

Addressing the Disparate Impact of the Federal Response to the Opioid Epidemic

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Introduction

When Medicaid was established in 1965, federal financial participation (FFP) was prohibited for health care services provided to individuals in Institutions for Mental Disease (“IMDs”) and inmates of a public institution (the “Inmate Exception”).¹ These exclusions served important roles in the advent of nationwide indigent health care: they created disincentives for ineffectual and inhumane institutional treatment of individuals with mental health needs, and they avoided incentives for local jurisdictions to transfer their own health care costs to the newly minted state-federal payment system.

Much has changed since 1965. The advent of the Patient Protection and Affordable Care Act (ACA); public health policy’s focus on the Triple Aim of individual health, population health, and cost containment; a growing opioid abuse epidemic; and better understanding of treatment regimes have led to a reassessment of whether providing Medicaid coverage for services in IMDs still poses the same risks it did in 1965. On July 27, 2015, the Centers for Medicare and Medicaid Services (CMS) released a letter (“IMD Letter”) to state Medicaid directors inviting them to craft 1115 Medicaid waivers to enable states to use IMDs as a part of a comprehensive plan to tackle the opioid abuse epidemic.² This letter opened the door to Medicaid reimbursement for care plans that include residential treatment.

1115 waivers crafted under the new CMS guidance, however, would still leave large numbers of people affected by the opioid epidemic without access to the health care necessary for recovery. These are individuals who have been placed into jails and prisons as a result of their addiction. Indeed, without an accompanying letter from CMS that encourages states to draft narrowly crafted 1115 waivers for services that would typically fall within the Inmate Exception, the racial disparities that exist within our health and public safety systems could increase. Given the historical context and the racialized consequences of not addressing the needs of people in the criminal justice system, CMS should invite states to craft a narrow waiver of the Inmate Exclusion similar to the IMD waiver. This Action Paper describes the historical context of the IMD and Inmate Exception and provides recommendations for policy changes that could both combat the opioid epidemic and reduce racial and economic disparities that would be a consequence of failing to address the entire population affected by the opioid epidemic.

Background to IMD and the Inmate Exception

The federal government has had many reasons to be skeptical of incentivizing the creation of facilities that would cordon individuals off from the community. Arguably, the process of “deinstitutionalization” began in 1955 with the introduction of the anti-psychotic medication Thorazine.³ Ten years later, the introduction of Medicaid and Medicare provided a driving force for further deinstitutionalization by codifying the IMD and Inmate Exclusions into law. Following the revelations in the 1970s of the horrors at Willowbrook State School in Staten



Island—where developmentally disabled individuals were warehoused under appalling conditions—and the Supreme Court’s seminal decision in *Olmstead v. L.C.*⁴ in 1999, public and governmental opinion were decidedly opposed to the overuse of institutional settings.

The history of IMDs follows a different track than the history of inmates of public institutions. While the IMD Exclusion incentivized treatment in the community, the Inmate Exception kept health care costs for correctional facilities off the federal ledgers. Health care costs for individuals who were held in state and county facilities, such as jails and prisons, were the responsibilities of those jurisdictions, and the Inmate Exception aimed to keep it that way. In 1976, the Supreme Court ruled that correctional facilities that were deliberately indifferent to the serious medical needs of incarcerated individuals violated the Eighth Amendment to the Constitution,⁵ but the Inmate Exception meant that the costs of adequate health care would always remain state or local costs.

The combination of these two exclusions created a two-tiered response to behavioral health needs. For individuals with behavioral health needs, the struggle for effective community treatment continued—and still continues to this day—but FFP was not denied as long as treatment was not provided in an IMD. For individuals with behavioral health needs that resulted in entanglement in the criminal justice system, including substance use disorder—which only received treatment parity with the advent of the ACA—the benefits of services funded by FFP were removed. IMDs shrank, but correctional facilities became warehouses for individuals with behavioral health needs and no health care.

Today we see that jails have become *de facto* behavioral health facilities. In these institutions, public safety takes precedence over the effective treatment of behavioral health conditions—minimizing the possibility of effectively meeting the health needs of these individuals or helping avoid recidivism. Studies estimate that fourteen percent of male inmates and thirty-eight percent of female inmates meet the criteria for serious mental illness (SMI), compared to five percent in the general population.⁶ Sixty-eight percent of jail inmates demonstrate signs of substance use disorder.⁷ It is estimated that two-thirds of the people that leave correctional facilities will be arrested again.⁸ The implication is clear: Individuals in correctional facilities are not having their behavioral health care needs met. Upon release from the facility, their unmet needs mean that they will repeat the behaviors that resulted in their initial entanglement in the criminal justice system.

This dual track is even more significant when considering the racial disparities of our correctional system. Correctional facilities disproportionately hold young, poor, people of color. Collectively, black and Hispanic populations are twenty-four percent of the general population, but comprise fifty-four percent of the jail population. A black male born in 2001 has a thirty-two percent chance of spending time in prison at some point in his life. A Hispanic male has a seventeen percent chance. A white male, on the other hand, only has a six percent chance.⁹

CMS Response to Opioid Crisis: A New Look at IMDs

Today, CMS and others are recognizing the need to change their approach to IMDs. Fifty years after the Social Security Act was passed, we have entered a new era that is reshaping the way health care is delivered, conceptualized, and administered. Since the 1960s, we have come to understand that addiction is an illness, and not a moral failing. This means that we need new approaches to addiction crises. The opioid abuse epidemic has become the example *par excellence* of our evolving understanding of addiction and drug abuse. New tools, such as the American Society of Addiction Medicine’s (ASAM) diagnostic criteria for acuity of treatment, provide elegant means of assessing and responding to the needs of individuals struggling with addiction. Indeed, the evolution of our response to substance

abuse needs has re-surfaced questions regarding the utility of IMDs. For example, according to the ASAM criteria, under certain DSM-IV diagnoses and levels of acuity, the appropriate treatment regime should include a short stay in an IMD to effectively administer addiction treatment.

At the same time, we have come to understand that health care is best delivered through what public health professionals call the Triple Aim: individual health, population health, and controlling costs. All three parts of the Triple Aim must be undertaken simultaneously—otherwise, the optimal outcomes will remain elusive. Tackling the opioid abuse epidemic means not merely looking at the individual health of a consumer of health care services, but also at population health outcomes. If the health of the population as a whole is not considered, individual health and cost savings will both suffer.

This evolution in science and policy has placed CMS in a difficult situation. The ASAM criteria clearly indicate that IMD services are necessary for some individuals with substance use disorder. To effectively combat the opioid abuse epidemic, CMS can no longer act as though an IMD is never appropriate for both health outcomes and health care savings. CMS' initial response to the opioid epidemic has been laudable. On July 27, 2015, CMS invited states to use their 1115 Medicaid waiver authority to include IMDs into the full panoply of services available to states in their attempt to combat the opioid abuse epidemic. CMS has recognized the value of IMDs in treating crises and in addressing substance use disorders.

The Inmate Exclusion

CMS' efforts, however, still fail to provide a means of treatment for a significant portion of the population affected by the opioid use epidemic. As noted above, many of the individuals in jail, who are disproportionately people of color, are there because of untreated behavioral health disorders—including substance use disorders. Without creating a waiver that would cover the entire population affected by the opioid epidemic, CMS will fail to effectively address the population health impacts of the opioid abuse epidemic. Further, the separate courses created by the IMD and Inmate Exclusion described above are further exacerbated by this new policy. Many media outlets are already beginning to point out that the loosening of the IMD restrictions only occurred upon the advent of the current prescription-opioid fueled heroin epidemic, which has been largely affecting suburban and white populations.¹⁰

Understandably, it would be bad policy to allow all health care services in the jail to receive FFP, but CMS can limit the opportunities for exploitation of FFP by inviting states to craft narrow waivers that would target FFP in certain circumstances. CMS already attempted to limit the perverse incentives that would be associated with opening the flow of FFP to IMDs by requiring that IMDs merely be one part of a comprehensive Substance Abuse Treatment. In the same fashion, a narrowly crafted waiver of the Inmate Exclusion could eliminate the perverse incentives associated with allowing FFP to flow to inmates of a public institution.

Conclusion: The Inmate Exclusion Waiver and its Implications

There are four clear ways that FFP could improve the health status of the population affected by the opioid abuse epidemic, while simultaneously improving individual health status, and decreasing the costs of combating the epidemic. A narrow Inmate Exclusion waiver would:

1. Allow states and counties to use FFP to work with Medicaid providers to both identify patients in county jails who are receiving community-based opiate treatment and to maintain their treatment protocols. Better coordinating care would reduce the risk that inmate progress outside the jail would be squandered once inside the jail, thereby

reducing both Medicaid spending and health disparities for justice-involved beneficiaries.

2. Allow states and counties to use FFP for Medicaid providers to work with county jails to develop opioid treatment and continuity of care plans for released or diverted individuals subject to the ASAM criteria. Access to care upon release or diversion from jail is essential to good health outcomes – especially in the crucial 24-to-72 hours immediately following release or diversion. Delays in reactivating Medicaid increase overall Medicaid costs, lead to treatment interruptions and can adversely impact communities, especially when access to opioid treatment is hindered. Allowing the use of FFP to prescribe and dispense treatment prior to the point of release or diversion would reduce Medicaid spending and improve the health and safety of individuals and communities.
3. Allow states and counties to use FFP to initiate medication-assisted therapy or other forms of medically necessary and appropriate intervention for jailed individuals with opiate addiction whose release is anticipated within 7-to-10 days. Many individuals booked into county jails have previously undiagnosed and untreated disorders. Allowing FFP to be used to cover the costs of treatment prior to release would prevent medical disorders from deteriorating upon release and save federal dollars. A disproportionate number of unintentional overdoses occur after release from jail. Planned interventions can avoid these tragedies and improve overall health outcomes.
4. Allow states and counties to use FFP to reimburse peer counselors to facilitate reentry and increase jailed individuals' health literacy. The Center for Medicare and Medicaid Innovation has invested in a peer counseling demonstration project through the Transitions Clinic Network, which has already demonstrated lower rates of Emergency Department visits for individuals who participate in its program.¹¹

A letter from CMS encouraging states to develop 1115 waivers with these components is not only essential for combatting the public health crisis that is the opioid abuse epidemic, but it is also essential to ensuring that the IMD waivers will not have the unintended consequence of increasing racial disparities.

Endnotes

¹ See The Social Security Act, 42 U.S.C. § 1396d(i) (1965) (describing the IMD). See also, 42 U.S.C. § 1396d(a)(29)(A) (describing the Inmate Exception). See also, 42 C.F.R. § 435.1009(a)(1)-(2) (stating “FFP is not available in expenditures for services provided to [i]ndividuals who are inmates of public institutions . . . or [i]ndividuals under age 65 who are patients in an institution for mental disease”).

² Letter from Vicky Wachino, Director, Centers for Medicare & Medicaid Services, to State Medicaid Directors (July 27, 2015), <http://medicaid.gov/federal-policy-guidance/downloads/smd15003.pdf>.

³ See E. Fuller Torrey, *OUT OF THE SHADOWS: CONFRONTING AMERICA'S MENTAL ILLNESS CRISIS* (1997).

⁴ 527 U.S. 581 (1999).

⁵ *Estelle v. Gamble*, 429 U.S. 97 (1976).

⁶ Henry Steadman, et al., *Prevalence of Serious Mental Illness Among Jail Inmates*, 60 *PSYCH. SERVS.* 761 (2009).

⁷ Jennifer C. Karberg, *Substance Dependence, Abuse, and Treatment of Jail Inmates, 2002*, Bureau of Justice Statistics (2006).

⁸ Andrew Papchristos, *Recidivism and the Availability of Health Care Organizations*, 3 *JUST. Q.* 31 (2014).

⁹ Thomas P. Bonczar, *Prevalence of Imprisonment in the U.S. Population, 1974-2001* (Bureau of Justice Statistics, August 2003).

¹⁰ See, e.g., Andrew Cohen, *How White Users Made Heroin a Public-Health Problem*, *ATLANTIC MONTHLY*, August 12, 2015; and Katharine Q. Seelye, *In Heroin Crisis, White Families Seek Gentler War on Drugs*, *N.Y. TIMES* Oct. 30, 2015 at A1.

¹¹ Emily A. Wang, et al., *Engaging Individuals Recently Released From Prison Into Primary Care: A Randomized Trial*, 102 *AM. J. OF PUB. HEALTH* e22-e29 (Sept. 2012).