

November 6, 2020

SUD Incarceration Amendment Comment
c/o DMS Commissioner's Office
275 E. Main St. 6W-A
Frankfort, KY 40621

To Whom It May Concern:

Comments re: 1115 Waiver Amendment – SUD Incarceration Services
Submitted via Email to: DMS.ISSUES@ky.gov

Kentucky is currently applying for an amendment to its 1115 waiver to provide federal Medicaid matching funds for substance use disorder (SUD) treatment to people who are incarcerated. Given how common SUD is among people who are incarcerated, the intention of the amendment — which is to provide much-needed treatment to people who need it — is positive. However, we are concerned that the current proposal could lead to an increase in incarceration by incentivizing the criminal legal system to incarcerate — particularly pretrial — people for the sake of receiving treatment. This is especially concerning given the harmful impacts that incarceration has on people, and that SUD treatment is most effective when received in the community. Before submitting the plan to the Centers for Medicaid and Medicare Services (CMS) these concerns should be addressed so as not to inadvertently increase incarceration in Kentucky.

All Kentuckians who are incarcerated need quality medical care including SUD treatment

Under House Bill (HB) 352, Kentucky's Department for Medicaid Services is required to submit an 1115 waiver amendment to cover SUD treatment to Kentuckians who are incarcerated.¹ Language from HB 352 states: "Within ninety days after the effective date of this Act, the Department for Medicaid Services shall develop and submit an application for a Section 1115 demonstration waiver...to provide Medicaid coverage for substance use disorder treatment, including peer support services, to individuals incarcerated for a conviction under KRS Chapter 218A. Upon approval of the waiver, the cost of treatment for a substance use disorder or patient navigation provided by a licensed clinical social worker shall be a covered Medicaid benefit for an incarcerated individual."

There are two aims of the Medicaid proposal. The first is to provide SUD treatment to eligible individuals who are incarcerated to ensure this population receives needed treatment before release, as Medicaid does not currently provide federal matching funds to people who are incarcerated; this would significantly expand current SUD treatment in prisons and jails paid for by the state. The second aim is to allow the recipient of treatment's chosen Managed Care Organization (MCO) to coordinate services in the community with a Medicaid provider 30 days before release (services provided during incarceration will be Fee-For Service).

All Kentuckians with SUD deserve the ability to get treatment, and in Kentucky that need is great; in 2017, over 1,400 Kentuckians died from drug overdoses and Kentucky is ranked 9th-highest among states in drug overdose fatalities. According to DMS, there are currently 2,650 people who are incarcerated



receiving SUD treatment provided by the Kentucky Department of Corrections (DOC), with over 2,400 people on a waiting list. The proposed number of people who are expected to be treated through the amendment waiver ranges from 5,300 in the first year to 5,700 in the fifth (final) year.

The eligibility criteria are aimed at people who are both pretrial and post-conviction. The eligibility for individuals who are pretrial include:

- Having a confirmed SUD diagnosis,
- Being in custody in a county jail for pending charges,
- Having no felony convictions (in any state) within the past 10 years,
- Not currently being on probation or parole,
- Not charged with a Class A or B felony or a sexual offense under KRS 17.500,
- And currently charged with an offense under KRS 218A or another offense and has a record of recent/relevant substance use.

For post-conviction, the criteria are being age 18 or older, being U.S citizen or lawfully residing immigrant and resident of Kentucky, currently uninsured and meets SUD criteria through assessment completed by DOC staff.

Being connected to an MCO 30 days pre-release would be major benefit because it would enable a “warm handoff” to health care providers, community services and family and friend support networks, which can reduce the likelihood of recidivism. Too often people fall through the cracks when transitioning from incarceration back to the community, so being given supports during that transition would increase the likelihood of success, at least when it comes to receiving medical care – including SUD treatment and care for co-occurring disorders.

Reforms should emphasize broader access to treatment and community-based alternatives that don’t involve incarceration

In addition to SUD, people who are incarcerated also experience other medical illnesses alongside SUD, especially other mental and behavioral health issues, and a concern with this proposal is that individuals must have a primary diagnosis of an SUD in order to qualify for services — including those involving a warm handoff to an MCO before release. For many people, Serious Mental Illness (SMI) and SUDs are co-occurring, often with SMI being the primary diagnosis; according to the National Institute on Drug Use, “Multiple national population surveys have found that about half of those who experience a mental illness during their lives will also experience a substance use disorder and vice versa.”² It’s unclear why SMI couldn’t be allowed as a primary diagnosis if accompanied by an SUD (further clarification is needed on what SMI services would be covered on the waiver, as they are not listed in the proposal). And while treatment for SMI is a serious need, as a diagnosis it only represents a part of the broader range of mental illness that can be exacerbated through incarceration, and is seldom treated during incarceration.

Outside of SUD and SMI, people who are incarcerated experience higher rates of other illnesses including chronic conditions like hypertension, diabetes and asthma, as well as infectious diseases like HIV and Hepatitis C.³ People who are incarcerated are both more likely to begin incarceration with a higher disease burden because many of them come from lower socioeconomic situations, and incarceration itself lead to/exacerbate medical problems among incarcerated populations.⁴ People with other illnesses who are incarcerated also deserve ongoing treatment whether they have primary/co-occurring SUD or not, and would be well served by also having a “warm handoff” to an MCO for receiving services after incarceration.



Attempting to provide SUD treatment to every Kentuckian who needs it, including incarcerated ones, is an understandable goal, and we believe the MCO transition-focused part of the proposal that will assist people as they leave incarceration is a step in the right direction. However, broadly speaking, community treatment options that don't involve incarceration are more effective than ones that do and as currently designed, by focusing on treatment within incarceration, this waiver proposal could lead to even less treatment in communities and a missed opportunity to truly address substance use disorder in the community.

Incarceration itself is an obstacle to recovery for people with SUD, even with the provision of treatment. Incarceration causes harms such as poor mental health, minimizing of community support and chronic financial hardship, which are linked to substance use disorders. Research has demonstrated that incarceration leads individuals to use substances at higher rates and increases their risk of overdosing. While theoretically the provision of treatment during incarceration would help address this, we know from evidence that recovery requires long-term services alongside having basic needs addressed (like housing and steady employment).⁵ Because incarceration is a barrier to economic stability, it contributes to relapse rather than recovery.

Because of these harms resulting from incarceration, community treatment options are preferred for people with SUD. Unfortunately, there are currently not enough evidence-based SUD treatment programs with available slots in the community to serve all of the justice-involved (or otherwise) individuals who need treatment. People with SUD have few community options, and as a result, many will experience unnecessary incarceration that can and should be prevented. We are concerned the focus on increasing SUD treatment in jails and prisons could further enhance the deficit of long-term SUD treatment options in the community due to resources from counties being used instead for pretrial incarceration.

Providing treatment within jails and prisons also does not address root causes of substance use that, if unaddressed, may lead an individual to return to substance use. In addition to incarceration rates having a large impact on drug overdose rates, household income also has a strong impact on overdose rates, even more so than the prevalence of opioid prescriptions in a community.⁶ Given the current rising costs to counties for incarceration, any increase in pretrial incarceration or jail expansion (which will not be covered by the waiver but is likely necessary to provide capacity for actually implementing expanded on-site SUD treatment) will be very costly to localities at the expense of alternative community investments in root causes that can help prevent substance upstream.

Without significant guardrails, emphasizing SUD treatment in jails and prisons could increase incarceration, especially pretrial

Mass incarceration is a significant problem in Kentucky. There are currently nearly 30,000 people being held in Kentucky state prisons and county jails, and the state has the 7th-highest incarceration rate in the nation.⁷ Incarceration in Kentucky is very expensive; currently, the average county in Kentucky spends \$2,656,555, or 20% of its total budget, on jail expenses.⁸ Incarceration is also a public health problem, with recent studies showing higher incarceration rates being associated with increased mortality rates and overdose deaths.⁹ As proposed, we have serious concerns that the Medicaid waiver could worsen Kentucky's incarceration problems.

Many people (disproportionately low-income people and people of color) are detained in Kentucky because of an inability to pay cash bail, regardless of what they are charged with and before they are found guilty of a crime.¹⁰ These individuals detained pretrial are more likely to plead guilty in order to be released even when innocent and more likely to be found guilty and receive a harsher sentence if their case does go to trial, among many other negative impacts.¹¹



Expanding treatment options to people being held pretrial may incentivize judges and the legal system to incarcerate people for longer periods of time than would otherwise be the case. In the case of pretrial detention, the presence of SUD treatment options could lead some judges to detain people who may have been released on bail or on their own recognizance for the sake of forcing them into treatment. Although participation in SUD treatment would be voluntary under the plan, as written it borders on compulsory treatment. The plan states “upon an agreement between the judge, the commonwealth attorney, the client in question, and their attorney, successful completion of a jail based six month treatment program may serve as an alternative to a felony conviction.” That sets up a potentially coercive dynamic for individuals to enter into treatment. But rather than addressing the problem, that can create unintended harmful consequences given that treatment in punitive contexts such as jails has worse health and safety outcomes (as noted previously).¹²

In addition to concerns about increases in pretrial incarceration, judges may be more likely to grant a custodial rather than a noncustodial sentence for some drug-related crimes so that the individual will receive treatment while incarcerated. As an example, a person charged with possession of cannabis, a Class B misdemeanor, can be sentenced to up to 45 days in jail, and a judge who may have otherwise elected not to impose a sentence on an individual may choose to do so to “help” the individual access SUD treatment (given the lack of clarity on details on implementation for pretrial detention and education for criminal legal system actors like judges and prosecutors, we can’t rule out such a scenario occurring). This potential unintended consequence – an increase in incarceration – would be costly to counties, detrimental to the detained individuals, and unhelpful in the efforts to help communities address SUD.

If we want to increase the number of pretrial defendants with SUD who receive treatment, we should be connecting them to services in the community. One example of such a diversion effort comes from Bexar County, Texas where individuals can receive Personal Recognizance (PR) bonds for mental health (and other) reasons.¹³ PR bonds in this case are an example of a pretrial release mechanism that is part of a larger continuum of pre-arrest, post-booking, and pre-trial diversion, with an emphasis on connecting people to community-based wraparound care. After a person is arrested, a judge, nurse or detention officer can make a mental health screening request to determine eligibility for Mental Health PR bond. The person in question can then be scheduled for a screening with a Registered Nurse or referred immediately to a Crisis Care Center or psychiatric hospital. If the person is eligible for Mental Health PR bond, they’re released without financial conditions and transported to the least restrictive and most clinically appropriate treatment setting. If the person has a charge that makes them ineligible for release on personal recognizance, they can be released with additional mental health criteria.

Way forward should remove incentives for incarceration and expand access to community-based treatment

There is no question that the aim of the Medicaid waiver amendment is well-intended for attempting to provide much need treatment to people who are incarcerated who also have SUD. We support implementing the MCO transition for individuals to help them obtain the treatment, continuity of care and support services needed to address SUD. That element of the proposal could be widened to allow people incarcerated in jails/ prisons who have other primary diagnosed illnesses such as SMI and chronic conditions like HIV/AIDS and secondary diagnoses of SUD to also have the opportunity to transition to an MCO 30 days before release. In 2019, New York State submitted an 1115 Medicaid waiver amendment focused entirely on providing Medicaid services to individuals who were leaving incarceration within 30 days and have 2+ chronic physical/behavioral conditions, SMI, HIV/AIDS or opioid use disorder, and we believe this is to be a great example of reentry-focused Medicaid service design.¹⁴



In addition, there are changes that should be made to ensure this program doesn't lead to increased incarceration. It is especially important in the wake of the COVID-19 pandemic's impact on jails and prisons (and surrounding communities) to avoid implementing policies that would increase incarceration.¹⁵ We recommend the pretrial aspect of the proposal be eliminated entirely, which removes much of the opportunity for perverse incarceration incentives. Furthermore, it is important for comprehensive, evidence-based treatment programs be available to individuals *instead of* incarceration to provide options for people in the community seeking treatment before becoming justice-involved and for people to have treatment diversion options if they do become justice-involved because of SUD. Instead of resorting to incarcerating people for the sake of treatment, Kentucky should focus on enhancing the availability of long-term SUD treatment options in the community, and counties should invest local dollars in social support programs that address housing and economic security in order to reduce the likelihood of individuals developing SUD in the first place.

¹ HB352 20RS, <https://apps.legislature.ky.gov/recorddocuments/bill/20RS/hb352/bill.pdf>.

² Stephen Ross and Eric Peselow, "Co-occurring Psychotic and Addictive Disorders: Neurobiology and Diagnosis," *Clin Neuropharmacol* (September – October 2012), pp. 235-43. Thomas M. Kelly and Dennis C. Daley, "Integrated Treatment of Substance Use and Psychiatric Disorders," *Soc Work Public Health*, (June 2013), pp. 388-406.

³ Laura M. Maruschak, "Medical Problems of Prisoners," Bureau of Justice Statistics, <https://www.bjs.gov/content/pub/html/mpp/mpp.cfm>. Alexi Jones and Wendy Sawyer, "Arrest, Release, Repeat: How Police and Jails Are Misused to Respond to Social Problems," Prison Policy Initiative, August 2019, <https://www.prisonpolicy.org/reports/repeatarrests.html>.

⁴ A. Binswanger, P.M. Krueger and J.F. Steiner, "Prevalence of Chronic Medical Conditions Among Jail and Prison Inmates in the USA Compared with the General Population," *Journal of Epidemiology & Community Health* (July 2009), pp. 921-919, <https://jech.bmj.com/content/63/11/912.short>. Josiah D. Rich, et al., "Clinical Care of Incarcerated People with HIV, Viral Hepatitis, or Tuberculosis," *The Lancet Public Health* (September 2016), pp. 1102-1114, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5504684/>.

⁵ Binswanger, Krueger and Steiner, "Prevalence of Chronic Medical Conditions Among Jail and Prison Inmates in the USA Compared with the General Population." Elias Nosrati, Jacob Kang-Brown, Michael Ash, Martin McKee, Michael Marmot and Lawrence P King, "Economic Decline, Incarceration, and Mortality from Drug Use Disorders in the USA Between 1983 and 2014: An Observational Analysis," *The Lancet Public Health* (July 2019), pp. e326-e333, <https://www.sciencedirect.com/science/article/pii/S2468266719301045>.

⁶ Nosrati et al., "Economic Decline, Incarceration, and Mortality from Drug Use Disorders in the USA Between 1983 and 2014."

⁷ Kentucky Department of Corrections, "Daily Count Sheet," <https://corrections.ky.gov/About/researchandstats/Pages/dailycount.aspx>. In Our Backyards, "Kentucky Jail Dashboard," Vera Institute of Justice, https://public.tableau.com/profile/in_our_backyards#!/vizhome/KentuckyJailDashboard/Summary?publish=yes. U.S. Department of Justice, "Prisoners in 2019," <https://www.bjs.gov/content/pub/pdf/p19.pdf>.

⁸ Vera Institute of Justice, "Fiscal and Policy Implications of COVID-19," Presentation to the Kentucky Jail Task Force, Nov. 6, 2020, <https://apps.legislature.ky.gov/CommitteeDocuments/338/12903/Nov%2006%202020%20Updated%20Vera%20Institute%20Heiss%20PPT.pdf>.

⁹ Sandhya Kajepta, Carolina G. Rutherford, Katherine M. Keyes, Abdulrahman M. El-Sayed and Seth J. Prins, "County Jail Incarceration Rates and County Mortality Rates in the United States, 1987-2016," *American Journal of Public Health* (January 2020), <https://ajph.aphapublications.org/doi/full/10.2105/AJPH.2019.305413>. Nosrati et al., "Economic Decline, Incarceration, and Mortality from Drug Use Disorders in the USA Between 1983 and 2014."

¹⁰ Ashley Spalding, "Disparate Justice: Where Kentuckians Live Determines Whether They Stay in Jail Because They Can't Afford Cash Bail," Kentucky Center for Economic Policy, June 11, 2019, <https://kypolicy.org/disparate-justice-where-kentuckians-live-determines-whether-they-stay-in-jail/>.

¹¹ Spalding, "Disparate Justice."

¹² Drug Policy Alliance, "Drug Courts Are Not the Answer: Toward a Health-Centered Approach to Drug Use," 2011, https://www.drugpolicy.org/sites/default/files/Drug%20Courts%20Are%20Not%20the%20Answer_Final2.pdf.

¹³ Pretrial Services, "PR Bonds," Bexar County Courthouse, <https://www.bexar.org/3090/PR-Bonds>.



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- ¹⁴ New York State Department of Health, “Continuity of Coverage for Justice-Involved Populations,” Medicaid Redesign 1115 Demonstration Amendment Application, Aug. 9, 2019, https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/special_populations/docs/cj_cms_amendment_final.pdf.
- ¹⁵ Ashley Spalding, Dustin Pugel, Pam Thomas and Carmen Mitchell, “Kentucky Must Continue Momentum Reducing Jail and Prison Population,” Kentucky Center for Economic Policy, Sept. 3, 2020, <https://kypolicy.org/kentucky-must-continue-momentum-reducing-jail-and-prison-population/>. The Marshall Project, “A State-by-State Look at Coronavirus in Prisons,” <https://www.themarshallproject.org/2020/05/01/a-state-by-state-look-at-coronavirus-in-prisons>.

