan's "Vocational Village" where individuals have the opportunity to leave not just with training, but also with confirmed employment in hand.

CARE COORDINATION IS A HUGE CHALLENGE FOR MANY POPULATIONS, BUT INTENSIVE CASE MANAGEMENT PROGRAMS HAVE BEEN DEMONSTRATED TO HELP.

Medicaid provides states with funding opportunities to expand care coordination to targeted population groups. Each state has flexibility in choosing and designing Medicaid-funded care management programs to address specific populations with complex needs. By choosing to expand care coordination for people reentering the community after incarceration, states can reduce incarceration and related costs. Intensive case management programs are good investments for this target population. For example, specific options such as Medicaid Health Home (MHH) or Targeted Case Management (TCM) programs allow states to seek federal approval to amend their Medicaid programs to include reimbursement for health home and targeted case management models.[3] Both MHHs and TCMs are predicated on a strong care management foundation that is instrumental in meeting the healthcare coordination needs for the 80 percent of individuals returning home from incarceration who have chronic conditions, including mental illness and addiction.

It is noteworthy that there is a lot of variability amongst the states in whether they choose to implement special care coordination models, which populations they target, and which Medicaid policy path (i.e. MHH, TCM, etc.) they choose to pursue. There are different pros and cons

associated with the program of choice. For example, MHHs can be attractive to state Medicaid programs because they offer a 90/10 federal/state match for health home services for the first eight quarters of implementation, while TCM model payments receive the state's regular federal Medicaid assistance percentage (Centers for Medicare and Medicaid Services 2013). But MHHs tend to have more administrative requirements than the TCMs. Each state must submit a request to add a MHH and the request must specify the desired targeted population to receive MHH services. The individuals the state chooses to cover must (1) have at least two chronic conditions,[4] (2) have one chronic condition and be at risk for another, or (3) have one serious and persistent mental health condition; and states must ensure that patients are not receiving more than eight quarters of MHH services at the 90/10 match rate. Furthermore, MHH billing is more complex for providers—there may be a need for significant technological changes for successful implementation—and MHHs have specific quality monitoring and reporting requirements (Social Security Act 2019). TCMs have more flexibility specifying the populations they serve.

Whichever model is chosen, health home experiences in other states have demonstrated that both of these programs result in overall reductions in emergency department visits and inpatient hospital admissions. For example, Bleich et al. (2015) noted that medical homes can decrease emergency department visits and inpatient admissions by better coordinating care for individuals with chronic diseases. Fillmore et al. (2014) found that while emergency department visits were higher for individuals enrolled in a health home initially, they then decreased and became insignificant. New York found that inpatient service costs decreased by approximately 30 percent for people who were enrolled in a MHH. And Missouri's Community Mental Health Center MHH has shown a 13 percent reduction in hospital admissions for the study population, and a decrease of 8 percent for emergency department use (CMS 2013). Consistent with these MHH models, Cantor et al. (2014) found that 39 percent of the hospitalizations being studied had a co-occurring behavioral health diagnosis and that successful MHH models reduced inpatient admissions by 29 percent (CMS 2013).

In 2016, Michigan implemented a MHH model. Over the first 18 months of program implementation, emergency department use and inpatient hospital admissions decreased steadily. These reductions were statistically significant when measured at the 6-month, 7- to 12-month, and 13- to 18-month timeframes.[5] Additionally, healthcare service utilization cost spending decreased over the time period of review (University of Michigan 2019).

INTENSIVE CASE MANAGEMENT MODELS ARE EFFECTIVE INVESTMENTS THAT CAN TRANSFORM OUTCOMES FOR PEOPLE RECENTLY RELEASED FROM INCARCERATED SETTINGS.

Managing care for people with chronic health conditions in the primary care setting is further compounded for low-income individuals and those who were recently released from an incarcerated setting, as they may lack access to healthcare or other critical social services (Prokop et al. 2019). Barriers to accessing care may lead to poor health outcomes and complicate the ability of these individuals to reintegrate into the community. Creating a community-based model that integrates physical and behavioral health is key to successfully addressing their needs and advancing safety.

Tailored health home and targeted case management models are showing positive results for people exiting jail or prison (CMS, 2018; Goyer, et al. 2019; Prokop et al, 2019). States such as Arizona, New York, New Mexico, and Ohio have implemented health homes or other care coordination models predicated on the principle of "integrated health care management," where healthcare provision is paired with social supports for people exiting jails or prisons. Creating systems of care through healthcare delivery models can help individuals address healthcare and social needs, improving care management and preventing costly emergency room or inpatient hospital stays. Improved coordinated care can reduce emergency department visits, improve access to appropriate outpatient visits, provide behavioral health services, and promote health equality (AHRQ 2007; Prokop 2016). Pilot initiatives have been successful in significantly reducing recidivism rates. Some have reported reducing incarceration-return rates from 57 percent to 16 percent in a three-year time period (Goyer et al. 2019). It is important that these models focus on establishing relationships and trust, providing patient-centered care, and addressing social determinants of health (SDOH) (Prokop et al. 2019).

The Transitions Clinic Network (TCN), a model of coordinated care for people under community supervision or exiting incarceration, has seen a lot of success

integrating care by establishing trusted relationships with patients who were formerly incarcerated. TCN was co-founded by Dr. Emily Wang and Dr. Shira Shavit in 2006, and is a national network of medical homes for people reentering society post incarceration who are experiencing chronic disease. Grounded in community and a public health approach to serving people reentering society with intensive health needs, TCN caters to the most vulnerable to support them in the successful reintegration into their lives and neighborhoods.

The San Francisco Department of Public Health opened the first Transitions Clinic (TC) to provide transitional and primary care as well as case management to people with chronic illness that are reentering society post-incarceration in San Francisco. Dr. Wang published a formal analysis of the effectiveness of the San Francisco TC in 2010, which measured the rates of program participants' attendance for the initial appointment and the six-month follow-up appointment post-incarceration. Results of the study show that of the 185 TC participants observed between January 2006 to October 2007, attendance at initial appointments was reported at 55 percent, with a six-month follow-up rate of 77 percent, compared with 40 percent and 46 percent, respectively, for non-TC patients seen at Southeast Health Center (Wang 2019). Furthermore, clinics with community health workers who had personal histories of incarceration contributed to increasing the average of new patients from seven to eleven per month (Wang 2019).

People reentering society after incarceration who are experiencing mental illness and substance use problems need the kind of care that TCN provides, rather than traditional community supervision. States can seek federal approval to amend their Medicaid programs to include reimbursement for health home or targeted case management models predicated on the principles of TCN. Through either of these Medicaid mechanisms (TCM or MHH), states can provide an enhanced system of care coordination to assist individuals in managing their chronic conditions and integrating into the community. Medicaid can be the foundation upon which justice reformers can build and finance a new model that provides critical healthcare and social support.

Similarly, in Michigan, a specialized model that was piloted in October 2017 has seen a great deal of success. Several Federally Qualified Health Centers (FQHC) partnered with the Department of Corrections to implement a health program to coordinate care for people on parole. The program, called Connection to Care (C2C), was designed to address and ensure that the behavioral and physical health needs of

justice-involved people are addressed after prison release. The model is centered on a peer support specialist or "health coach," and allows the person soon-to-be-released on parole to establish a relationship with FQHC staff before leaving the incarcerated setting. In the first year of operation, 100 percent of C2C patients had an appointment scheduled and were seen by their primary care provider within seven days from discharge. The FQHC staff were successful in connecting with paroled patients as the peer support specialist or health coach contacted each patient an average of twice per month (Boinapally 2019).

The FQHCs completed a patient satisfaction survey for the 73 individuals served by the program that focused on access to care measures. People under supervision were very receptive to ongoing engagement in this model and with their health coach. All of the respondents indicated that it was not hard to get to the appointment, 91 percent indicated that they received help to access healthcare, 98 percent indicated that it was easy to share health problems with the doctors and the C2C staff, and they provided a high rating for their first visit (4.7 on a 5.0 scale) (Boinapally 2019).

FOR PEOPLE RECENTLY RELEASED FROM INCARCERATED SETTINGS, CREATING A COMMUNITY-BASED MODEL THAT INTEGRATES PHYSICAL AND BEHAVIORAL HEALTH IS KEY TO SUCCESSFULLY ADDRESSING THEIR NEEDS AND ADVANCING SAFETY.

CONCLUSION

Justice reform strategies to reduce mass incarceration will not be successful without healthcare and social supports for people with chronic health conditions.

This is particularly true for those with mental illness or substance use problems. Community supervision today is overly punitive and offers little support for successful return to the community. Until probation and parole are replaced with a system that can address these serious health needs, people with behavioral health conditions will continue to be over-represented in the penal system, suffer high rates of re-incarceration, and remain incarcerated for longer periods of time.

Health system reform built upon the foundation of Medicaid programs can provide many of the health and social supports needed to help people with health problems successfully return and remain in their communities. For states that expand Medicaid, these supports and services can be offered to most people released from jails and prisons. Care coordination and management models provided through Medicaid are effective and can be powerful tools to finance the provision of health and behavioral health services in a socially supportive environment.

Eliminating punitive supervision while providing healthcare recaptures the spirit of rehabilitation at the core of community corrections when it was first envisioned. State Medicaid leadership can build specialized community-based care management models into Medicaid programs for those returning home from incarceration. When state Medicaid leadership receives federal approval for specialty care coordination models, the financing of these services is shared between the state and federal governments, thus increasing the resources available for these impactful and cost-effective strategies. Financing of community supervision models is not similarly shared, however, when Medicaid is not available. Because of this, states that do not expand Medicaid will be greatly limited in their ability to substantially reform and reduce punitive community supervision.

While this paper focuses on tools that can be used to reduce mass incarceration of people with chronic physical and behavioral health needs, these health reform tools have potential application to address unique needs of other people who are overrepresented in jails and prisons. With the disproportionate incarceration of people in poverty and of racial and ethnic minority populations, more attention needs to be given to how these tools and models can

be designed and utilized to address racial health and justice disparities. Further study is warranted to determine whether specialty care coordination models need refinement to address unique needs of specific races, cultures, and localities.

In conclusion, specialty care management models built upon state Medicaid programs provide an opportunity to reduce and ultimately end the use of current parole and probation models for targeted populations with better results. This opportunity is exponentially increased for states that expand Medicaid. Medicaid care coordination models can improve access to healthcare and quality of care and help to prevent future incarceration. When used together by state Medicaid and state correctional system leadership, these tools at the intersection of health and justice reform provide a powerful opportunity to improve health and help end mass incarceration.

STATE MEDICAID LEADERSHIP CAN BUILD SPECIALIZED COMMUNITY-BASED CARE MANAGEMENT MODELS INTO MEDICAID PROGRAMS FOR THOSE RETURNING HOME FROM INCARCERATION.

ENDNOTES

1 In August of 2020 the Kaiser Family Foundation released an interactive map of the current status of state decisions on the Affordable Care Act.

2 Immigrants with income below 133 percent of the federal poverty level would not be eligible for Medicaid services.

3 A "Medicaid health home" is a comprehensive system of care coordination for Medicaid-eligible individuals with chronic conditions. "Targeted case management" refers to case management for specific Medicaid beneficiary groups or for individuals who reside in state-designated geographic areas, thus "targeted" by the state for services.

4 Qualifying chronic conditions listed in section 1945(h)(2) of the Social Security Act.

5 6- to 12-month: emergency department $p < 0.001$, inpatient hospital $p = 0.011$; 7- to 12-month: emergency department $p < 0.001$, inpatient hospital $p = 0.003$, and 13- to 18-month: emergency department $p < 0.001$, inpatient hospital $p = 0.24$.

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Please note that the policy recommendations put forth in this paper do not reflect those of the Michigan Department of Health and Human Services.

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Matthew Desmond | Professor of Sociology, Princeton University & Founder, The Eviction Lab

Melissa Nelson | State Attorney, Florida's 4th Judicial Circuit

Nancy Gertner | Professor, Harvard Law School & Retired Senior Judge, United States District Court for the District of Massachusetts

Nneka Jones Tapia | Inaugural Leader in Residence, Chicago Beyond

Pat Sharkey | Professor of Sociology and Public Affairs, Princeton University

Robert Rooks | Vice President, Alliance for Safety and Justice & Associate Director, Californians for Safety and Justice

Sylvia Moir | Chief of Police, Tempe, Arizona

Thomas Harvey | Director, Justice Project, Advancement Project

Tracey Meares | Walton Hale Hamilton Professor, Yale Law School & Founding Director, The Justice Collaboratory

Vikrant Reddy | Senior Fellow, Charles Koch Institute

Vincent Schiraldi | Senior Research Scientist, Columbia University School of Social Work & Co-Director, Justice Lab, Columbia University

Vivian Nixon | Executive Director, College and Community Fellowship

THE SQUARE ONE PROJECT

REIMAGINE JUSTICE

The Executive Session on the Future of Justice Policy, part of the Square One Project, brings together researchers, practitioners, policy makers, advocates, and community representatives to generate and cultivate new ideas.

The group meets in an off-the-record setting twice a year to examine research, discuss new concepts, and refine proposals from group members. The Session publishes a paper series intended to catalyze thinking and propose policies to reduce incarceration and develop new responses to violence and the other social problems that can emerge under conditions of poverty and racial inequality. By bringing together diverse perspectives, the Executive Session tests and pushes its participants to challenge their own thinking and consider new options.

COLUMBIA UNIVERSITY | JUSTICE LAB