

How Connecting Justice-Involved Individuals to Medicaid Can Help Address the Opioid Epidemic

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Summary

Providing treatment to people with addiction who are involved with the criminal justice system can help address the epidemic of opioid use disorder (OUD) and increasing rates of overdose in the U.S. Many people with OUD and other substance use disorders (SUD) are involved with the criminal justice system. The period that immediately follows incarceration poses extremely high health risks for them. The ACA Medicaid expansion provided new opportunities to connect individuals leaving incarceration to coverage and services that can mitigate these risks and help people successfully transition into the community with services to support recovery and treatment.

This issue brief identifies key lessons learned from how four states (Missouri, Ohio, New Mexico, Rhode Island) are connecting people leaving the criminal justice system to Medicaid coverage and services, with a focus on medication-assisted treatment (MAT) and supports for people with OUD. It builds on previous briefs that assessed state efforts to connect people involved in the justice system to Medicaid coverage.¹ It is based on interviews conducted in late 2018 and early 2019 with state Medicaid, behavioral health, and corrections officials in the four states and in Bernalillo County, New Mexico, as well as interviews with managed care organizations, providers, and advocates in those states and published information on the states' experiences. In sum, it finds:

- **Medicaid expansion has served as a key impetus for re-entry efforts.** It significantly increased opportunities to provide coverage to individuals moving into and out of incarceration and to connect individuals to services to address their health and recovery needs as they transition back into the community. Re-entry initiatives are a key component of broad statewide strategies to address the opioid epidemic given the high rates of SUD among the justice-involved population and the elevated risk of death upon release into the community.
- **States can facilitate connections to coverage for individuals transitioning into and out of incarceration by suspending eligibility for those that enter incarceration with Medicaid coverage and providing enrollment assistance prior to release.** Experiences from the study states show that initiating enrollment efforts early, establishing automated processes, and providing peer supports can help overcome challenges associated with enrolling eligible individuals as they move into and out of incarceration. The study states that expanded Medicaid have realized significant increases in coverage rates among justice-involved individuals and positive impacts on state budgets. As a result of increases in Medicaid coverage, some have been able to redirect state and local

resources to support services not covered by Medicaid. In addition, corrections departments reported savings due to Medicaid coverage for inpatient care provided to incarcerated individuals.

- **States are advancing coordination of care and access to services, including MAT, to support successful re-entry.** The study states are utilizing Medicaid Managed Care Organizations (MCOs) and providers to facilitate connections to care for individuals as they transition back into the community by coordinating care prior to release. The study states also are supporting treatment and recovery and transitions into the community by providing access to Medication Assisted Treatment (MAT) while individuals are incarcerated or just prior to release and linking individuals to MAT providers in the community. Experiences from the study states point to improvements in access to care and promising impacts on health and recidivism from efforts to connect individuals to care in the community, but data on impacts remain limited.
- **Even with enrollment and care coordination efforts in place, there remain gaps and challenges in covering justice-involved individuals and connecting them to care as they transition back into the community.** One major challenge is the lack of behavioral and SUD providers within the community, particularly in rural areas. States also are working to overcome operational obstacles like systems compatibility and unpredictable release dates. In addition, ongoing stigma associated with SUD and OUD, as well as stigma with justice system involvement, remain key challenges for supporting recovery initiatives and efforts, particularly MAT.

Background

People in the justice system have significant health needs, including high rates of OUD and other SUDs.^{2,3} When people with SUD leave incarceration, they are at extremely high risk of overdose and death.⁴ Opioid overdoses are the leading cause of death among people who are formerly incarcerated.⁵ Providing evidence-based treatment to people with OUD, including MAT, as they leave incarceration can help reduce the risk of overdose in this population. MAT, which is the evidence-based standard for OUD, refers to the provision of one of three medications (methadone, buprenorphine, and naltrexone), in conjunction with behavioral health services, such as counseling. Evidence is emerging that it also reduces recidivism and criminal justice costs.⁶

Medicaid coverage provides individuals access to treatment and services to address OUD and other SUDs, including MAT. Medicaid coverage of mental health and SUD treatment has expanded since 2010.⁷ Currently, all state Medicaid programs cover at least one of the three Food and Drug Administration (FDA)-approved MAT medications. States are also expanding access to MAT through section 1115 demonstrations that establish a continuum of care for people with SUD.⁸ The SUPPORT Act, enacted last year, requires states to cover MAT between 2020 and 2025, unless a state faces substantial provider shortages.

A growing number of states are adopting policies and approaches to facilitate connections to Medicaid coverage and care for people transitioning into and out of incarceration. State efforts to connect justice-involved individuals to Medicaid coverage increased following the Affordable Care Act

(ACA) since it expanded Medicaid eligibility to many low-income adults previously excluded from the program. The expansion made coverage available to more people involved in the criminal justice system. Previously, few adults involved with the criminal justice system qualified for Medicaid due to restrictions that excluded low-income adults without dependent children from the program.

Key Findings

Factors Driving Re-Entry Initiatives

The Medicaid expansion was a key driving factor behind re-entry initiatives in the study states that implemented the expansion. The three study states that expanded Medicaid—New Mexico, Ohio, and Rhode Island—launched re-entry programs in 2014, when the Medicaid expansion was initially implemented. Respondents noted that the re-entry work was spurred by the increased opportunities to secure Medicaid payments for inpatient care provided to incarcerated individuals and to provide coverage to individuals as they transition back into the community. New Mexico passed a state law in 2014 that requires eligibility to be suspended rather than terminated for individuals entering incarceration with Medicaid coverage. The law also allows individuals who enter incarceration to apply for Medicaid if they are not already enrolled, and enhanced data sharing across agencies, including county and state correctional facilities, juvenile and adult prisons, jails and detention centers. In contrast, Missouri did not implement the Medicaid expansion, and eligibility for justice-involved individuals remains very limited.

Re-entry initiatives are a key component of broad statewide strategies to address the opioid epidemic. Respondents noted that re-entry initiatives play a major role in broad efforts to address the opioid epidemic given the high rates of SUD among the justice-involved population and the elevated risk of death upon release into the community. Officials in Rhode Island indicated that the Governor created an opioid addiction prevention task force focused on re-entry in 2015 due to high rates of overdose death and began increasing the budget for OUD in 2016. Missouri's re-entry work grew from a 2002 grant to address recidivism, and has since been spurred by the Governor's focus on addressing the opioid epidemic and the recognition that most of the prison population is incarcerated due to drug-related offenses.

Respondents universally pointed to leadership and collaboration as the most important factors contributing to successful efforts to strengthen connections to Medicaid coverage and promote use of treatment and other services at re-entry. They noted that leadership support and coordination at the agency cabinet level is key for resolving operational challenges and promoting a consistent message about the states' efforts to address SUD. Some noted that it is important to set a common goal across agencies and to promote buy-in of staff at all levels of the organization, particularly in corrections departments. It was noted that identifying how re-entry initiatives can support safer environments with lower rates of recidivism can help garner support from partners in corrections. Respondents also emphasized that translating leadership commitment to agency operations and fostering cross-agency alignment through memorandums of understanding (MOUs) and other arrangements improves coordination and smooths operations.

Strategies to Connect Individuals to Coverage

Individuals who are incarcerated and meet eligibility criteria can enroll or remain enrolled in Medicaid. However, under federal policy, Medicaid does not pay for health services to people who are in jail or prisons, with the exception of inpatient treatment. To facilitate coverage among individuals transitioning into and out of incarceration, federal policy encourages state agencies to suspend, rather than terminate, Medicaid eligibility during incarceration. It also assigns states responsibility to accept applications and renew eligibility while an individual is incarcerated. As of 2018, 38 states suspend rather than terminate Medicaid eligibility for people in prison, and 36 suspend Medicaid coverage for individuals in jail.⁹

Suspending eligibility has enabled the states to access Medicaid payments for inpatient care provided to incarcerated individuals and facilitate reinstatement of full Medicaid coverage for individuals upon release. New Mexico, Ohio, and Rhode Island each maintain coverage for individuals that enter incarceration with Medicaid coverage, but suspend it or change it to a limited status to reflect that payment is only available for inpatient care while incarcerated. These states use automated processes that rely on data sharing between Medicaid and corrections facilities, which minimizes administrative efforts required by eligibility workers and facilitate individuals' access to full coverage upon release. For example, in New Mexico and Rhode Island full coverage is automatically reinstated as individuals are released. Respondents also indicated that use of suspension policies enhances states' ability to access Medicaid payments for inpatient care provided to an individual while incarcerated. In contrast to the other study states, Missouri terminates Medicaid coverage for individuals when they become incarcerated. As such, a new application must be completed to access payment for inpatient care or coverage when an individual transitions back into the community.

The states are providing enrollment assistance prior to release to help ensure individuals have full Medicaid coverage in place when they transition back into the community. All four study states have processes to enroll eligible individuals into Medicaid coverage as they transition from incarceration into the community. However, the scope and approach of these efforts varies across the states. New Mexico initiates enrollment efforts when individuals first enter incarceration, which helps the state connect with individuals even if they have short stays. The other states begin their enrollment efforts about 90-120 days prior to release. New Mexico and Rhode Island target their efforts broadly to individuals leaving both prison and jail, while Ohio's efforts thus far focus on prisons. In Missouri, which has not expanded Medicaid, assistance is focused on individuals who are over age 65 or who have a serious health condition, since eligibility remains limited to elderly adults and adults with disabilities. The states educate individuals about Medicaid coverage and assist in completing and submitting an application as well as selecting a Managed Care Organization (MCO). Individuals either leave with their Medicaid card or it is mailed to their home. These efforts are primarily conducted by corrections staff who are trained as presumptive eligibility determiners; Ohio also has trained some inmates to serve as peer navigators.

The expansion study states have realized significant increases in coverage rates among justice-involved individuals and positive impacts on state budgets. New Mexico estimates that 70% of

people entering incarceration are enrolled in Medicaid. Ohio estimates that it enrolls between 800 and 1,000 people each month. Ohio reports that more than 40,000 incarcerated people have applied for Medicaid and 35,000 have been enrolled in a plan. In New Mexico, more than 80 percent of people leaving incarceration are enrolled in Medicaid. In contrast, in Missouri, a small share of individuals moving into and out of incarceration are eligible for Medicaid because the state has not implemented the Medicaid expansion. The increases in coverage among justice-involved individuals also have had positive impacts on the expansion study states' budgets. For example, some respondents noted that Medicaid coverage replaced state and local programs, which allowed them to redirect those resources to meet other needs, such as housing and other support services not covered by Medicaid. In addition, corrections departments reported savings due to Medicaid coverage for inpatient care provided to incarcerated individuals. For example, Ohio estimates that \$20 million per year has been shifted from corrections to Medicaid and New Mexico estimates that state and federal Medicaid spending produced Department of Corrections (DOC) savings of about \$1.5 million per year.

Even with enrollment efforts in place, the states continue to face gaps and challenges in covering justice-involved individuals. For example, Rhode Island suspends coverage for individuals who enter incarceration with Medicaid, and Ohio enrolls people in a limited inpatient benefit. However, individuals in these states typically lose coverage at renewal if they are incarcerated at the time of redetermination. In contrast, New Mexico primarily relies on administratively renewing incarcerated individuals' coverage to prevent these coverage losses. In addition, respondents indicated that creating automated processes to suspend and reinstate coverage is challenging and requires overcoming major technology hurdles and addressing variations in systems and processes across agencies and corrections facilities. These challenges limit the participation of some facilities in these processes. For example, several counties in New Mexico have not yet been able to implement the automated processes to suspend and reinstate coverage due to technology limitations. Respondents also emphasized that unpredictable release dates and connecting people with short stays to coverage are ongoing challenges. New Mexico waits 30 days and Rhode Island waits 5 days to place people in suspension status to minimize coverage transitions among individuals with short stays. Finally, respondents pointed to challenges reaching people in community supervision arrangements, including those in halfway houses or under parole or probation.

Connecting Individuals to Care Upon Release

The Medicaid expansion increased opportunities to connect individuals to services to address their health and behavioral needs as they transition from incarceration back into the community. Prior to the Medicaid expansion, many individuals were uninsured when they were released from jail or prison, leaving them with access to limited services through a patchwork of localized programs. With the Medicaid expansion, a larger share of individuals can transition back into the community with Medicaid, which provides coverage for a broad array of services to address their physical and behavioral health needs and support recovery and treatment for OUD or other SUDs, including MAT. Medicaid also covers non-emergency transportation and other supportive services, which often are vital for helping individuals access needed health services. See Box 1 on findings on how Ohio's pre-release program has facilitated access to and utilization of care and broader benefits for individuals.

Box 1: Impacts of Ohio's Pre-Release Medicaid Program

In 2018, Ohio published survey, focus group, and administrative data on the impact of its Medicaid pre-release enrollment program, which began in 2014. Ohio's report found:

Individuals in the pre-release program face significant health challenges. They reported being significantly more likely to smoke, binge drink, and have significant mental health conditions than did Ohio's Medicaid expansion population as a whole. More than one in five (22%) people in the pre-release program had Hepatitis C. Rates of incidence of other major chronic conditions measured were generally similar between the Medicaid expansion population and those in the pre-release program.

Individuals in the pre-release program face economic and social challenges. Relative to the overall Ohio Medicaid expansion group, people in the pre-release program were disproportionately male, black, and possessed low levels of education. Roughly one in five is a caregiver to a child and/or family member with a health condition. Respondents described significant economic stress. More than one in ten reported being homeless, 58% do not have a computer, and more than a third do not have a vehicle.

Medicaid facilitated access to care and benefited the health of people in the pre-release program. Nearly 94% of people in the pre-release program said that Medicaid was beneficial to their physical health; just under 85% said it was beneficial to their mental health. One respondent said, "To me, [Medicaid] gives me a reason to get up. I am a member of society and it gives me purpose." Nearly one-third of respondents in the pre-release program reported participating in substance use treatment post-incarceration, and 88% of those who received treatment said that Medicaid facilitated access to it. One respondent said, "Medicaid helps me stay out of trouble and stay in treatment, and pays for counseling and groups. If I didn't have it, I wouldn't be clean right now." More than 9 in 10 people in the pre-release program with OUD received MAT or psychosocial treatment according to state administrative data. People in the pre-release program with OUD were less likely to receive MAT but received psychosocial services at equal or greater rates than those in the overall Medicaid expansion group.

Two thirds of pre-release program respondents said having Medicaid made it less likely that they would return to prison or jail. Respondents indicated that Medicaid helped reduce their risk of recidivism by providing relief from health care costs and enabling them to access care that helps them manage their health. One said, "[Life was] a rollercoaster ride but now [because of Medicaid] I have balance and stability. My therapist sees it, my case manager sees it, my pastor sees it, and everyone I associate with sees it. And I'm still getting better, this is the first time I've been out over a year and a half in 10 years, I've hit my mile marker and I have no intent on going back."

A majority of pre-release program respondents (55%) were working or looking for work and, of those, most indicated that having Medicaid made it easier to continue working (89%) or to search for work (60%). Four in ten described facing challenges with low paying, piecemeal work, and irregular hours. Some also anecdotally reported coercive tactics such as employers charging employees high fees for equipment rentals. Ohio is one of 14 states with proposed or approved 1115 waivers from CMS to require Medicaid beneficiaries to work or volunteer as a condition of receiving Medicaid coverage.¹⁰

Source: 2018 Ohio Medicaid Released Enrollees study, A Report for the Ohio Department of Medicaid, <https://medicaid.ohio.gov/Portals/0/Resources/Research/OMRES-Final-Report.pdf>

The study states are facilitating connections to care in the community by initiating care coordination efforts prior to release. Ohio and New Mexico have established contracting requirements for their Medicaid MCOs to coordinate care for individuals transitioning out of incarceration. In Ohio, the efforts focus on enrollees transitioning from prison with two or more chronic conditions, including mental

illness and a history of SUD, while New Mexico has begun implementing a broad statewide effort.¹¹ Care managers meet with individuals prior to release to assess needs, develop transition plans, establish appointments with community providers, and link individuals to social support services. In Ohio, these meetings take place via telemedicine. The care managers also follow-up with individuals post-release. Rhode Island also began providing additional care management and support when it implemented the Medicaid expansion in 2014. In Rhode Island, discharge planners within the DOC meet with individuals prior to release to conduct a needs assessment and make appointments with community providers. State officials indicate that the goal is for a discharge planner to meet with everyone prior to release, but there currently is not sufficient capacity to accomplish this goal and discharge planning services are prioritized for people with health needs, including SUD. Once in the community, individuals may also receive care management through MCO health homes.

Missouri faces challenges connecting individuals to care in the community due to limited availability of services for uninsured individuals. In Missouri, the prison medical provider helps to set up appointments for individuals prior to release. The state also has a re-entry project for individuals with severe mental illness that seeks to provide a warm hand-off for individuals to community providers and a justice reinvestment initiative through which probation and parole officers assess needs and seek to link individuals to behavioral and mental health services. However, access to services in the community remains limited. Respondents noted that individuals cannot be placed into residential treatment or nursing facilities without coverage. The state is trying to shift resources from institutional treatment to community treatment to expand the availability of care in the community.

The study states are facilitating access to MAT as people transition into and out of incarceration to support treatment and recovery. Each of the study states is providing access to MAT while individuals are incarcerated or just prior to release. Rhode Island offers all three FDA-approved MAT medications to individuals in prisons and jails. Upon incarceration, individuals are assessed to determine whether to continue or begin MAT. Treatment begins within two days of intake, enabling people to start even if they have a short stay. When individuals leave incarceration, they can continue treatment at one of eight community sites operated by the corrections MAT provider or apply to a different provider. Respondents indicated that having the same provider within facilities and in the community supports continuity of care. Some community providers are centers of excellence in opioid treatment or integrated health homes for people with complex conditions, including OUD. These programs facilitate connections to health services as well as community resources like food, shelter, housing and employment. In New Mexico, three counties operate a pilot project to provide methadone treatment during incarceration. People identified with OUD at entry can continue methadone treatment or be induced while incarcerated and are transitioned to community-based methadone clinics upon release. One of the counties also established a re-entry center to help link people with behavioral health needs and SUD to health and support services in the community. Ohio and Missouri offer individuals the option to receive MAT just prior to release. As of 2018, Ohio began offering Vivitrol to individuals at release. Ohio also operates a pilot project offering Naloxone at release from institutions that serve female inmates; this will be expanded to male correctional facilities this summer. The corrections department notifies the individual's MCO that the individual received a Vivitrol shot, and the MCO is responsible for making post-release follow up

appointments. Missouri operates a pilot project in four state prisons for individuals who have been sentenced to prison-based treatment. Individuals can elect to receive one Vivitrol injection 3 days before release and a second shot post-release. The MAT provider in the prisons has reentry specialists that call probation/parole officers and treatment providers to minimize gaps in treatment and plan for housing and other needs as individuals are released. Post-release, parole officers are responsible for ensuring that individuals receive second Vivitrol shots.

Experiences from the study states point to improvements in access to care and promising impacts on health and recidivism from re-entry efforts, but data on impacts remain limited.

Respondents reported that the increased Medicaid coverage among individuals leaving incarceration along with enhanced efforts to link them to care have increased the ability of individuals to obtain more consistent and broader care and services to address their health needs and opened up new opportunities to address population health. Ninety-four percent of enrollees in Ohio with a primary diagnosis of opioid use disorder received one or more types of substance use treatment, and early data show positive impacts on recidivism. Rhode Island officials estimate that 78% of individuals who receive MAT while incarcerated continue to receive treatment in the community. Research evaluating the first year of the program's implementation estimated that post-incarceration opioid deaths fell 61% and that, as a result, the opioid death rate in Rhode Island fell 12%.¹² Primary care visits for the SUD population leaving incarceration have increased 7%. Officials in Missouri indicate that since implementing their broader efforts to address the opioid epidemic, they have seen a significant reduction in overdose death rates. They also report that the re-entry project has helped reduce recidivism rates among individuals with severe mental illness and that individuals receiving MAT are more likely to stay in treatment longer.

States are making progress in coordinating care at re-entry, but they also face many challenges to coordination. Respondents pointed to difficulties meeting with individuals prior to release to assess needs and coordinate care, including insufficient resources in facilities to provide for telehealth and/or in-person visits and varied facility schedules and policies that make scheduling visits challenging. Moreover, they emphasized that Medicaid payment currently is not available for any assessment or coordination services provided prior to release due to the limitations on Medicaid financing for incarcerated individuals. Representatives from MCOs and states indicated that they recognize the value and longer-term benefits on health and costs of providing the upfront planning. However, some respondents suggested that policy changes to allow for Medicaid coverage of services for a defined period of time prior to release would help support transition efforts. Respondents also described challenges engaging with individuals post-release due to inaccurate contact information, unpredictable release dates, data lags, and other issues. In addition, respondents indicated that social challenges, including homelessness and lack of transportation, make it difficult to connect with people post-release. Moreover, respondents reported that gaps or delays in reinstatement of full Medicaid coverage or enrollment into an MCO when a person is released can lead to delays in accessing services. For example, Rhode Island had encountered some difficulties accessing residential treatment programs for individuals upon release because there often is a 24-hour gap between release and Medicaid activation and a delay in MCO enrollment and residential programs are not covered by fee-for-service Medicaid. The state now expedites enrollment for people who need residential

treatment to address these issues. Some respondents also indicated that federal privacy and data sharing rules make it difficult to share information between facility and community providers, particularly information related to behavioral health and SUD.

The states face challenges linking individuals to services to due major gaps in availability of behavioral and SUD providers within the community. One major obstacle respondents identified is the lack of sufficient community providers to meet individuals' needs, particularly MAT providers in rural areas. Some respondents indicated that this challenge is exacerbated by onerous policies associated with becoming a MAT provider or prescribing via telemedicine. Respondents in Missouri also expressed concern that federal limits on buprenorphine prescribing contribute to MAT access challenges. Ohio is seeking to address some of these challenges by offering broader certification to providers to offer MAT. In addition, the state recently carved behavioral health services into its managed care contracts, which respondents indicated would expand the network of behavioral health providers for Medicaid enrollees. In Missouri, respondents reported that a bias for institutional care and lack of funding for community-based behavioral care has led to limited access to community-based services. The state currently is working to transition a greater share of treatment beds from prisons and jails into community treatment.

Respondents across the study noted that addressing ongoing stigma associated with SUD and OUD remains important for successful recovery initiatives and efforts. They suggested that it is necessary to educate both the corrections community and providers about use of MAT as an evidence-based model of treatment. Moreover, they stressed that use of peer supports can help build trust and support individuals in seeking treatment. Ohio also developed a broad public facing campaign to help individuals understand OUD and SUD through a chronic disease lens. Rhode Island sponsors public events celebrating recovery.

Looking Ahead

Together these findings illustrate that some states have achieved major progress connecting justice-involved individuals with OUD to Medicaid coverage and care, building on increased opportunities created by the Medicaid expansion. These efforts are translating into increased rates of coverage and enhanced access to care and treatment services as individuals re-enter the community, which are anticipated to lead to long-term improvements in health and recovery and reduced recidivism rates, although data on these broader outcomes is limited to date. Although states have achieved significant success through these initiatives, many challenges remain to connecting individuals to coverage and care. Looking ahead, it will be important to enhance enrollment efforts to address remaining gaps for some individuals and to explore policies and approaches that may further support and smooth efforts to coordinate and connect individuals to care as they transition from incarceration to the community, including strategies that make it easier for plans and providers to meet with individuals prior to release and facilitate sharing of information between facilities and community providers. In addition, expanding the availability of providers in the community, particularly MAT and behavioral health providers, will be key for addressing treatment and recovery needs and ultimately improving health and reducing recidivism.

Vikki Wachino is Principal, Viaduct Consulting, LLC and Samantha Artiga is with the Kaiser Family Foundation. The authors thank the state officials, and plan and provider representatives in each of the four states who generously provided information, time and expertise to make this report possible. They also thank Misty Downey for outstanding research assistance and the staff of Community Oriented Correctional Health Services for providing input into the development of this report.

ENDNOTES

¹ See, most recently, Ryan, Pagel, et al., “Connecting the Justice-Involved Population to Medicaid Coverage and Care: Findings from Three States,” Kaiser Family Foundation, June 1, 2016 <https://www.kff.org/medicaid/issue-brief/connecting-the-justice-involved-population-to-medicaid-coverage-and-care-findings-from-three-states/>

² Kamila Malik-Kane and Christy A. Visher, “Health and Prisoner Re-entry: How Physical, Mental and Substance Abuse Conditions Shape the Process of Reintegration,” Urban Institute, February 2008, <https://www.urban.org/sites/default/files/publication/31491/411617-Health-and-Prisoner-Reentry.PDF>

³ Jennifer Bronson, et al., “Drug Use, Dependence and Abuse among State Prisoners and Jail Inmates, 2007-2009,” Bureau of Justice Statistics, 2017, Washington, D.C. The rate of drug dependence and abuse in the general population age 18 and over is five percent.

⁴ A North Carolina study estimated that the state’s post release overdose death rate outpaced that of the general population by a factor of 40. Shabbar I. Ranapurwala et al., “Opioid Overdoses Mortality Among Former North Carolina Inmates,” *Journal of the American Public Health Association*, 108, no. 9 (2018). In Washington State, researchers estimated that former prisoners were 129 times more likely to die of overdose in the immediate post-release period than the general population, Ingrid Binns-wanger et al., “Release from Prison –a High Risk of Death for Former Inmates,” *the New England Journal of Medicine*, 356, no. 2 (2007).

⁵ World Health Organization, Preventing Opioid Overdose Deaths in the Criminal Justice System Ingrid A. Binns-wanger, MD, MPH, Patrick J. Blatchford, PhD, Shane R. Mueller, MSW, and Marc F. Stern, MD, Mortality After Prison Release: Opioid Overdose and Other Causes of Death, Risk Factors and Time Trends from 1999 to 2009; <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5242316/>; http://www.euro.who.int/_data/assets/pdf_file/0020/114914/Preventing-overdose-deaths-in-the-criminal-justice-system.pdf

⁶ Larney, Sarah, Natasa Gisev, Michael Farrell, Timothy Dobbins, Lucinda Burns, Amy Gibson, Jo Kimber, and Louisa Degenhardt. “Opioid Substitution Therapy as a Strategy to Reduce Deaths in Prison: Retrospective Cohort Study.” *BMJ Open* 4, no. 4 (2014): e004666. <https://doi.org/10.1136/bmjopen-2013-004666>; Mancuso, David, and Barbara E.M. Felver. “Providing Chemical Dependency Treatment to Low-Income Adults Results in Significant Public Safety Benefits.” Olympia, Washington: Department of Social and Health Services, Research and Data Analysis Division, February 2009. <https://www.dshs.wa.gov/sites/default/files/SESA/rda/documents/research-11-140.pdf>; National Sheriff’s Association and National Commission on Correctional Health Care, 2018.

⁷ The ACA required coverage of mental health and SUD services for people in Medicaid expansion, and regulatory and other administrative changes have also strengthened mental health and substance use coverage. See Application of Mental Health Parity Requirements to Coverage Offered by Medicaid Managed Care Organizations, the Children’s Health Insurance Program, and Alternative Benefit Plans, Final Rule, Federal Register vol. 81, no. 61 (March 30, 2016) <https://www.govinfo.gov/content/pkg/FR-2016-03-30/pdf/2016-06876.pdf>; Medicaid Managed care, CHIP delivered in managed care, and revisions related to third party liability, Federal Register, vol. 81, no. 61 (May 1, 2016) <https://www.govinfo.gov/content/pkg/FR-2016-05-06/pdf/2016-09581.pdf>. In addition, the SUPPORT Act permits states to cover 30 days of residential treatment for SUD in a calendar year.

⁸ Center for Medicaid and CHIP Services, “Strategies to Address the Opioid Epidemic,” SMD 17-003, <https://www.medicaid.gov/federal-policy-guidance/downloads/smd17003.pdf>

⁹ Kathleen Gifford, Eileen Ellis, Barbara Coulter Edwards, Aimee Lashbrook, Elizabeth Hinton, Larisa Antonisse, Robin Rudowitz, “States Focus on Quality and Outcomes Amid Waiver Changes; Results from a 50-state Medicaid Budget Survey for State Fiscal Year 2018 and 2019” Kaiser Family Foundation, October 25 2018, <https://www.kff.org/medicaid/report/states-focus-on-quality-and-outcomes-amid-waiver-changes-results-from-a-50-state-medicaid-budget-survey-for-state-fiscal-years-2018-and-2019/>

¹⁰ This count does not include the waivers in Arkansas and Kentucky, which have been set aside by the court. See “Medicaid Waiver Tracker: Approved and Pending Section 1115 Waivers by State,” Kaiser Family Foundation, April 18, 2019 <https://www.kff.org/medicaid/issue-brief/medicaid-waiver-tracker-approved-and-pending-section-1115-waivers-by-state/>

¹¹ According to Ohio, individuals automatically qualify for pre-release transition assistance if they have HIV, Hepatitis-C, are pregnant or have delivered a baby during incarceration, or are receiving MAT in the corrections department. In addition, individuals with at least two of the following also qualify: severe and persistent mental illness, recovery services (highest acuity level) or a chronic condition. Written communication from Ohio Medicaid staff, May 17, 2019.

¹² Traci C. Green, Jennifer Clarke, Lauren Brinkley-Rubinstein, "Postincarceration Fatal Overdoses After Implementing Medications for Addiction Treatment in a Statewide Correctional System," research letter published in JAMA Psychiatry 2018.