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THE COSTS AND BENEFITS OF THE REENTRY INTENSIVE CASE MANAGEMENT SERVICES PROGRAM

A Program of the Los Angeles County Justice, Care and Opportunities Department

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For more than a decade, California has been enacting policy changes that are intended to lower the number of people who are incarcerated in the state. These policy changes include sentencing reforms and new funding streams for programs aimed at addressing underlying causes that can lead to incarceration, such as mental health and substance use disorders.[1] Los Angeles County's Reentry Intensive Case Management Services (RICMS) program, which began in 2018, is one such program. The RICMS program connects people who have been involved in the criminal legal system to community health workers who work at community-based organizations. Community health workers help people reintegrate into their communities by providing case management and connecting them with supportive services.

This brief presents the results of a benefit-cost study of the RICMS program. The RICMS program comes with a cost, mostly borne by the state of California and Los Angeles County, since the program is publicly funded, as are many of the services it refers clients to. However, these costs could be offset by benefits such as reductions in participants' involvement in the criminal legal system. Benefit-cost analysis provides a tool to compare these costs and benefits, which provides decision makers with a monetary lens through which to assess the potential effects of the program. The study, which is led by MDRC, is part of the Los Angeles County Reentry Integrated Services Project, a multiyear, multistudy evaluation of services that are offered by the Justice, Care and Opportunities Department (JCOD) of Los Angeles County.[2]

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Policy Context

California embarked on massive reforms to its criminal legal system in the early 2010s. In 2011, the Public Safety Realignment Act shifted responsibility for the incarceration and supervision of people with lower-level felony convictions from the state prison system to local jails. In 2014, a California ballot measure called Proposition 47, or the Safe Neighborhoods and Schools Act, sought to further reduce the prison population by reclassifying certain nonviolent and drug-possession crimes into misdemeanors, reducing the penalties for them. Both efforts resulted in reductions in the state prison population and shifted the burden for jailing and supervision for certain types of crimes to counties.[3] Los Angeles County, the focus of this brief, has the largest jail system in the United States. It grew from 15,000 to 18,000 after realignment, and then started declining after Proposition 47 was enacted.[4] In the first quarter of 2023, the average daily population stood at over 14,000.[5]

Proposition 47 stipulates that all financial savings that resulted from its implementation were to be directed to mental health and substance use disorder treatment, schools, and victim services.[6] Los Angeles County's RICMS program is one of the programs that receives funding from Proposition 47. The program is delivered by community-based providers under contract with JCOD. It connects people who have been involved in the criminal legal system to community health workers based at community-based organizations.[7] The community health workers, who also have lived experience with the issues faced by clients, help clients gain access to and navigate services available in their community.[8]

The RICMS program's theory of change posits that centralizing the coordination of services for people who have been involved in the legal system and connecting clients to community health workers who have had experiences similar to theirs will improve clients' health and well-being and lead them to have less contact with the legal system in the future. Community health workers are the key component of the model; they conduct outreach to engage clients, identify their needs, and help them connect with services they need. After a client enrolls in the RICMS program, community health workers complete a comprehensive assessment of the client's needs, which is used to form a personalized care plan. Care plans address clients' physical health, mental and behavioral health, housing, transportation, benefits enrollment, education, and employment.

Earlier Findings from the Evaluation of the RICMS Program

MDRC's study of the RICMS program has used qualitative and quantitative methods to examine the program model, goals, and implementation, as well as the outcomes of clients. The findings from the implementation and outcomes study are documented in an earlier report.[9]

As described in that report, MDRC conducted a quasi-experimental analysis using propensity score matching to generate information about the differences in service receipt and criminal legal system outcomes that could be the result of the RICMS program. Drawing on the full sample of individuals who enrolled in the RICMS program between April 2018 and March 2021, MDRC used background characteristics of enrollees to construct participant and comparison groups that were as similar as possible. Participants were defined as clients who were enrolled in the RICMS program for at least 30

days and had a care plan recorded in the program's database. Comparison group members were similar individuals who were enrolled in the RICMS program but who did not continue to participate in it. Propensity score matching is a powerful analytic tool that can be used when a randomized controlled trial is not feasible, yielding stronger evidence than simply comparing outcome levels of unmatched groups. However, this technique cannot determine whether the program caused the differences in outcomes observed between the two groups, if there are any. There may be unobserved characteristics or unmeasured factors (factors for which the team does not have data) that could predict engagement in the program or outcomes that are not accounted for in the matching process.

The quasi-experimental analysis found that, over a 24-month follow-up period, participants in the RICMS program spent fewer days in jail, and had fewer arrests, convictions, or parole revocations than comparison group members. These differences are statistically significant, meaning that it is unlikely that they would have been observed by chance if there were no real difference between participants and comparison group members.[10] The analysis further found that RICMS program participants were more likely to visit a primary care provider and less likely to visit an emergency room than comparison group members. These differences are also statistically significant. The participant group also spent fewer days in inpatient mental health treatment or in the hospital, but these differences are not statistically significant. The analysis found that RICMS program participants had slightly higher rates of inpatient admissions and outpatient courses of treatment for substance use disorder, but these differences are also not statistically significant. These results were used to conduct the benefit-cost analysis in this report and are presented in more detail later in this brief.

RICMS Benefit-Cost Analysis and Research Questions

Benefit-cost analysis provides a way to describe the RICMS quasi-experimental results in economic terms. A benefit-cost analysis sums the benefits of an intervention and subtracts its costs to arrive at its net benefits. See Box 1 for definitions of some benefit-cost terms.

Research Questions

This brief answers the following questions:

- What are the costs of the RICMS program, including the direct costs of providing the program and the health care costs it induces?
- What are the benefits of the RICMS program to Los Angeles County in terms of the money it avoids spending on criminal legal system costs?
- What are the net benefits of the RICMS program?

Box 1. Glossary of Benefit-Cost Terms

Direct costs. Costs of services provided by the RICMS program.

Induced costs. Costs of other services the RICMS program intends to connect participants with, such as health care.

Fixed costs. Costs that do not change as a result of changes in the volume of services provided or goods produced.

Marginal costs. The costs of adding one additional unit of a service or product.

Unit cost. The estimated cost of one unit of a service or activity.

Net costs. The total costs of services to the participant group minus the total costs of services to the comparison group.

Total benefits. The sum of all benefits.

Net benefits. Total benefits minus net costs.

Data Sources

This analysis used multiple data sources:

- JCOD financial records: The study team used financial records provided by JCOD to estimate the cost of the RICMS program.
- The Comprehensive Health Accompaniment and Management Platform (CHAMP—a case management system operated by the LA County Department of Health Services): CHAMP provided information on the number of people enrolled at each community-based organization each month. This information was used to estimate the cost per enrollee.
- InfoHub: The study team estimated costs and benefits associated with health services and the criminal legal system using data provided by InfoHub, which merges service-use data from the LA County Department of Mental Health, the LA County Department of Public Health, the LA County Department of Health Services, the LA County Sheriff's Department, the LA Superior Court, and the LA County Probation Department, among others.
- Publicly available price estimates: Prices for inpatient mental health and hospital admissions, primary care visits, emergency room visits, substance use disorder treatment, and arrests and stays in jail were derived from publicly available estimates, as described in Table 1.

Table 1. Pricing Sources

Outcome	Description	Source
Primary care visits	Cost per primary care visit for patients on Medicaid	Machlin and Mitchell (2018)
Emergency room visits	Cost per visit for large metropolitan locations	Moore and Liang (2020)
Inpatient mental health treatment and hospital admissions	Cost per hospital-day using the rate for California state/local government hospitals	KFF (2023). Reporting estimates were calculated from the American Hospital Association Annual Survey.
Substance use disorder treatment	Cost per incident for nonmethadone outpatient treatment and adult residential treatment	French, Popovici, and Tapsell (2008)
Arrests	Court cost per case using a weighted average for property crimes	RAND (2024)
Jail	Annual cost per incarcerated person divided by 365 days to arrive at a cost per day	Vera Institute of Justice (2024)

Limitations to the Analysis

There are limitations to the analysis and information included in this brief:

- Because the quasi-experimental method used to compare RICMS participants with the comparison group cannot determine whether the program caused the differences in outcomes observed, readers should be cautious about interpreting those estimated differences, along with the estimated costs and benefits derived from them.

- The analysis only considered benefits based on the perspective of the government, but participants and their families may also experience monetary and nonmonetary benefits from the RICMS program, including higher earnings, better mental health and physical health, and lower collateral costs from involvement in the criminal legal system.

- Averting potential crime yields benefits for victims and communities that are also not considered in this analysis.

- The study team used average unit costs for its estimates, which include both fixed and marginal costs. Savings from marginal costs can be realized in the short term, as these costs are sensitive to reductions in the number of people served. However, fixed costs would need to be reduced as well for an entity to realize all of the estimated savings represented in average cost estimates. For example, an average cost estimate for a day in jail would include both marginal costs (such as food and laundry) and fixed costs (personnel and utilities required to operate the facility, regardless of the size of the population housed within). All these costs would need to be reduced to realize the full savings from a reduction in jail population.

RICMS and Induced Health Care Costs

This section provides the costs of the RICMS program, including the direct costs of the program and the program's induced health care costs. First it presents the analysis approach that was used to calculate each cost, and then discusses the net costs and total cost associated with the RICMS program.

Analysis Approach

Cost estimates were created for those clients who enrolled in the RICMS program between April 2018 and March 2020 in the matched participant and comparison groups (4,500 clients).[11] Costs were calculated for the 24-month period following enrollment. All dollar values provided in this brief are adjusted for inflation and expressed in 2022 dollars.

Direct Costs of the RICMS Program

The direct costs are the amounts JCOD invoiced the state, which represented both its costs and those of the 29 community-based organizations implementing the RICMS program. Each organization was allowed to invoice JCOD for at least 20 clients each month per community health worker it employed, up to a maximum of 30 clients per community health worker, at a rate of $300 per client.[12] If an organization enrolled fewer than 20 clients per community health worker and submitted invoices for the minimum guaranteed amount, it would actually receive more than $300 per client. If an organization had more than 30 clients enrolled per community health worker, it would only be able to invoice for 30 of them, and thus would receive less than $300 per client. Therefore, the study team used actual enrollment totals and invoice amounts to calculate the cost per client, by dividing the total dollar amount each organization invoiced in each month by the total number of clients who were enrolled in that same month.[13]

Next, the study team had to calculate the cost per sample member, since not all clients were included in the research sample.[14] They did so by multiplying the monthly cost per client by the number of sample members in the participant group who were enrolled at that organization in that month. A monthly cost was calculated for each month a participant was enrolled, and the results were then summed across all months and all participant group members to calculate a total cost for the participant group.[15] This total cost was then divided by the sample size of the participant group to arrive at an average cost per participant group member. Since comparison group members also enrolled in services, the same process was followed to calculate an average cost per comparison group member.[16]

JCOD also invoiced the state for the costs of administering and evaluating the RICMS program. The study team estimated a JCOD overhead rate of 3 percent, which was added onto the average RICMS program costs for the participant and comparison groups.[17] Evaluation costs paid to MDRC are not included. An important limitation of these cost estimates is that most community-based organizations probably drew on resources from other sources to operate the RICMS program or provide services to participants, for example, in paying for time spent by supervisors or managers or in giving clients bus passes. Those additional resources are not captured in this analysis, and the cost estimates of the RICMS program that are presented here should be considered a floor.

Table 2. RICMS Program Outcomes

Outcome	Participant Group	Comparison Group	Estimated Difference	P-Value	90 Percent Confidence Interval
Cost of outpatient mental health services[a] ($)	4,364.87	3,639.55	725.32**	0.016	(227.90, 1,222.74)
Number of days of inpatient mental health services	1.61	2.31	-0.70	0.207	(-1.61, 0.21)
Number of primary care visits	0.94	0.64	0.30***	0.001	(0.15, 0.46)
Number of emergency room visits	0.50	0.63	-0.13*	0.093	(-0.25, 0.00)
Number of days in the hospital	0.70	0.91	-0.21	0.231	(-0.50, 0.08)
Number of outpatient courses of treatment for substance use disorder	0.18	0.17	0.01	0.469	(-0.01, 0.04)
Number of inpatient treatments for substance use disorder	0.18	0.16	0.02	0.297	(-0.01, 0.05)
Number of arrests	0.91	1.29	-0.38***	0.000	(-0.48, -0.28)
Number of days in jail	24.44	37.97	-13.54***	0.000	(-17.15, -9.93)
Sample size	2,281	2,219			

SOURCE: Calculations based on data from InfoHub.

NOTES: All measures are calculated using a 24-month follow-up period from the point of enrollment in the program. Statistical significance levels are indicated as: *** = 1 percent; ** = 5 percent; * = 10 percent.

Results in this table are regression-adjusted, controlling for characteristics at the time of program enrollment, and reported means are estimated marginal means derived from the regression model using the emmeans package in R.

The p-value indicates the likelihood that the estimated difference (or larger) would have been generated by a program with no true effect.

[a]The cost of outpatient mental health services is adjusted for inflation and shown in 2022 dollars.

Induced Health Care Costs

In addition to the direct costs of the RICMS program, the team estimated the induced costs of the program to the extent possible. A core aim of the RICMS program is to connect clients with mental and physical health care, substance use disorder treatment, job training, housing services, and other social services. While these services are not a part of the direct operating costs of the RICMS program, they are a core part of the model and incur a cost, mainly to the government, which pays for many of them. The analysis includes induced costs for outpatient and inpatient mental health care, outpatient and inpatient physical health care, and outpatient and inpatient substance use disorder treatment. Due to data limitations, the research team was not able to capture induced costs for housing services, employment services, and other social services.[18]

The cost of outpatient mental health treatment services received by clients was available in InfoHub as an amount billed per service provided. The study team estimated the average cost of outpatient mental health treatment per sample member by summing each sample member's costs for the 24-month period after enrollment in the RICMS program. These per-sample-member costs were then used to calculate an average cost for the participant and comparison groups by dividing the total cost for each group by the sample size for that respective group. Since billing costs were not available for other health care services, publicly available pricing estimates were used to estimate costs for inpatient mental health treatment, primary care visits, emergency room visits, and inpatient hospital admissions. See Table 1 for a breakdown of the data sources for pricing estimates.

Costs and Net Costs of the RICMS Program

The cost and benefit estimates provided in this section and the next rely on the results of the outcome analysis. Table 2 shows the estimated averages and differences between the participant and comparison groups for certain outcomes, after accounting for background characteristics of sample members at the time they enrolled in the RICMS program.[19] It also reports statistical significance and confidence intervals for the estimated differences between the two groups.[20]

Costs are reported in the top panel of Table 3. The cost of the RICMS program is the average cost of the program per sample member in the participant and comparison groups, as described earlier. The cost of outpatient mental health treatment is the average gross cost of services received among the participant and comparison groups, also as described earlier. The study team calculated the average costs of inpatient mental health treatment, primary care visits, emergency room visits, and inpatient hospital admissions by multiplying the pricing estimate for each service by the estimated usage rate (number of visits, admissions, or days) among the participant and comparison groups.[21] Net costs are the costs of services for the participant group minus the costs for the comparison group. Net costs reported are either positive (indicating the participant group cost more than the comparison group per sample member), or negative (indicating the participant group cost less).

Costs are higher for the participant group than the comparison group for the direct cost of the RICMS program, outpatient mental health treatment, primary care visits, and substance use disorder treatments. The estimated cost of the RICMS program for the participant group is $3,410 and for the comparison group, $1,285, a net cost of $2,125. Members of the participant group spent more time enrolled in the RICMS program than comparison group members on average (7.3 months compared with 2.3 months for the comparison group), incurring greater costs. Estimates suggest that participants also used more outpatient mental health treatment and primary care services than comparison group members on average. Participants had an average of $4,365 in outpatient mental health care costs in LA County and comparison group members had an average of $3,640, a net cost of $725. This estimated difference is statistically significant. Estimates indicate that participants had slightly more primary care visits than comparison group members on average, and this difference is also statistically significant. The resulting net cost of primary care visits is $29.

Table 3. Costs and Benefits of the RICMS Program

Cost or Benefit ($)	Unit Cost	Participant Group	Comparison Group	Net Cost or Benefit
Costs				
Direct RICMS services	NA	3,410	1,285	2,125
Outpatient mental health services	NA	4,365	3,640	725
Inpatient mental health services	4,298	6,924	9,930	-3,006
Primary care visits	96	91	62	29
Emergency room visits	645	324	405	-81
Inpatient hospital stays	4,298	3,025	3,932	-907
Outpatient substance use disorder treatment	3,376	612	573	39
Inpatient substance use disorder treatment	14,850	2,701	2,403	299
Total cost		21,453	22,229	-776
Benefits				
Arrests	827	749	1,063	314
Jail	265	6,477	10,066	3,589
Total benefits				3,902
Net benefits				4,678

SOURCES: Calculations based on financial records from JCOD and data from the CHAMP management information system and InfoHub.

NOTES: All numbers are presented in 2022 dollars.
All measures are calculated using a 24-month follow-up period from the point of enrollment in RICMS. The cost per group member is calculated by multiplying the estimated unit cost by the estimated outcome for the group shown in Table 2, with the exception of direct RICMS services and mental health services, which use actual costs.

The team also estimated the cost differences in access to substance use disorder treatments. Participants were admitted on average to 0.01 more outpatient substance use disorder treatments and 0.02 more inpatient substance use disorder treatments than the comparison group.[22] These estimated differences are very small and are not statistically significant, and result in net costs of $39 and $299, respectively, because the unit costs of treatments are high.

Costs for the participant group are lower than those for the comparison group for inpatient mental health treatment, emergency room visits, and hospital admissions in LA County. Participant group members spent 0.7 fewer days in inpatient mental health treatment than comparison group members on average. This small difference is not statistically significant, and results in an estimated net cost of -$3,006. Participants on average had 0.1 fewer emergency room visits than comparison group members. This difference is statistically significant, and results in an estimated net cost of -$81. Participants spent 0.2 fewer days in the hospital than comparison group members on average. This difference is not statistically significant, and results in a net cost of -$907. These net costs suggest that the comparison

group may have used more costly inpatient or emergency care. However, it is important to note that the difference in usage rates between the participant group and comparison group is very small. The large net costs are indicative of the high unit costs for these types of services, rather than markedly different usage rates between the two groups. Additionally, the estimated differences in usage rates between the participant group and comparison group are not statistically significant for the more costly inpatient mental health treatment and inpatient hospital care outcomes. Thus, it is possible that the estimated differences are not due to real differences between the groups, but rather due to chance. This possibility is explored in a subsequent section dedicated to sensitivity analyses.

The estimated net total cost of the RICMS program is -$776. While the estimated direct cost is much higher for participants than comparison group members, the estimated induced health care costs of the program were higher for comparison group members than participants. Taken together, the estimates may suggest that on average, comparison group members used more costly, acute care than participants, while participants used more RICMS program services, substance use disorder treatment, and outpatient mental health care and primary care. The next section explores the estimated benefits of the RICMS program resulting from reduced criminal legal system costs.

Benefits of the RICMS Program

The goal of the RICMS program is to improve well-being and reduce contact with the criminal legal system, which could lead to a cost savings for the government if fewer resources are required to arrest, prosecute, and jail people. However, this analysis uses an average unit cost, which includes both fixed and marginal costs, and in order for the county to realize the full estimated monetary benefits of reductions of crime, it must see reductions in the fixed costs of the criminal legal system. Fixed costs are those that occur regardless of the number of cases or the jail population, such as building or facility maintenance and the staff needed for administration or facility management. Marginal costs are the short-term changes in cost when the unit of activity—such as the number of people incarcerated or the number of court cases—changes.[23] For example, the marginal cost of each additional person who is incarcerated is the cost of that person's food and clothing. The fixed costs associated with a single person's incarceration will not be affected unless there are changes in the staffing levels at the jail or in the number of facilities. For a policy change in the criminal legal system to have a large monetary impact, it needs to reduce both marginal and fixed costs. Readers should keep this fact in mind as they consider the findings presented in this section.

A previous report about RICMS measured involvement in the criminal legal system in the two years after enrollment, describing arrests, convictions, probation, and stays in jail.[24] This analysis focuses on arrests and days in jail to avoid double counting benefits since the unit-cost measures used in the analysis include activities related to multiple outcomes. The unit-cost measure for arrests includes the cost of prosecution. Additionally, some arrests were for violations of probation, which can lead to court cases and revocations; thus, a portion of the benefits that may have resulted from reductions in probation revocations are captured in the arrest and jail estimates.

Benefits and Net Benefits of the RICMS Program

The bottom panel of Table 3 presents the estimated benefits of the RICMS program. Participants had 0.38 fewer arrests than comparison group members during the two-year follow-up period.[25] The unit-cost estimates for this outcome focus on the costs to the court system to process cases. Every case has its own set of charges and the time required for court and legal staff members to prosecute or defend the case will vary by case, thus precise cost estimates are not possible. The most common charges among the sample were for possession of drugs or drug paraphernalia, but theft, burglary, parole violations, and driving with a suspended license were also common. This analysis uses a unit-cost estimate for California for property crime from a separate study, which includes the estimated cost to the court system (including costs for judges, prosecutors, and public defenders) to address reported crimes. The estimate, adjusted to 2022 dollars, is $827 per arrest.[26] Multiplying the estimated difference in arrests by the unit cost results in an estimated average benefit from the reduction in arrests of $314 per participant.

Participants were incarcerated for an average of 13.5 fewer days during the two-year follow-up period than comparison group members (38.0 days compared with 24.4 days).[27] The $265 cost per day in jail in LA County comes from a separate study.[28] The estimated benefit of the reduction of days in jail for RICMS program participants is an average of $3,589 per person during the two-year follow-up period.

The total estimated benefits from reductions in criminal legal system costs is $3,902. Benefits must be considered in the context of the costs of the services that were required to achieve the benefits. Subtracting the net costs of the RICMS program and induced health care use described above results in a total estimated net benefit of $4,678 per participant group member.

Sensitivity Tests

Sensitivity analyses explore whether changes to the underlying assumptions of the analysis affect the overall findings, and, if so, by how much. The research team conducted the following sensitivity analyses:

- Assessment of net benefits of the RICMS program excluding statistically insignificant health care outcomes
- Best-case scenario and worst-case scenario
- Adjusting the direct cost of the RICMS program to $309 per participant per month
- Discounting costs and benefits in year 2

Excluding Statistically Insignificant Health Care Differences in Outcomes

Inpatient health care and substance use disorder treatment have high unit costs, and the differences between the participant group and comparison group with respect to these measures are not statis-

tically significant, meaning any differences between groups may have been caused by chance. When these outcomes are excluded from the model (and thus assumed to have a $0 difference between groups), the total cost per participant is $2,799, meaning participants cost more than the comparison group. The net benefits are reduced to $1,104. In other words, if the RICMS program is assumed to have no effect on the use of these health care services, the overall savings to the government are smaller.

Examining the Best-Case and Worst-Case Scenarios

The analysis presented so far uses the estimated difference between the two groups, but the confidence interval provides the range of values within which one can have 90 percent confidence that the actual difference lies. The worst-case scenario would be one where the actual difference between the two groups is the high value of the confidence interval for cost estimates (thus the scenario where the RICMS program is most expensive) and the lowest value of benefits (assuming the lowest values for reductions in arrests and jail time). Under those assumptions, the net benefit of the RICMS program would be -$2,679, meaning the RICMS program would result in a loss to the government. Reversing these assumptions and assuming the lowest values for costs and highest values for benefits yields a best-case scenario of $12,036 per participant. Of course, these scenarios are highly implausible, but they give a sense of the range of possible values for net benefits and show that there is uncertainty in the positive net benefit findings.

Adjusting the RICMS Program Monthly Cost per Client

JCOD allowed community-based organizations to invoice $300 per month per participant, but as discussed above, because they could invoice for no fewer than 20 and no more than 30 clients per community health worker, the actual cost per month per participant was not $300. Rather, the average cost per month for each member of the sample was higher, at $389, because many community-based organizations did not have more than 20 participants enrolled per community health worker consistently, especially when they first started implementing the RICMS program. In this sensitivity test, the study team analyzed the effects on the results if the cost per participant were $309 per month: the $300 per month organizations would invoice if their community health workers had caseloads in the target range, plus 3 percent for JCOD's overhead. In this scenario with slightly lower per-participant program costs, the RICMS program results in slightly higher net benefits of $5,202, so the overall findings are not changed much.

Discounting Costs and Benefits in Year 2

The estimates presented so far are not discounted to present values. Present values reflect the idea that people value the money they have now more than the money that they will earn or spend in the future.[29] Most of the RICMS program costs were incurred in in the first year after participants enrolled. The study team looked at the distribution of estimated differences in outcomes between the participant and comparison groups in the first 12 months and the second 12 months of the follow-up period to see whether they were consistent from year to year and found that there was not a consistent pattern across variables. To see how much discounting costs or benefits incurred in the second year would change the results, the study team assumed that the costs and benefits were evenly distributed across

the two years and discounted 50 percent of the net cost or benefit using a 3.5 percent discount rate. The result was an estimated net benefit of $4,599, a reduction of less than $100 from the main analysis. This finding shows that applying a discount rate for the second year does not have much effect on the overall findings.

Summary of the Sensitivity Tests

The sensitivity tests demonstrate that adjusting the program cost per client and applying a discount rate does not change the overall results much. However, when the analysis is altered to either remove nonsignificant outcomes or to assume the best- or worst-case scenarios for those outcomes, the overall results change substantially. Given that the analysis of outcomes relies on a quasi-experimental method, readers should give weight to these sensitivity tests, as the actual costs and benefits of the RICMS program may differ dramatically from the results presented earlier.

Discussion

The results of this analysis suggest that the direct costs of the RICMS program can be offset by decreases in participants' use of costly inpatient health services and reductions in criminal legal system costs. The results are presented just from the perspective of government. Participants (and their families) are also likely to experience benefits from improving their mental and physical health and reducing their contact with the criminal legal system, but those benefits were not measured for this analysis. Other members of the community are also likely to experience benefits from reductions in crime—they may be less fearful or avoidant of crime, and fewer victims would experience emotional and physical harm. Thus, factoring in other perspectives could show that the RICMS program is more beneficial to society than the results presented here might suggest.

Many costs of the criminal legal system are fixed, and thus the hypothesized benefits described here have probably not yet been realized by LA County. Information on the budget and composition of LA County's jail population over the last decade shows that although the jail population has declined slightly, the budget for the Los Angeles Sheriff's Department (the entity that operates the jails) has increased substantially.[30] For LA County to realize the potential cost savings from reductions in RICMS program participants' involvement in the legal system, it would need to reduce its expenditures on jail and courts.

Proposition 47 has resulted in savings at the state level, which, per the policy, are being reinvested in the RICMS program and similar programs in LA County and throughout the state. This brief shows how investing in case management programs like the RICMS program could lead to reduced criminal legal system costs, which could yield a net benefit for government. Importantly, improving people's well-being and reducing involvement with the criminal legal system can lead to broader benefits for individuals, families, and their communities.

Notes and References

1 California Board of State and Community Corrections (2024).

2 JCOD was established by the LA County Board of Supervisors in November 2022 to centralize preexisting justice reform efforts in LA County, including prevention, diversion, and reentry services, with an emphasis on the nonclinical components of this work. Previously, the Reentry Division and its programs and staff were housed within the LA County Department of Health Services' Office of Diversion and Reentry.

3 Bird et al. (2018).

4 Vera Institute of Justice (2023).

5 Luna (2023).

6 See the text of Proposition 47: California Secretary of State (2014). California's Department of Finance has estimated that the state has saved nearly $600 million between fiscal years 2016-2017 and 2022-2023 because of reductions to the prison population. Of these savings, nearly $400 million have been reinvested in prevention programs designed to reduce incarceration. For more detail, see Washburn (2022).

7 The number of providers has varied over time; this report focuses on a period during which there were 29 providers.

8 Most community health workers either had personal experience with homelessness, incarceration, extended unemployment, or ongoing physical or mental health issues, or had a family member or someone else close to them who had had those experiences. See Manno et al. (2023).

9 Manno et al. (2023).

10 In an earlier report, the analysis sample was split into two groups: community enrollments and jail enrollments. "Community enrollment" indicates people whose RICMS program enrollment date occurred after their release date, as recorded in the Comprehensive Health Accompaniment and Management Platform (CHAMP). "Jail enrollment" indicates people whose RICMS program enrollment date occurred between their booking date and their release date (including enrollment on their date of release), as recorded in CHAMP. These two groups were pooled in the analysis for this brief, so the numbers presented here do not exactly match those in the prior report.

11 Because of the quasi-experimental design, the matched participant and comparison groups here are a subsample of the total population of enrollees in the RICMS program.

12 Two community-based organizations had negotiated rates with JCOD of $400 per client.

13 This brief uses the term "client" to refer to anyone who enrolled in RICMS. Because of the quasi-experimental design, not all clients are included in the sample.

14 If a client was enrolled for any portion of a month, that client was counted toward the enrollment total for the entire month. Monthly per-client costs were calculated where possible. Some invoices, however, were only available at the quarter or multimonth level. For these periods of time, the research team totaled the number of client-months enrolled across the entire period (usually quarters) and calculated the per-client cost for that period.

15 Some periods were missing cost-per-participant information due to missing invoice information or enrollment information. For these periods, the cost per participant was imputed at a rate of $300 per month.

16 Unlike traditional experimental designs where the comparison group does not receive program services (and therefore does not incur any program costs), comparison group members in this study have program costs associated with them. The quasi-experimental design used in the evaluation relies on matching participants (clients who enrolled in the program for at least 30

days and had care plan records) to comparison group members (similar individuals who were enrolled in the program but then did not participate in it). Because these clients enrolled in the RICMS program, organizations would have been able to invoice JCOD for comparison group clients for an initial span of time.

17 The amount that JCOD invoiced the state varied across invoices. The study team arrived at a 3 percent overhead rate by taking the total amount that JCOD invoiced during the study period and dividing it by the total amount invoiced for community-based organization costs during that same period. This overhead rate was incorporated into the per-sample member costs by multiplying the average cost estimates for the participant and comparison group members by 3 percent and adding the result to their respective average cost estimates.

18 For a full breakdown of these services, see Manno et al. (2023).

19 Differences between the participant and comparison groups were estimated using linear regressions, controlling for client characteristics at the time of enrollment. For a full list of covariates (with one additional binary covariate indicating whether a sample member was in jail at the time of program enrollment to account for the pooling of the sample in this analysis), see Appendix A in Manno et al. (2023). Reported averages for the participant and comparison groups are estimated marginal means derived from a linear regression model controlling for characteristics at the time of program enrollment.

20 The threshold for statistical significance used in this study is a p-value below 0.10. The p-value indicates the likelihood that the estimated effect (or larger) would have been generated by an intervention with zero true effect (that is, if the estimated effect had occurred by chance). For example, a p-value of 0.10 means there is a 10 percent chance that an intervention with no effect would have generated the observed estimated difference. Estimates are considered statistically significant if there is no more than a 10 percent likelihood that the observed effect is due to chance.

21 Estimated usage rates are reported in Table 2.

22 Both inpatient and outpatient substance use disorder treatments refer to the number of treatment courses that a sample member was enrolled in, rather than distinct meetings attended or services received. A single course of outpatient treatment could last months, or even years.

23 Henrichson and Galagano (2013).

24 Manno et al. (2023).

25 Arrest data were limited to arrests made in LA County.

26 The research team was not able to identify a price for the costs of processing drug crimes. For more, see RAND (2024).

27 Jail data were also limited to LA County, so time incarcerated in state prison or other counties is not included.

28 The annual cost of $96,725 (adjusted to 2022 dollars) to incarcerate a person in an LA County jail was divided by 365 to arrive at a daily cost of incarceration of $265 per day. See Vera Institute of Justice (2024).

29 Moore et al. (2004).

30 Chief Executive Office of Los Angeles County (2022); Vera Institute of Justice (2024).

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