



February 19, 2019

The Honorable Seema Verma, Administrator
The Centers for Medicare & Medicaid Services (CMS)
U.S. Department of Health and Human Services (HHS)
200 Independence Avenue, SW
Washington, DC 20201

Dear Administrator Verma:

As advocates and people who represent millions of Americans affected by mental illness, we want to thank you for your stewardship of the Medicare and Medicaid programs, which provide critical health care services for tens of millions of beneficiaries with serious mental illness (SMI) and children with serious emotional disturbances (SED). We greatly appreciate the active participation of CMS staff in the Interdepartmental Serious Mental Illness Coordinating Committee (ISMICC) implementation process and commend you for issuing guidance which allows states to design innovative service delivery systems for adults with SMI and children with SED within Medicaid. We write to you to offer our assistance in efforts to improve care for beneficiaries with SMI and SED involved in the criminal and juvenile justice systems. We speak only for ourselves and not for all of the non-federal or federal members of ISMCC.

Specifically, we hope to work with you to reduce barriers that impede access to Medicaid treatment and recovery services upon release from correctional facilities. This provides an excellent opportunity for interdepartmental/interagency coordination between CMS, SAMHSA, DOJ and other federal departments, and is an activity that is directly connected to recommendations that were included in ISMICC's initial report to Congress (specifically "Recommendation 4.8 - Reduce barriers that impede immediate access to treatment and recovery services upon release from correctional facilities").

The "SUPPORT for Patients and Communities Act" (P.L. 115-271, section 5032) requires HHS to convene a stakeholder group to develop best practices to ease and carry out the health care-related transition of Medicaid beneficiaries who transition from incarceration to the community. We believe that facilitating enrollment in Medicaid and supporting access to services following incarceration will make a significant difference in the health and well-being of people with SMI, SED, and SUD. Therefore, based on the breadth and depth of our experience as health care providers, law enforcement officials, advocates, families and individuals affected by mental illness, we would like to offer our collective expertise to CMS as you move forward with implementation efforts. Specifically, non-federal members who are spearheading the Justice and Finance workgroups would be very interested in participating in



the stakeholder group. We have unique understanding of the needs of individuals transitioning back into the community and would welcome the opportunity to serve as a resource to you.

Mental health and substance use disorders (SUD) are common amongst the incarcerated population and most people leaving prison have at least one chronic problem with physical health, mental health or SUDⁱ. Prisons, jails and other penal institutions are required to ensure the provision of appropriate and necessary health care to individuals while incarcerated. However, the responsibility of these facilities ends when individuals return to the community and too many individuals are released from incarceration without appropriate access to coverage and continuity of care. Reentry is a particularly crucial period for those with SMI, SED, and SUD because it is associated with significant stress and high risk of recidivism, relapse, or crisis. On release, people with serious mental illnesses, particularly those with co-occurring substance use disorders, recidivate at higher rates than other offenders. This is frequently attributable to lack of timely access to needed services and supports for their conditionⁱⁱ. In fact, the risk of opioid-related overdose death dramatically increases in the first days and weeks after an individual with untreated opioid use disorder is released from jail or prisonⁱⁱⁱ. According to one study, former inmates' risk of a fatal drug overdose is 129 times as high as it is for the general population during the two weeks after release^{iv}.

Research has shown, though, that when people are enrolled in health care upon release, they are more likely to engage in community-based services and less likely to recidivate^v. In contrast, a lapse in treatment, especially for those with SMI, SED and SUD, can result in negative health consequences for individuals and greater costs to federal and state governments for uncompensated care. Providing access to coverage and warm handoffs to community-based care upon release can reduce this risk and help save lives and money.

The legislation also requires CMS to take the best practices developed by the stakeholder group and issue a State Medicaid Director letter regarding section 1115 demonstrations to improve health care transitions, including Medicaid coverage for up to 30-days prior to release. This is an especially important step to ensuring uninterrupted access as it is challenging for beneficiaries to navigate the process of enrolling in Medicaid and connecting to health care providers in the community. We are excited to see that the state of New York intends to request authority to provide 30-days of coverage prior to release, case management services to link beneficiaries with care upon release, and housing-support services. We are hopeful that your subsequent guidance will encourage other states to also seek to facilitate the successful transition of individuals with SMI, SED and SUD back into the community and urge prioritizing the guidance in your work as early as possible.

Mental health and substance use disorders make it harder to successfully reenter society after incarceration—affecting people's ability to avoid reoffending and maintain employment,



housing, family relationships, and sobriety^{vi}. Facilitating enrollment in Medicaid and supporting access to services following incarceration has the potential to make a significant difference in the health and well-being of people with SMI, SED and SUD. We look forward to further collaboration with CMS to achieve our shared vision of improving access to and quality of treatment for beneficiaries with SMI and SED. If you have any questions, please contact Mary Giliberti at mgiliberti@nami.org who will coordinate with the other non-federal ISMICC members below.

Sincerely,

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¹ Mallik-Kane K, Visher C. Health and Prisoner Reentry: How Physical, Mental, and Substance Abuse Conditions Shape the Process of Reintegration. Urban Institute. February 2008. Available at: <https://www.urban.org/sites/default/files/publication/31491/411617-Health-and-Prisoner-Reentry.PDF>

² Wrenn G., McGregor B, and Munetz M, "The Fierce Urgency of Now: Improving Outcomes for Justice Involved People with Serious Mental Illness and Substance Misuse," Psychiatric Services, published online, 4/16/2018, <https://ps.psychiatryonline.org/doi/10.1176/appi.ps.201700420>

³ Binswanger IA, Blatchford PJ, Mueller SR, and Stern MF. Mortality After Prison Release: Opioid Overdose and Other Causes of Death, Risk Factors, and Time Trends From 1999 to 2009. Ann Intern Med 2013 Nov 5; 159(9): 592-600.

⁴ Binswanger IA, Stern MF, Deyo RA, Heagerty, P, Cheadle, A, Elmore JG, & Koepsell TD (2007). Release from prison--a high risk of death for former inmates. The New England journal of medicine, 356(2), 157-65.

⁵ Santorius P, Woodbury V. Michigan Pathways Project Links Ex-Prisoners to Medical Services, Contributing to a Decline in Recidivism. February 2007. Available here: <https://innovations.ahrq.gov/profiles/michigan-pathways-project-links-ex-prisoners-medical-services-contributing-decline>

⁶ Mallik-Kane K, Paddock E, Jannetta J. Health Care after Incarceration. Urban Institute. February 2018.