



# Connecting Justice-Involved Individuals with Health Homes at Reentry: New York and Rhode Island

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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.

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The Medicaid Health Home is an optional state plan benefit through which states provide comprehensive care management and integrated primary, acute, behavioral, and long-term health services to Medicaid beneficiaries with chronic conditions. Of particular relevance to many justice-involved people, qualifying conditions include serious mental illness, HIV/AIDS, substance use disorder, and other complex conditions prevalent among this population.<sup>1</sup> Although Medicaid does not cover benefits provided to incarcerated people, health homes can be a significant resource upon reentry into the community for Medicaid-eligible people who meet the health home eligibility criteria. We examined how Rhode Island and New York are using the health home model to create links with the criminal

justice system and improve continuity of care for justice-involved individuals. We interviewed public officials and selected providers serving justice-involved beneficiaries in each state, and we reviewed publicly available documents and documents provided by interviewees. This brief describes the targeted strategies that New York and Rhode Island are using to connect health home providers with vulnerable individuals involved with the criminal justice system and promote access to and continuity of health services at reentry. The strategies employed by these states, correctional entities, and health home providers may help other states conceptualize what links between the justice system and health homes could look like in their communities.

## Overview

Health homes were authorized as an optional Medicaid state plan amendment in Section 1945 of the Social Security Act. The health home model is designed to provide integrated, person-centered primary, acute, behavioral, and long-term health care to Medicaid beneficiaries with chronic conditions. The aim is to transform care delivery in ways that will improve care and health outcomes for people with complex needs and ultimately reduce unnecessary use of emergency department, inpatient hospital, and nursing facility care and Medicaid costs.

The general eligibility requirements for health home benefits are that someone must be enrolled in Medicaid and have two or more chronic conditions, one chronic condition and the risk of developing a second, or one serious and persistent mental health condition. States have considerable flexibility in the proposed design of their programs, including the conditions they focus on, qualifications and organization of providers, payment methods for required health home core services, and whether to offer the benefits in specific areas or statewide, all of which are specified in Medicaid state plan amendments that the Centers for Medicare and Medicaid Services (CMS) must approve.

Apart from the qualifying conditions and geographic limitations, states may not design programs limited to specific populations, such as those with justice involvement; so far, however, many have focused on conditions prevalent among justice-involved people. Required core health home services include comprehensive care management, care coordination, health promotion, comprehensive services, and follow-up for those transitioning between care settings; individual and family supports; and referral to social and community services. Referrals to community services, such as transportation and sources of stable affordable housing, intend to facilitate enrollees' access to health services and to support their ability to manage their chronic conditions. Spending on those core services, like other state plan services, is reimbursed at a state's usual federal matching rate after an initial eight quarters during which the federal government pays 90 percent as an incentive for states to implement health homes.<sup>2</sup>

As of November 1 2016, 29 Medicaid health home models had been approved in 20 states and the District of Columbia.<sup>3</sup> Among these are three health home programs in Rhode Island focusing on different groups defined by their chronic disease profiles, and a single, broadly focused health home program in New York.<sup>4</sup> In both states, the decision to expand Medicaid coverage to low-income adults

has significantly increased the share of justice-involved people who are potentially eligible for health homes, providing an incentive for community-level collaborations between the criminal justice system and health homes. Both states are using the health home model to promote continuity of needed services by engaging and enrolling eligible people at the beginning of their transition back to the community, reconnecting people previously enrolled with their health home at reentry, or—through nonfederal funding sources (because health home services cannot be provided while someone is incarcerated)—maintaining connections during brief incarcerations.

## New York

### Creation and Development of Health Homes

New York rolled out its health home implementation geographically in three waves: implementation started with 10 counties in the eastern part of the state, effective January 1, 2012; expanded to 13 additional counties, effective April 1, 2012; and finally expanded statewide, effective July 1, 2012 (CMS 2016). The New York Department of Health is the lead agency for the state's health home program, in which health homes assemble networks of providers to assure that enrollees have access to the full range of required core health home services and other health, behavioral, and supportive services they need. As of April 2016, 31 health homes were serving about 230,000 of an estimated 900,000 Medicaid enrollees potentially eligible for health homes throughout the 62 counties in the state.<sup>5</sup>

To be eligible for health homes in New York, someone must be Medicaid enrolled and have two or more of an extensive list of chronic conditions (including HIV/AIDS), or serious mental illness. Substance use disorder (SUD) is an included chronic condition and can qualify someone for health home services if it occurs with another chronic condition.<sup>6</sup> In the early phases of implementation, New York identified eligible individuals by analyzing Medicaid claims, prioritized people with most severe illnesses, assigned them to health homes, and distributed assignment lists to the designated health homes. Currently, the state relies more on community-based referrals than on claims analysis. In either case, health home providers are responsible for locating and attempting to enroll the beneficiaries assigned to them. Enrollment is voluntary. Managed care organizations, hospitals, and other community-based organizations also may refer individuals who meet eligibility criteria and would benefit from health home services.

Health homes are a core element of New York's Medicaid redesign, which has been implemented through a Section 1115 Medicaid demonstration waiver and includes a delivery system reform incentive payment program providing additional funding and flexibility to support reforms. The Medicaid Redesign Team has guided the state's effort to improve care and reduce costs, assisted by work groups charged with exploring not only delivery and payment system reform, but also specific areas that affect the success of reforms, including health disparities, social determinants of health, and supportive housing (New York State Department of Health 2011). New York also has a criminal justice health home work group, coordinated by the Legal Action Center, that brings together health home providers, stakeholders (including local advocacy groups and nonprofit organizations), and state agency

partners (including the governor's office and the New York City mayor's office) to share updates on their programs and initiatives; the group is also a platform for identifying, examining, and addressing barriers to health care for people transitioning out of the justice system.<sup>7</sup>

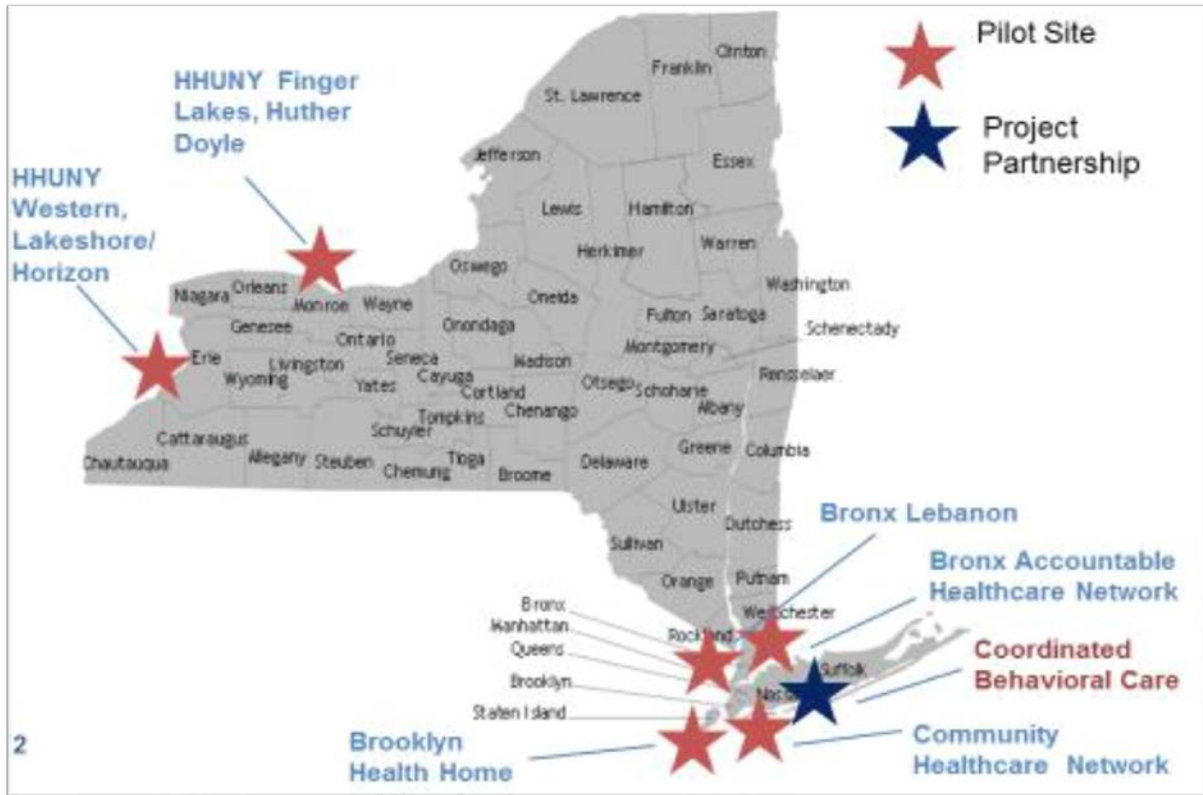
## **Health Homes and Criminal Justice Pilot Programs**

The state has undertaken seven criminal justice pilot programs involving six health homes and one partnership of behavioral health providers that were selected in 2012–13 because of their high level of engagement with the criminal justice population. The intent is to add an infrastructure that can bridge Medicaid health homes and Medicaid-eligible, criminal justice-involved people who qualify for health homes based on their health needs. The criminal justice pilot programs develop and test models to engage individuals being released from state prisons or jails, or in probation or alternative to incarceration programs, and to connect them to health home services when they are not incarcerated. The services are designed to assure access at community reentry to appropriate primary and other care, reduce the cost and threats to care continuity associated with avoidable use of emergency departments and inpatient hospitals, improve public safety, and reduce recidivism. Ultimately, the state hopes to identify models suitable for replication in health homes statewide, initially using health home care management funding to cover the services provided. State officials are deciding how to distribute \$5 million in state funding approved by the legislature, with a focus on hiring specialized staff to provide a link between correctional staff and health home care managers before release.

All seven criminal justice pilots and their related health homes work predominantly with their local jail populations; five of the pilots operate downstate in the New York City area and focus on people incarcerated by the New York City Department of Correction at Rikers Island (figure 1). Pilots also are working with state correctional facilities, the Division of Parole, and court systems for early identification of potential candidates or current health home enrollees. One pilot includes the county sheriff and district attorney on the lead health home agency's board to foster buy-in and collaboration (Teixeira et al. 2014).

FIGURE 1

Health Homes and Criminal Justice Pilots



Source: [https://www.health.ny.gov/health\\_care/medicaid/program/medicaid\\_health\\_homes/docs/hh\\_cjs\\_summary.pdf](https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/hh_cjs_summary.pdf).

Our interviewees are involved in the New York City–area criminal justice pilots. These downstate pilot organizations became involved through their long-standing relationships with the New York City Department of Correction (DOC) and Department of Health and Mental Hygiene (DOHMH). Funding for these downstate pilots has come from multiple sources besides Medicaid funding for health homes care management services and development money from the state. Other sources used to initiate, sustain, and expand the downstate pilots include grants, internal funds available from the health home lead agencies, and New York City funding through the Mayor’s Office and NYC Health + Hospitals. NYC Health + Hospitals, which recently took over responsibility for the city’s Correctional Health Services (CHS) from the DOHMH, is the city’s largest public health care provider and a health home lead agency serving the Bronx, Brooklyn, Manhattan, and Queens.<sup>8</sup> Grant support that has been particularly important for development of the downstate models includes a Health Resources and Services Administration Special Projects of National Significance grant to DOHMH under the Ryan White HIV/AIDS program. The grant funds supported “in-reach” services for incarcerated people with HIV/AIDS before they are released to facilitate care linkage to community providers—services that cannot be paid for by federal Medicaid dollars under current law (Teixeira et al. 2014). Interviewees estimated that people with jail involvement are 5 to 10 percent of the health home organizations’

patient populations, but stated that the percentage could be as much as 20 to 40 percent if arrests, probation, parole, and any other justice system involvement is included.

The fact that justice-involved individuals often move in and out of incarceration, and go back and forth between correctional and community-based care, is an added challenge for meeting the health home goals of continuity of care, improved health outcomes, and reduced cost of care. These transitions cause disruptions and delays in care, and the criminal justice work group has identified reducing such delays as a key goal. So, besides addressing general goals, the health homes involved in the pilots focus on ways to “retain therapeutic alliance with members who find their way into the jail,” avoid disruptions in treatment, establish links with DOC staff, and bring proficient and culturally appropriate services for criminal justice-involved individuals that may also be able to reduce recidivism.

## **Eligibility and Enrollment**

Health homes are responsible for locating and attempting to enroll people on the state-provided lists and community referrals, but eligible people, particularly those without stable living situations or links to providers, are often difficult to find. Finding the referred people can be a challenge generally for health homes, which often reach people after they present in a hospital emergency department. One provider interviewee estimates that “the best find rates are 12–20%.”

These difficulties are aggravated if health homes are unaware that an enrollee has been incarcerated or when incarceration or other justice involvement is contributing to the health home’s inability to locate assigned eligible people. The state encourages correctional and detention facilities to reach out to health homes they would like to work with and is exploring mechanisms for giving people being released from detention and correctional facilities priority access to health homes.<sup>9</sup> New York also encourages health homes to establish relationships with the criminal justice system, so transitional services personnel are aware of the enrollee’s health home membership and the health home’s willingness to reconnect with the enrollee as soon as he or she is released. Collaborations between several state and New York City entities are contributing to connections between the criminal justice system and the health home pilots and are improving tracking of enrollees and location of health home-eligible people who have not been enrolled, although challenges remain. The health homes in the pilots often locate and enroll clients through cross-system data sharing, but enrollments can also be referral based.

Cross-agency data sharing is a fundamental tool in New York’s efforts to link health homes and criminal justice. At the state level, the DOH and the Division on Criminal Justice Services have established a data-sharing partnership to facilitate identification of potentially eligible justice-involved people. State efforts are under way to match Medicaid identification numbers with criminal justice system-assigned state identification numbers, but Medicaid officials noted technical considerations, including some reporting gaps that need to be filled to have a full reporting base. For the downstate health homes, data sharing appears to be farther along.

CHS, which provides health services to all people incarcerated at Riker’s Island, has data sharing agreements in place with nine health homes. The health homes send CHS biweekly patient rosters to match against the historical and current jail census (Jordan and Gonzalez 2014). Health home information is then documented in the CHS electronic medical record, and lists of incarcerated health home members are returned to health homes, identifying the member’s current location, the projected discharge date, and whether the member is eligible for discharge planning. Additionally, the New York City Department of Probation (DOP) has data-sharing agreements with DOHMH and a mental/behavioral health-focused pilot with which DOP works, as well as access to the state DOH’s Health Home Tracking Portal, which includes both eligible and enrolled individuals. These links allow outreach through probation officers and offices and “bottom-up” referrals through the health home pilot’s care managers embedded in DOP branch offices.<sup>10</sup>

New York City’s required comprehensive discharge planning for justice-involved people with mental illness or HIV who are being released is a second important tool for connecting downstate health homes and the criminal justice system. Discharge planning provides an important locus for partnership with health homes before release. DOP estimates indicate that about 90 percent of people under the agency’s supervision who are health home-eligible qualify on the basis of a mental health diagnosis, with or without co-occurring SUD or physical health conditions. The remaining individuals qualify based on physical conditions only (4 percent) or physical conditions and SUD (5 percent).

These data matches involve only justice-involved people who already are health home enrollees or appear on assignment lists of eligible people, who are the majority of people involved in the pilots. Additional “bottom-up” referrals may come, however, from managed care organizations or hospitals, and in some cases from alternative to incarceration programs. One downstate health home works fairly frequently with diversion and defense attorneys and recently has begun working in arraignment court, placing care management staff on site three days a week to screen defendants referred by defense attorneys for health home eligibility.

## **Health Home Services and Medicaid Reimbursement in the Criminal Justice Pilots**

For the criminal justice pilots, managing clients’ health needs includes some degree of care coordination as people enter and leave correctional facilities. Through the data matches described, the downstate health home pilots can find out when their members have been arrested and booked into jail. They then coordinate with the CHS medical services personnel, social workers, and discharge planners (when applicable) to facilitate treatment continuity on the inside. One health home participating in the downstate criminal justice pilots funds (with non-Medicaid money) a project director and two care coordinators to serve assigned justice-involved people. A second participating health home employs (also with non-Medicaid funds) a project director and a project coordinator. The project director supervises the health home’s criminal justice-related activities, provides advocacy, and works to develop more partnerships with stakeholders, with the intent of ultimately expanding support services beyond Rikers Island to the courts and the state DOC, as well as the federal Bureau of Prisons and the US Courts’ Probation and Pretrial Services. The project coordinator liaises between the health home,

the social workers at Rikers Island, and care managers in the health home network and is present at discharge to provide a “warm handoff” and make sure each person discharged is connected to his or her care manager. Best practices are considered to include a face-to-face connection with enrollees before release, a personal introduction to community providers upon release, and transportation and accompaniment to the “first right place” after release to avoid losing contact with the enrollee.

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*You might be thinking it's easy to engage incarcerated people because they're a captive audience, but it isn't.*

*—New York correctional health official*

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Care coordination with the jail can be labor intensive. An interviewee characterized Rikers Island as having “tricky logistics.” The island has nine separate facilities, and people under pretrial detention move around considerably. They are often being assessed, taken back and forth from court, attending programs, or moved within or across facilities. Community providers sometimes spend time and energy traveling to Rikers Island only to discover they cannot meet with a particular person. DOC and health home staff are exploring other ways to connect individuals with care managers, like phone- and videoconferencing. Additionally, DOC encourages providers to include pictures of the care managers in written communications with individuals because face-to-face recognition is essential for linking this population to postrelease care.

Similarly, finding the correct DOC point of contact for care coordination can be complex because of the sheer size and number of facilities on Rikers Island and the organization of CHS services. Discharge planning at Rikers is not centralized. Specialized teams handle discharge planning for the required populations, primarily those with mental health treatment needs or HIV/AIDS.

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*We educate and condition the network [of care managers]. Everyone working with the [justice-involved] population is receiving additional ongoing training and support.*

*—New York City health home provider*

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Beyond the logistical difficulties of establishing connections in jail, interviewees spoke of the complex socioeconomic and health challenges among justice-involved people. Noting the need for a justice-informed approach to care management, one health home provider reported providing monthly



criminal justice–specific training to its care managers. Another interviewee said that justice-involved people, perhaps more than other populations, need personal contact and a warm handoff to facilitate connection to and engagement in health care and supportive social services; providing written instructions on a sheet of paper tends to be unsuccessful. This interviewee suggested that much of the need for care management among justice-involved people stems from their high level of social and survival needs: “They are so busy surviving they don’t have time for the bureaucracies that are involved in accessing health care. If you can meet the[ir] survival needs, you can facilitate accessing health care at the right level of care. If you can’t...people will use the emergency department.”

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*Recently released persons should not have to commit minor crimes just to be able to access food, shelter and medical care that they don’t know how to find in the community.*

*—New York Medicaid official*

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Medicaid payments for health home services in New York are per member per month to the lead health home entity, which distributes the funds to care managers and other providers of health home services. Payments are distributed at two levels based on severity of illness and adjusted for geography (upstate or downstate) and case mix; but payments are evolving, based on provider feedback on the actual cost of caring for enrollees with complicating factors, such as homelessness, uncontrolled substance use, or HIV/AIDS. The state is developing a revised system with three severity bands incorporating such factors and different payment rates within bands, depending on the intensity of care needed. Our interviewees indicated that supporting data collection and analysis was still in process. The new payment system was not expected to go live until fall 2016 at the earliest.

## **Challenges and Workarounds**

Multiple interviewees emphasized the special needs of the justice-involved population and, consequently, the importance of making timely connections during transitions between the community and corrections so individuals would not get “lost.” However, there are challenges to accomplishing best practices in New York City jails and elsewhere, notably limits on Medicaid reimbursement for services provided to inmates of correctional facilities. Medicaid health home services cannot be provided to people while they are incarcerated; Medicaid’s “inmate exclusion” prohibits reimbursement for services other than inpatient services provided to inmates of jails and other correctional facilities in a community-based medical institution. New York suspends Medicaid coverage for inmates after 30 days, rather than terminating it, but that provides only a 30-day window during which health homes and care managers can receive Medicaid reimbursement for in-reach to their enrollees or social workers to establish relationships and plans for care continuity while in the facility, which are health home services that otherwise would be covered for non-incarcerated individuals. This creates barriers to care

coordination when people are incarcerated for longer than 30 days and difficulties in making prerelease referrals to post-release services.

Technically, there is no limit on the time an individual can remain in Medicaid suspension, based on a state law providing that time incarcerated does not count against the required annual Medicaid redetermination period (Council of State Governments 2013). Interviewees noted, however, that in practice Medicaid sometimes is nevertheless terminated. They also noted that there sometimes are delays in removing suspension or reinstating Medicaid coverage at release.

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*Billing becomes a barrier...care management agencies don't want to engage people while they are in jail because they can't get paid.*

*—New York correctional health official*

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Care managers cannot be paid for any case conferencing, discharge planning, or other care coordination activities while Medicaid is suspended or terminated, and case management agencies frequently are reluctant to provide services until they are certain they will be reimbursed. But waiting until release is less effective in preventing loss of connection with providers and care. One interviewee felt “the first transition from jail to community needs to be managed to be successful,” and that care management agencies should view any unreimbursed time as an investment in a long-term relationship with a given client that over time would “pay for itself.” However, short-term reimbursement needs overwhelm longer-term health home goals for some care management organizations.

One health home pilot site has hired two central office staff to coordinate the agency’s network of care managers and fill service gaps before release using a combination of agency and DSRIP funding. These two staff members conduct the data matching needed to identify admissions and releases from jail, and they conduct care coordination activities using internal funds when Medicaid reimbursement for care managers is not available. For example, they generate reports to identify when people in the health home have been admitted to jail, when they are going to court, when they have a projected release date, and when they are released from jail. These “actionable events” trigger case coordination workflows, such as alerting the individual’s care manager at the health home that this person is incarcerated so the care manager can coordinate with staff inside the jail. The health home central office staff takes over the monitoring of the case when Medicaid is suspended after 30 days. Additionally, central office staff members are often present to receive enrollees at discharge and provide a personal introduction to their care manager.

A separate challenge related to the “inmate exclusion” is the difficulty of scheduling postrelease community-based appointments for people before their release. Medicaid suspension is not lifted until incarcerated people leave prison. Medicaid officials report that providers are reluctant to schedule

appointments for individuals while they are still under suspension. This makes it difficult to assure continuity of care in the community for people leaving incarceration with significant medical needs (e.g., patients needing dialysis or nursing home care).

## Outcomes and Future Directions

Health home outcome data are still being analyzed, but staff believe there have been positive health care utilization and justice outcomes. They note improved medication adherence, decreased inpatient service use, more regular use of outpatient support services, and a person-level reduction in jail days.

Health home stakeholders in New York are looking to state funding to help fill some gaps between Medicaid reimbursement and the service needs of justice-involved people. The \$5 million in additional state funding planned to support the work of the criminal justice health home pilots has not yet been allocated.

State Medicaid officials are considering three particular uses of the \$5 million approved to further develop the criminal justice pilot health homes: (1) liaison services between correctional facilities and the health home network; (2) enhanced integration of community-based alternatives to integration with the health home network; and (3) enhanced integration of reentry programs into the health home network. Liaisons would be identified individuals that people in corrections could connect with to “build a bridge to care management.” Liaisons would *not* provide care management or arrange services. However a liaison would identify people coming out of incarceration, learn what their needs are, and communicate those needs to the health home, thus establishing a point of contact between corrections and the health home and enabling a warm handoff. A liaison might also get people to where they need to be after release without providing care management services. Enhanced integration of alternative to incarceration and reentry programs refers to plans to incorporate these programs into the health home provider network. Some of these programs provide Medicaid-billable services but are not part of the Medicaid provider network.

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*We're trying to close a gap of two weeks...[We] know this is where we lose people: if they come out and don't have that place to go, and they have to make the connection themselves, we know that this is where they get lost.*

*—New York Medicaid official*

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Finally, state Medicaid officials are pursuing two changes in policy to “support the criminal justice pilots because they could not bill for the services” and provide more effective transitional services when people leave incarceration.

- First, because providers have difficulty scheduling appointments while Medicaid is suspended, the state is seeking to reinstate coverage 30 days before release with administrative systems’ “blocks” in place to ensure that no Medicaid services could be billed before release. This would make it possible to set up timely postrelease appointments with community providers before release, removing one barrier to continuity of care.
- Second, the state plans to submit a Section 1115 waiver application to allow Medicaid billing for a “very small number of transitional services, where the benefit is really accrued outside the criminal justice system.” This change would facilitate transitional care management so the health homes could establish face-to-face or video contact with individuals before release, in keeping with our interviewees’ understanding of best practices. The state has submitted a concept paper to CMS but has not yet submitted a waiver application.

## Rhode Island

### Creation and Development of Health Homes

Rhode Island was one of the first four states to receive CMS approval to implement health homes for Medicaid enrollees with chronic conditions as a state option. Rhode Island used existing networks of health care providers to serve specific health home populations through three health home State Plan Amendments (Nardone and Paradise 2012). One health home serves children and youth with severe mental illness and/or other disabling or chronic physical or developmental conditions served by Comprehensive Evaluation, Diagnosis, Assessment, Referral, Re-evaluation (CEDARR) family centers, overseen by the state Department of Human Services. The second health home is for adults with severe mental illness served by community mental health organizations (CMHOs), overseen by the Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH). The third health home, the opioid treatment program (OTP) (approved 11/6/13 and effective 7/1/13)<sup>11</sup> provides services to individuals who have opioid dependence or who meet criteria for Medication Assisted Treatment (MAT) and are at risk for another chronic physical or mental health condition.<sup>12</sup> As of spring 2016, enrollment was about 1,500 for CEDARR health homes, 8,000 for CMHO health homes, and 2,800 for the OTP health homes.<sup>13</sup>

The development of the OTP health homes was a collaboration between multiple agencies and groups, including BHDDH and a multisite nonprofit outpatient drug and alcohol treatment provider in the state. In 2012, these entities collaborated to create the OTP health home program, in time to provide comprehensive services for the increase in individuals eligible for Medicaid under the ACA expansion, particularly the reentry population. OTP providers have developed strong connections with the justice system over many decades of collaboration, and are now providing prerelease care and a warm hand-off to postrelease care.

OTP health home teams include a physician, a team coordinator, a case manager who assists with health insurance navigation before release, and a medical liaison who helps as a patient advocate in the

community after release. After release, each OTP health home provides comprehensive counseling and MAT, such as methadone (a pill, liquid, or wafer that has been used for decades to treat opioid use disorder); treatment may also include buprenorphine products (a film, such as Suboxone, or tablet to treat opioid use disorder) and Vivitrol (an extended-release injectable naltrexone to prevent relapse to opioid use disorder with or without co-occurring alcohol use disorder). Services include general outpatient counseling and psychiatric services. There are prescribers at each OTP site and licensed mental health counselors to address co-occurring mental disorders and other comorbidities such as hepatitis C. The OTP health home helps secure stable housing and employment. Motivational interviewing is the foundational approach, and all nursing staff, administrative staff, and security staff are exposed to the philosophy and practice. In addition, the health home team works with multiple social services agencies to meet patients' needs.

### **In-Reach: Providing Maintenance MAT Treatment to OTP Patients at Adult Correctional Institutions**

BHDDH receives data from the Rhode Island Department of Corrections (DOC) to identify OTP patients that are admitted to the pretrial detention facility. This information alerts providers of their clients' incarceration and facilitates continuity of care. BHDDH has access to data listing all individuals who are receiving methadone maintenance treatment, as well as individuals who are in health homes or served by community mental health centers. BHDDH provides information to the OTPs so they can arrange care coordination. Care coordination for these individuals may also occur at reentry when transitioning an individual from a jail or prison setting into the community. Because the Rhode Island DOC operates a unified prison and jail system, it has control of both pretrial detainees and convicted individuals, regardless of length of sentence or crime.

This process started to develop nearly two decades ago, when the Rhode Island DOC initiated discussions about how to address the discomfort and disruption caused when individuals on methadone maintenance therapy who entered incarceration had to go into infirmary because of symptoms of withdrawal. Rhode Island DOC entered into a contractual relationship with a large community-based opioid treatment program in the state "to create protocols to allow a more humane withdrawal from methadone for people who will be in [prison or jail] for greater than 30 or 60 days." Expanding on that arrangement, the OTP service provider (under a contract with Rhode Island DOC for payment) now maintains inmates on methadone treatment if they are sentenced for one year or less. The OTP service provider believes that this has helped individuals who would have become destabilized during incarceration, a population that they report had high mortality from overdoses within 48 hours of release from incarceration. The DOC has received funding to expand MAT services. It continues to maintain individuals who are verified as having received MAT in the community; will initiate methadone and buprenorphine treatment for those who assess as being appropriate for up to one year; and will initiate methadone, buprenorphine, or Naltrexone for those who assess as appropriate before release. One corrections official described the relationship with OTPs this way:

If we start to have more folks here on MAT, we need support of OTPs in the community to accept these individuals when they are released. So our relationship with OTPs is critical, and we need to nurture those relationships. We need to reach out to other OTPs in regard to health homes. We've developed MOUs with two of the OTP programs for our Vivitrol program, and we want to expand that MOU to include all MAT.

In addition to medication, the OTP provides inmate patients with a full clinical assessment, behavioral health and other services, maintaining weekly or more frequent contact. For inmate patients sentenced for more than one year, the OTP begins a protocol in which the patient's medications are tapered, while continuing to provide behavioral health care about substance abuse for the tapering period.

These services to incarcerated clients are generally not paid for through Medicaid health home funding but by the Rhode Island DOC. The OTP health home agency has separate contracts with the department to provide MAT during incarceration. Additionally, interviewees noted that it is critical to build cultural competency among all vendors and providers who will be interacting with individuals with SUD and facilitating MAT service delivery.

## **Connection to Medicaid and Health Homes for Inmates before Release**

Most inmates are incarcerated for less than a year, during which the state puts Medicaid enrollees in suspension status. For the past year, a hospital social worker based in the Intake Service Center at Rhode Island DOC has been screening individuals to see if they are enrolled in Medicaid. About one-third of those released are enrolled in Medicaid at the time of release.

Before returning to the community, every sentenced inmate is assigned a community-based discharge planner who works for contracted vendors paid by the DOC. The discharge planner is responsible for Medicaid applications and for planning for continuity of care, such as arranging medication on release, but receives no Medicaid reimbursement. There are discharge planners for each region of the state, as well as others who specialize in behavioral health and links to services. None of these activities are reimbursed by Medicaid, but through DOC contracts with community agencies.

The discharge planners facilitate Medicaid enrollment before release. Individuals who are six to nine months away from their expected release dates are given needs assessment questionnaires, and discharge planners help them with paper applications if they report needing health care coverage. At that time, the discharge planner prompts them to select one of the two Medicaid managed care organizations. The discharge staff uses paper applications instead of web-based applications because the online application is blocked if the applicant is identified as currently incarcerated. The paper application is sent to Rhode Island's Department of Human Services (DHS), where it is a priority for data entry, with a DOC cover sheet clearly indicating the circumstances and the inmate's release date. People usually have coverage by the time they are released and can get services even if they do not have an insurance card because the provider can use a Medicaid portal to confirm coverage. OTP staff indicated that most or all inmates eligible for Medicaid have enrollment turned on within seven days of

release; though managed care organization enrollment can take up to one month, the providers can bill retroactively.

In addition to facilitating Medicaid enrollment, the discharge planners discuss health homes and the services available with inmates. Under contract paid by Rhode Island DOC, OTP staff have met with DOC discharge planners to educate them on methadone treatment and health home services. As noted before, the discharge planner gives each inmate a questionnaire before release that asks what he or she wants for the discharge plan—including help with housing, employment, or treatment for opioid dependence. If an inmate is interested in methadone treatment and in going to an OTP health home, the discharge planner notifies the OTP. The OTP sends staff to do in-reach and make the program eligibility determination, and then preliminary intake work 30 days before the individual is released. This process is being implemented but is not common or widespread. The DOC and the OTP health homes are building their connections to increase the number of people receiving prerelease screening by OTP health home staff for eligibility and enrollment. Upon release, the individual is a client of the OTP and can receive services immediately. The corrections coordinator at DOC makes sure that on the day of release, the individual is transported directly to the health home location and admitted into the MAT program. The OTP staff suggested that 90 percent of their MAT-related clients had prior justice involvement, though were not typically directly referred from the Rhode Island DOC as part of the reentry transition.

Another facet of care collaboration is that the Rhode Island DOC has created a space in the electronic health record (EHR) for health home provider staff to document their interaction with the individual. Access to the DOC's EHR enables effective communication between the department and the health home and helps keep the prisoner's record complete. The time spent entering information into the EHR is built into the daily rate charged to the prison for their treatment programs within the Rhode Island DOC.

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*As we look at collaborating with discharge planners... some of the time it's covered, and a lot of the time it isn't... [But] it is well worth that type of "warm handoff" that allows people to attach a face to a service and starts engagement before someone is released. The literature says it's effective and it's worth it.*

*—Rhode Island OTP health home staff member*

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Medicaid cannot reimburse for the time spent by health home employees on prerelease services, and the health homes must absorb the cost of staff time devoted to prerelease health home eligibility screening and enrollment. However, Rhode Island has worked on assuring enrollment in Medicaid for most eligible individuals upon release, which enables health homes to begin receiving payment for their

services almost immediately. If there is a gap in health insurance coverage, health homes are able to retroactively bill the Medicaid managed care organization an individual is covered under.

According to a Medicaid official, the OTP health homes are able to retain patients at a greater rate and have resulted in greater patient satisfaction than traditional MAT because eligible enrollees can choose a particular OTP health home. This same official is under the impression that access to OTP health homes is lowering recidivism and incarceration rates, although data on the impacts of health homes on recidivism and recovery from SUD are not available.

## Lessons Learned in New York and Rhode Island

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*It takes quite a few people around the table.*

*—New York Health Homes provider*

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**Medicaid health homes can be an important component in the development of continuity of care planning for justice-involved individuals with serious chronic health conditions.** Continuity of care remains a problem as justice-involved individuals cycle between community and correctional health care providers. New York and Rhode Island have used the health home model to increase the possibility that care plans will not be disrupted, leading to potential relapses and deterioration of health status for individuals entering and leaving correctional facilities.<sup>14</sup>

**Stakeholders must collaborate and communicate across systems.** Collaboration across traditional systems of care and organizations is a challenging process, but is essential to establish health homes that can effectively serve the justice-involved population at all stages, including pretrial diversion and release from incarceration. Links between health homes and the justice system help each group identify the health and social needs of an individual, provide appropriate care, and promote continuity of care, as well as understand both the constraints to be overcome or worked around and the mutual benefits to be realized. New York has accomplished this with a formal state-level work group focused on promoting and supporting these collaborations.

**Prerelease discharge planning to assure a “warm handoff” to care managers is fundamental to success.** Without planning and immediate connection to care managers and services, the risk of losing connection to returning justice-involved people is increased and the likelihood of achieving reductions in costs and recidivism is reduced. In New York, plans are under way to reactivate suspended Medicaid enrollees 30 days before release so community-based providers can schedule postrelease appointments beforehand. In Rhode Island, discharge planners are available who can connect individuals to Medicaid so health services are available at the time of release and other needs can be met.



**Staff liaisons between the health home providers and criminal justice system help promote continuity of care and successful transitions in and out of incarceration.** In New York staff coordinators at the health homes bridge the gap between the health system and the criminal justice system by identifying members who become incarcerated and communicating their needs to correctional health providers. Additionally, as members approach their release, staff coordinators help make the connections with community providers that are critical to successful transitions into health homes. Such liaisons can conduct data-matching activities to identify transitions in and out of jail and perform care coordination during incarceration if Medicaid is suspended. Some health homes are performing these functions with non-Medicaid-funded staff but have reported that staffing falls short of the level of need.

**Creativity and commitment at the state level can help bridge funding gaps.** New York is investing state funds in health home-criminal justice liaison activities and improving data sharing between criminal justice and health homes to support links, as well as pursuing ways to increase access to Medicaid reimbursement for a very limited number of transitional activities in the 30 days before release “where the benefit accrues outside the criminal justice system.” Such activities include allowing case managers to connect with incarcerated health home enrollees before release to plan for the transition and arrange services. Likewise the Rhode Island DOC’s investment in discharge planners protects the state’s correctional health investment by ensuring that Medicaid is available immediately upon release.

**It is important to assess the benefits of the home health model from a state perspective rather than by each agency or entity.** Medicaid reimbursement may not always be aligned with health homes’ financial risks and incentives. In New York, care management agencies that coordinate the discharge of justice-involved members in advance of release sometimes do so without Medicaid reimbursement or find other payment sources. However, the cost savings that result from their members receiving regular care in nonemergency settings may not be realized by the health home agency, but by hospital systems that incur fewer emergency care costs later on.

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*The problem is, where the money’s saved is not where it’s spent.*

*—New York correctional health official*

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**A culture shift may be necessary for MAT health home services to be effective.** For example, while all individuals interviewed indicated that a good working relationship between the Rhode Island DOC and OTPs in the community is critical, the OTP staff also indicated that “one of the most important pieces is for those providing the care and for vendors coming in [to a corrections facility] is that there is a lot of attention paid to the needed culture change for those services to be effective.” In particular, the staff noted the importance of reducing stigma related to pharmacological interventions and getting

everyone “on board”: wardens, corrections medical staff, inmate patients, and other inmates. They encouraged others to examine the cultural issues that could get in the way, and how to reduce these through changing and normalizing procedures such as how inmates receive methadone treatment.

**Sharing of a patient’s electronic health record between the health home and the DOC is essential to a continuity of care model.** New York has developed data-sharing agreements with nine downstate health homes. The electronic systems are connected so health home information is documented in the CHS electronic medical record information on incarcerated health home members and is returned to health homes. In Rhode Island, the EHR systems are not connected, so the prison staff gives the OTP health home staff space, access, and training to enter medical documentation into the DOC health care EHR. Rhode Island staff acknowledged that “there would be a tremendous challenge in attempting to have systems that integrate with each other, and that’s not going to happen.” The workaround is quite helpful and when OTP staff are in the correctional facility, they have access to corrections EHR and can update medical documentation to keep the complete record at the prison.

**When automated links between the electronic files of justice agencies and health agencies are limited, alternative arrangements to support Medicaid enrollment and coverage can be developed.** According to interviewees, the Rhode Island DOC can send a daily data feed to the Medicaid agency to trigger the suspension or termination of benefits as appropriate. However, the same mechanism is not in place to turn enrollment “on” again after release. Rather, the released person, discharge planner, or provider needs to call the Medicaid office to confirm release and un-suspend benefits. Likewise DOC’s enrollment efforts require self-reporting and manual searches of the state’s Medicaid database to identify individuals in need of Medicaid coverage upon release. This is feasible because of the state’s small size, where an average of 300 people are released each month, and because an externally funded hospital social worker conducts some of this screening.

## Conclusion

The Medicaid Health Home state plan option has been implemented in different ways in New York and Rhode Island, in each case providing certain chronically ill justice-involved populations with comprehensive care management and integrated health services on reentry. New York’s efforts highlight the importance of interagency and stakeholder collaboration through a formal state-level work group, as well as the importance of staff liaisons between the health and justice systems to promote continuity of care on reentry. In both New York and Rhode Island, prerelease discharge planning was also key to successful reentry, while reimbursement for coordination and enrollment services prerelease was an ongoing challenge in both states. Creativity and commitment of key state leaders or stakeholders was used to develop practical, technical workarounds to promote continuity of care for justice-involved individuals upon release from incarceration.

## Notes

1. See generally 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>.
2. <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Supports/Integrating-Care/Health-Homes/Health-Homes.html>
3. <https://www.medicaid.gov/state-resource-center/medicaid-state-technical-assistance/health-homes-technical-assistance/health-home-information-resource-center.html>
4. Detailed information about Medicaid Health Homes and their implementation in the first 13 approved programs in 11 states, including New York and Rhode Island, is available in Spillman et al. (2014).
5. Personal communication from staff at the New York Department of Health.
6. Full list of qualifying chronic conditions found here: [https://www.health.ny.gov/health\\_care/medicaid/program/medicaid\\_health\\_homes/docs/09-23-2014\\_eligibility\\_criteria\\_hh\\_services.pdf](https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/09-23-2014_eligibility_criteria_hh_services.pdf)
7. Health Homes and the Criminal Justice Population [https://www.health.ny.gov/health\\_care/medicaid/program/medicaid\\_health\\_homes/hh\\_and\\_cjs.htm](https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/hh_and_cjs.htm)
8. <http://www.nychealthandhospitals.org/hhc/html/news/press-release-20150610-hhc-to-run-correctional-health-services.shtml>
9. Medicaid Health Homes: Questions and Answers [https://www.health.ny.gov/health\\_care/medicaid/program/medicaid\\_health\\_homes/questions\\_and\\_answers.htm](https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/questions_and_answers.htm)
10. NYC Departments of Probation and Health and Mental Hygiene. “Health Home Collaborative Pilot: Care Management/Coordination for Criminal Justice Involved Individuals.” [https://www.health.ny.gov/health\\_care/medicaid/program/medicaid\\_health\\_homes/docs/hh\\_collab\\_pilot.pdf](https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/hh_collab_pilot.pdf)
11. “Rhode Island—Medical Homes,” National Academy for State Health Policy, June 1, 2015, <http://www.nashp.org/rhode-island-154/>.
12. A description of Rhode Island health home programs is available at the Patient-Centered Primary Care Collaborative’s website, <https://www.pccpc.org/initiative/rhode-island-health-homes>. See also “Rhode Island—Medical Homes,” <http://www.nashp.org/rhode-island-154/>.
13. Personal communication from staff at the New York Department of Health.
14. Because New York is testing models for collaboration developed by seven criminal justice pilot programs, some of what we learned about the challenges encountered and strategies used in their specific programs may not be generalizable to all seven pilot programs.

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