THE HENRY J. KAISER FAMILY FOUNDATION

THE KAISER COMMISSION ON
Medicaid and the Uninsured

*Filling the need for trusted information on national health issues...*

June 2016 | Issue Brief

# Connecting the Justice-Involved Population to Medicaid Coverage and Care: Findings from Three States

Jennifer Ryan, Lucy Pagel and Katy Smali, Harbage Consulting
Samantha Artiga, Robin Rudowitz and Alexandra Gates, Kaiser Family Foundation

## Executive Summary

This brief provides an overview of initiatives to connect the justice-involved population to Medicaid coverage and care in three states—Arizona, Connecticut, and Massachusetts. These states are leading efforts in these areas and provide key lessons about how to coordinate across health care and corrections and the potential of such initiatives to better link individuals to physical and behavioral health services. While their experiences to date point to important benefits stemming from these efforts, more time and data are needed to examine the effects on health and criminal justice outcomes. In sum, this brief finds:

**Each of the case study states is connecting individuals to Medicaid coverage at multiple points within the justice system.** The states have processes to suspend Medicaid eligibility for incarcerated individuals and to enroll incarcerated individuals who receive inpatient care. They also have initiatives to enroll inmates prior to release from incarceration and individuals on probation and parole. In Connecticut, about 60% of the incarcerated population is enrolled in Medicaid upon release, and, in Massachusetts, the majority of individuals released from prison each year are enrolled. Arizona reaches a smaller share of the incarcerated population since it targets efforts to those with serious mental illness and complex health conditions, but plans to broaden its scope in the future. Even with these efforts, there remain enrollment barriers, including difficulty reaching individuals who move into and out of custody quickly and system limitations.

**The study states also connect individuals to health care in the community as they are released from jail or prison.** To date, the initiatives primarily target individuals with significant health needs. They help individuals establish connections with community providers, schedule appointments, and obtain referrals for care or other services. The study states also have processes to provide individuals access to prescription drugs upon release. Newly released individuals face a range of access barriers even with this support. Providing assistance through individuals with a shared incarceration history, helping individuals address their priority needs, and identifying culturally competent providers can help overcome these challenges.

**These approaches have increased coverage, facilitated access to care, and contributed to administrative efficiencies and state savings, but effects on criminal justice outcomes have not been measured.** Savings include avoided capitation payments, increased federal funds for inpatient care for incarcerated individuals, and reduced costs in other programs. More research is needed on the effects on health and criminal justice outcomes, including recidivism rates. Strong leadership and close collaboration across stakeholders are key to success given that these are complex initiatives that involve multiple agencies.

# Introduction

Many individuals who are involved with the criminal justice system have significant physical and mental health needs. With the Affordable Care Act (ACA) Medicaid expansion to low-income adults adopted in 32 states to date, many individuals involved with the justice system are now eligible for Medicaid. Connecting these individuals to health coverage can facilitate their integration back into the community by increasing their ability to address their health needs, which may contribute to greater stability in their lives and broader benefits. An increasing number of states have efforts underway to enroll eligible individuals moving into and out of the justice system into Medicaid. Moreover, some states are looking beyond coverage to help link individuals to health services in the community upon release from incarceration.

Building on previous briefs about health coverage and Medicaid eligibility for the justice-involved population, this brief provides an overview of initiatives to connect the justice-involved population to Medicaid coverage and care in three states—Arizona, Connecticut, and Massachusetts. These states are leading efforts in these areas and provide key lessons about how to coordinate across health care and corrections and the potential of such initiatives to better link individuals to physical and behavioral health services. It is based on telephone interviews conducted in early 2016 with a range of stakeholders, including Medicaid agency staff, staff from the state Departments of Corrections (DOCs), Justice departments, providers and health plans, and advocates.

# Background

**The justice-involved population has significant physical and behavioral health needs.** They have high rates of disease, including tuberculosis, HIV, Hepatitis B and C, arthritis, diabetes, and sexually transmitted disease compared to the general population.[1] They also have significant behavioral health needs. Over half of prison and jail inmates have a mental health disorder, with local jail inmates experiencing the highest rate (64%). Moreover, the majority of inmates with a mental health disorder also have a substance or alcohol use disorder.[2]

**The criminal justice system is comprised of a range of different correctional facilities.** It includes prisons, which typically house longer-term felons or inmates serving a sentence of more than one year, and jails, which house individuals awaiting trial or sentencing and those convicted of misdemeanors and serving shorter terms that are typically less than one year. There also are community-based supervision arrangements, including probation, parole, and halfway houses. The federal correctional system consists of prisons overseen by the Federal Bureau of Prisons, which house individuals convicted of a federal crime and generally serving a term of more than one year. State correctional systems oversee prisons housing individuals convicted of state crimes and generally serving terms of more than one year. Each state governs its own prison system through a Department of Corrections. Jails typically are governed by the local city or county governments. However, the structure of the system varies across states. For example, some states, including Connecticut, have a unified system in which the state oversees both the state prisons and jails.

**Individuals may be enrolled in Medicaid while incarcerated.** There is no federal statute, regulation, or policy that prevents individuals from applying for, being enrolled in, or being renewed for Medicaid while incarcerated. In April 2016 guidance, the Centers for Medicare and Medicaid Services (CMS) reiterated that incarcerated individuals may be determined eligible for Medicaid and that the state Medicaid agency must accept applications and process renewals for incarcerated individuals (Box 1).[3]

**Box 1: Medicaid Eligibility for Incarcerated Individuals**

In guidance released in April 2016, CMS clarified that:

- Incarceration does not preclude an inmate from being determined Medicaid-eligible.
- The state Medicaid agency must accept applications from inmates to enroll in Medicaid or renew Medicaid enrollment during the time of their incarceration.
- If the individual meets all applicable Medicaid eligibility requirements, the state must enroll or renew the enrollment of the individual effective before, during, or after the period of time spent in the correctional facility.
- Once enrolled, the state may place the inmate in a suspended eligibility status during the period of incarceration.

Source: Centers for Medicare & Medicaid Services, "To facilitate successful re-entry for individuals transitioning from incarceration to their communities," State Health Official Letter SHO #16-007, April 28, 2016, https://www.medicaid.gov/federal-policy-guidance/downloads/sho16007.pdf

**Although individuals may be enrolled in Medicaid while they are incarcerated, Medicaid will not cover the cost of their care, except for inpatient services.** In its recent guidance, CMS clarified who is considered an inmate of a public institution and therefore only able to receive Medicaid coverage for inpatient care. It also clarifies some groups that are not considered inmates of a public institution and, thus, can receive Medicaid coverage for all covered services if enrolled (Box 2).

**Box 2: Who is an Inmate of a Public Institution?**

**An inmate of a public institution is a person living in a public institution, including a correctional institution.** Correctional institutions include state or federal prisons, local jails, detention facilities, or other penal settings. An important consideration of whether an individual is an "inmate" is his or her legal ability to exercise personal freedom. Inmates may be enrolled in Medicaid but are only able to receive Medicaid coverage for inpatient care.

**The following groups are NOT inmates of a public institution and can receive Medicaid coverage for all covered services if enrolled:**

- Individuals on probation, parole, or community release pending trial;
- Individuals residing in corrections-related, supervised community residential facilities, unless the individual does not have freedom of movement and association while residing at the facility; and
- Individuals on home confinement.

Source: Centers for Medicare & Medicaid Services, "To facilitate successful re-entry for individuals transitioning from incarceration to their communities," State Health Official Letter SHO #16-007, April 28, 2016, https://www.medicaid.gov/federal-policy-guidance/downloads/sho16007.pdf

# Overview of Study State Initiatives

## Medicaid Enrollment Efforts

Historically, most states terminated Medicaid coverage for enrollees who became incarcerated because reimbursement was not available for most services provided to inmates of public institutions and most individuals involved with the justice system were not eligible for Medicaid prior to the ACA. However, given eligibility gains as a result of the ACA Medicaid expansion and CMS guidance encouraging states to facilitate connections to coverage and care, there has been increased movement among states to suspend rather than terminate Medicaid coverage for enrollees who become incarcerated.[4] Over 30 states reported that they suspend Medicaid coverage as of January 2016.[5] Suspending Medicaid coverage allows individuals to have their coverage active immediately upon release, facilitating their ability to access services. It also expedites access to federal Medicaid funds if an individual receives inpatient care during a period of incarceration that qualifies for Medicaid reimbursement. Beyond increased use of suspension, there also are growing efforts to enroll uninsured individuals into Medicaid prior to release from incarceration. For example, New York and Maryland recently released proposals to facilitate individuals' connections to Medicaid upon release from incarceration.[6]

As described below, each of the case study states—Arizona, Connecticut, and Massachusetts—is connecting individuals involved with the justice system to Medicaid coverage in multiple ways, including suspending Medicaid eligibility for incarcerated individuals, enrolling incarcerated individuals into Medicaid when they receive inpatient care that qualifies for Medicaid coverage, enrolling individuals in Medicaid prior to release from incarceration, and enrolling individuals in other areas of the justice system, including those on probation and parole.

### Suspending Medicaid Eligibility

**In Arizona, the Medicaid agency has suspense agreements in place with the Arizona DOC, Arizona Department of Juvenile Corrections (ADJC), and 9 out of the state's 15 county jail systems, which together account for 90% of the state's incarcerated population.** (See agreement template here.) These efforts began as a pilot in one of the state's larger county jail systems around 2005 and have expanded over time. Participating jails and prisons send a daily file of bookings and releases to the state Medicaid agency to identify cases to be placed in suspension status and those that need the suspension status lifted due to release. This is an electronic, automated process in most participating counties. When an individual is placed in suspension status, the state discontinues capitation payments to managed care plans for the individual, since he or she is only eligible for coverage of inpatient care while incarcerated. About 9,000 Medicaid enrollees are in suspension status in any given month. Upon release from jail or prison, individuals' coverage is reactivated without them having to reapply. The Medicaid agency also processes renewals while individuals are incarcerated.

**Connecticut places an enrollee in suspension status once he or she has been in custody for 60 days.** Waiting 60 days before moving an enrollee into suspension status helps prevent disruptions in coverage for individuals who move into and out of incarceration over very short periods of time. Because Connecticut does not have managed care in its Medicaid program, there are no financial consequences related to waiting 60 days to activate the suspension. About 2,300 people were in suspension status as of April 2016. The DOC notifies the Medicaid agency as individuals are released and full benefits are restored. The state implemented

this suspension process in June 2015. Prior to implementing this process, Medicaid coverage was discontinued for approximately 1,200 individuals each month due to their incarceration status.

**Massachusetts has established a special fee-for-service limited inpatient Medicaid benefit.** When the Medicaid agency is notified that an enrollee is incarcerated, eligibility staff update the individual's coverage to this limited hospital benefit. Full benefit coverage is turned back on upon release.

## Enrolling Incarcerated Individuals Who Receive Inpatient Care

**In Arizona, the state has a separate agreement with counties regarding Medicaid coverage for inpatient hospital care for incarcerated individuals.** (See agreement template here.) The Medicaid agency receives information from the hospital when inpatient care is provided to an inmate. If an individual is not already in suspension status, an application is initiated and processed to initiate Medicaid coverage for the care that is provided during the inpatient stay.

**Connecticut processes new applications for individuals who receive inpatient care and are not in suspension status in order to access Medicaid coverage for the care.** Hospitals are no longer required to submit an application if an inmate is in suspension status to access the coverage. The state hopes to implement a more automated process in the future that will rely on data matching rather than applications.

**In July 2015, Massachusetts launched a statewide effort to enroll inmates with inpatient stays into Medicaid.** If an individual has a scheduled inpatient stay, the individual is enrolled prior to receiving the care. If the care is unexpected, the individual is enrolled while in the hospital. The state's DOC medical care vendor is assisting with these enrollments. As part of implementation of this policy, the DOC conducted significant outreach to the hospitals to educate them about the change in financing for this care.

## Pre-Release Enrollment Efforts

**Arizona began enrolling individuals into Medicaid prior to release a number of years ago with targeted efforts for people with serious mental illness and complex health needs.** Medicaid applications for uninsured individuals are submitted via the online application or faxed or mailed from the jails and prisons to the Medicaid agency about 30 days prior to release. There is a dedicated unit within the Medicaid agency to process these applications. Approval is pended until there is a confirmed release date. Once release is confirmed, enrollment information and the Medicaid card is provided to the facility to give to the individual upon release. Since its initial efforts began, the state has expanded its focus to include women prisoners. Over time, the state plans to expand these efforts to the broader population with mental health and substance abuse needs and eventually to the entire pre-release population. The state recently passed legislation establishes new requirements for Arizona DOC to increase enrollment and care coordination for people transitioning out of prison.[7] Arizona also has county-led initiatives to connect individuals to coverage prior to release (Box 3).

**Box 3: Connecting Individuals to Coverage in Maricopa County, Arizona**

Maricopa County is Arizona's most populous county and includes the Tucson area. The county is working in partnership with local organizations to connect individuals to Medicaid:

- Health insurance navigators are placed in the county's Probation Assessment Centers to provide education and enrollment assistance to individuals eligible for release. Since February 2014, over 1,000 individuals have been enrolled in Medicaid through this pathway.
- Inmates in the Maricopa County jail ALPHA program also are connected to coverage prior to release. ALPHA is an intensive 16 week substance abuse treatment program that provides transitional planning for integration into the community, including assistance enrolling in Medicaid. Nonprofit health educators educate ALPHA participants on health coverage options and how to use health coverage and provide assistance with completing applications. Since the program began in November 2015, 95 ALPHA participants have qualified for Medicaid upon release.[8]

**Connecticut has a dedicated Pre-Release Entitlement Unit within the Department of Social Services to facilitate processing of applications prior to release.** The positions in the unit are funded through the DOC, the Judicial Branch, and the Department of Mental Health and Addiction Services. The unit works with staff at correctional facilities to expedite processing of applications for people prior to release. These efforts began many years ago with an initial focus on the seriously mentally ill population and have gradually expanded over time. Currently, the goal is to target everyone upon release.

**Massachusetts launched a MassHealth/DOC Prison Reintegration Pilot Program beginning in 2015, under which MassHealth, the Medicaid agency, works with the DOC to enroll prisoners into Medicaid prior to their release.** Previously, pre-release enrollment efforts within jails occurred on an ad hoc basis, but a statewide approach was launched in 2015. Currently, jails and prisons submit a notification to Medicaid 30 days prior to an individual's release. If there is a Medicaid application on file from within the past 12 months, eligibility is determined based on that application and a prospective date is established for full Medicaid coverage based on the individual's expected release date. If an application is not on file, a new application is completed. Some corrections staff have been trained as Certified Application Counselors (CACs) and assist individuals nearing release with completing the application and explaining the benefits.

## Enrollment for Individuals in Other Areas of the Justice System

**The study states also have initiatives to connect individuals in other areas of the justice system to coverage, including those on probation and parole.** Community supervision arrangements account for 70% of the justice-involved population and nearly all jurisdictions have more individuals under community supervision than in jail or prison.[9] As such, connections with individuals under community supervision provide important opportunities to enroll individuals into health coverage. In **Connecticut**, every person sentenced to probation from court is screened for Medicaid. If they are not already enrolled, a new application is initiated with the probation officer. Once complete, the applications are scanned and sent to DSS, where a dedicated eligibility worker enters them into the system and a determination is made. The Judicial Branch funds one eligibility position at DSS to process these applications. Currently over 400 probation officers are involved in

this process. **Massachusetts** has trained parole officers as CACs, and they assist with completing applications. In addition to enrollment efforts through adult probation offices, **Arizona** also recently began working to enroll individuals who are awaiting trial into coverage.

## Connecting Individuals to Care in the Community

Beyond connecting individuals to coverage, efforts to connect individuals to care in the community upon release are important for supporting their reintegration and enabling them to address their health needs. Each of the three study states has various initiatives underway to establish connections to care in the community.

### Arizona

**Arizona's care coordination efforts currently are focused on people with serious mental illness and complex health needs.** Beginning as many as 180 days prior to release, a release planner is notified of an individual's upcoming release. In cases where the individual has a serious mental illness diagnosis, a connection is then established with one of the state's Regional Behavioral Health Authorities (RBHAs) to initiate the planning and care coordination process. A liaison from the RBHA works with staff at the correctional facility to help ensure the individual completes their Medicaid application as well as a care coordination form that identifies conditions. The RBHA liaison then provides necessary treatment referrals, schedules appointments, and ensures that the individual has a supply of medications upon release. Stakeholders noted that one challenge they face in coordinating care is that correctional facilities are scattered throughout the state, and where an individual is incarcerated may not necessarily be the same area as where they will reside after release. To address this challenge, the state has tried to release individuals with higher needs closer to Phoenix and Tucson, where the majority of the population is concentrated.

**Among the broader population being released, individuals are provided a 30 day medication supply.** In addition, the pharmacy system will show individuals enrolled in Medicaid prior to release as having active Medicaid coverage within 24-48 hours of release, enabling them to fill prescriptions at community pharmacies if necessary.

**Looking ahead, the state plans to have managed care plans play a similar role as the RBHAs in coordinating care for physical health needs.** The state is amending contract language with each health plan to require increased care coordination for individuals as they transition out of jails and prisons. Plans will be required to connect with individuals with complex health needs prior to release to establish appointments and connect them to care in the community. The state is also developing plan performance measures in this area. The goal is to have all plans in progress with this effort by October 2016. In addition, the state is working closely with the RBHAs and managed care plans to establish clinics that will be collocated within probation and parole offices.

## Connecticut

**Beginning 60-90 days prior to release, Discharge Planners begin working with people who have identified physical and mental health needs to coordinate care.** Connecticut has implemented a detailed screening process to identify inmates with health issues. Discharge Planners work with individuals who have identified health needs to coordinate medical and mental health appointments, identify community providers, connect individuals to a local community health center, and provide 30-day prescriptions and prescription drug vouchers to ensure they have immediate access to required medications upon release. These discharge planning services are included as part of the contract with the DOC medical care vendor. The contract requires the vendor to have discharge planners in all correctional facilities.

**The Department of Public Health also funds a program that provides release planning for people diagnosed with HIV.** As part of this program, 90 days prior to release, case managers from outside of the facilities meet with individuals to connect them to care in the community and make sure they will have all their medications available upon release.

**Re-entry Counselors work with individuals without identified health needs.** Re-Entry Counselors help ensure that individuals have complete Medicaid applications but provide less personalized care coordination than Discharge Planners. For example, they may hold group pre-release planning sessions.

**Probation officers also provide health education.** Individuals are required to report to their probation officer within ten business days of sentencing if the sentence does not include a term of incarceration, providing an opportunity to discuss health care. In addition to assisting with enrollment if needed, probation officers provide education on the importance of Medicaid coverage and how to use coverage. The probation department developed FAQs to assist with these efforts.

**Building off of a pilot that was launched in 2010, individuals are provided a voucher to obtain up to 30 days of prescription drugs from a community pharmacy.** This helps ensure that individuals can obtain a supply of medications without being dependent upon what the facility has on hand at the time an individual is released.

## Massachusetts

**Since 2013, the DOC in Massachusetts has utilized its medical vendor to provide patient education and continuity of care for individuals being released.** Re-entry counselors help individuals make appointments with providers, ensure appropriate placements in care facilities as needed, and provide referrals to social services. If individuals already have a provider in the community, re-entry staff help to reconnect them to that provider or similar care. Individuals receive a paper copy of their medical record upon their release. If a community provider needs a copy of a patient's medical record, the provider can contact DOC and obtain information with the patient's permission. The state also provides individuals with a supply of medication upon release and a prescription. In addition, the state has a Recovery Support Navigator program designed to help address the opioid epidemic by providing targeted care coordination assistance to people with substance use disorders as they transition back to the community (Box 4).

**Box 4: Recovery Support Navigator Program in Massachusetts**

Originally funded through a grant from the state Attorney General's Office and expanded through the Massachusetts Bureau of Substance Abuse Services, Massachusetts provides reentry support for individuals receiving Medication Assisted Treatment (MAT) for substance use. The program matches individuals preparing for release from state prison with Recovery Support Navigators, who are trained to provide non-clinical peer support services. The Navigator ensures that the person connects with an outpatient treatment program within 24 hours of release and maintains contact for a year to provide ongoing support. Since it began two years ago, the program has enrolled 229 participants, exceeding its initial goal of 150 enrollees. More than 100 participants have accessed MAT in the community and 100% report having had all their reentry needs addressed through this program.[10]

## Experiences to Date and Lessons Learned

### Impacts on Individuals, Administration, and Budgets

**The study states' enrollment efforts have increased coverage among individuals moving into and out of the justice system.** Facilitating enrollment through multiple pathways is key for reaching people at different points within the justice system, including when they enter the system, during incarceration, prior to release, and when under community supervision. **Connecticut** reports that about 60% of the incarcerated population is enrolled in Medicaid upon release, either through reinstatement of suspended coverage or through the pre-release enrollment process. In **Massachusetts,** over 70% of individuals released from prison in Fiscal Year 2015 had a MassHealth application submitted, and over three-quarters of submitted applications were approved.[11] (Most individuals who did not have an application submitted were already enrolled.) **Arizona's** enrollment efforts have reached a smaller share of the total incarcerated population, since they have been targeted to those with serious mental illness and complex health needs. The state plans to expand enrollment efforts to the broader incarcerated population, including individuals with a substance use disorder. However, as the state broadens its focus, the volume of individuals to reach may be challenging since approximately 120,000 inmates are released each year from county jails and state prisons. To expand its capacity to reach individuals, the state is making changes to its eligibility system to support more pre-release applications being submitted online. In addition, because of the state's robust suspension process, there are fewer individuals that need to be newly enrolled prior to release.

**Anecdotal experiences and data suggest that the study states' initiatives have facilitated access to care for individuals as they transition back to the community.** Stakeholders reported that coverage and care coordination initiatives support greater access to health services in the community for newly released individuals, particularly with respect to behavioral health services. Research from **Connecticut** found that individuals who were enrolled in Medicaid prior to release connected to outpatient care more quickly than those that were not pre-enrolled.[12] They also used more outpatient care and had reduced use of inpatient care.[13] However, there were no significant differences in their number of visits to the emergency room, and they were more likely to use the emergency room than those that were not pre-enrolled.[14] Data from **Massachusetts** show that, among former prisoners that had Medicaid coverage in the year after their release, 84% used any

covered service, including nearly half (47%) who had a behavioral health visit.[15] Moreover, more than half of those who had a medical or behavioral health visit were seen within the first 60 days post release.[16]

**The enrollment initiatives have contributed to gains in administrative efficiencies and state savings.** In **Arizona**, implementation of suspension policies reduced state costs by avoiding capitation payments to managed care plans while individuals are incarcerated. The state reports $30 million in avoided capitation payments in Fiscal Year 2015. In **Massachusetts**, the jails and prisons have realized savings as a result of receiving federal Medicaid funds for inpatient care provided to incarcerated individuals. The state DOC estimates that, since it initiated these efforts in July 2015, it has offset more than $4.2 million in costs for inpatient care provided to prisoners at private hospitals. Massachusetts anticipates that these savings will continue to increase, since the state will soon begin to claim reimbursement for inpatient care provided in the state hospital that serves a large share of inmates. In **Connecticut**, gains in Medicaid coverage among the probation population have led to savings for the state's Judicial Branch, allowing them to increase capacity of other services that do not qualify for Medicaid reimbursement. Stakeholders in the study states also pointed to administrative savings and efficiencies. For example, they indicated that suspension policies have reduced the volume of applications that need to be processed for individuals who receive inpatient care while incarcerated as well as prior to release.

**There remains very limited data how these efforts impact criminal justice outcomes, including recidivism rates.** Research in **Connecticut** found that individuals enrolled in Medicaid prior to release had more days in the community prior to re-incarceration compared to those that were not pre-enrolled. However, overall, there is a lack of data on the impact of these initiatives on criminal justice outcomes. Stakeholders universally agreed that more research is needed for increased understanding of how connections to coverage and care among this population are impacting their health and broader criminal justice outcomes, including recidivism rates, over time.

## Remaining Enrollment and Access Barriers

**Even with multiple enrollment efforts in place, some subsets of individuals remain difficult to reach.** In particular, stakeholders commented that it is difficult to reach the jail population because a large share of the population moves in and out of custody quickly and their release dates are often unpredictable. Stakeholders in **Massachusetts** indicate that working with the parole board is helpful for reaching cases in which there is a quick turnaround and the facility does not have adequate time to assist the individual with enrollment before release.

**System limitations remain a key challenge to enrollment efforts.** Although states have significantly upgraded or launched new modernized Medicaid eligibility systems as part of implementation of the ACA, due to coding and other system limitations, the three study states rely on workarounds or manual processes for some of their enrollment efforts targeted to justice-involved populations. For example, all three case study states primarily rely on paper applications for pre-release enrollment efforts. In addition, some of the smaller counties in Arizona have not implemented suspension due to limits in their system functionalities that would make it difficult to transfer information to Medicaid. Moreover, **Connecticut** and **Massachusetts** use manual processes to reactivate people from suspension status upon release. Because of the manual process, there are some cases in which individuals are released without their coverage being reactivated. The states are

planning for continued system modifications to make the pre-release enrollment efforts and suspense processes more automated in the future.

**Establishing connections with individuals early is key for facilitating connections to community care, but individuals face a range of challenges to accessing care even with support.** All three study states initiate care coordination efforts prior to individuals being released back to the community. However, stakeholders noted that individuals face many barriers to care even with this support. They indicated that health care is one of many competing priorities for newly released individuals. They often have many requirements to meet associated with parole/probation and more pressing needs that take priority over health care. Stakeholders stressed the importance of meeting people where they are to address their priority needs and recognizing that health care is one piece of interrelated issues, including housing, food, and employment. Stakeholders also pointed to the importance of finding culturally competent providers in the community and noted that discrimination among providers against people with a criminal history can present a barrier to care. Community health workers with a shared history of incarceration can play a key role in overcoming these barriers, as seen in the Transitions Clinic program, which has two locations in **Connecticut** (Box 5).

**Box 5: Using Community Health Workers to Overcome Barriers to Access to Care at the Transitions Clinics in Connecticut**

The Transitions Clinic Network (TCN) is a national network of medical homes for individuals with chronic diseases recently released from prison. The network is comprised of 14 clinics in several states, including 2 locations in Connecticut. Each clinic that adopts the Transitions Clinic Program employs a community health worker with a history of incarceration as part of the clinical team. This shared history facilitates their ability to develop trusted relationship with individuals that are reentering the community. The community health workers establish connections with individuals prior to release to initiate initial appointments at the clinic and play a key role as part of the health care team post-release by helping individuals engage in health care services and connect to broader supports to address social determinants of health.

**Sharing information between jails and prisons and community providers remains a challenge, but the study states are working to improve this coordination.** Stakeholders noted that continued reliance on paper processes and medical charts limits the ability to share information from jails and prisons to community providers. For example, in **Connecticut**, the DOC utilizes a paper chart and medical records often do not get passed on to community providers. The DOC recently purchased an electronic health record and is currently in the design phase of implementation. Similarly, work is underway in **Arizona** to connect the DOC and jails to the state's health information exchange, and the DOC recently implemented an electronic health record.

## Operations and Implementation

**Approaches and challenges vary based on the structure and organization of the state correctional system.** For example, **Connecticut** has a unified state correctional system in which the state oversees both the state prisons and jails. As such, the state can implement statewide approaches that will reach all of its state prisons and jails through a single agency. In contrast, **Arizona** and **Massachusetts** have state

run prisons, but the jails are overseen at the county level. As such statewide initiatives in these states require coordination across counties. Moreover, the organizational relationship across the state agencies, including DOC and jail systems, Medicaid, Departments of Health and mental health agencies also varies across states and impacts how states approach enrollment and care connection efforts.

**Initiatives in the study states started with a focus on targeted, high-need populations and have gradually expanded over time.** For example, **Arizona** began its efforts focused on the seriously mentally ill population and individuals with complex health needs and has expanded to broader populations over time. Similarly, **Connecticut's** efforts began back in the early 2000's under a federally-funded grant that supported work by the mental health agency and Medicaid agency to connect individuals with serious mental illness to coverage and have broadened significantly over time. **Massachusetts'** work in this area began as a small pilot program to keep people connected to coverage and has expanded to a statewide effort. Stakeholders indicated that starting with smaller, focused efforts provided an opportunity to launch initiatives with more limited staff and financial resources and to work through challenges before broadening the scope of efforts and investment of resources.

**Leadership and collaboration is key for supporting successful initiatives.** Stakeholders unanimously pointed to the importance of strong leadership for driving policy, process, and operational changes to support these efforts. For example, **Arizona** selected justice as one of three topic areas for its Statewide Innovation Model grant, which has helped raised the profile of the state's work in this area. In addition, the Governor announced in his "State of the State" address that reducing recidivism is one of his key priorities for the year. In **Massachusetts**, the Governor and legislative leaders formed a bipartisan working group to explore criminal justice policy reform. Stakeholders also consistently stressed the need for vested interest and commitment from both the Medicaid and Corrections side and the importance of sharing resources across agencies. A strong partnership between the DOC and the state Medicaid agency was consistently noted as key element of each of the study states' successes.

**Consistent and clear communication among stakeholders were also cited as important components of success.** In **Massachusetts**, a statewide task force was established that brought together Medicaid, DOC, and the jails. Stakeholders noted that having the Medicaid agency convene with the jails was key for understanding each jail's processes and operations and establishing processes that would work within each facility. **Connecticut** held re-entry roundtables around the state, in which eligibility specialists, discharge planners, community providers and other stakeholders came together to share lessons learned and improve processes. In **Arizona**, a statewide criminal justice stakeholder group with over 50 participants across the continuum of health and justice meets on a quarterly basis. Stakeholders also pointed to the importance of documenting everyone's role through written agreements. In **Arizona** suspension policies are established through Memoranda of Understandings between Medicaid and each county jail, the ADJC, and the Arizona DOC that clarify roles and responsibilities. Similarly, in **Connecticut**, written agreements are in place between each involved agency that document roles, responsibilities, and funding of positions.

**Recognizing that this is a long-term effort is important for maintaining ongoing support.** Stakeholders noted that these are complex initiatives that require coordination across multiple agencies as well as system upgrades and modifications to facilitate new processes. They noted it is important to enter into these

efforts recognizing that success does not happen overnight and sometimes multiple approaches are needed to address the many moving parts of the system.

## Conclusion

The three case study states profiled in this brief have achieved success enrolling individuals involved with the justice system into Medicaid and facilitating their connections to care in the community, particularly for individuals with significant health needs. Supported by strong leadership, commitment, and close collaboration across agencies, the initiatives in these states have led to increased coverage, facilitated access to care, and contributed to gains in administrative efficiencies and state savings. However, more research is needed to understand effects on broader criminal justice outcomes, including recidivism rates. Even with these successful efforts, there remain barriers to enrollment and access among the justice-involved population. The study states are working to address many of these barriers as they continue to expand and refine their efforts moving forward.

This brief was prepared by Jennifer Ryan, Lucy Pagel and Katy Smali with Harbage Consulting and Samantha Artiga, Robin Rudowitz and Alexandra Gates with the Kaiser Family Foundation. The authors extend their appreciation to all the participants for sharing their time and perspectives to inform this project.

# Endnotes

[1] National Institute of Corrections, "Solicitation for a Cooperative Agreement—Evaluating Early Access to Medicaid as a Reentry Strategy," Federal Register 76, no. 129 (2011): 39438-39443; Ingrid Binswanger, Nicole Redmiond, and LeRoi Hicks, "Health Disparities and the Criminal Justice System: An Agenda for Further Research and Action," *Journal of Urban Health* 89, no. 1 (2012): 98–107; and Laura Maruschak, *Medical Problems of Prisoners* (Washington, DC: US Department of Justice, Office of Justice Programs, Bureau of Justice Statistics, April 2008), http://www.bjs.gov/content/pub/pdf/mpp.pdf.

[2] Doris James and Lauren Glaze, *Mental Health Problems of Prison and Jail Inmates*, (Washington, DC: US Department of Justice, Office of Justice Programs, Bureau of Justice Statistics, September 2006), http://www.bjs.gov/content/pub/pdf/mhppji.pdf

[3] Centers for Medicare and Medicaid Services, *To facilitate successful re-entry for individuals transitioning from incarceration to their communities,* State Health Official Letter SHO #16-007, (Baltimore, MD: Centers for Medicare and Medicaid Services, April 2016), https://www.medicaid.gov/federal-policy-guidance/downloads/sho16007.pdf

[4] Catherine McKee, Sarah Somers, Samantha Artiga, and Alexandra Gates, *State Medicaid Eligibility Policies for Individuals Moving Into and Out of Incarceration,* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, August 2016), http://kff.org/report-section/state-medicaid-eligibility-policies-for-individuals-moving-into-and-out-of-incarceration-issue-brief/

[5] Unpublished data from a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured with the Georgetown University Center for Children and Families, 2016.

[6] *Governor Cuomo Marks National Re-Entry Week by Seeking to Expand Medical Coverage for Individuals Leaving Incarceration*, (Albany, NY: New York Governor's Office, April 2016), https://www.governor.ny.gov/news/governor-cuomo-marks-national-re-entry-week-seeking-expand-medical-coverage-individuals-leaving and, *Maryland HealthChoice Section 1115 Waiver Renewal Application,* (Baltimore, MD: Maryland Department of Health and Mental Hygiene), https://mmcp.dhmh.maryland.gov/Documents/1115%20HealthChoice%20Waiver%20Final%20Draft%20V2%204.29.16.pdf

[7] HB2701, Budget Reconciliation 2016-2017, (Arizona 2016) http://www.azleg.gov/DocumentsForBill.asp?Bill_Number=hb2701&Session_Id=115

[8] *County partners with state, nonprofits to help inmates get care before release*, Mesa Independent, March 31, 2016, http://mesaindependent.com/maricopa-county/maricopa-county-helping-inmates-get-health-care-before-release/

[9] Danielle Kaeble, Lauren Glaze, Anastasios Tsoutis, and Todd Minton, *Correctional Populations in the United States, 2014* (Washington, DC: U.S. Department of Justice, January 2016), http://www.bjs.gov/content/pub/pdf/cpus14.pdf.

[10] *Spectrum's Recovery Support Navigator Program Changes Lives,* Spectrum Health Systems, March 2016, http://www.spectrumhealthsystems.org/2015/spectrum-s-recovery-support-navigator-program-changes-lives

[11] Massachusetts Department of Correction Performance and Outcome Measurements, Fiscal Year 2015.

[12] Hsiu-Ju Lin, Linda Frisman, and Coleen Gallagher, *Expedited Medicaid Restoration in Connecticut*, American Public Health Association Annual Meeting, Boston, MA, November 2013.

[13] Ibid.

[14] Ibid.

[15] Paul Kirby, Warren Ferguson, and Ann Lawthers, *Post-Release MassHealth Utilization*, Center for Health Policy and Research, University of Massachusetts Medical School.

[16] Ibid.