

Leveraging Federal Medicaid Dollars to Build Service Capacity in Illinois' Mental Health and Addiction Treatment Sectors to Prevent Recidivism and Entry into the State's Correctional System

*Report to the Illinois State Commission on Criminal Justice and Sentencing Reform,
Budgeting and Capacity Committee*

I. INTRODUCTION

The Illinois State Commission on Criminal Justice and Sentencing Reform is tasked with making recommendations for how to reduce Illinois' prison population by 25% by 2025. In the Commission's Initial Report, it acknowledged that an estimated 55% of male inmates and 73% of female inmates have a mental health condition, and 80% have substance use conditions.¹ This population, and particularly the segment with serious conditions, not only needs treatment while incarcerated, but also will need treatment upon release if they are to remain out of the correctional system. Yet, as the Commission pointed out, the service capacity in the treatment sector in Illinois does ***not*** currently exist despite the Affordable Care Act (ACA) and Medicaid expansion because the state has simply never made this investment.² ***Without a significant investment in community-based treatment for this population, Illinois will continue to see high rates of incarceration and recidivism because this population does not have access to treatment.***

The Medicaid expansion presents a tremendous opportunity to significantly reduce Illinois' correctional population for individuals with serious mental illnesses (SMI), such as schizophrenia or bi-polar disorder, and for those with significant substance use conditions, including heroin addiction, by addressing this population's treatment needs (thereby, preventing criminal justice involvement). With Medicaid expansion most of Illinois' criminal justice population will now be eligible for health coverage upon release. This will enable those with SMI and significant substance use conditions access to treatment (as long as the treatment capacity across the state is developed), and will reduce recidivism and high rates of preventable hospitalizations for this population.

Medicaid, which is financed by both the federal government and the states, leverages significant federal dollars and will free up state General Revenue Funds (GRF) currently being spent by the Illinois Department of Corrections (IDOC). This is not merely a cost shift between state agencies. It is an infusion of new federal money into the state budget. For traditional Medicaid enrollees, Illinois receives a federal match rate of 50%, and for the ACA/Medicaid expansion population – which includes a significant percentage of the justice population – the match rate is much higher, at 100% between 2014-2016, and phasing down to 90% between 2017 and 2020, and remaining at 90% for all future years. For these reasons, investing in treatment not only is the right thing to do, but also is a fiscally smart investment because the costs are shared with the federal government.

While the state has not invested in building up the mental health and substance use treatment sectors, it is not difficult to do and makes fiscal sense. The way to significantly build service capacity across the sector is to pay a Medicaid reimbursement rate that covers the actual cost of providing treatment services and that allows providers to grow to meet the state's needs. Current reimbursement rates for community mental health and substance use treatment services **do not come close to covering the actual cost of services.**³ **This makes it nearly impossible for providers to expand** (i.e., hire more treatment professionals). This is a structural problem that has existed for decades and is a significant driver for why so many individuals with significant mental health conditions go untreated end up in Illinois' correctional facilities.



For individuals with SMI, a root cause of this problem goes back to deinstitutionalization from state psychiatric hospitals as significant strides were made in effective community treatment models (e.g., Assertive Community Treatment and step-down models)⁴ and the effectiveness of antipsychotic medications.⁵ In the 1960's and 1970's, in line with the national movement toward deinstitutionalization, Illinois closed nearly 35,000 state psychiatric hospital beds but failed to invest in a robust community treatment infrastructure and affordable housing for this population.⁶ This failure has resulted in this population now often being institutionalized in our state's prisons and jails. Individuals with SMI need access to treatment and affordable housing to lead stable lives.

According to a recent study, reimbursement rates for community mental health treatment have not changed since 2008.⁷ Just to keep pace with inflation alone from when rates were set (ignoring whether rates cover cost), rates would need to increase by an average of 16%.⁸ Psychiatry rates only cover somewhere between 40-60% of cost.⁹ Substance use treatment rates would need a rate increase of 27%. While these suggested rate increases are based on the base rate's failure to keep pace with inflation rather than whether the rates cover costs, a base rate that is never adjusted to keep pace with the growing cost of doing business (wages, healthcare and other employee benefits, transportation and other business costs), it highlights a shrinking real-dollar investment in treatment services.

Treatment is far more cost effective than incarceration and a significant percentage of the cost is covered by the federal government through Medicaid. Even the most intensive level of community treatment for those with the most severe mental illnesses – Assertive Community Treatment (ACT), which is a team-based model led by a psychiatrist, and typically includes other mental health professionals trained in nursing, social work and substance use treatment, and can include daily home-based and community-based visits (rather than treatment in a clinic setting) – costs far less than incarceration.¹⁰ ACT costs an estimated \$10,000 per year.¹¹ At least 50% of this cost, and up to 90% for the ACA population, is paid for with federal Medicaid dollars, meaning it costs the state just \$5,000 if a 50% match rate applies, and just \$1,000 if the 90% federal match rate applies. Because any Medicaid rate increase would not go into effect until state fiscal year 2018, this report will use the 90% match rate for the ACA population. This is compared to a year in prison, which costs Illinois approximately \$37,000, all of which is state GRF.¹² If ACT rates were increased by 16%, the cost would be \$11,600 (half or 90% paid for by the federal government), still far less expensive than prison. **Without rates that cover costs – which would allow treatment**

providers to grow their services to meet the existing need – there simply will continue to be significant service shortages across Illinois, leading thousands of individuals with mental illnesses and substance use conditions to go without treatment and end up in the justice system.



Medicaid rates adjusted to cover the actual cost of community-based treatment services and allow for growth in service capacity will still save the state significant dollars when compared to incarceration. The chart below shows that even with a rate increase of 16% for community mental health services and 27% increase for substance use treatment services (rate increases in line with recent studies), the state would save between \$209 million and \$240 million for inmates released with a serious mental illness and between \$218 million and \$231 million for inmates released with significant substance use conditions. **A 16% rate increase for community mental health services would cost an estimated \$20 million and a 27% rate increase for community-based substance use treatment services would cost an estimated \$20 million, with a federal match rate of either 50% or 90% depending on the Medicaid enrollee, meaning a state fiscal impact of less than half of the estimated cost.**¹³ **These Medicaid rate increases would yield state GRF savings between \$427 million and \$471 million by preventing recidivism of this population, as the chart below illustrates.**

Investment in Treatment for the Release Population with Increased/Adequate Medicaid Reimbursement Rates Saves Significant State Dollars¹⁴

Estimated Reduction Population with MH & SUD Treatment Needs ¹⁵	Annual Cost of Treatment/PP w/ Current Rates	Treatment Cost w/ Rate Increase (16% for MH; 27% for SUD) ¹⁶	State Medicaid Share with 50% Fed Match w/ Rate Increases	State Medicaid Share with 90% Federal Match for ACA Adults w/ Rate Increase	Incarceration Cost Paid for 100% with GRF (\$37,000/PP) ¹⁷	Estimated State Savings from Investment in Treatment w/ Rate Increases
6,720 Need Mental Health Services	\$10,000 ¹⁸	\$11,600	\$39M	\$7.8M	\$248.6M	\$209M - \$240M
6,360 Need Substance Use Treatment	\$4,200 ¹⁹	\$5,334	\$17M	\$3.4M	\$235.3M	\$218M - \$231M

Investment in a strong treatment sector would have a positive fiscal impact not only on IDOC, but also the state’s Medicaid program. A recent federal GAO report found that 57% of the most expensive five percent of Illinois’ Medicaid enrollees have a mental health condition while 22% have a substance use condition.²⁰ This population is so expensive because they do not have access to treatment. Further, Illinois Hospital Association data shows that when Illinois cut mental health treatment between 2009-2011 by over \$100 million, behavioral health emergency room

visits skyrocketed by 19%, an increase of 12 percentage points higher than other medical ER visits, costing the state far more than what it saved in cuts to treatment services.²¹

This report, accompanied by 12 recommendations, is intended to summarize why Medicaid will be instrumental in reducing Illinois' prison population and the trajectory into the correctional system for those living with serious mental health and addiction conditions. In Section II, we provide a basic overview of the Medicaid program, including an explanation of the ACA's "Medicaid expansion" to all low income adults and the expansion's importance in reducing the correctional population. In Section III, we set out the special rules governing Medicaid and the justice-involved population, and the ways in which IDOC, working in partnership with the HFS, could enroll inmates into Medicaid prior to their release, or while on parole or mandatory supervised release, leveraging federal funds for a substantial part of the cost of such activities. Section IV sets forth specific recommendations for how the state can leverage federal Medicaid dollars to grow the treatment sector; better coordinate between state agencies to serve this population upon release; and invest in rental subsidies (combined with treatment) targeted at the most expensive segment of this population to enable affordable housing. Section V discusses the need to evaluate the reforms put in place after a sufficient amount of time to determine if the measures implemented are achieving the intended outcomes.

Finally, it is important to acknowledge that the Rauner Administration is developing its "Plan for Transformation for Behavioral Health," with Medicaid as the central funding source through a Section 1115 Medicaid Waiver, among other waivers. Informed by the information and recommendations in this report, which also address many of the concerns outlined in Illinois' State Health Improvement Plan (SHIP),²² we hope the Commission will see this as an opportunity to include in its recommendations to the Administration and the General Assembly ways to build the treatment sector to stop the trajectory into IDOC for those with serious mental illnesses and addictions.

II. MEDICAID BASICS AND OVERVIEW

The Medicaid expansion under the ACA provides a way out of over-incarceration and the justice system revolving door for the population with serious mental illnesses and addictions if the state makes the right investments in treatment and IDOC works in close partnership with the Illinois Department of Healthcare and Family Services (HFS), the state's Medicaid agency. Medicaid expansion now means almost *all* low income Illinois residents have access to health coverage, including mental health and substance use treatment coverage. Before the Medicaid expansion in 2014, hundreds of thousands of low income Illinois adults simply did not qualify for Medicaid and had no other health insurance. Their access to care was, at best, haphazard. Medicaid expansion is a game changer, particularly for those who are returning to their communities after completing incarceration and have significant mental health and substance use conditions. As of early 2016 over 650,000 low income Illinois adults have enrolled in Medicaid through the expansion, under the category of "newly-eligible ACA adults."

Medicaid is the public health care program that provides comprehensive health care coverage for low-income children and adults who are Illinois residents and meet the applicable income and

citizenship/immigration requirements. The Medicaid program is funded by a combination of federal funds and state GRF dollars and is administered by the federal Centers for Medicare and Medicaid Services (CMS) and HFS.

A. Medicaid Funding

The federal government pays for a substantial portion of Medicaid. The federal matching rates vary for different Medicaid populations (categories), ranging from approximately 50% for seniors and people with disabilities, to 100% (phasing down to 90%) for adults newly eligible under the Medicaid expansion. Federal reimbursement for the ACA Medicaid expansion population started at 100% for years 2014 through 2016. The rate phases down to 90% by 2020 and will remain at 90% thereafter. The match rate phase-down begins on January 1, 2017, when the federal match rate reduces slightly to 95%; then to 94% for 2018; 93% for 2019; and 90% for 2020. ***After 2020, the federal match rate will remain at 90% for all future years for the ACA population.*** This means that for every dollar Illinois pays for health care for seniors and people with disabilities, the federal government reimburses Illinois 50 cents, and for every dollar Illinois pays for the ACA's newly eligible adults, the federal government reimburses Illinois 90 cents from year 2020 and future years. ***Most of the justice-involved population that qualifies for Medicaid are newly-eligible ACA adults whose care is paid for between 100% – 90% with federal Medicaid dollars. This means that when Illinois spends dollars on mental health and substance use treatment covered by Medicaid, the federal government pays for a substantial portion of the costs; whereas the state pays 100% of the cost of incarceration with state GRF.***

B. Medicaid Eligibility

With Medicaid expansion, most low income adults earning up to 138% of the federal poverty level (\$1,366/month) are eligible for Medicaid.²³ The eligibility criteria such as income level and asset limits vary somewhat for different groups (categories) of beneficiaries. For more detail on the various categories and income levels see HFS's website's description of [Medical Programs](#).

C. Medicaid Services, Medicaid Providers and Medicaid Managed Care

Individuals covered by Medicaid can access a comprehensive set of medical and behavioral health services for care. Illinois is moving from a fee-for-service Medicaid system to a Medicaid managed care system, requiring most beneficiaries living in five geographic areas of the state, called the Medicaid "mandatory managed care areas,"²⁴ to enroll with a Medicaid health plan/managed care organization (MCO). HFS pays Medicaid MCOs a per-member-per-month fee, and the MCO pays health providers for all necessary care the plan member receives. Individuals not mandated to enroll in a managed care plan must designate a primary care physician whom they see for routine care, for management of their chronic conditions and whom they must consult for referrals to other physicians or specialists.

As a practical reality, most of the justice-involved population returns to one of the metropolitan areas where Medicaid managed care is mandatory when they leave an IDOC facility. Ideally, these individuals would be enrolled in Medicaid and in an MCO serving the community to which they are returning prior to their release from IDOC. ***Also, their IDOC medical records including***

their diagnoses, test results, and treatment plan should be sent to their new doctor prior to their release. We will discuss how this can be accomplished below.

III. SPECIAL MEDICAID RULES FOR THE JUSTICE POPULATION

Medicaid law specifies that inmates of public institutions are ineligible to receive Medicaid benefits while incarcerated. CMS defines an inmate as a person living in “an institution that is the responsibility of a governmental unit or which a governmental unit exercises administrative control.”²⁵ A person is considered an inmate of such an institution if they are in custody and held involuntarily. Therefore individuals at correctional facilities including state/federal prisons, local jails, detention facilities or other settings such as boot camps or wilderness camps are unable to use their Medicaid benefits. A good barometer of whether someone is considered an inmate is whether he or she has the legal ability to exercise personal freedom.²⁶

While federal law prohibits individuals who are incarcerated from actively using their Medicaid coverage and the state from claiming federal Medicaid match for health care provided to them during incarceration, incarcerated individuals are not precluded from applying for Medicaid, being enrolled in Medicaid, or staying enrolled in Medicaid. As long as the individual meets all Medicaid eligibility requirements the state may enroll or renew the individual before, during, or after the period of time spent in the correctional facility. In fact CMS actively encourages states to enroll individuals that come into contact with the justice system. Further, Illinois law prohibits the state from denying someone Medicaid eligibility just because they are incarcerated and requires that individuals leaving the state’s correctional system have the opportunity to apply for Medicaid at least 45 days prior to release. It also allows for the suspension rather than termination of existing Medicaid coverage during time served.²⁷

Medicaid Eligibility at Different Points in the Criminal Justice System	Eligibility to <u>Actively</u> Use Medicaid/Draw Federal Match
Pre-trial	If detained pre-trial - not eligible; If released on bond/bail - eligible
Serving a sentence in prison/jail	Not Eligible
On probation/parole	Eligible
Work release or house arrest	Eligible
Halfway house/supervised community residential	Eligible if facility meets certain criteria

Medicaid funding can be utilized to assist with enrolling inmates in Medicaid *prior to release*, linking them to treatment and housing, covering case management pre-release and while on probation/parole. There are three primary avenues to obtain federal Medicaid matching funds for these purposes while an inmate is still incarcerated: an 1115 Waiver, Medicaid Administrative Claiming (MAC), and Targeted Case Management (TCM).

A. Using 1115 Medicaid Waivers

Section 1115 of the Social Security Act allows states to use federal Medicaid funds in a way that is not ordinarily allowed under federal law (an “1115 Waiver”). An 1115 waiver is often pursued by states for demonstration projects that reduce healthcare and other costs of high-cost populations,

including the justice population. The Rauner Administration is currently pursuing an 1115 waiver (and other Medicaid waivers) focused on reforming the state's behavioral health system as part of its "Health and Human Services Plan for Transformation."

Other states are looking at leveraging 1115 waivers for their criminal justice population. Maryland has submitted a waiver request to allow for presumptive eligibility for their re-entry population. Presumptive eligibility would allow individuals going through re-entry to enroll in Medicaid for an initial two-month period with limited information. After two months they would complete the full application including income eligibility and identification.²⁸ New York announced they are submitting a waiver to allow Medicaid to cover some medical, pharmaceutical and home health care coordination services to individuals with serious behavioral and physical health conditions within the 30 days prior to their release.²⁹ Illinois should consider these options, particularly in light of the Administration's goal of significantly reducing the prison population by 2025.

Another option Illinois should consider as part of a waiver is securing Medicaid reimbursement for care for inmates with opioid addiction. Possibilities here include working with community providers to identify patients who have started opiate treatment in the community and need to continue while incarcerated. Additionally, the state could propose Medicaid cover medication-assisted treatment (MAT) for individuals with opiate addiction in jail but due to be released within 7-10 days.³⁰

B. Medicaid Administrative Claiming

Medicaid costs can be divided between medical service costs (*i.e.*, health care delivery) and administrative costs (*e.g.*, outreach and enrollment activities). Illinois currently receives federal Medicaid matching dollars on its administrative costs through Medicaid Administrative Claiming (MAC) for work done through the Department of Human Services. Illinois should increase federal funding for the activities being done to enroll the pre-release, probation and parole populations into Medicaid and to provide case management as part of parole and probation services. Federal CMS allows states to claim MAC for work being done enrolling individuals into Medicaid 30 days prior to their release from a state facility. Some examples of potentially reimbursable administrative claiming activities for serving inmates post-release (*i.e.*, during parole) include:

- ❖ Referral, Coordination & Monitoring: For example, a parole agent monitoring his client's progress in a substance abuse treatment program.
- ❖ Medicaid Outreach: For example, informing a client where she can receive mental health treatment and helping her schedule an appointment.
- ❖ Arranging Transportation to a Medicaid Covered Service: For example, driving or arranging transportation for a client to a detox center for services.
- ❖ Medicaid Eligibility Intake: For example, helping a client fill out a Medicaid application.
- ❖ Interagency Coordination: For example, working with other agencies to improve the coordination of and access to Medicaid services, reducing and closing gaps in services.

C. Targeted Case Management

A related Medicaid funding stream that could also be utilized is the Targeted Case Management (TCM) option. Medicaid can reimburse for costs incurred for providing TCM services. TCM covers four components of comprehensive case management:

- ❖ Assessment
- ❖ Development of a care plan
- ❖ Referrals (connection to treatment providers and location of housing) and related services
- ❖ Follow-up and monitoring

In order to draw federal funding under MAC or TCM for TCM activities, criminal justice agencies would need to work with HFS to add these activities into the Illinois Medicaid State Plan and to do a time study to identify the appropriate billing codes and to demonstrate the claim. A sample TCM State Plan Amendment can be found here: <http://cochs.org/files/medicaid/TCM-SPA.pdf>.

IV. RECOMMENDATIONS

We offer the Commission the following 12 recommendations for inclusion in its recommendations to the Governor, his Administration, and the Illinois General Assembly. Without implementation of these recommendations, the state will continue to see high volumes of individuals with serious mental illnesses and substance use conditions churn through the state's justice system, costing the state and taxpayers far more than the following investments.

1. To Build Service Capacity in the Community Mental Health and Substance Use Treatment Sectors, Medicaid Reimbursement Rates Must be Increased to Cover Actual Costs and Allow for Growth, and the Rules Governing Medicaid Service Delivery for Mental Health and Addiction Conditions Need to be Modernized.

- ❖ ***Rationale: Below-cost reimbursement rates and antiquated rules are structural problems that prohibit the growth of treatment providers to meet the state's needs.***

Treatment is far less expensive than incarceration and a significant percentage of treatment is covered by the federal government through Medicaid. Assertive Community Treatment (ACT), the most expensive level of community mental health treatment, which only a small segment of individuals even with the most serious of mental illnesses needs, costs an estimated \$10,000 per year. Fifty percent (90% for the ACA population) of ACT is matched by federal Medicaid dollars meaning it cost the state just \$5,000 (for ACA adults the federal government will pay for 90%), while a year in prison costs the state approximately \$37,000, all of which is state GRF. If ACT rates were increased by 16%, the cost would be \$11,600 (half paid for by the federal government; 90% for ACA adults), still far less expensive than incarceration.

Additionally, the administrative rules (Rules 132, 2060 and 2090) governing Medicaid mental health and substance use treatment services are outdated and do not allow for integration of mental health and substance use treatment nor do they allow for integration with other medical treatment. The rules do not reflect a managed care environment or value-based payment models. To allow providers to deliver high quality services that deliver good health outcomes, the rules for mental health and substance use treatment must be integrated, modernized and streamlined (many redundancies currently exist with the move to Medicaid managed care). Rule reform coupled with rate reform are critical to building the capacity to serve the release population with significant behavioral health

conditions and prevent individuals from entering the justice system because of an untreated serious mental illness or addiction.

Further, if Illinois' Medicaid program invested in early treatment of serious mental illnesses such as schizophrenia and bi-polar disorder, the current trajectory into the justice system for this population could be bent toward preventing disability and all that comes with a life-long struggle with poverty and serious illness, including justice involvement. Illinois Medicaid rules often mean a person must wait until they are disabled by their SMI before they are eligible for intensive treatment. This is too late. An evidenced-based intervention Illinois should cover through Medicaid as a bundled rate is First Episode Treatment for Psychosis, which national research shows can prevent the progression of schizophrenia and SMIs that cause psychosis.³¹ Studies indicate that the case management component of the model, including helping the individual navigate the criminal justice system and finding/keeping affordable housing, is much more significant than traditional community treatment.³² The federal Center for Medicare and Medicaid Services, in partnership with National Institute of Mental Health, published a bulletin earlier this year outlining how to get First Episode Treatment covered by Medicaid.³³

2. Rental Subsidies and Transitional Housing Targeted to the Release Population with SMI who are Medicaid Super-Utilizers due to Homelessness/Unstable Housing will Reduce Recidivism and Medicaid Costs.

- ❖ ***Rationale: Without a solution to transitional and affordable housing for high-expenditure Medicaid enrollees with SMI who are homeless/unstably housed, and who are often also chronic reoffenders because they cannot manage their illness on the streets, the state will continue to see high incarceration rates and high Medicaid costs for this population.*** Many states target rental subsidies for high-cost individuals living with a SMI who are homeless or unstably housed to prevent recidivism, homelessness and high Medicaid costs.³⁴ For many individuals who are disabled by their serious mental illness, their only income source is Supplemental Security Income (SSI), which is just \$733 a month,³⁵ putting affordable housing out of reach. Because of their extremely low income, many have to spend 70-80% of their income toward rent. Many lose their housing as a result. Once homeless, they are unable to manage their illness, and often commit low-level crimes to survive (e.g., trespassing to sleep or theft of basic necessities), and therefore ultimately end up in state prisons for multiple minor non-violent crimes. The state's Bridge Subsidy Program (i.e., rental subsidies where the individual pays 30% of their income toward rent and 70% is paid for by the state) has been extremely successful for housing individuals who are being deinstitutionalized from nursing home settings. The Bridge Subsidy Program should be expanded to high-cost Medicaid enrollees with SMI who are homeless/unstably housed who are likely to enter the state's criminal justice system for survival crimes.

The annual cost of a rental subsidy (\$10,000) plus treatment (\$10,000) is far less combined (\$20,000) than incarceration (\$37,000). While the cost of a rental subsidy is not covered by Medicaid, the state expense for a rental subsidy plus treatment is approximately \$15,000

when Medicaid match for treatment is taken into account – a far smarter fiscal investment than IDOC.



For individuals with significant mental health and/or substance use disorder conditions leaving prison who are not ready to hold their own leases immediately at the time of release, the state should invest in transitional housing. Transitional housing with clinical/case management provides a higher level of support during the transition time to those who need it.

3. Using Medicaid Administrative Claiming, Medicaid Waivers and/or Medicaid State Plan Amendments to Connect the Correctional Population with Serious Mental Health and Substance Use Conditions to Medicaid Prior to Release to Ensure Connection to a Community Treatment Provider Immediately upon Re-Entry, the Establishment of SSI for those Disabled by their SMI and Location of Affordable Housing will Prevent Recidivism.

- ❖ **Rationale: IDOC must set this population up for successful re-entry by maintaining continuity of care and can do this by maximizing Medicaid funding prior to release.** Without the following three things established prior to release, the correctional population with serious mental illnesses and substance use conditions who are also at high risk for overdose death,³⁶ will likely become homeless shortly after re-entry, meaning a high probability of recidivism: (1) an immediate connection to community-based treatment (the service capacity must be developed), (2) for those disabled by their SMI, the establishment of an income source (SSI) to enable them to live in the community, and (3) location of affordable housing. While the use of Medicaid in the correctional arena prior to release is new to most states (because leveraging Medicaid is still very new to the justice system across the country), a few states that are ahead of the curve that Illinois should look to are California, Wisconsin, New York and Maryland. Medicaid payment for these activities can be done on a fee-for-service basis pre-release to eliminate the complications of payment under the Medicaid managed care system. Activities for which IDOC may not have the right expertise, such as successful SSI applications which require significant legal knowledge of disability laws, we recommend that IDOC outsource those activities to a legal aid organization with such expertise (Wisconsin has a successful model Illinois should look to. While Wisconsin uses a small amount of GRF to fund SSI applications pre-release (rather than using Medicaid), this investment pays dividends by preventing recidivism of those with serious mental illnesses).

4. Illinois Should Create Mental Health Parole for those Re-Entering who have Serious Mental Illnesses, Modeled after Cook County’s Mental Health Probation, to Help this Population Remain in Treatment Post-Incarceration and Access Affordable Housing.

❖ ***Rationale: Inmates living with serious mental illnesses who are disabled by their illness have unique challenges the rest of the correctional population does not have (such as extreme poverty due to disability and frequent homelessness), and for these reasons are more likely to have their probation/parole revoked because they cannot access and maintain treatment and affordable housing.***³⁷ In recognition of the needs of this population to successfully complete probation, Cook County created Mental Health Probation, which is much more case-management focused than regular probation, to help this population successfully re-enter society after completing their jail term. The state should develop a model similar to this for parole – with a strong focus on case management – to help this population maintain treatment post-incarceration. A Mental Health Parole Unit should be separate from regular parole and the mental health parole officers should be specifically trained on serious mental illnesses and addictions, the challenges this population faces and the community resources (treatment and affordable housing) they need to successfully manage their illness and remain out of the justice system. Medicaid could cover a significant portion of the case management done by mental health parole officers.

5. IDOC Should Expand Existing Case Management Re-Entry Models; Specifically, the Sheridan and Southwestern Re-Entry Program Model Elements – Including Pre-Release Re-Entry Planning, Community-Based Treatment, and Case Management – For Every Releasee with SUD and MH Treatment Needs.

❖ ***Rationale: These proven programs should be scaled up to meet the needs of all releasees with behavioral health disorders, thus increasing the potential for improved recidivism rates and cost outcomes.*** National surveys estimate that 53% of state prison inmates have a diagnosable substance use disorder,³⁸ and 56 percent have a mental health problem.³⁹ Case management has been shown to improve addiction treatment completion rates. TASC’s criminal justice clients demonstrate 62% greater completion rates for addiction treatment compared to other individuals referred to treatment by Illinois’ justice and corrections systems (2011 referrals).⁴⁰ The Sheridan and Southwestern Drug Treatment and Reentry Programs, which provide prison drug treatment and reentry planning, aftercare, and case management, have demonstrated not only improved treatment retention/completion over the first several years of operation,⁴¹ but also a 15% reduction in participants’ likelihood to recidivate in the 2-3 year period following release.^{42, 43} Subsequent evaluation found that this effect was long-lasting, for at least seven years following release.⁴⁴ Combined program savings have been estimated at \$5 million per year in reduced incarceration costs due to earned good conduct credits received by many program participants.^{45, 46}

Through an 1115 waiver, Medicaid could be permitted to cover pre-release planning activities to help prepare individuals for linkage to indicated services immediately upon release. Medicaid resources would support post-release community-based mental health

and addiction treatment services, as well as mental health case management. *(As noted elsewhere in this report, Illinois should convert substance use case management into a Medicaid-eligible service so costs can be paid for with federal Medicaid dollars.)*

6. To Implement Parity and Maximize Federal Matching Dollars, Illinois Should Include the Full Continuum of Substance Use Treatment Services in the Medicaid State Plan.

- ❖ ***Rationale: Providing individuals with substance use disorders coverage for fewer services compared to those with mental health disorders runs counter to parity, prevents access to life-saving overdose prevention services, and prevents the state from maximizing federal dollars to build community capacity and provide substance use services that will prevent recidivism and incarceration.***

Via a State Plan Amendment and subsequent administrative rule changes, the State could elect to offer a full array of substance use treatment services, as implemented in other states and as encouraged by CMS. In a 2015 letter to state Medicaid Directors, CMS encourages states to offer the full array of substance use treatment services, citing the levels of care established by the American Society for Addiction Medicine as the nationally accepted set of treatment criteria that states should adopt. CMS also cites cost savings from a number of states that offer such services, (e.g., Washington, California, and Massachusetts).⁴⁷

Today in Illinois, substance use prevention services such as Screening, Brief Intervention, and Referral to Treatment (SBIRT) are not covered in Illinois' state Medicaid plan, nor is case management for individuals diagnosed with a substance use disorder, or peer support services. Medicaid-eligible individuals with substance use disorders currently do not have access to these services, although their peers with mental health disorders do. This lack of coverage makes connection to services upon release that can prevent recidivism difficult, as state-funded case management for substance use disorders is not sustainable. Additionally, without immediate connection to service, the risk of relapse and overdose death among releasees is exponentially increased.⁴⁸

Further, via an 1115 Waiver, the state could elect to add recovery homes (as defined in 77 Ill Admin Code 2060.509) as a Medicaid-covered substance use service, which could be offered in combination with intensive outpatient as an alternative option to more costly residential treatment.

Rule 132 (Medicaid-covered mental health services)	Rule 2090 (Medicaid-covered substance use services)
<ul style="list-style-type: none"> • Mental Health Assessment • Psychological Evaluation • Treatment Plan Development, Review and Modification • Assertive Community Treatment • Case Management—Client-Centered Consultation • Case Management—Mental Health • Case Management—LOCUS Assessment • Case Management—Transition Linkage and Aftercare • Community Support (Individual, Group) • Community Support (Residential) • Community Support—Team • Crisis Intervention • Crisis Intervention— Pre-Hospitalization Screening • Crisis Intervention— State Ops • Mental Health Intensive Outpatient • Psychosocial Rehabilitation • Psychotropic Medication Administration • Psychotropic Medication Monitoring • Psychotropic Medication Training • Therapy/Counseling 	<ul style="list-style-type: none"> • SA Outpatient/Admission and Discharge Assessment • Psychiatric Evaluation • Individual - Therapy/Counseling, Substance Abuse Level I • Individual - Intensive Outpatient, Substance Abuse Level II • Group - Therapy/Counseling, Substance Abuse Level I • Group - Intensive Outpatient, Substance Abuse Level II • Medication Monitoring

7. Medicaid Should Cover Forensic Assertive Community Treatment and Community Support Treatment (CST) Teams Targeted Specifically for the Release Population with Serious Mental Health Conditions to Prevent Recidivism.⁴⁹

❖ ***Rationale: Individuals with significant criminal justice backgrounds have a different set of challenges in addition to their mental illness that need to be addressed to prevent recidivism.*** The state should pilot forensic team-based models such as Assertive Community Treatment teams and lower-intensity models under the Medicaid program that are specifically targeted for the needs of individuals leaving IDOC with significant mental health and substance use conditions who have a long history of criminal justice involvement due to untreated SMI and homelessness.

8. Expand Crisis Intervention Training for Public Safety Personnel to Divert those Experiencing a Mental Health Crisis from the Justice System and into Treatment.

❖ ***Rationale: Law Enforcement Officers with Crisis Intervention Training (CIT) are better equipped to de-escalate a situation with someone experiencing a mental health crisis and can divert these individuals from the criminal justice system and into the appropriate treatment.*** CIT teams are groups of law enforcement officers that have received specialized training to equip them to manage interactions with community members experiencing a mental health crisis and is considered a best practice.⁵⁰

As of 2015, the City of Chicago had the nation’s largest CIT force with more than 1400 officers having completed CIT training across all 25 police districts in the city.⁵¹ Research shows that compared to non-CIT-trained peers, CIT-trained Chicago Police Department officers were more likely to direct people to mental health services (18% more often), report feeling better prepared to respond without needing to resort to use of force, and use less force when subject agitation/resistance increases.⁵²

Increasing law enforcement referrals to treatment is an important step toward avoiding unnecessary incarceration. ***However, without an adequate investment in treatment***

capacity in the behavioral health sector, CIT will not be effective in diversion because there simply is not enough capacity today.

9. Illinois Should Seek a Narrow Medicaid Waiver for Exemption of Residential Substance Use Treatment Centers from the IMD Exclusion to Allow for Federal Medicaid Matching Funds for Services Provided and Allow Medicaid Reimbursement for Cutting-Edge Substance Use Treatment Models, Including Providing Services Outside the Four Walls of a Clinic Similar to Assertive Community Treatment for SMI.

- ❖ ***Rationale: Residential substance use treatment centers that have more than 16 beds have been tangled up in the IMD exclusion, meaning no federal Medicaid match is received on services provided in these treatment centers.*** The federal IMD Exclusion, which refers to Institutions for Mental Disease, was originally intended to discourage the institutionalization of individuals with serious mental illnesses in nursing home-type settings by denying federal Medicaid matching funds to these institutions.⁵³ The state should seek a ***narrow*** waiver of the IMD exclusion for residential substance use treatment centers to enable federal Medicaid matching funds. ***In addition, the state should allow for Medicaid reimbursement for cutting-edge substance use treatment interventions that are not currently covered by the existing rules*** (e.g., allowing substance use providers to provide services beyond the four walls of the certified site using the same principle as Assertive Community Treatment and Community Support Treatment for serious mental illnesses – delivering the service where the person is).

10. Enhanced Medicaid Rates for Specific Mental Health Professionals Would Grow the Mental Health Workforce and Encourage Participation in Illinois' Medicaid Program.

- ❖ ***Rationale: Illinois' mental health workforce shortage, particularly in certain areas of the state, means long treatment lags, high rates of preventable disability, homelessness and incarceration.*** Illinois has the 6th largest number of mental health professional shortage areas among states.⁵⁴ There are 123 shortage areas in Illinois that have less than one psychiatrist per 30,000 people.⁵⁵ In 2006, the Illinois Psychiatric Society reported that 84 out of the state's 102 counties did not have a child psychiatrist.⁵⁶ Illinois should incentivize specific mental health professionals, including psychiatrists, child psychiatrists, psychologists, child psychologists, psychiatric advanced practice nurses (APNs) and social workers, to participate in the Medicaid program and to locate in workforce shortage areas. Some professionals (psychologists) currently do not even have direct Medicaid billing authority under Medicaid in Illinois, as most other states allow. It has been demonstrated that low Medicaid reimbursement rates mean fewer medical professionals participate in the Medicaid program and curtail access to care.⁵⁷

11. The State Should Make Strategic Investments to Expand Community Mental Health and Substance Use Treatment Service Capacity in Communities Where it is Necessary to Meet the Treatment Needs of Returning Citizens.

- ❖ ***Rationale: In order to build treatment capacity, investments are needed to facilitate the development of service provision in the geographic areas to which***

large numbers of releasees are returning. The Administration's Plan for Transformation for Behavioral Health is focused on expanding Medicaid-sustainable community behavioral health capacity, and is interested in investing in high-need communities. To achieve this, the high-risk/high-need communities from which people are sent to prison and to which they return upon release⁵⁸ should be prioritized for such investments, as well as those with high rates of opiate overdose. Investing in these areas of concentrated risk and need to build community capacity is a critical strategy for improving individual and community health and stability, and for reducing behavioral health-related crime and recidivism.

However, to operate, community service providers must hire and train staff and build billing and administrative systems. While many of the services that organizations seek to provide are Medicaid-eligible, and there would be a sustainable funding source for them once the organizations become functional, the initial start-up administrative activities are not covered by Medicaid. Up until the point at which providers can begin providing and billing for services, they would assume all start-up or expansion costs themselves – an impossible scenario considering the challenges presented by chronically inadequate rates and late payments. Simply put, there is little to no way for community providers to pursue Medicaid-sustainable capacity expansion on their own.

The State should provide modest start-up investments to facilitate the development and expansion of Medicaid-reimbursable service provision in these communities. Substance use service investments should include medication-assisted treatment (MAT), which has been demonstrated effective for opioid addiction.⁵⁹ Mental health treatment capacity should focus on building Assertive Community Treatment and Community Support Treatment teams as well as making a significant investment in early intervention, such as First Episode Treatment.

12. Strong Coordination between IDOC, HFS and the Department of Human Services Division of Mental Health (DHS-DMH) and Alcoholism and Substance Abuse (DHS-DASA) is Needed on the Administration's Plan for Transformation for Behavioral Health to Sustain a Reduction in the State's Correctional System of People with SMI and Substance Use Conditions.

- ❖ ***Rationale: Medicaid and the ACA provide a way out of over-incarceration for individuals with serious mental health and substance use conditions.*** But this will require multiple state agencies to partner together to make it happen. Not only will access to effective and early treatment and affordable housing result in lower recidivism rates, but it will also translate into fewer people entering Illinois' justice system and lower overall Medicaid costs.

V. USING DATA TO EVALUATING OUTCOMES

The state should track the necessary data and analyze the outcomes of the reforms that are put in place aimed at growing the service capacity of the mental health and substance use treatment sectors and to modernize the sector to determine whether the additional capacity, system and

provider integration and a stronger focus on prevention and early intervention is having the intended effect – a significant reduction in recidivism and entry into the criminal justice system and reduced Medicaid costs. The analysis should take into account that systems change and cost reductions take time. We recommend an analysis after the five-year and seven-year point post-implementation to understand what is working and what changes need to be made to get the desired outcomes.

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