Case Management for Justice-Involved Populations: Colorado

Medicaid Areas of Flexibility to Provide Coverage and Care to Justice-Involved Populations

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Medicaid and the Justice-Involved Population

States have flexibility in deciding who will be covered under their Medicaid program within established federal guidelines. Many states have increased the number of justice-involved individuals covered by Medicaid by expanding eligibility to low-income adults. Medicaid cannot pay for medical services provided to persons while they are incarcerated, except when in-patient services are provided in a community based hospital setting. However, many other people involved in the justice system—from arrest through community-based supervision—are eligible to receive Medicaid benefits when they are not incarcerated, if they are income eligible and meet certain other criteria. Providing health care services to people involved with the justice system could improve public health and public safety, given their high prevalence of mental health issues, substance abuse, and chronic health conditions including HIV and hepatitis. This series of briefs highlights areas of flexibility within Medicaid that can facilitate enrollment in health coverage and access to necessary care in the community for justice-involved people.

Research suggests that intensive case management[1] improves outcomes for people returning from incarceration, particularly by helping them address mental health needs.[2] This brief describes efforts that Colorado is making to connect individuals returning from prison or jail to Medicaid-funded case management and care coordination in the community,[3] including the challenges Colorado has faced implementing the policy. The state provides case management and treatment for many people while they are incarcerated, but Medicaid cannot pay for these services. It can, however, pay for case management in the community for people with chronic health care needs, and Colorado has developed a structure to deliver care coordination and behavioral case management to Medicaid enrollees. The state is now working to meet the challenges of connecting people returning from prison and jail to that

structure. Progress and challenges in Colorado can inform efforts to introduce Medicaid-funded case management services to people returning from incarceration nationwide.

This brief is based on interviews with key individuals involved in Colorado's reentry, case management, and care coordination efforts; published materials accessible to the public at large; and documents provided by the interviewees.

Overview

Colorado has expanded Medicaid coverage to low-income adults. As a result, many adults involved in the justice system are newly eligible for Medicaid. The state has made a substantial effort to enroll eligible individuals who are in contact with the criminal justice system and is now planning how to link people to services once they are enrolled and are in the community.

Health First Colorado, the Colorado Medicaid program, has a strong commitment to providing care coordination[4] and case management services and the state is now considering how that process can be targeted specifically to the justice-involved population. Previous efforts have targeted individuals with high risk chronic health care needs, such as those with serious mental illness, a history of substance abuse, and conditions such as HIV, many of the conditions that are prevalent for justice-involved groups. Medicaid-eligible people with mental health needs who leave incarceration have access to the same Medicaid-funded case management available to all. But having access is not synonymous with receiving care, so Colorado is developing case management services to meet the unique needs of this population.

This planning is complicated by several challenges. One challenge is jurisdictional complexity. Similar to many states, a single agency oversees all state prisons and jails are managed independently by county sheriffs. The Medicaid program is also administered at the county level. Thus Medicaid enrollment procedures vary significantly across the prison system and the county jails. A second challenge is the time it takes to ensure that information sharing is consistent with the state's privacy restrictions. Identification of the challenges Colorado is experiencing can help inform other states efforts to develop Medicaid-funded case management services to people returning from incarceration.

Colorado's Regional Care Collaborative Organizations and Behavioral Health Organizations

Colorado provides comprehensive mental health and substance use disorder services, including case management, to Medicaid enrollees by assigning them to one of five regional behavioral health organizations (BHOs) based on their county of residence. The state also contracts with seven regional care collaborative organizations (RCCOs) to coordinate care.[5] The entire RCCO program is known as Colorado's Accountable Care Collaborative. All Medicaid enrollees living in the region are eligible to enroll in the RCCO; even though participation is optional, more than one million people are enrolled. RCCOs provide case management and are compensated by the state on a per member per month basis.

The RCCOs are not at risk financially for the cost of care, but have opportunities to receive financial incentives for producing positive outcomes, such as reduced hospital readmissions. Optional risk-based managed care is available in the Denver area, as an alternative to the RCCO.

Medicaid Enrollment in Prisons and Jails

State officials have made concerted efforts to ensure that individuals returning from Colorado prisons are able to access health care in the community. Staff of the Colorado Department of Corrections (CDOC), which operates the prisons and post-release parole supervision in the community,[6] enroll people in Medicaid up to 41 days before their release. Yet people often exit custody with only a reference number because their Medicaid cards have not arrived, and the lack of the card can inhibit their ability to access care. While staff from the CDOC Division of Adult Parole have the responsibility to work with paroled people to ensure they obtain their Medicaid cards and medical records once released, they are not always trained in how people enrolled in Medicaid can request and obtain their Medicaid cards,[7] or how to help individuals secure Medicaid coverage if not yet enrolled. In recognition of the ongoing need for case managers to help people newly released from prison navigate the health care system and use their benefits, interviewees indicated that the Parole Division is developing new post-release case manager positions, funded by CDOC, to help people access care in the community.

Health Homes as Another Approach to Intensive Case Management for Justice-Involved People

The Medicaid Health Home optional state plan benefit, authorized by the Affordable Care Act, provides comprehensive care management and integrated primary, acute, and behavioral health services to Medicaid beneficiaries with chronic conditions, including serious mental illness, HIV/AIDS, substance use disorder, and other complex conditions. While not the strategy that Colorado is pursuing as of September 2016, health homes can be thought of as another form of intensive case management. States must design health homes program eligibility around health conditions rather than specific populations, such as justice-involved people; yet most health homes programs to date have focused on conditions that are prevalent among justice-involved individuals. As a result, several states have reached out to justice-involved individuals as part of their health home strategy.

Health home initiatives interacting with justice-involved people are discussed in "Connecting Justice-Involved Individuals with Health Homes at Reentry: New York and Rhode Island," a separate brief in this series.

Providing community-based health care services to individuals exiting Colorado jails, which are managed independently by the 64 counties, presents additional coordination challenges, but efforts to enroll people in Medicaid at jail reentry are under way. While some counties (including larger ones such as Denver and El Paso) have well-established enrollment procedures and strong working relationships with the state Medicaid agency, Colorado is still bringing other counties on board. The state uses financial incentives to encourage enrollment efforts. While counties and their sheriffs are free to

participate or not in these collaborative enrollment efforts, a small financial incentive is given to those counties whose sheriffs attend regular meetings to discuss Medicaid enrollment. Additional small grants are available to counties to cover some of the expense of enrollment.

Community-Based Case Management

For people exiting prison, Medicaid-funded case management is currently limited to individuals with behavioral health needs, who are eligible to receive the same services as other BHO enrollees. Case management is offered through the RCCOs and BHOs (when members present with chronic conditions and behavioral health concerns). BHOs can authorize more intensive targeted case management services in addition to routine care coordination when it is medically necessary. Contracts with the Department of Health Care Policy and Financing, the state's Medicaid agency, contain specific language requiring that BHOs "collaborate with agencies responsible for the administration of jails, prisons and juvenile detention facilities to coordinate the discharge and transition of incarcerated adult and child/youth members."[8] The costs of all custody-based case management are incurred by the CDOC. Additionally, the CDOC staff try to establish a care continuity plan before release. An interviewee described the case management services provided to people with mental health needs before release:

> We have case management and nursing staff and mental health staff and our prerelease specialists trying to work with that person on the inside, and then out there we have a parole officer, a reentry specialist, and mental health clinicians. We now have four mental health clinicians in our division throughout the state that guide a parole officer with mental health intervention and crisis. They don't provide treatment, but they help us figure out how to manage it.

BHOs are contractually obligated to coordinate the transition to community-based case management for people released with behavioral health needs, however, practitioners report that there are significant hurdles in developing a process that ensures coordination happens consistently and efficiently. One challenge is the timeliness of information sharing. It is taking substantial time for CDOC to determine how it can provide information, consistent with its data privacy obligations and agency rules, to the BHOs regarding which individuals might be appropriate for BHO enrollment, and when they will be released. The counties have similar concerns with data sharing for the jail population. These internal barriers to data-sharing have made coordinated efforts to enroll individuals and develop prerelease care plans difficult to execute. The Department of Health Care Policy and Financing, CDOC, and BHOs are working together to overcome these barriers and provide case management for individuals returning from incarceration with mental health needs.

In addition to behavioral health case management, care coordination, which may not involve regular face-to-face contact, is provided by the RCCOs. Like the behavioral health case management, care coordination provided to justice-involved populations does not differ from that available to any other individuals with Medicaid coverage. Recognizing that the needs of many justice-involved individuals are greater than the current system can address, there are discussions underway about requiring RCCOs to provide more intensive care coordination. One option is for an enhanced monthly per capita rate to cover these services; however, no decision has been made at this time.

Until recently, RCCOs, BHOs, and the county sheriffs managing local jails have rarely collaborated. To improve services for the population being release from jails, the Department of Health Care Policy and Financing is establishing the necessary linkages by meeting with local sheriffs to discuss how data-sharing can enable case management for individuals returning home. One issue is that unless individuals will continue to be under supervision, jail staff often do not know where the individuals who are released from jail will be going so they don't know who to contact when they leave custody. Without notification the RCCOS and BHOs are unaware of who is leaving jail and returning to their geographic areas of responsibility.

For people returning from both jails and prisons, uncertainty regarding how to share information consistent with privacy regulations also hinders the handoff from custodial settings to RCCOs and BHOs. Currently, RCCOs and BHOs are not provided information on such factors as health history and housing circumstances that would inform case management for individuals transitioning to the community. One option under discussion would be to add a flag to the enrollment data sent to RCCOs to indicate that an application was filed from jail or prison. This would alert the RCCOs that this individual might need extra outreach to sign up and is likely to need more care coordination attention. Similarly, information does not flow from Medicaid to correctional facilities, so jail and prison officials have no automated interface to let them know that an incarcerated person is already enrolled in Medicaid.

While state officials improve Medicaid enrollment, care coordination, and case management services for the incarcerated, recent federal policy clarifications will extend Medicaid eligibility to people in halfway houses, if the halfway house meets certain criteria. This additional coverage may be critical to providing health care to justice-involved individuals and may provide another entry point for establishing care coordination and case management services.[9]

I think the rubber will hit the road for services in the last quarter of this year…We hope to know more about who DOC and the jails are enrolling and what their health care needs are. —Colorado Medicaid official

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Lessons Learned

Five lessons from Colorado's experience connecting the reentry population to intensive case management might be useful to other states considering similar initiatives.

Prerelease Medicaid enrollment efforts are a necessary foundation for case management. Colorado's BHOs can authorize targeted case management only for individuals enrolled in Medicaid,

and many people exit prison (and particularly jail) without being enrolled. Colorado's progress on Medicaid enrollment for reentry populations has made case management possible for some people presenting with chronic conditions and behavioral health concerns, but until enrollment efforts are established state-wide, case management for the justice-involved population cannot be fully implemented.

Current care coordination and case management structures are the building blocks for additional efforts. Colorado is connecting reentry populations to the BHO and RCCO structures already in place to facilitate care coordination and case management services, using existing capacity rather than developing different structures.

Building better data links between corrections agencies and community-based health agencies is essential to improve coordination. Colorado has found their confidentiality provisions particularly challenging as they examine data sharing potential between corrections departments and BHOs/RCCOs. Under current practice corrections staff do not have the ability to determine whether people in their custody are enrolled in Medicaid, and care coordination organizations cannot easily identify the population returning from incarceration. Every state will face some challenges in this area, and state privacy experts need to be engaged in efforts to build data-sharing capacity. For examples of data-sharing initiatives between correctional and Medicaid agencies, see "Information Sharing between Medicaid and Corrections Systems to Enroll the Justice-Involved Population: Arizona and Washington," another brief in this series.

Uncertainty in where the individuals being released from prison and jail will reside creates complexity for county and regionally based health care structures. Enrollment in Colorado's BHOs and RCCOs depends on the county or region where Medicaid enrollees live. However, because the reentry population can be transient and have unstable housing situations, jails and prisons often don't know where people exiting their facilities will be living. Sometimes this is because the people returning do not know themselves, or because post-release living arrangements are often subject to unexpected changes. Clarification of federal policy regarding increased Medicaid eligibility for people residing in halfway houses may increase opportunities to connect individuals to case management who are released to such facilities.

The complexity of justice system and community-based health provision must be considered in any plans for improved service delivery. Medicaid staff, RCCOs, BHOs, and prison and jail staff must all help with the connection to care coordination and case management services. In Colorado, 64 different sheriffs oversee the jails, 64 counties run Medicaid programs, and there are seven RCCOs and five BHOs. Having a large number of independent agencies and organizations that must be coordinated in order to implement state-wide coverage requires planning, patience, and a long-term commitment to the importance of improving services for justice-involved individuals through case management.

Conclusion

Expanding Medicaid coverage to low-income adults has provided new opportunities for states to establish health-related case management services to the justice-involved population. In Colorado, collaborative efforts to enroll justice-involved individuals in Medicaid have laid the groundwork for coordinated care on reentry. Ongoing challenges to a successful handoff from prisons and jails to community-based case management include jurisdictional complexity, restrictions on sharing information, and the time it takes to resolve these legal and jurisdictional issues. Colorado's efforts highlight the importance of interagency collaboration, particularly with behavioral health providers and care coordinators, to develop targeted and appropriate case management systems for people leaving state jails and prisons.

Notes

1. Case management has been defined as "a collaborative process that assesses, plans, implements, coordinates, monitors, and evaluates the options and services required to meet the client's health and human service needs" (https://ccmcertification.org/about-us/about-case-management/definition-and-philosophy-case-management). It can take a variety of forms and levels of intensity. Here we use the term case management to include intensive in-person case management as well as less intensive case management such as the care coordination provided by health plans.
2. See Theurer and Lovell (2008) and Burke and Keaton (2004).
3. For more information on the health care needs of recently incarcerated persons see, for example, Howard et al. (2016) and Kamala Mallik-Kane and Jane B. Wishner, "New Medicaid guidance could help people get much-needed health care after prison or jail," *Urban Wire* (blog), Urban Institute, May 16, 2016, http://www.urban.org/urban-wire/new-medicaid-guidance-could-help-people-get-much-needed-health-care-after-prison-or-jail.
4. "Care Coordination," Agency for Healthcare Research and Quality, last reviewed July 2016, http://www.ahrq.gov/professionals/prevention-chronic-care/improve/coordination/index.html.
5. Information about Colorado's RCCOs and its accountable care collaborative may be found at https://www.colorado.gov/pacific/hcpf/regional-care-collaborative-organizations.
6. Most people exiting Colorado prisons are released to the community on parole.
7. See "Health First Colorado Card Frequently Asked Questions," Health First Colorado, accessed September 26, 2016, https://www.healthfirstcolorado.com/frequently-asked-questions/health-first-colorado-card/.
8. See, for example, Colorado's contract with Behavioral Health, Inc., available at https://www.colorado.gov/pacific/sites/default/files/Behavioral%20Healthcare%2C%20Inc.%20Contract.pdf.
9. The Colorado Department of Health Care Policy and Financing recently revised its policy concerning people in halfway houses. As mentioned in the policy, approximately 4,000 people are living in such facilities on any given day, with an average stay of six to seven months. Previously, those residents were considered incarcerated and were not enroll in Medicaid. Following April 2016 guidance from the Centers for Medicare and Medicaid Services, they are no longer considered incarcerated if their confinement meets certain criteria and they may be eligible for Medicaid. This clarification of Medicaid policy opens up opportunities for links between RCCOs and residents of halfway houses, and consequently for improved access to physical and behavioral health services covered by Medicaid. (Colorado Department of Health Care Policy and Financing, "Medicaid Eligibility of Individuals Residing in Community Corrections Facilities [or 'Halfway Houses']," policy statement, June 1, 2016, https://www.colorado.gov/pacific/sites/default/files/June%202016%20Medicaid%20Eligibility%20Policy%20for%20Community%20Corrections%20%28Halfway%20Houses%29.pdf)

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