Achieving Public Health Goals Through Medicaid Expansion: Opportunities in Criminal Justice, Homelessness, and Behavioral Health With the Patient Protection and Affordable Care Act

Barbara DiPietro, PhD, and Lisa Klingenmaier, MPH, MSW

States are currently discussing how (or whether) to implement the Medicaid expansion to nondisabled adults earning less than 133% of the federal poverty level, a key aspect of the Patient Protection and Affordable Care Act.

Those experiencing homelessness and those involved with the criminal justice system—particularly when they struggle with behavioral health diagnoses—are subpopulations that are currently uninsured at high rates and have significant health care needs but will become Medicaid eligible starting in 2014.

We outline the connection between these groups, assert outcomes possible from greater collaboration between multiple systems, provide a summary of Medicaid eligibility and its ramifications for individuals in the criminal justice system, and explore opportunities to improve overall public health through Medicaid outreach, enrollment, and engagement in needed health care. (*Am J Public Health.* 2013; 103:e25–e29. doi:10.2105/AJPH.2013.301497)

STARTING IN 2014 (OR EARLIER should states choose), the Patient Protection and Affordable Care Act (ACA)[1] will give states the option to expand Medicaid to most people earning at or below 133% of the federal poverty level (FPL). Those experiencing homelessness will greatly benefit from this policy change because most nondisabled adults were previously ineligible for Medicaid. Of the 836 980 patients seen in 2012 at federally funded Health Care for the Homeless clinics, 61.1% were uninsured (even though the vast majority of these individuals lived below the poverty level).[2] (Health Care for the Homeless grantees are part of the Health Center Program as authorized under section 330 of the Public Health Service Act, as amended, and administered by the Health Resources and Services Administration. They are also sometimes referred to as "federally funded health centers" or "Health Resources and Services Administration–funded health centers.") Although the health of all those living in poverty is a concern to the public health community, those who are both homeless and involved with the criminal justice system are even more vulnerable. In particular, when individuals experiencing homelessness with a behavioral health diagnosis are unable to access broad-based mental health treatment, untreated symptoms can lead to incarceration.[3] Focusing attention on these subgroups could yield wider individual and system benefits from the Medicaid expansion, because these groups tend to have even lower income, lack health insurance at a higher rate, and need a wider range of health care services than their stably housed but still impoverished counterparts.

Providers and administrators in both the criminal justice system and the community not only share a common set of patients, they also share important public health goals. Such goals include increasing community safety, reducing incarceration and recidivism rates and health care costs, improving patients' health status, and increasing the community's capacity to deliver needed medical and behavioral health services to improve overall individual and public health.

Decisions that directly influence these goals are happening now. It is critical for health care providers who serve homeless populations and persons within the criminal justice system to inform and influence the outcomes of a changing environment in health care access and delivery. Because of eligibility and enrollment changes, the ACA creates new possibilities for stronger partnerships between service providers and policymakers, and public health advocates can initiate and guide this process.

HOMELESSNESS, INCARCERATION, AND BEHAVIORAL HEALTH

Among adults in jail in the United States, 15.3% were homeless at some point in the year before their incarceration. This is 7.5 to 11.3 times the estimate of homelessness among the entire US adult population (1%–2%).[4] In the state and federal prison population, this rate drops to 9%, with those who are homeless more likely to be incarcerated for a property crime, have had previous criminal justice system involvement for property and violent crimes, and have mental health problems, substance abuse problems, or both.[5] Individuals experiencing homelessness who are incarcerated for such offenses can spend significant time "behind the wall"—more than 40% of respondents in a recent study in Baltimore, Maryland, spent a combined total of five or more years incarcerated over their lifetime.[6] These two public health issues have a direct relationship: homelessness can lead to incarceration, and incarceration can lead to homelessness.[7]

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.

MEDICAID ELIGIBILITY AND HOMELESSNESS

One of the most important provisions of the ACA is the option for states to expand Medicaid to most

low-income people. Starting January 1, 2014, nonpregnant, nondisabled adults aged 19 to 64 years who earn at or below 133% FPL will become eligible for Medicaid (a 5% income disregard makes the actual eligibility limit 138% FPL).[1] Using 2012 FPL guidelines, 138% FPL is equivalent to an individual earning $15 856 per year, or about $26 951 for a family of three. For the first three years, the expansion is 100% federally funded (dropping to 90% in 2020 and thereafter).

An Urban Institute analysis found that if all states expand Medicaid to individuals at or below 138% FPL, more than 15 million adults will be eligible to enroll.[8] Although the Supreme Court upheld the ACA as constitutional, it determined that the Medicaid expansion would be a state option rather than mandatory.[9] At the same time, 4.3 million adults in the United States are currently eligible for Medicaid but not enrolled.[10] Because of state expansion variance and past experiences with enrollment among eligible populations, the Congressional Budget Office has projected that only eight million will enroll in the first year (2014) and only 11 million two years after implementation (2016).[11] Of those remaining uninsured after 2014, just more than one third are projected to be eligible for Medicaid but not enrolled (36.5%).[12] These reports have demonstrated that eligibility does not automatically equate to enrollment; hence, it is important for all states to expand and implement strong outreach and enrollment practices.

Indeed, the ACA requires states to establish procedures to conduct outreach to and enroll vulnerable and underserved populations eligible for medical assistance and to include racial and ethnic minorities, individuals with mental health or substance-related disorders, and individuals with HIV/AIDS (among others).[13] Individuals with these characteristics are overrepresented in the adult homeless population and have encountered historic barriers to enrollment and accessing care. Individuals in these populations may currently be eligible for Medicaid because of disabilities but are not enrolled. For example, the 2011 Annual Homeless Assessment Report to Congress found that 38% of those staying in homeless shelters were disabled, compared with only 15% of the total US population.[14] As expansion efforts unfold, these individuals no longer have to demonstrate disability to gain access to health insurance.

MEDICAID ELIGIBILITY AND CRIMINAL JUSTICE

Nearly all (90%) persons entering local and county jails and detention centers in the United States are uninsured.[15] One profile of jail inmates found that 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.[16] Of all those potentially eligible for Medicaid under the ACA, more than one third (35%) had prior criminal justice involvement.[17] Those who are enrolled in Medicaid traditionally have coverage terminated on incarceration on the basis of a federal law that prohibits Medicaid expenditures within correction environments (the ACA does not alter this policy). Federal guidance recommends suspension of benefits during incarceration, rather than termination,[18] because it simplifies and accelerates resumption of Medicaid coverage on discharge; however, many states still terminate. Although the criminal justice system in general has made efforts to improve connections to health services as part of reentry planning—particularly for those serving longer terms in prison—greater eligibility for health insurance once released can help bolster those community connections to care.

Jails and Detention Centers

At midyear 2010, nearly 750 000 individuals were incarcerated in county and city jails in the United States on a single day; of these, 61% were awaiting court action on the current charge (e.g., the pretrial population).[19] In 2010, 12.9 million people were admitted to these types of facilities, making them a prime population to target for Medicaid enrollment and services on release. This policy development offers a wide range of possibilities for increasing access to community health care, reducing recidivism, improving the reentry process, and engaging criminal justice agencies in Medicaid enrollment.

The size of the jurisdiction's jail or detention center may affect the opportunities for intervention, because this population has a wide range of average weekly turnover (51.5%–136.7%). Overall, smaller jails see greater turnover than larger jails (Table 1), so the time needed for enrollment and other reentry planning will need to be tailored to the length of time an individual is incarcerated.

Prison and Community Corrections

Those released from prison are also likely to benefit from the expansion of Medicaid to childless adults starting in 2014. Although 1.6 million adults were incarcerated in federal and state prisons in 2009, 730 000 were released that year (21% higher than releases in 2000).[20] A recent study has estimated that as many as one third (33.6%) of those released from prisons annually could enroll in Medicaid after the expansion becomes effective.[21] Of the nearly five million people already involved in community corrections, most are on active supervision (which may require participation in some type of treatment).[22] ("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.) Hence, opportunities also exist to expand Medicaid enrollment for those reentering from prisons and those already in the community but still in need of services. Those able to access adequate treatment may be at reduced risk of probation violation or re-arrest for behaviors related to untreated mental health problems or addictions.

IMPROVED ENROLLMENT

The new Medicaid enrollment guidelines include a number of changes that should make it much easier to enroll in the program than the current process.[23] In general, the new system is designed to enable individuals to apply independently (including via a home computer connection), although many of those in the homeless population will want or need assistance in doing so. Improvements include moving to a modified adjusted gross income, faster determination timelines, electronic verification of information, more flexible residency and address options, limited use of paper documentation, a 12-month renewal process, and application assistance if needed.

These improvements should make applying for Medicaid (and

TABLE 1—Daily Census and Turnover Rate of Adults Incarcerated in the United States, Based on Size of Jail: US Bureau of Justice, 2010

Jurisdiction Size, No. Inmates	Average Daily Population	Weekly Turnover Rate, %
< 50	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
≥ 1000	375 442	51.5
Total	748 553	64.9

Source. Minton.[19] (Data from demographic information from inmates at mid-year report, accessed December 10, 2012.)

reenrollment) easier for both clients and those assisting them. Because under the new system an application can be submitted online with electronically verified information, personnel working in jails and prisons now have a greater opportunity to participate in the enrollment process as part of reentry standard operating procedures.

HEALTH STATUS OF THE CRIMINAL JUSTICE POPULATION

A wide body of literature has focused on the health status of those involved with the criminal justice system, who demonstrate poorer health than the general population, increased rates of chronic and infectious disease, and very high rates of behavioral health disorders.[24,25]

Chronic and Infectious Disease

One report on medical problems of jail inmates found that half of women (53%) and one third of men (35%) reported a current medical problem; the most commonly reported conditions were arthritis (19% and 12%, respectively), hypertension (14% and 11%, respectively), asthma (19% and 9%, respectively), and heart disease (9% and 6%, respectively).[26] One study conducted in Maryland jails found that nearly 7% tested positive for HIV, and the prevalence of HCV reached nearly 30% and that of hepatitis B reached just more than 25%.[27] Overall, persons released from criminal justice venues (both jails and prisons) have been found to represent 17% of the total AIDS population, 13% to 19% of those with HIV, 12% to 16% of those with hepatitis B, 29% to 32% of those with HCV, and 25% of those with tuberculosis.[28] These conditions pose important public health implications, as well as significant fiscal expenditures 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 that 64% of those in jail have some form of mental illness,[29] and 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.[30] Other research has found that 10% to 15% of those in state prisons also have severe mental illness.[31] The prevalence of substance use is even higher. More than two thirds of jail inmates are dependent on or have abused alcohol or drugs (with men and women having similar rates).[32] The rates of substance abuse among jail inmates can be as much as seven times that of the general public.[33] Often, mental illness and substance abuse are co-occurring conditions in this population. In jails, an estimated 72% of individuals with serious mental illness have a substance use disorder.[34] In prisons, individuals with co-occurring disorders ranged from 3% to 11% of the total incarcerated population.[35] Clearly, addressing mental health and substance use disorders must be a priority for both community health care providers and the criminal justice system.

ESSENTIAL HEALTH SERVICES

The ACA requires Medicaid coverage for the newly eligible population to include 10 categories of services: ambulatory services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services (including behavioral health treatment), prescription drugs, rehabilitative and habilitative services, laboratory services, preventive and wellness services and chronic disease management, and pediatric services, including oral and vision care.[1]

Many of those who have criminal justice system involvement—and those individuals who might experience homelessness—will have access to insurance that covers a wide range of health care services, particularly behavioral health care. 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, incarceration, and homelessness. 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, a Washington State study found that rates of rearrest were 21% to 33% lower in three groups treated for chemical dependency than among other adults needing, but not receiving, treatment. This reduction saved $5000 to $10 000 for each person treated.[36,37] At the same time, future funding for services targeted to this population such as mental health and substance abuse treatment grants, Services in Supportive Housing, and Ryan White HIV/AIDS programs are uncertain. Framing the conversation in terms of cost savings and a larger public health interest may help engage a broader range of support among public policymakers.

A CALL TO ACTION

Rarely are the needs of those who are homeless and those who are involved with the criminal justice system incorporated into policy decisions unless those who work most closely with these vulnerable populations make a concerted effort. Indeed, a major challenge may be first to convince corrections officials that improving health care should be a priority issue to which they should dedicate resources. State and local governments—along with myriad partners—are (or should be) currently attempting to redesign the health care system, and they are likely focused on the health and

service utilization patterns of the general public in their quest to meet federal deadlines and other mandates. Because Medicaid expansion is initially 100% federally funded and current health services in correction settings are 100% state and locally funded, officials in these venues should take note of the significant cost savings possible if an adequate community services system can be developed. The public health community can add to that conversation by taking 12 key steps:

1. Educate state health reform policymakers about the connections among homelessness, behavioral health, and the criminal justice system.
2. Work with the criminal justice system to develop its commitment to improving the health status of individuals who are incarcerated and who are being released.
3. Develop new protocols for screening incoming detainees for health insurance enrollment and ensuring connection to community care at discharge.
4. Incorporate data links between community providers and jails and detention centers to better coordinate health care and reentry services.
5. Commit to adequately funding a wide range of behavioral health programs and introduce greater service flexibility so that treatment can be accessed on demand.
6. Develop a health care system and trained workforce that can meet the needs of those with severe, multiple morbidities (especially behavioral health).
7. Reduce the connection between homelessness and incarceration by decriminalizing activities related to homelessness, such as nuisance crime arrests.
8. Encourage states to suspend—not terminate—Medicaid benefits for those who are incarcerated.
9. Ensure each state fully expands Medicaid to 133% of the FPL.
10. Ensure jail and detention center administrators are aware of policy changes and the potential financial implications for their operations and are active in state decisions.
11. Track public health data related to these populations and tie them to state health reform outcome measures.
12. Commit to the larger goal of ending homelessness by investing in adequate housing, particularly for individuals after release, so they are not released to the streets.

Criminal justice administrators and health care providers for the homeless share goals related to reducing recidivism and improving public health, especially for populations with high rates of chronic and communicable disease, and are particularly in need of ongoing behavioral health services. The recommendations included in this article are intended to increase awareness about the needs of a vulnerable group, maximize outreach and Medicaid enrollment levels, and identify opportunities for which stronger connections to care are possible. Striking now while the proverbial iron is hot will help ensure that system changes include provisions tailored to these special populations. Not only will individual and community health benefit from such an approach, but significant cost savings are possible when investments in health care can offset savings in the criminal justice system. Galvanizing these changes will require a wide range of stakeholders who can see across fences and walls—figuratively and literally—to the common goals that are possible through effective Medicaid expansion policies. ■

About the Authors

Barbara DiPietro is with the National Health Care for the Homeless Council, Nashville, TN, and Health Care for the Homeless of Maryland, Baltimore. At the time of the study, Lisa Klingenmaier was with Health Care for the Homeless of Maryland.

Correspondence should be sent to Barbara DiPietro, PhD, Health Care for the Homeless, 421 Fallsway, Baltimore, MD 21202 (e-mail: bdipietro@nhchc.org). Reprints can be ordered at http://www.ajph.org by clicking the "Reprints" link.

This commentary was accepted June 1, 2013.

Contributors

B. DiPietro provided overall direction and was the primary author of and researcher for the article. L. Klingenmaier provided secondary writing and research assistance. Both authors contributed to the content and design of the final article.

Acknowledgments

The authors would like to thank the National Health Care for the Homeless Council as well as Health Care for the Homeless of Maryland for their unswerving dedication to the needs of people experiencing homelessness and commitment to progressive public policies aimed at preventing and ending homelessness.

References

1. Patient Protection and Affordable Care Act, Pub. L. No. 111–148, § 3502, 124 Stat. 119, 124(2010). Available at: http://www.gpo.gov/fdsys/pkg/PLAW-111publ148/content-detail.html. Accessed November 28, 2012.

2. Health Services and Resources Administration. 2012 Health center data, homeless program grantee data plus additional analysis on unpublished data. Available at: http://bphc.hrsa.gov/uds/datacenter.aspx?fd=ho&year=2012. Accessed October 15, 2013.

3. Aron L, Honberg R, Duckworth K, et al. Grading the states 2009. Available at: http://www.nami.org/Content/NavigationMenu/Grading_the_States_2009/Full_Report1/Full_Report.htm. Accessed May 5, 2013.

4. Greenberg GA, Rosenheck RA. Jail incarceration, homelessness, and mental health: a national study. *Psychiatr Serv.* 2008;59(2):170–177.

5. Greenberg GA, Rosenheck RA. Homelessness in the state and federal prison population. *Crim Behav Ment Health.* 2008;18(2):88–103.

6. Health Care for the Homeless, Inc. Still serving time: struggling with incarceration and re-entry in Baltimore. Available at: http://www.hchmd.org/research.shtml#reentry. Accessed December 27, 2012.

7. Metraux S, Culhane D. Recent incarceration history among a sheltered homeless population. *Crime Delinq.* 2006;52(3):504–517.

8. Kenney GM, Dubay L, Zuckerman S, Huntress M. Opting out of the Medicaid expansion under the ACA: how many uninsured adults would not be eligible for Medicaid? 2012. Available at: http://www.urban.org/UploadedPDF/412607-Opting-Out-of-the-Medicaid-Expansion-Under-the-ACA.pdf. Accessed December 26, 2012.

9. Kaiser Family Foundation. A guide to the Supreme Court's Affordable Care Act decision. Available at: http://www.kff.org/healthreform/upload/8332.pdf. Accessed December 24, 2012.

10. Kenney GM, Dubay L, Zuckerman S, et al. Opting in to the Medicaid expansion under the ACA: who are the uninsured adults who could gain health insurance coverage? 2012. Available at: http://www.urban.org/UploadedPDF/412630-opting-in-medicaid.pdf. Accessed December 26, 2012.

11. Congressional Budget Office. CBO's February 2013 estimate of the effects of the Affordable Care Act on health insurance coverage. Available at: http://www.cbo.gov/sites/default/files/cbofiles/attachments/43900_ACAInsuranceCoverageEffects.pdf. Accessed May 13, 2013.

12. Buettgens M, Hall MA. Who will be uninsured after health insurance reform? 2011. Available at: http://www.urban.org/UploadedPDF/1001520-Uninsured-After-Health-Insurance-Reform.pdf. Accessed December 23, 2012.

13. Patient Protection and Affordable Care Act, Pub. L. 111–148 and 111–152, § 2201, Enrollment and simplification and coordination with state health insurance exchanges; amends USC Title 19 of the Social Security Act, § 1943.

14. US Department of Housing and Urban Development. The 2011 annual homeless assessment report to Congress. 2012. Available at: https://www.onecpd.info/resources/documents/2011AHAR_FinalReport.pdf. Accessed May 13, 2013.

15. Wang EA, White MC, Jamison R, Goldenson J, Estes M, Tulsky J. Discharge planning and continuity of health care: findings from the San Francisco county jail. *Am J Public Health.* 2008;98(12):2182–2184.

16. James DJ. Bureau of Justice Statistics special report: profile of jail inmates, 2002. 2004. Available at: http://bjs.ojp.usdoj.gov/content/pub/pdf/pji02.pdf. Accessed December 13, 2012.

17. US Department of Justice, National Institute of Corrections. Solicitation for a cooperative agreement—evaluating early access to Medicaid as a reentry strategy. *Fed Regist.* 2011;76(129):39438–39443.

18. US Department of Health and Human Services, Center for Medicaid and State Operations, Disabled and Elderly Health Programs Group. Ending chronic homelessness: letter from Glenn Stanton, acting director, to state Medicaid directors. Available at: http://jfs.ohio.gov/ohp/bcps/OHMedAdvComm/documents/ENDING_CHRONIC_HOMELESSNESS.PDF. Accessed December 27, 2012.

19. Minton TD. Jail inmates at midyear 2010—statistical tables. 2011. Available at: http://bjs.ojp.usdoj.gov/content/pub/pdf/jim10st.pdf. Accessed December 10, 2012.

20. Guerino P, Harrison PM, Sabol W. Prisoners in 2010. 2011. Available at: http://bjs.ojp.usdoj.gov/content/pub/pdf/p10.pdf. Accessed December 27, 2012.

21. Cuellar AE, Cheema J. As roughly 700,000 prisoners are released annually, about half will gain health coverage and care under federal laws. *Health Aff (Millwood).* 2011;31(5):931–938.

22. US Department of Justice, Office of Justice Programs, Bureau of Justice Statistics. Community corrections (parole and probation). Available at: http://bjs.ojp.usdoj.gov/index.cfm?ty=tp&tid=15. Accessed December 10, 2012.

23. Manatt Health Solutions. Overview of the final Medicaid eligibility regulation. Available at: http://www.hca.wa.gov/hcr/documents/Medicaid_Eligibility_Final_Rule_Overview.pdf. Accessed December 13, 2012.

24. Veysey BM. The intersection of public health and public safety in US jails: implications and opportunities of federal health care reform. 2011. Available at: http://www.cochs.org/files/Rutgers%20Final.pdf. Accessed December 10, 2012.

25. National Reentry Resource Center. Frequently asked questions: health, mental health and substance use disorders. Available at: http://csgjusticecenter.org/reentry/frequently-asked-questions/#FAQ2. Accessed December 18, 2012.

26. Maruschak LM. Bureau of Justice Statistics special report: medical problems of jail inmates. 2006. Available at: http://bjs.ojp.usdoj.gov/content/pub/pdf/mpji.pdf. Accessed December 18, 2012.

27. Solomon L, Flynn C, Muck K, Vertefeuille J. Prevalence of HIV, syphilis, hepatitis B and hepatitis C among entrants to Maryland correctional facilities. *J Urban Health.* 2004;81(1):25–37.

28. Conklin TJ, Lincoln T, Wilson R. *A public health manual for correctional health care.* Ludlow, MA: Hampden County Sheriff's Department; 2002.

29. James DJ, Glaze LE. Mental health problems of prison and jail inmates. 2006. Available at: http://bjs.ojp.usdoj.gov/content/pub/pdf/mhppji.pdf. Accessed December 21, 2012.

30. Steadman HJ, Osher FC, Robbins PC, Case B, Samuels S. Prevalence of serious mental illness among jail inmates. *Psychiatr Serv.* 2009;60(6):761–765.

31. Lamb HR, Weinberger LE. Persons with severe mental illness in jails and prisons: a review. *Psychiatr Serv.* 1998;49(4):483–492.

32. Jemelka RP, Rahman S, Trupin EW. Prison mental health: an overview. In: Steadman HJ, Cocozza JJ, eds. *Mental Illness in America's Prisons.* Seattle, WA: National Coalition for the Mentally Ill in the Criminal Justice System; 1993:9–23.

33. Rothbard AB, Wald H, Zubritsky C, Jaquette N, Chhatre S. Effectiveness of a jail-based treatment program for individuals with co-occurring disorders. *Behav Sci Law.* 2009;27(4):643–654.

34. Center for Mental Health Services GAINS Center. The prevalence of co-occurring mental illness and substance use disorders in jails. Available at: http://gainscenter.samhsa.gov/pdfs/disorders/gainsjailprev.pdf. Accessed December 17, 2012.

35. Edens JF, Peters RH, Hills HA. Treating prison inmates with co-occurring disorders: an integrative review of existing programs. *Behav Sci Law.* 1997;15(4):439–457.

36. Mancuso D, Felver B. Providing chemical dependency treatment to low-income adults results in significant public safety benefits. 2009. Available at: http://www.dshs.wa.gov/pdf/ms/rda/research/11/140.pdf. Accessed December 17, 2010.

37. Shah MF, Mancuso D, Yakup S, Felver B. The persistent benefits of providing chemical dependency treatment to low-income adults. 2009. Available at: http://www.dshs.wa.gov//pdf/ms/rda/research/4/80.pdf. Accessed December 17, 2012.