POLICY GUIDE

Strategies for Connecting Justice-Involved Populations to Health Coverage and Care

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Acronyms

ABP	Alternative Benefit Plan
APD	advanced planning document
CMS	Centers for Medicare and Medicaid Services
DOC	Department of Corrections
EE	Medicaid eligibility and enrollment
FE	facilitated enrollment
FMAP	Federal Medical Assistance Percentage
FQHC	Federally Qualified Health Center
IAPD	implementation advance planning document
IT	information technology
MAC	Medicaid Administrative Claiming
MCO	managed care organization
MH/SUD	mental health or substance use disorders
PE	presumptive eligibility
WPC	Whole Person Care

Connecting Criminal Justice and Health

Over the past decade, states across the country have implemented innovative strategies to connect justice-involved people to Medicaid coverage and connect them to care so they can better manage their physical and behavioral health care needs. This national policy guide provides a road map for state and local justice and health care officials and other stakeholders who want to increase coverage and improve health outcomes for justice-involved people, enhance public safety, reduce recidivism, and more efficiently use public resources. The guide presents a menu of practical strategies aimed at

1. efficiently enrolling justice-involved people into Medicaid and other health coverage,
2. helping justice-involved people who have returned to the community obtain coordinated physical and behavioral health care that meets this population's distinctive needs, and
3. supporting efforts to increase enrollment and the provision of appropriate coordinated care.

To underscore the feasibility of these approaches and allow for peer-learning opportunities, this guide emphasizes strategies and tools that are either already in use or under development by states and localities.[1]

[1] The framework presented in this guide assumes the continued operation of Medicaid under federal law and policy in effect as of April 2017. If federal Medicaid law changes, states' Medicaid and justice agency approaches might have to adjust to accommodate new federal requirements.

BOX 1

The Connecting Criminal Justice to Health Care Initiative

The Urban Institute and Manatt Health have partnered, with support from the Bureau of Justice Assistance, in the Connecting Criminal Justice to Health Care Initiative (CCJH). This project brings together state and local corrections and health care officials focusing on the state of Maryland and Los Angeles County, California, to develop and implement strategies for connecting justice-involved people with health care. State and local teams from the two sites worked intensely with national experts at Urban and Manatt to develop, test, and implement innovative strategies in three key areas: (1) enrolling the justice–involved population into Medicaid and other forms of health coverage, (2) establishing systems of health care tailored to meet the distinctive needs of the justice-involved population, and (3) creating sustainable financing mechanisms to support those activities. The Urban and Manatt team also assisted in the development of performance measurement tools to monitor and assess the impact of changes. The menu of operational strategies identified by the Urban and Manatt CCJH team for consideration by our Maryland and California partners is the basis for this policy guide.

The Importance of Connecting Justice-Involved Populations to Health Coverage and Care

The importance of connecting justice-involved people to health coverage and care is evident from the high levels of somatic and behavioral health issues they experience. People in prisons have 4 times the rate of active tuberculosis found in the general population, 9 to 10 times the rate of Hepatitis C, 8 to 9 times the rate of human immunodeficiency virus (HIV) infection, 3 times the rate of serious mental illness, and 4 times the rate of substance abuse disorders (Davis and Pacchiana 2004). Jail populations have similarly elevated prevalence levels (Steadman et al. 2009; Karberg and James 2005).

Although the Constitution requires states and localities to provide health care to people in prisons and jails, many still fail to receive needed care (Howard et al. 2016). When they are released from those institutions, they often face disruptions in medical care and treatment that contribute to recidivism, drug use, and poor and costly health outcomes, including a 12-fold increase in the risk of death in the two weeks following release (Binswanger et al. 2007). A large survey study of people returning from prison in Ohio and Texas found that, within 10 months of release, a fifth had been hospitalized, and a third had sought care in emergency rooms (Mallik-Kane and Visher 2008). Another study found that 1 in 12 individuals leaving prisons and jails with Medicare coverage were hospitalized within 90 days of release (Wang, Wang, and Krumholz 2013). Further, there was a particular nexus between behavioral health and reoffending, with people returning from prison with mental health conditions and substance

abuse problems reporting higher levels of criminal behavior. The "revolving door" between incarceration and the community leaves many people alternating between correctional and community-based providers, and thus switching drug regimens and clinicians, resulting in unnecessarily high rates of relapse or decompensation.

There is emerging evidence that connecting justice-involved people to health coverage and care in the community can increase rates of behavioral health treatment (Morrissey et al. 2006) and increase levels of well-being and health for reentering populations (Mallik-Kane and Visher 2008). If states and localities can facilitate such linkages, they will be in a stronger position to address substance abuse issues, chronic physical and mental illness, unemployment and employment instability, and homelessness that result in many justice-involved people cycling in and out of jail or the hospital.

The Opportunities and Challenges of Connecting Justice-Involved Populations to Coverage and Care

The Medicaid program—in particular, the Affordable Care Act's Medicaid expansion option for states to provide coverage to low-income, nondisabled adults under age 65 with incomes below 138 percent of the federal poverty level—presents manifold opportunities to improve upon poor health outcomes for people reentering the community. Upon release from jail or prison, people are typically unemployed and uninsured (Mallik-Kane and Visher 2008; Visher, Debus, and Yahner 2008), making them eligible for Medicaid.

Although the Medicaid program began in the 1960s, justice agencies have long been constitutionally obligated under the Fourth Amendment to avoid cruel and unusual punishment by providing people in jail or prison essential health care. Federal law seeks to prevent federal Medicaid dollars from paying jails and prisons to meet this basic constitutional duty. The rules surrounding when services rendered to justice-involved people may be reimbursed by Medicaid are complex and vary from state to state. Key federal requirements and options include the following:

- **Federal rules prohibit Medicaid from paying for medical services and prescription medications for people while they are incarcerated, except when inpatient or other institutional services are provided in a community-based setting.** Prison and jail facilities are obligated to provide health care for the people they house, and their health care generally cannot be funded by federal Medicaid dollars (Howard et al. 2016). The exception is when a person has to receive inpatient care in the community for 24 hours, such as if someone serving a jail term must be hospitalized outside the jail for care. As a result, entering or leaving jail or

prison typically requires people to cross a frontier between two separate systems for funding medical care, which typically translates into disconnected provision of care. The fundamental challenge of connecting reentry populations to coverage and care is how to manage this discontinuity and "bridge" the frontier. At the same time, justice-involved people who are not incarcerated—for example, people awaiting trial or subject to community-based supervision—are eligible to receive Medicaid on the same terms as everyone else. This applies to residents of halfway houses, provided they have entry and exit privileges that allow them to obtain health care in the community.[2]

- **People who meet Medicaid eligibility requirements may be determined eligible for Medicaid before, during, and after their incarceration as long as the state does not use federal Medicaid funds for their health care services while they are incarcerated.** In other words, states and localities can sign people up for Medicaid at any time, including while they are incarcerated, as long as they do not seek to secure Medicaid reimbursement for services provided in prison or jail.[3]

- **Medicaid enrollment can be suspended upon incarcerated and reactivated upon release.** When Medicaid-enrolled people are incarcerated, states can either place their Medicaid eligibility in suspended status or set up claims processing structures so services are limited to inpatient hospitalization outside the prison or jail facility during incarceration.[4] Such arrangements promote continuity of coverage and care by letting full Medicaid eligibility be "turned on" immediately upon release, and several states have implemented systems to ensure the state Medicaid agency is apprised of releases in order to do so.

- **Medicaid federal administrative funding is available to support the development and operation of eligibility and enrollment functions to serve the justice-involved population.** The activities that can be supported with federal Medicaid administrative funds include (1) application assistance, (2) eligibility determination, (3) enrollment system updates, and (4) the transfer of medical records from correctional institutions to community health care providers to promote care continuity. Generally, such funding covers 50 percent of administrative costs, but depending on circumstances, it may be higher, potentially reaching 75 or 90 percent, as allowed under federal law and regulations. Chapter 3 explores these issues in detail.

[2] The Centers for Medicare and Medicaid Services issued clarification on this point in April 2016 guidance; see Vikki Wachino, "To Facilitate Successful Reentry for Individuals Transitioning from Incarceration to Their Communities," letter to state health officials, April 28, 2016, https://www.medicaid.gov/federal-policy-guidance/downloads/sho16007.pdf.
[3] State Plans for Medical Assistance, 42 U.S.C § 1396a(6) (2010).
[4] These points are covered by questions 12 and 13 in Wachino, "To Facilitate Successful Reentry."

Criminal justice and state Medicaid agencies face challenges in fully realizing the opportunities before them to increase community safety, improve health outcomes for justice-involved people, and potentially lower recidivism and incarceration costs. First among them is developing the necessary communication and mutual understanding to support effective collaboration. Medicaid and health care system policies and processes are complex, as are justice processes, and mutual education is required to work across the two areas. Many justice-involved people cannot provide the information and documents that are typically required to verify Medicaid eligibility, and the "churn" of justice-involved people through the legal process can leave justice officials without enough time to identify which people need coverage and need help to establish eligibility, facilitate enrollment, and establish connections to community-based care. These problems are particularly acute for local jail populations, where lengths of stay can be limited to hours or days, and release dates are subject to change.

Road Map for the Guide

We present in this guide a menu of options that states and localities may consider for meeting the challenge of connecting justice-involved populations to health coverage and coordinated systems of care. The guide content is organized around three broad substantive areas:

1. Enrolling the justice-involved population into Medicaid[5]
2. Fostering linkages to coordinated, comprehensive systems of health care that can meet the distinctive needs of the justice-involved population[6]
3. Identifying financing options for enrollment and delivery system initiatives for justice-involved populations

The following chapters present several policy options in each of these substantive areas. These options constitute approaches that can generally be adopted alone or in combination to meet the unique needs of the state or locality. Whenever possible, we present concrete examples from states or localities that have adopted versions of these strategies. Although this guide focuses on incarcerated and reentry populations, many strategies described here are applicable throughout the justice

[5] A recording of the CCJH webinar on strategies for linking justice-involved populations to health coverage is available online. See "Webinar #1: Strategies for Linking Justice-Involved Populations to Health Coverage-20170323 1847-1," webinar, Manatt, downloadable recording, http://bit.ly/2Fym7eC.
[6] A recording of the CCJH webinar on strategies for providing coordinated, comprehensive systems of care to justice-involved populations is available online. See "Webinar #2, Strategies for Providing Coordinated, Comprehensive Systems of Care to Justice-Involved Populations-20170406 1845-1," webinar, Manatt, downloadable recording, http://bit.ly/2FFnlRo.

continuum, including from arrest, through pretrial and community supervision, and alternative dispositions to incarceration.

Some of these strategies would require collaboration and regular communication between the state Medicaid agency, state and local criminal justice agencies, and perhaps local health agencies. Each participating agency should consider designating a coordinator or contact person for interfacing with other agencies and quickly resolving problems when they arise. To monitor the target population and success of selected initiatives, jurisdictions could also identify and attempt to collect performance measures when implementing these strategies (see the companion CCJH brief on performance measurement for a fuller treatment of these issues).[7] Finally, the strategies may also require state Medicaid agencies to seek federal administrative funding and identify the source of nonfederal matching dollars, which we discuss in chapter 3.

[7] For a fuller treatment of these issues, see Kamala Mallik-Kane, Jesse Jannetta, and Harry Hatry, with Jeremy Marks and Travis Reginal, *Strategies for Connecting Justice-Involved Populations to Health Coverage and Care* (Washington, DC: Urban Institute, 2018), https://www.urban.org/research/publication/strategies-connecting-justice-involved-populations-health-coverage-and-care.

1. Enrolling the Justice-Involved Population into Medicaid

In this chapter, we offer strategies in three areas: (1) bolstering the eligibility and enrollment workforce for justice-involved people, (2) setting enrollment priorities, and (3) improving suspension and renewal processes. Table 1 provides an overview of the proposed strategies covered in this chapter and an assessment of the potential impact for each strategy. See Chapter 3 for a discussion of financing options for many of these eligibility and enrollment strategies.

TABLE 1

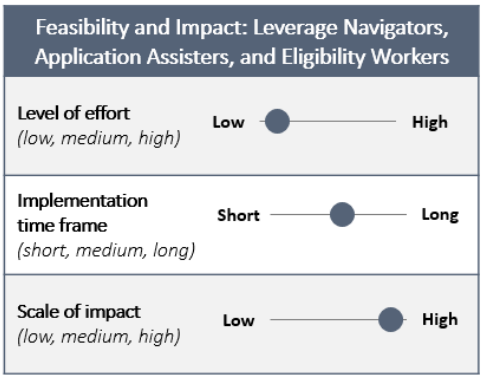
Enrollment Strategies

Strategy	Potential impact
Bolster the eligibility and enrollment workforce	
1.1 Leverage navigators, application assisters, and eligibility workers	High
1.2 Establish a special populations enrollment unit	Moderate
1.3 Engage existing justice agency vendors in enrollment	Moderate
1.4 Train justice-involved peer assisters to support enrollment	Low to moderate
Set enrollment priorities	
1.5 Target high-need populations for enrollment	Moderate
1.6 Establish IT processes for checking Medicaid status to enroll uninsured people	Moderate
Improve suspension and renewal processes	
1.7 Establish effective processes for suspension or reclassification	Moderate to high
1.8 Renew eligibility for incarcerated beneficiaries using available data sources	Moderate to high

Bolster the Eligibility and Enrollment Workforce

The first set of strategies (1.1–1.4) seeks to increase the capacity of state and local eligibility and enrollment workers (the "workforce") to help justice-involved populations enroll in and retain coverage.

Strategy 1.1: Leverage Navigators, Applications Assisters and Eligibility Workers



States and localities may be able to leverage existing enrollment staff—including community-based navigators, application assisters, and eligibility workers—to conduct outreach and enrollment for justice-involved people. There are numerous locations at which they could be deployed, such as jails and prisons, parole and probation offices, and specialized courts.

The workforce could assist the population either in-person and on-site at locations such as jails and prison facilities or remotely by way of telephone or video-conferencing technology. A major advantage of this approach is that it allows justice agencies to tap into existing enrollment expertise, rather than retraining their own staff in the intricacies of Medicaid eligibility rules and application procedures. Navigators, who work in community-based organizations that help consumers enroll into health coverage and are generally focused on the Marketplaces that offer private insurance to people with incomes too high for Medicaid, and application assisters can help clients fill out applications and satisfy documentation requirements but cannot effectuate coverage. If a state can deploy eligibility workers, by contrast, the eligibility workers could effectuate coverage.

The three Maryland counties participating in the CCJH Initiative (Baltimore, Harford, and Washington Counties) made substantial progress in building collaboration between the county detention centers and the county health departments to support health department enrollment staff from the latter agencies going into the detention centers to carry out enrollment. Baltimore County identified four chief enrollers and one supervisor to do this work, and the county facilitated provision of internet-connected laptops and established a schedule for routine enrollment sessions covering the male, female, and work release populations in the jails. Harford County already had health department staff assisting with enrollment before engaging with CCJH but moved enrollment activity to jail intake instead of discharge. As a result, inmates did not lose enrollment opportunities because of earlier-than-expected release into the community. Washington County identified two case workers from the local health department as volunteers to do enrollment five days a week.

Some eligibility and enrollment staff may be daunted by the prospect of working in a jail or prison setting, but states and localities can address potential concerns, including educating staff about the importance of the work, providing appropriate training that empowers them to understand how they can work effectively with the justice-involved population, and providing additional fiscal incentives in recognition of the added complexity associated with working in a jail or prison setting. In preparing the workers, it will likely be necessary to identify strategies for addressing the lack of internet access in most parts of jails and prisons—for example, they could use tablets or laptops to fill out applications in areas of a facility without internet access, obtaining the applicant's signature if required, and then submit the applications electronically after returning to an area where such access is available. Ultimately, however, some workers may still not want to work in these settings, making it important to focus training opportunities on those who are interested and prioritizing and coordinating enroller assignments across facilities. As a practical matter, state Medicaid agencies may need to amend contracts as part of the requests for proposals renewal cycle for navigators and assisters or call centers to identify specific responsibilities associated with the justice-involved population.

Justice agencies may need to adopt some practices to accommodate hosting eligibility workers, navigators, and application assisters from outside their agency. State or local justice agencies may want to issue a policy directive that encourages or requires facilities to work with eligibility and enrollment workers. Facilities will need to address a range of practical issues, such as providing clearance into jail and prison facilities, a safe space in which to conduct the work, and, if allowed, internet access for eligibility and enrollment staff.

BOX 2

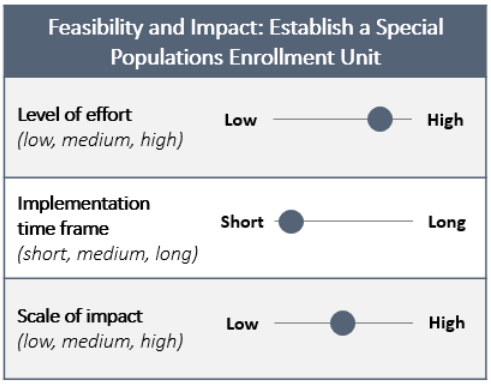
Leveraging Enrollment Workforce in Illinois and Colorado

In Illinois, community-based organizations, known as local assister entities, work with low- and moderate-income populations and conduct the majority of enrollment for justice-involved populations. The state supported the efforts of the local assister entities by having the state-federal partnership organization in Illinois, "Get Covered Illinois," provide the assisters information about how the Affordable Care Act affects justice-involved populations and some technical assistance on connecting with justice agencies.

In Colorado's state prison facilities, enrollment into health coverage is folded into processing as people are released from incarceration. To drive these enrollment efforts, the state has employed two nurse case managers to remotely complete applications on behalf of incarcerated people nearing release. People who decline enrollment assistance before release can also reconnect with the nurse case managers and receive postrelease application assistance through parole officers.

Sources: "Illinois: State Strategies to Enroll Justice-Involved Individuals in Health Coverage," National Academy for State Health Policy, December 17, 2015, http://www.nashp.org/illinois-state-strategies-to-enroll-justice-involved-individuals-in-health-coverage/; and Sarabeth Zemel, Chiara Corso, and Anita Cardwell, "Toolkit: State Strategies to Enroll Justice-Involved Individuals in Health Coverage (Washington, DC: National Academy for State Health Policy, 2015).

Strategy 1.2: Establish a Special Populations Enrollment Unit



Given the unique issues that can arise for justice-involved people and the importance of providing them coverage without even brief gaps, states could establish a specialized unit (or expand an existing unit) within the Medicaid agency to process applications and support enrollment for these people. The specialized unit could help address unique challenges and systemic issues for this population, such as identity proofing and the need for highly expedited application processing to prevent interruptions in care. It could be empowered to troubleshoot ad-hoc enrollment challenges, be a central point for gathering information on systemic issues and challenges that could be brought to Medicaid leadership

for broader policy consideration, be a point of contact for justice officials with questions, and provide training to justice agency and Medicaid call-center and other eligibility staff.

Setting up an enrollment unit will require resources to hire and train the specialized staff. In doing so, it will be important to ensure that the staff have in-depth knowledge about the specific policies, rules, and procedures regarding eligibility and enrollment that apply to people moving through the criminal justice system.

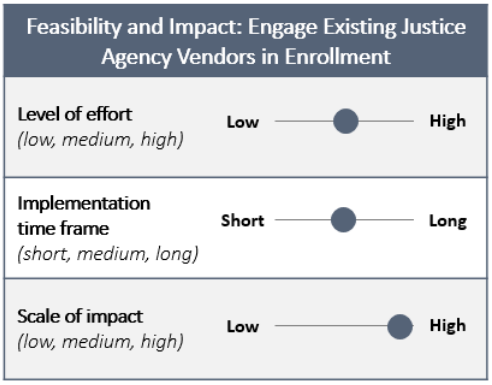
BOX 3

State Staff Dedicated to Enrolling People Returning from Prison in Ohio

Medicaid enrollment in Ohio is generally done by county government, but the Ohio Department of Medicaid decided to assign state staff to handle enrollment and eligibility determination for the population returning from prisons. The department did this as part of the Medicaid Pre-Release Enrollment Program, a collaboration with the Ohio Department of Rehabilitation and Correction intended to avoid gaps in health coverage, ensure continuity of care, and potentially reduce recidivism. The Department of Medicaid also established a dedicated toll-free number through which people soon to be released from prison are connected to an enrollment broker at the Ohio Medicaid Consumer Hotline, who assists them with completing the enrollment process. To prevent confusion, this phone line is kept separate from the hotline available to the general public, because the enrollment processes established for those in prison are different than those available to the general public. Ohio thus combined the specialized-unit strategy with the above-described strategy of leveraging existing enrollment infrastructure—in this case, the Medicaid call center.

Source: Jesse Jannetta, Jane B. Wishner, and Rebecca Peters, "Ohio's Medicaid Prerelease Enrollment Program: Medicaid Areas of Flexibility to Provide Coverage and Care to Justice-Involved Populations" (Washington, DC: Urban Institute, 2017).

Strategy 1.3: Engage Existing Justice Agency Vendors in Enrollment

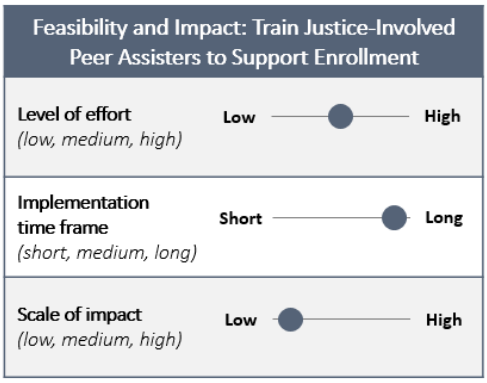


State and local criminal justice agencies could leverage existing justice agency medical, behavioral health, case management, and social service vendors to conduct enrollment. Whereas strategy 1.1 engages the Medicaid agency's infrastructure, this strategy engages justice agency infrastructure. Under this strategy, health care service vendors who are already engaged with the incarcerated population are trained to conduct enrollment and identify resources for incarcerated people. Typically, vendors already enroll inmates into Medicaid for claiming federal funding for inpatient care furnished off jail or prison grounds. This strategy would extend that role to include people who are about to reenter the community.

Putting this strategy in place might require practice changes. State and local criminal justice agencies might need to amend contract language requiring vendors to support Medicaid application and enrollment efforts in a way that goes beyond qualifying for Medicaid inpatient care furnished in community settings. Vendors who do not already have the necessary Medicaid application experience to support prerelease enrollment would need to participate in enrollment training. Vendors would have to identify how they will submit applications and regularly engage in meetings between vendor, Medicaid, and justice agency staff to identify and address enrollment challenges and other emerging issues.

Administrative systems may be needed to track and report application assistance costs for federal funding. Justice agencies could require vendors to submit full applications, rather than limited applications that may suffice to obtain reimbursement for inpatient care off jail or prison grounds, and track Medicaid enrollment costs separately to qualify for federal matching funds. Additionally, state Medicaid agencies would have to identify sources for the nonfederal share of funding and could assist vendors by assigning a coordinator to provide technical assistance.

Strategy 1.4: Train Justice-Involved Peer Assisters to Support Enrollment



Understanding the Medicaid application process and what it means to have health coverage through Medicaid can be challenging for justice-involved people, many of whom may have limited experience with health insurance of any kind. Further, people involved in the justice system may be wary of formal systems such as the health care and coverage systems and be reluctant to engage in the enrollment process. Connecting them with knowledgeable and credible peers could increase their engagement in the enrollment process and perhaps their subsequent motivation to access needed care in the community.

Incarcerated people could assist their peers in accessing coverage. As trained peer assisters, incarcerated people's duties could range from providing general education about Medicaid to helping peers complete parts of their Medicaid applications. Under this strategy, the state Medicaid and justice agencies could develop and facilitate recruitment, training, and implementation of the peer assister program. Specifically, they would need to develop eligibility criteria and a selection process for peer assisters, determine which agencies are best suited to train peer assisters, and define the precise duties of peer assisters.

In institutional settings, this approach may be more feasible in prisons, where people serve longer sentences, than in jails, where people generally serve shorter sentences and the peer assister corps would turn over much more frequently. This turnover would mean that recruiting and training peer assisters would be a more continuous and resource-intensive undertaking.

Agencies employing peer assisters would need to develop safeguards for maintaining privacy, as health coverage applications involve sensitive information such as Social Security numbers. For this reason, it would be necessary to limit the role of peer assisters to providing general education or helping with only selected elements of the application process that do not involve sensitive information. As peer assisters will not be able to complete the application for the justice-involved people they are helping, it

is critical to have an appropriate handoff to the state Medicaid agency or to an authorized enrollment assister for the processing of the application.

BOX 4

Peer Assistance in Ohio

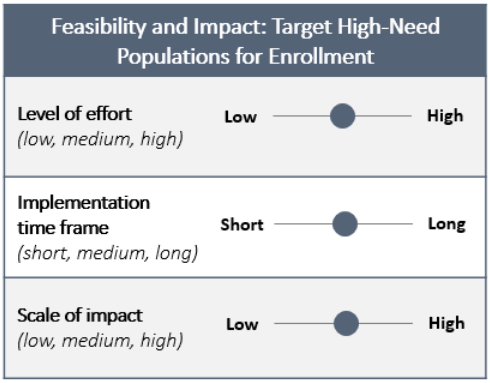
People incarcerated in Ohio prisons are invited by Ohio Department of Rehabilitation and Corrections staff to become trained Medicaid peer educators, called Peer-to-Peer Medicaid Guides. The educators facilitate a preenrollment class that covers various topics, such as what Medicaid is, why someone would want to enroll in it, and the process for enrolling before release from Ohio. The guides are their peers' point of contact for any follow-up Medicaid or managed care questions. New volunteer guides are trained jointly by the Ohio Department of Rehabilitation and Corrections and the Ohio Department of Medicaid.

Source: Jesse Jannetta, Jane B. Wishner, and Rebecca Peters, "Ohio's Medicaid Prerelease Enrollment Program: Medicaid Areas of Flexibility to Provide Coverage and Care to Justice-Involved Populations" (Washington, DC: Urban Institute, 2017).

Set Enrollment Priorities

In this section, we identify strategies to prioritize where to target outreach and enrollment efforts within the justice-involved population and to use information technology (IT) systems to efficiently identify those in need of coverage and trigger enrollment activity.

Strategy 1.5: Target High-Need Populations for Enrollment



Health coverage is important for everyone, but it is particularly so for people with chronic conditions and an immediate need for care. State and local justice agencies and their partners faced with limited time and resources for Medicaid enrollment could identify incarcerated people with serious physical and behavioral health issues who are not yet Medicaid beneficiaries and prioritize them for enrollment. Both social and financial gains could result if high-need members of the justice-involved population have coverage upon discharge that lets them manage chronic conditions and receive appropriate care in cost-efficient settings. Corrections staff could use health status or health care coverage status information obtained during intake or incarceration to identify the target population.

Target conditions could be chosen based on potential gains to the justice and health care systems. Criteria for "serious health issues" might include substance use disorders; severe persistent mental illness that is treated with psychotropic medications; pregnancy; HIV/AIDS; or severe, complex physical conditions requiring medical supervision, medical technology, or multiple prescriptions. Jails and prisons already identify high-need incarcerated people for various purposes, such as in-custody care provision. A corrections agency may need to establish or enhance administrative policies for assessing needs and identifying people who are high need (and perhaps add some additional classification categories). Agencies could also consider specific strategies for addressing high-need people who may resist enrollment into coverage, such as using peer assisters (see strategy 1.4).

Once a justice agency has defined prioritization criteria for targeted enrollment assistance, it can integrate it with a process for identifying a person's coverage status (see strategy 1.6) and establish a process flow for proactive enrollment. Proactive enrollment can be established as a routine component of either orientation at intake or discharge planning for high-need populations. One advantage of including coverage reviews at initial orientation, particularly in the jail context, is that if an inmate is released earlier than expected, Medicaid eligibility has already been established, and there is no need to begin an application from scratch. An advantage of including coverage reviews within discharge

planning is that, at the same time eligibility is being established rather than during a second intervention point during incarceration, staff can make sure full Medicaid payments are activated immediately following release. Once the target population for proactive enrollment is being successfully enrolled, the infrastructure developed for proactive enrollment can be expanded to engage larger proportions of the reentry population.

BOX 5

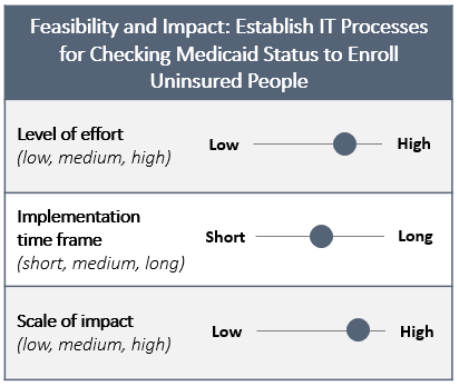
Prioritizing High-Need Incarcerated People in Los Angeles County, California

Under California's Whole Person Care (WPC) initiative, local agencies are authorized to run five-year pilots to "test locally based initiatives that will coordinate physical health, behavioral health, and social services for vulnerable [Medicaid] beneficiaries who are high users of multiple health care systems and continue to have poor outcomes." According to the state's guidance materials for organizations piloting WPC efforts, target populations include people who are at risk of homelessness, including people who will experience homelessness upon release from institutions (e.g., county jails or state prisons). Thus, people who are at a high risk of experiencing homelessness upon release from incarceration—particularly those with mental health issues, those with substance use disorders, and those who were high users of health care services while incarcerated—are being prioritized for enrollment in pilot programs across the state.

To be eligible for Los Angeles County's WPC program targeting the reentry population, someone must be Medicaid eligible and have either one or more emergency department visits in the past 6 months or one or more inpatient hospitalizations in the last 12 months, and either a chronic or complex medical condition, severe mental illness, homelessness, substance use disorder, or pregnancy—health conditions that affect the vast majority of people in jail.

More information can be found in California Department of Health Care Services, "Medi-Cal 2020 Waiver: Whole Person Care (WPC) Pilots Frequently Asked Questions and Answers" (Sacramento: California Department of Health Care Services, 2017), and at "Whole Person Care–Los Angeles (WPC-LA)," Los Angeles County Health Services, accessed October 24, 2017, https://dhs.lacounty.gov/wps/portal/dhs/!ut/p/b1/hYzLCoMwFAU_6Z7UJOoyKW20D5U0pZpNyaKI4GNT-v1F6KIVimd3YGbIU8PiKJU8hmRUkx_Dq2vDs5vG0M_fy_segCn1ZYPzKYKyTu9MXuFoZ6H5BhJRaChwUSYZZ1uBNf9G_hdZFsQagA-AP1NYFiC4hDpcnTM2QSliKrJpeNDg-zTvqvYNhM9qiA!!/dl4/d5/L2dJQSEvUUt3QS80SmtFL1o2X0YwMDBHT0JTMjBNTDMwQVJUQkVHSVAwS1Qz/.

Strategy 1.6: Establish IT Processes for Checking Medicaid Status to Enroll Uninsured People



Jurisdictions could establish an automated IT mechanism for corrections and state Medicaid agencies to communicate with each other about a person's incarceration and Medicaid coverage status. Under this strategy, corrections agencies send Medicaid agencies, files identifying people who have been incarcerated, are scheduled for release, or have been released. The Medicaid agency uses that information to suspend and reinstate eligibility, sending justice agencies information about the Medicaid status of identified people in jail or prison. The justice agency uses the latter information to target people for appropriate enrollment assistance (see strategy 1.7 for more information on suspension/reinstatement of benefits).

Putting this strategy in place could involve developing automatic daily data feeds from jails or prisons that identify newly incarcerated people, people with release dates being set or revised, and people released or transferred. In response to the file identifying newly incarcerated people, the Medicaid agency could automatically transmit information to the corrections agency (state or local) indicating the Medicaid eligibility status and managed care organization enrollment of each newly incarcerated person. The corrections agency could use that information to target uninsured people for enrollment and identify the "suspended" people whose coverage would need to be reinstated promptly following release. When data from a corrections agency indicates a person's release date, the Medicaid agency could use that information to prioritize enrollment efforts. The specific use will depend on the enrollment strategy being pursued. When data from a justice agency indicates that a Medicaid-eligible person has been released from custody, Medicaid can automatically reinstate full coverage and notify the affected MCO (if any). If such reinstatement is not immediate, the Medicaid agency could consider placing messages in the eligibility confirmation system for providers indicating that the beneficiary is eligible for Medicaid and can be served without delay (as happens in Arizona).

BOX 6

Data Exchange in Arizona

Participating jails in Arizona correspond with the state Medicaid agency daily by sending a file of people who were booked or released to facilitate enrollment and coverage suspension or reinstatement. The program began in 2005 as a pilot and has expanded to include most prisons and jails in the state. It now reaches more than 90 percent of the jail population. Even small, rural counties participate by sending Excel files securely to the state Medicaid agency. This system includes automated suspension, notice to managed care organizations, automated reinstatement of coverage upon release, and special notices to providers confirming immediate eligibility. Officials report that developing this IT infrastructure was not cumbersome or costly.

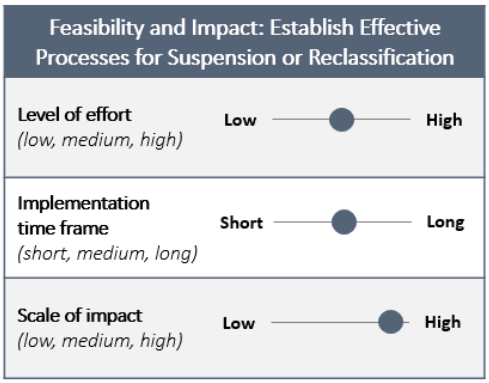
Source: Jane B. Wishner and Kamala Mallik-Kane, "Information Sharing between Medicaid and Corrections Systems to Enroll the Justice-Involved Population, Arizona and Washington: Medicaid Areas of Flexibility to Provide Coverage and Care to Justice-Involved Populations" (Washington, DC: Urban Institute, 2017).

Improve Suspension and Renewal Processes

In this section (1.7 and 1.8), we explore suspension and reclassification, alternatives to terminating Medicaid coverage for people admitted to prison or jail. Improvements in suspension and reclassification practices are encouraged by the Centers for Medicare and Medicaid Services (CMS)[8] and is intended to ensure coverage is activated at the time of release and to reserve Medicaid enrollment resources for people without prior coverage. In this section, we also review federal requirements that states must administratively renew coverage for people using available data sources.

[8] Per CMS guidance provided in a letter to state health officials dated April 28, 2016. See Wachino, "To Facilitate Successful Reentry."

Strategy 1.7: Establish Effective Processes for Suspension or Reclassification



State Medicaid agencies could develop processes to suspend or reclassify Medicaid coverage status when a person becomes incarcerated. In turn, the agency reinstates the enrollee's full-benefit coverage upon release. Under this strategy, Medicaid agencies establish a process for receiving and processing incarceration alerts to effectuate coverage suspension or reclassification of benefits, including termination of capitated payments and notice to MCOs of their members' incarceration. Justice agencies notify the Medicaid agency before an enrollee's discharge from their institutions (e.g., 30 days before community reentry) to allow Medicaid to reactivate coverage promptly when the person is released. Before participating in CCJH, Maryland established a daily data file transfer from the prisons to the Medicaid agency to determine when suspension was necessary and avoid making MCO capitation payments for incarcerated people.

To ensure that full coverage is seamlessly activated upon discharge, corrections agencies would need to provide updates to the Medicaid agency when release dates change significantly. In states with Medicaid managed care, corrections agencies may also consider partnering with MCOs to conduct "in-reach" to incarcerated people shortly before release. Such efforts would prevent breaks in care at release, breaks that can lead to the rapid development of serious and costly health problems. In this context, a specialized processing unit for justice-involved populations (see strategy 1.2) can identify the Medicaid beneficiaries whose coverage needs to be "turned on" most rapidly.

BOX 7

Suspension in Practice: Arizona, Connecticut, and Massachusetts

Suspension of Medicaid benefits upon incarceration has become a fairly common practice. As of July 2016, 16 states and the District of Columbia suspend Medicaid coverage for the full duration of a person's incarceration, while 15 states suspend coverage for a defined period (e.g., 30 days) before eligibility is terminated and the person must reapply for coverage.[a] The Kaiser Family Foundation prepared a brief that summarizes the different approaches to suspension taken by Arizona, Connecticut, and Massachusetts. Arizona's Medicaid agency developed data-sharing agreements with the state prison system and the majority of the county jail systems to support the suspension and reinstatement of Medicaid coverage for Medicaid beneficiaries during periods of incarceration. The state classifies incarcerated people as fully eligible but places them during incarceration in an administrative category where neither monthly managed care organization payments nor other payments are made, except for limited inpatient or other institutional services provided during stays off jail or prison grounds.

Numerous counties in Arizona have entered into intergovernmental agreements with the state Medicaid program to allow for daily data transfers that "facilitate the identification of incarcerated individuals so that those individuals' Title XIX benefits may be suspended or placed on a no-pay status and so that those individuals will be immediately returned to their preincarceration status upon their release from custody."[b]

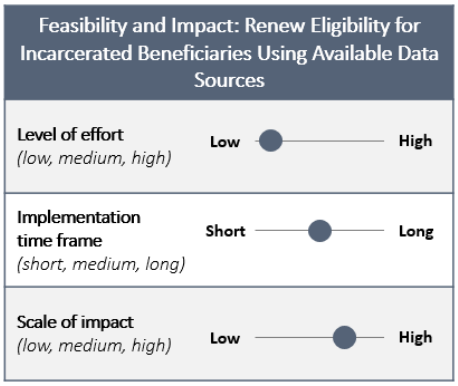
In Connecticut, which has a unified system in which the state operates both the prisons and jails, benefits are suspended after 60 days of incarceration to prevent disruptions in coverage because of short periods of incarceration. Connecticut can wait 60 days to suspend because it is not a managed care state, so it does not make unnecessary capitation payments for incarcerated people. Massachusetts developed a special limited fee-for-service inpatient Medicaid benefit that is applied when a person is incarcerated. Full benefit coverage is activated upon release.

Source: Jennifer Ryan et al., "Connecting the Justice-Involved Population to Medicaid Coverage and Care: Findings from Three States" (Menlo Park, CA: Kaiser Family Foundation, 2016).

[a] Elizabeth Hagen, *Medicaid Suspension Policies for Incarcerated People: 50 State Map* (Washington, DC: Families USA, 2016).

[b] Sample data use agreements and other contracts are available in Arizona Health Care Cost Containment System, "Intergovernmental Agreement for AHCCCS Enrollment Suspense" (Phoenix: Arizona Health Care Cost Containment System, n.d.).

Strategy 1.8: Renew Eligibility for Incarcerated Beneficiaries Using Available Data Sources



Federal regulations require state Medicaid agencies to administratively renew coverage of beneficiaries, using available federal and state data, and there is no exception for people who are incarcerated.[9] Under these requirements, if the state can renew eligibility using available data sources, a person's coverage should be extended for 12 months without any additional action needed by the beneficiary. The state sends the beneficiary a notice describing the basis for renewal of the beneficiary's Medicaid coverage and the beneficiary's legal duty to correct any errors described in the notice. Unless the state hears from the beneficiary, the eligibility is renewed. For Medicaid-eligible people in prison, administratively renewed coverage would be suspended for another year until the next redetermination date. If the state cannot find the beneficiary eligible using reliable data sources, it must send a prepopulated renewal form to the beneficiary so that the person can provide the necessary eligibility information to maintain coverage.

Federal regulations also grant state Medicaid programs the ability to renew eligibility based on reliable information available to the agency through the beneficiary's case files.[109] For example, because an incarcerated person's income is not likely to increase and his or her citizenship or immigration status is unlikely to change during incarceration, a state Medicaid agency could establish business rules providing that each Medicaid beneficiary who becomes incarcerated will remain eligible for Medicaid coverage on the basis of their income and citizenship or immigration status for the duration of their incarceration. Evidence from state Medicaid agencies suggests that the use of administrative renewals has significantly reduced administrative costs and renewal processing time while increasing the likelihood that beneficiaries experience care continuity year over year (MLC 2015).

[9] Periodic Renewal of Medicaid Eligibility, 42 C.F.R. 435.916 (2013).
[10] Periodic Renewal of Medicaid Eligibility, 42 C.F.R. 435.916(a)(2) (2013).

These impacts could include cost and time savings to health and justice agencies, as well as improved care continuity for formerly incarcerated people returning to the community.

If the state Medicaid agency is aware that a person is incarcerated, it may establish a process for sending prepopulated renewal forms to the government agency most likely to make sure those forms get completed. For example, in Maryland, the state began sending renewal forms to the county health department in the anticipated county of release for incarcerated people who do not have addresses (the homeless population) or if someone preparing for reentry requests to use the county health department's address. If states instead send forms to an incarcerated person's community addresses, those forms are unlikely to be received and completed.

2. Coordinated, Comprehensive Systems of Care

The strategies in Chapter 1 are intended to ensure people have active Medicaid coverage when they are released from prison or jail. Although health care coverage is an important first step, it is not sufficient to ensure that people receive the health care services they need. This chapter presents strategies to connect newly insured people to crucial health care services as they transition to the community. The strategies include strengthening coordination between community and justice settings, establishing systems to ensure that people receive necessary services in the community, and designing benefits tailored to the specific needs of the justice-involved population.

See Table 2 for an overview of the seven strategies covered in this chapter and our assessment of their scale of impact. The chapter also identifies examples of states or localities that have adopted these approaches.

TABLE 2

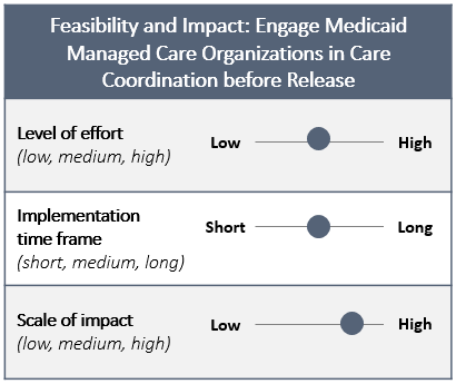
Care Coordination Strategies

Strategy	Potential impact
Enhance links to existing services and systems of care	
2.1: Engage Medicaid managed care organizations in care coordination before release	Moderate
2.2: Automatically assign justice-involved populations into managed care	High
2.3: Establish routine and robust care transition processes as part of discharge planning	High
Expand or create new coordinated, comprehensive systems of care	
2.4: Establish health home or health home–like initiatives	Moderate
2.5: Employ peer supporters to provide targeted care coordination support to the reentry population	Moderate
Increase access to critical Medicaid benefits	
2.6: Release from prison or jail with at least a 30-day supply of prescription medication	Moderate
2.7: Require that managed care organizations provide Medicaid-allowable services for reentry population	Moderate

Enhance Links to Existing Services and Systems of Care

The first set of strategies discussed in this section focuses on using the existing health care infrastructure to improve care for justice-involved people, focusing on encouraging health plans and providers to engage with people who are incarcerated before their return to the community ("in reach").

Strategy 2.1: Engage Medicaid Managed Care Organizations in Care Coordination before Release



State Medicaid agencies could amend their Medicaid MCO contracts to provide incentives for MCOs to support care coordination activities as enrolled people transition from jail or prison back to the community. Under this approach, MCOs would work with plan enrollees before their release from incarceration, including assigning a care coordinator, connecting with the enrollee while he or she is incarcerated, and scheduling an initial postrelease appointment in the community.

Managed care organizations could also coordinate with treatment providers in the community to promote more seamless transitions across care settings and support people with treatment and medication plan adherence. This could include creating a referral process to and sharing medical records with behavioral and physical health providers and linking members to community-based providers immediately following reentry, including transportation arrangements to appointments. The state may work with MCOs to prioritize the use of these in-reach services for incarcerated people who have a substance use disorder, mental health diagnosis, or serious physical condition, such as HIV/AIDS or Hepatitis C.

For such a strategy to work effectively, incarcerated people would need to be enrolled in Medicaid and select an MCO before release. Prerelease MCO selection requires state Medicaid agencies and health care agencies to develop strategies that address privacy and consent issues and ensure that people returning from incarceration are given meaningful choice in selecting an MCO. Managed care organization selection would have to occur early enough to facilitate connections between MCOs and returning people. This would allow corrections agencies to integrate MCO coordination into the routine inmate discharge process and clear MCO staff to enter institutions or videoconference with enrollees to prepare for postrelease care.

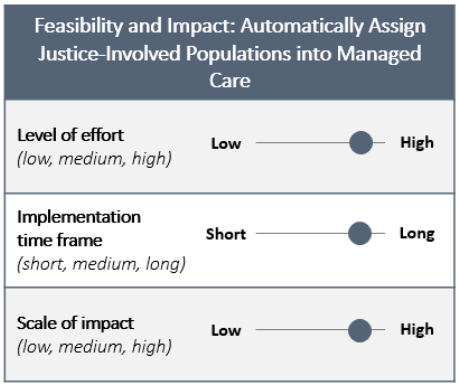
BOX 8

Prerelease MCO Care Coordination in Ohio

In Ohio, Medicaid managed care plans provide care management and coordination support during the discharge process for incarcerated people with high needs, including HIV, Hepatitis C, serious mental illness, a history of substance use disorders, or multiple chronic conditions. Ohio included selection of one of the five managed care plans into the prerelease Medicaid enrollment process so that Medicaid application forms and managed care organization (MCO) choice occurs during the same session. For designated high-need people, MCOs initiate care management 15 to 30 days before release for people selecting their plans, including reviewing clinical information, conducting a video conference with the individual 7 to 14 days before discharge, arranging services and supports in the community, and documenting services in a transition plan. Each enrollee is released with a copy of his or her Medicaid ID card, showing enrollment in a particular MCO. People with significant health care needs also receive a copy of the transition plan and an appointment for follow-up contact with a MCO care manager.

Source: Jesse Jannetta, Jane B. Wishner, and Rebecca Peters, "Ohio's Medicaid Prerelease Enrollment Program: Medicaid Areas of Flexibility to Provide Coverage and Care to Justice-Involved Populations" (Washington, DC: Urban Institute, 2017).

Strategy 2.2: Automatically Assign Justice-Involved Populations into Managed Care



For in-reach to work most effectively in a Medicaid managed care environment, justice-involved people would be connected to an MCO before their release. Minimizing delay in plan enrollment better positions MCOs to conduct in-reach activities before a person's release, such as developing care plans and connecting them with a primary care provider. The Medicaid managed care rule released in 2016 may give states new tools to facilitate the enrollment of justice-involved people into managed care plans before or at release. The rule provides states the option to "passively" enroll people into a plan

after a Medicaid eligibility determination, as long as the person has 90 days from the plan assignment date to change plans without cause.[11]

People may also change their plan after the 90 days if they demonstrate cause (e.g., an enrollee moves out of the plan's service area or lacks access to covered services). It is important that justice-involved enrollees who are automatically assigned to a plan be made aware of their option to change plans at any point in the first 90 days, without having to cite a reason for the shift. This is particularly important where plans are limited in service area, as people returning from incarceration often change their residence soon after release. For people returning from incarceration, notification of the option to change plans should be provided before release.

Under this strategy, a state Medicaid agency would automatically assign first-time Medicaid enrollees to MCOs. This approach builds on the policies of many managed care states that automatically assign MCOs to Medicaid enrollees when enrollees fail to affirmatively select an MCO after a defined period. The state Medicaid agency could develop an "assignment algorithm," which may include the enrollee's previous plan choice and provider use patterns, as well as factors such as the care organizations' coverage area. The state Medicaid agency could also automatically reenroll people who were covered before their incarceration into their previous plan choice.

If behavioral health is carved out of MCO contracts, the state Medicaid agency would need to address the implications for enrollee coverage. As further discussed in chapter 3, behavioral health systems or plans can sometimes play an important role with enrollment into Medicaid and connection to essential and appropriate care. Because such systems and plans may serve all beneficiaries within a county, they are exempt from certain marketing restrictions that apply to competing MCOs.

BOX 9

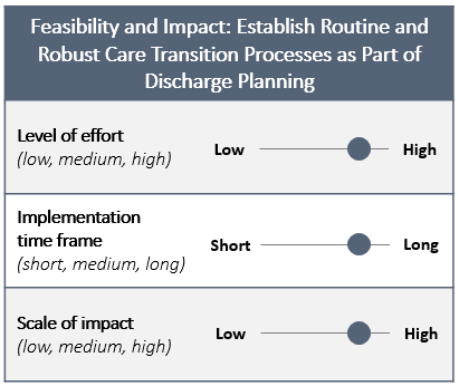
Louisiana Department of Health Automatic Assignment Strategies

The Louisiana Department of Health automatically assigns people into a managed care plan immediately after determining Medicaid eligibility and provides enrollees 90 days to switch plans, consistent with federal requirements. Justice-involved people are assigned using the state's standard automatic-assignment algorithm.

Sources: Louisiana Department of Health, "Healthy Louisiana: Justice-Involved Prerelease Enrollment Program Manual" (Baton Rouge: Louisiana Department of Health, 2017a); Louisiana Department of Health, *Informational Bulletin 12-16: Algorithm for Auto-Assignment to a Health Plan for Specialized Behavioral Health Service* (Baton Rouge: Louisiana Department of Health, 2017b);

[11] Managed Care Enrollment, 42 C.F.R. 438.54 (2016).

Strategy 2.3: Establish Routine and Robust Care Transition Processes as Part of Discharge Planning



Under this strategy, state and local justice agencies integrate health care transition planning into reentry services for people being released from prison and jail. The health care transition planning could include a short summary with prescriptions, clinical summaries, and previous treatment information, all of which would be conveyed to community providers, if the reentering person consents to such disclosure.

Prisons and jails could help establish links between released people and agencies that provide health care service coordination, such as county health departments, Federally Qualified Health Centers (FQHCs), and other systems of coordinated care that can deliver these services to the justice-involved population.

A critical issue may be role definition. Maryland CCJH participants were interested in identifying opportunities to partner with local community-based organizations to support care coordination for people returning from incarceration. But they noted the need to come up with a clear scope for that collaboration, given the many models and varying levels of intensity of care coordination.

Through its Whole Person Care (WPC) program, Los Angeles County is putting a system into place whereby the Los Angeles County Sheriff's Department notifies WPC staff several hours in advance of participants being released from jail. Participants are routed to a WPC release desk to receive point-of-discharge services which may include links to shelter or transportation assistance, notifying the Department of Public Social Services to process a pending Medicaid application, and notifying an assigned community health worker in the community of the participant's release.

BOX 10

Discharge Planning Approaches in Connecticut and New Hampshire

Discharge planners employed by the Connecticut Department of Correction (DOC) work with people who have physical and mental health needs 60 to 90 days before release from prison or jail to coordinate care. The DOC uses a detailed screening process to identify incarcerated people with health treatment needs, and the screening and coordination services ensure people have immediate access to care and required medications when they return to the community. Discharge planners

- provide prescriptions and a prescription voucher so people can fill a 30-day drug treatment supply in the community,
- identify providers in the community,
- coordinate medical and mental health appointments, and
- connect people to local community health centers.

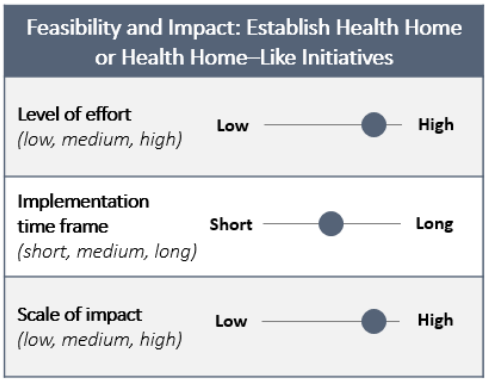
As part of New Hampshire's "Building Capacity for Transformation" Medicaid waiver, integrated delivery networks composed of providers and social service organizations focus on people in the criminal justice system who have substance use disorders or significant behavioral health concerns. Integrated care teams conduct screenings for behavioral health conditions before a client's release from incarceration and, for those who meet the eligibility requirements, conduct a discharge assessment, establish a transitional care plan, and provide ongoing case management services.

Sources: Lisa Clemans-Cope, Cybele Kotonias, Jeremy Marks, "Providing Medications at Release: Connecticut and Rhode Island: Medicaid Areas of Flexibility to Provide Coverage and Care to Justice-Involved Populations (Washington, DC: Urban Institute, 2017); Jocelyn Guyer, Deborah Bachrach, and David Rosales, "Manatt on Medicaid: New Hampshire's Building Capacity for Transformation Initiative: Putting a New Stamp on DSRIP Waivers," *Manatt on Medicaid* (blog), Manatt, March 18, 2016, https://www.manatt.com/Documents/Newsletters/2016-29.

Expand or Create New Coordinated, Comprehensive Systems of Care

In the second category of policy strategies (2.4–2.5), we explore opportunities to increase coordination across agencies, health plans, and treatment providers and to promote comprehensive systems of coverage and care that address the specific health needs of justice-involved people. States and localities could apply these strategies by creating new health care systems or enhancing existing ones.

Strategy 2.4: Establish Health Home or Health Home–Like Initiatives



States and localities need infrastructure to provide care coordination and ongoing support for people upon their release from prison or jail. State Medicaid agencies could establish Medicaid health homes, an integrated, team-based clinical approach through which providers coordinate care and support for people with serious or multiple chronic health conditions. The Medicaid health home is an optional state plan benefit authorized under section 1945 of the Social Security Act, which allows states to provide comprehensive care management and integrated primary, acute, behavioral, and long-term health services to Medicaid beneficiaries with chronic conditions.[12] Moreover, states are eligible to receive 90 percent enhanced Federal Medical Assistance Percentage (FMAP) during the first eight quarters of implementation to support the roll out of the integrated health home model of care.

Under this strategy, the state Medicaid agency establishes a network of providers to coordinate care as part of the health home.[13] The state Medicaid agency also coordinates with managed care organizations and health home providers to reach into facilities before a beneficiary's release to promote continuity of care across justice and community settings. The health home model is intended to provide integrated, person-centered primary, acute, behavioral, and long-term health care to Medicaid beneficiaries with chronic conditions. To be eligible for health home benefits, a person 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.

[12] For more information, see "Health Homes," Medicaid.gov, accessed October 20, 2017, https://www.medicaid.gov/medicaid/ltss/health-homes/index.html.
[13] States interested in implementing the Medicaid Health Home State Plan Option may look to the online "Health Home Information Resource Center" for more information. See "Health Home Information Resource Center," Medicaid.gov, accessed October 20, 2017, https://www.medicaid.gov/state-resource-center/medicaid-state-technical-assistance/health-homes-technical-assistance/health-home-information-resource-center.html.

Apart from these qualifying conditions and specifying geographic areas of service, states cannot design health home programs limited to serving specific populations, such as those with justice involvement. But many qualifying conditions, such as serious mental illness, HIV/AIDS, substance use disorder, and other complex conditions are prevalent in justice-involved populations, so ensuring that eligible people returning from incarceration or on community supervision are engaged in health homes appropriate for their needs is a powerful avenue to connect them with care, even if those homes serve other beneficiaries with similar conditions. State and local justice agencies could help identify and refer people eligible for services. Designated staff could compile rosters of people soon to be released from the facilities. But some incarcerated people's homes are not in the same catchment area as the discharging jail or prison, so area of return would influence provider referrals.

BOX 11

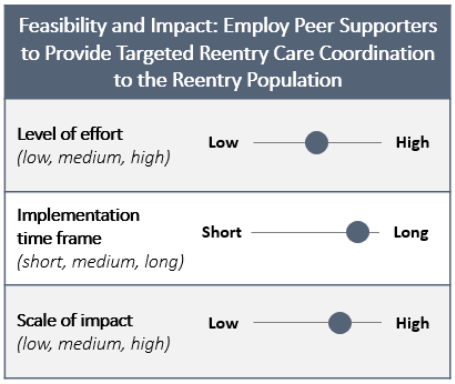
Health Home Initiatives in New York and Rhode Island

New York implemented a Criminal Justice Health Home Demonstration in 6 of its 37 health homes. These six programs enroll justice-involved people with one or more of the following conditions: serious mental illness, two or more chronic conditions (including substance use disorders), or HIV/AIDS. The state uses data exchanges to notify the health homes when their members are arrested and booked into jail. The health homes then work with the justice system's medical services personnel, social workers, and discharge planners to coordinate care as people enter and leave correctional facilities. Health homes are reimbursed for outreach and engagement of eligible members and for ongoing care management once enrolled.

Rhode Island established the Opioid Treatment Program (OTP), a series of health homes serving Medicaid recipients who are opioid dependent and agree to Medication Assisted Treatment. As part of prerelease reentry planning and Medicaid enrollment assistance, discharge planners inform people with opioid addictions about the OTP health homes and link the OTP staff to any person interested in methadone treatment. The health homes conduct in-reach to the facility to make eligibility determinations and conduct intake. Staff connect participants with services immediately upon release from prison or jail.

Sources: Christian Heiss, Stephen A. Somers, and Mark Lawson, "Coordinating Access to Services for Justice-Involved Populations" (New York: Milbank Memorial Fund, 2016); Brenda Spillman et al. "Connecting Justice-Involved Individuals with Health Homes at Reentry: New York and Rhode Island" (Washington, DC: Urban Institute, 2017).

Strategy 2.5: Employ Peer Supporters to Provide Targeted Care Coordination Support to the Reentry Population



Under this strategy, community health agencies establish a peer supporter program to assist people as they transition from jail back to the community. People with histories of incarceration are paid community health workers. As described under strategy 1.4 in prerelease peer enrollment support, people with incarceration experience are particularly well positioned to effectively engage justice-involved people in coverage enrollment and care access. The community support workers provide nonclinical targeted care coordination, including arranging treatment and general support to people being released from prison or jail and educating them about coverage and services. Peer support workers can bring newly discharged people to medical appointments, promoting continuity of care during the critical, early transition from incarceration to the community.

To help community support workers operate effectively, state Medicaid agencies could establish a process for certifying peer supporters and identify funding mechanisms to compensate them, such as through incorporation in health homes or other innovative primary care models that benefit from federal matching payments. States may also explore ways to coordinate peer supporters with existing programs, such as parole programs and community organizations that provide reentry or health care services.

BOX 12

Transitions Clinic Community Health Workers

The Transitions Clinic Network, which operates in 17 communities in 8 states and Puerto Rico, specializes in care delivery for people recently released from prison who have chronic disease. Clinics in the network include community health workers who have histories of incarceration within their clinical teams. These community health workers connect with people before release and help them postrelease to connect to care and more general supports that will help them remain healthy. Evaluation of the work of community health workers has found it has positive impacts on metrics such as emergency room use.[a]

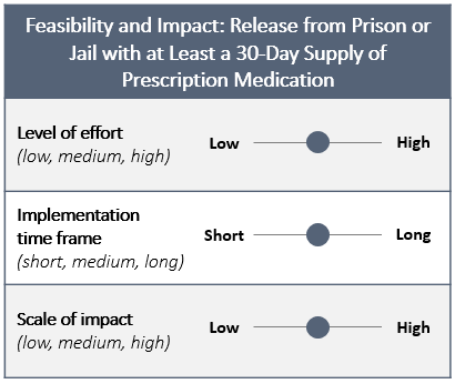
Source: See the Transition Clinic Network's home page at http://transitionsclinic.org/.

[a] Emily A. Wang et al., "Engaging Individuals Recently Released from Prison into Primary Care: A Randomized Trial," *American Journal of Public Health* 102, no. 9 (2012): e22–29.

Increase Access to Critical Medicaid Benefits

In the final category of policy strategies for enhancing care for people involved with the criminal justice system (2.6–2.7), we review opportunities to increase access to critical Medicaid benefits, such as medication and temporary respite for people currently or formerly incarcerated.

Strategy 2.6: Release from Prison or Jail with at Least a 30-Day Supply of Prescription Medication



Under this strategy, discharged people are given a supply of medication at release or a prescription to fill at a community-based pharmacy that accepts Medicaid reimbursement. Justice agencies may also decide to define a subset of high-priority medications that can be administered or taken just before release (e.g., Vivitrol, psychotropic medications). Two options are possible:

- **Give people departing jail or prison prescriptions, accompanied by a voucher guaranteeing payment.** This approach overcomes pharmacists' concerns about not being compensated for medication dispensed immediately after release, before Medicaid eligibility systems may reflect that the person's Medicaid coverage is active.
- **Give people departing jail or prison a supply of medication.** This overcomes the problem of incarcerated people not filling prescriptions. But work may be required to address federal prohibitions on leveraging Medicaid reimbursement for incarcerated people, as discussed in chapter 3.

State and local justice agencies may consider making these tasks part of discharge planners' or correctional health care provider's responsibilities. Although prescriptions or prescription vouchers are beneficial, immediate access to a medication supply is preferable, as people returning to the community have multiple, pressing needs at release. Moreover, even with a prescription voucher that assures payment, only 40 to 60 percent of such prescriptions may be filled, as was the case in Connecticut (Trestman and Aseltine 2014).

BOX 13

Prescription Vouchers in Connecticut

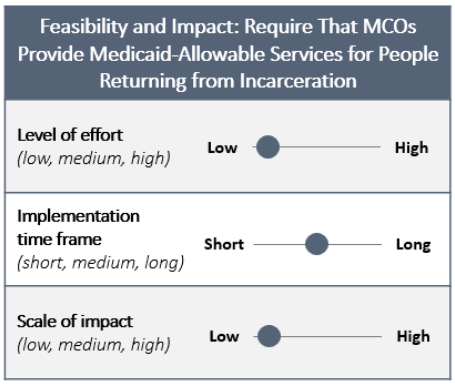
The Connecticut Department of Social Services (DSS) issues a two-week supply of medication and a prescription voucher to people leaving prison or jail. Recipients bring the vouchers to community-based pharmacies for a maximum 30-day supply of prescription medications.

The voucher guarantees payment by the DSS, even if the consumer's Medicaid application is still pending. The department has found that most people released from jail or prison qualify for Medicaid, particularly given the state's use of a dedicated Medicaid eligibility and enrollment unit. The voucher includes simple instructions printed in English and Spanish for the staff, patient, and community pharmacy.

This approach overcomes reluctance of community-based pharmacies to fill prescriptions before Medicaid eligibility can be verified. But an estimated 40 to 60 percent of people released from jail or prison do not fill prescriptions highlighting the benefits of providing the reentry population with actual medication, rather than prescriptions and vouchers.

Sources: Sachini N. Bandara et al., "Leveraging the Affordable Care Act to Enroll Justice-Involved Populations in Medicaid: State and Local Efforts," *Health Affairs* 34, no. 12 (2015): 2044–51; Lisa Clemans-Cope, Cybele Kotonias, and Jeremy Marks, "Providing Medications at Release: Connecticut and Rhode Island: Medicaid Areas of Flexibility to Provide Coverage and Care to Justice-Involved Populations" (Washington, DC: Urban Institute, 2017); Robert L. Trestman and Rob H. Aseltine Jr., "Justice-Involved Health Information: Policy and Practice Advances in Connecticut," *Perspectives in Health Information Management* 11 (2014).

Strategy 2.7: Require That Managed Care Organizations Provide Medicaid-Allowable Services for People Returning from Incarceration



Under this strategy, state Medicaid agencies request that managed care plans provide Medicaid-allowable services when people return to the community from incarceration, within specified timelines. This may include services not included in the state's Medicaid State Plan or covered under MCO capitation rates that are most needed by people involved in the criminal justice system (e.g., temporary respite housing and health and wellness coaching) and could be provided by MCOs as allowable value-added (or "in-lieu-of") services.[14]

Buy-in from the Medicaid managed care plans is crucial to providing value-added services as part of existing per member per month payments from the state Medicaid agency. This is particularly true given that value-added services are not built into the rate for Medicaid managed care plans. Although value-added services may make some aspects of serving members easier by keeping them engaged in care, state Medicaid agencies may need to identify ways to make it easier for MCOs to deliver high-priority value-added services, and once in place, monitor and evaluate the cost-effectiveness of those services.

[14] According to 42 CFR §438.3(e), a managed care organization, prepaid inpatient health plan, or prepaid ambulatory health plan may cover certain services that are "in addition to" or "in lieu of" those covered under the state plan. For more information, see Standard Contract Requirements, 42 C.F.R. 438.3 (2016).

BOX 14

Florida Managed Care Plan Requirements

In Florida, Medicaid managed care plans must "make every effort…to provide medically necessary community-based services for health plan enrollees who have justice system involvement." Under this provision, plans must "make every effort" to

- provide psychiatric services to enrollees and likely enrollees within 24 hours after release from a correctional facility;
- ensure enrollees are linked to services and receive routine care within seven days after release;
- conduct outreach to populations of enrollees "at risk of justice system involvement, as well as those health plan enrollees currently involved in this system, to assure that services are accessible and provided when necessary"; and
- develop cooperative agreements with justice facilities to enable the health plan to anticipate release of people who were health plan enrollees before incarceration and Medicaid recipients likely to enroll in the health plan in support of arranging the necessary services noted above.

Source: Florida Agency for Health Care Administration, *Health Plan Model Contract Attachment II–Core Contract Provisions* (Tallahassee: Florida Agency for Health Care Administration, 2013), 118–19.

3. Sustainable Funding

Many state and local officials seek sustainable funding to support application assistance, enrollment, case management, and transition services provided to justice-involved people before they reenter the community, as well as for IT investments that lower the operating costs of these activities. In this chapter, we begin with an overview of the relevant federal Medicaid financing mechanisms and the rules governing them. We then analyze strategies in three categories: (1) funding enrollment assistance, (2) funding IT development related to eligibility and enrollment, and (3) funding transition services, including covering prescription drugs at release and case management.

Background on Federal Medicaid Financing

The federal government provides federal matching funds to states to cover the costs of providing health care services to eligible enrollees and to help cover some of the state's administrative costs to run its Medicaid program. The activities that can be supported with federal Medicaid administrative funds include application assistance, eligibility determination, enrollment system updates, and the transfer of medical records from correctional institutions to community health care providers to promote care continuity. Generally, such funding covers 50 percent of administrative costs, but depending on circumstances, it may reach 75 or 90 percent, as allowed under federal law and regulations. Federal Medicaid matching financing fits into two broad categories:

1. Payment for health care services, or "Federal Medical Assistance Percentage" (FMAP); and
2. Funding for administrative expenses, or "Medicaid Administrative Claiming" (MAC), which includes some subcategories that are relevant to the strategies discussed in this guide.

A state's FMAP is the percentage rate used to determine the ratio of matching funds it will receive for covering the cost of Medicaid health care services. Averaging 57 percent, basic FMAP varies by state, ranging from 50 percent in affluent states such as California and New York to a high of 75 percent for Mississippi.[15] Certain populations and services qualify for enhanced FMAP, including family planning services, which receive 90 percent FMAP, and health home services, which receive 90 percent FMAP during the first eight calendar quarters during which a state provides those services to a designated group. For adults under age 65 who qualify as "newly eligible" under the Affordable Care Act

[15] "Federal Medical Assistance Percentage (FMAP) for Medicaid and Multiplier," Kaiser Family Foundation, accessed October 19, 2017, https://www.kff.org/medicaid/state-indicator/federal-matching-rate-and-multiplier/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

based on income at or below 138 percent of the federal poverty level in states that have implemented expanded eligibility, states receive substantially enhanced FMAP, which began at 100 percent in 2014 and is gradually phasing down to 90 percent in 2020 and following years (CMS 2013a).[16]

Federal MAC payments are generally available at a rate of 50 percent for a state's administrative costs.[17] MAC payments are generally available for administrative costs, including enrollment and application assistance. Several federal Medicaid provisions allow for higher MAC reimbursement rates including the following:

- **Information technology investments required for Medicaid eligibility and enrollment systems** can qualify for a 90 percent federal match. To claim such funding, a state must obtain CMS approval of implementation advance planning documents (IAPDs) specifying the details of such investments (Centers for MS 2013a). If an IT investment benefits other programs in addition to Medicaid, federal cost-allocation rules require such programs to share the IT investment costs. Generally, each program's cost share is proportional to the benefits realized by the program.[18] MAC is limited to the Medicaid program's share of costs.

- **Ongoing operating costs for IT systems** that were built with 90 percent funding can qualify for 75 percent MAC (CMS 2013a). This includes activities of call centers and social service case workers that are connected to the state's eligibility and enrollment system—for example, by taking Medicaid applications and entering the relevant information into the state's eligibility and enrollment system. Eligibility determinations must be made by merit-based public employees and may not be performed by contractors. But if a private vendor or other contractor is working with the Medicaid eligibility and enrollment system, and that system makes the final eligibility determination, the vendor's costs can potentially qualify for 75 percent MAC, as long as they were incurred through direct linkage with Medicaid's EE system (CMS 2013a).

- **Skilled professional medical personnel**, including nurses and psychologists, also qualify for 75 percent MAC. Such funding is limited to activities requiring specialized medical training.[19]

[16] Federal Financial Participation in State Assistance Expenditures; Federal Matching Shares for Medicaid, the Children's Health Insurance Program, and Aid to Needy Aged, Blind, or Disabled Persons for October 1, 2016 Through September 30, 2017, 80 Fed. Reg., 73779 (November 25, 2015).
[17] Rates of FPP for Administration, 42 C.F.R. 433.15 (2000).
[18] See Office of Management and Budget (OMB) Circular A-87 (Section C.3) and Section 200.405 of the superseding "Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards," 2 C.F.R. 200 (2014). See Centers for Medicare and Medicaid Services (2013a).
[19] Administrative Proceedings and Judicial Review, 42 U.S.C. § 432.50(b)(1) (2005).

The prohibition on using federal Medicaid funds to cover services provided to people who are incarcerated—and the exceptions to that prohibition—need to be considered when designing programs to maximize federal Medicaid funding to connect the justice-involved population to Medicaid when they are not incarcerated. States are generally prohibited from drawing down federal Medicaid funding for the provision of medical services to incarcerated people.[20] But federal funding is available for inpatient or other institutional care provided to incarcerated people who, for at least 24 hours, are served in a medical institution off jail or prison grounds.[21] Further, people are not considered "incarcerated" while they voluntarily remain in a jail or prison "for a temporary period pending other arrangements appropriate to [such individuals'] needs."[22] And MAC has no restrictions based on incarceration status, either in statute or regulations.[23]

States can choose from several funding sources to provide their matching share of Medicaid costs. In addition to state general fund dollars, localities can make intergovernmental transfers to the state Medicaid program. This lets local funds draw down federal resources. Localities can also make certified public expenditures (CPE) to obtain matching federal dollars.

Finally, while states have advanced coordination across Medicaid and justice agencies have prioritized efforts to enroll the justice-involved population in Medicaid and to facilitate links to essential care, most states have not yet sought to leverage available federal funding for these efforts. Thus, unlike the two preceding chapters, which provided examples of the strategies discussed, this chapter highlights financing strategies under Medicaid that appear to be available to further states' objectives of enhancing access to coverage and care, improving public safety and potentially reducing recidivism by linking justice-involved people to Medicaid services when they are living in the community. The Centers for Medicare and Medicaid Services approval of these federal financing strategies would generally be required before implementation. In an accompanying issue brief, the Urban Institute has highlighted several strategies that Arizona used to connect the justice-involved population to Medicaid coverage and services, along with some examples of financing of those strategies.[24]

[20] Definitions, 42 U.S.C. § 1396d(a)(29)(A) (2012); Institutionalized Individuals, 42 C.F.R. 435.1009 (2000); Definitions Relating to Institutional Status, 42 C.F.R. 435.1010 (2010).
[21] Definitions Relating to Institutional Status, 42 C.F.R. 435.1010 (2010).
[22] Definitions Relating to Institutional Status, 42 C.F.R. 435.1010 (2010).
[23] See Wachino, "To Facilitate Successful Reentry."
[24] See Jane B. Wishner and Jesse Jannetta, "Connecting Criminal Justice–Involved People with Medicaid Coverage and Services: Innovative Strategies from Arizona" (Washington, DC: Urban Institute, 2018), https://www.urban.org/research/publication/connecting-criminal-justice-involved-people-medicaid-coverage-and-services-innovative-strategies-arizona.

Financing Strategies

This chapter covers strategies to access Medicaid financing to support enrollment and care coordination for justice-involved populations in three categories: (1) funding enrollment assistance, (2) funding IT development related to eligibility and enrollment, and (3) funding transition services, including covering prescription drugs at release and case management. See Table 3 for an overview of the seven strategies covered in this chapter and our assessment of the scale of impact for each strategy.

TABLE 3

Medicaid Financing Strategies

Strategy	Potential impact
Funding enrollment assistance	
3.1 Use Medicaid administrative claiming for public employees' prerelease enrollment efforts	Varies
3.2 Partner with managed care organizations or leverage their capitation rates to fund reenrollment	Moderate to high
3.3 Use the Federal Medical Assistance Percentage for carved-out behavioral health plans or systems to enroll incarcerated people with mental health or substance use disorders	Moderate to high
3.4 Leverage funding sources for community-based organizations	Moderate to high
Funding IT development	
3.5 Leverage Medicaid funding to help build integrated IT interfaces	Moderate to high
Funding transition services	
3.6 Secure funding for Medicine provided at release from incarceration	Moderate to high
3.7 Pursue administrative claiming for case management activities	Moderate to high

The sustainable funding strategies presented in this chapter are closely related to many of the enrollment and care coordination strategies discussed in the previous chapters and in many places will make sense to implement as a package. Table 4 shows which financing strategies are most directly relevant to particular enrollment and care coordination strategies.

TABLE 4

Financing Strategies Relevant to Enrollment or Coordinated Care Strategies

Enrollment or coordinated care strategy	Relevant financing strategy
1.1 Leverage navigators, application assisters, and eligibility workers	3.1 Use Medicaid administrative claiming for public employees' prerelease enrollment efforts 3.4 Leverage funding sources for community-based organizations
1.2 Establish a special populations enrollment unit	3.1 Use Medicaid administrative claiming for public employees' prerelease enrollment efforts
1.5 Target high-need populations for enrollment	3.3 Use the Federal Medical Assistance Percentage for carved-out behavioral health plans or systems to enroll incarcerated people with mental health or substance use disorders
1.6 Establish IT processes for checking Medicaid status to enroll uninsured people	3.5 Leverage Medicaid funding to help build integrated IT interfaces
1.7 Establish effective processes for suspension or reclassification	3.5 Leverage Medicaid funding to help build integrated IT interfaces
2.1: Engage Medicaid managed care organizations in care coordination before release	3.2 Partner with managed care organizations or leverage their capitation rates to fund reenrollment
2.3: Establish routine and robust care transition processes as part of discharge planning	3.7 Pursue administrative claiming for case management activities
2.6: Release from prison or jail with at least a 30-day supply of prescription medication	3.6 Secure funding for medicine provided at release from incarceration

Funding Enrollment Assistance

The policy strategies in this section (3.1–3.4) seek to leverage federal and state funding to support enrolling incarcerated people into Medicaid before they reenter the community. Such enrollment can involve either assisting uninsured incarcerated people in completing Medicaid applications or ensuring that, as soon as possible following release, suspended eligibility ends and standard coverage reactivates.

Strategy 3.1: Use Medicaid Administrative Claiming for Public Employees' Prerelease Enrollment Efforts

State and local officials could use MAC to support prerelease enrollment efforts by public employees. Several approaches are possible, and some have the advantage of leveraging existing systems for taking Medicaid applications and claiming MAC:

- As of January 2017, 49 states had call centers that take applications for health coverage, including Medicaid (Brooks et al. 2017). Using such call centers to take telephonic applications

from inmates (see strategy 1.2) could let the state claim 75 percent MAC if call center staff are directly entering those applications into the Medicaid agency's eligibility and enrollment system.[25] Otherwise, 50 percent federal funding could be available.

- Government social services agencies that routinely take applications for Medicaid claim 50 percent MAC for their work. Such agencies could "outstation" staff in jail or prison to take applications for Medicaid, to be activated upon release.
- Justice agencies could claim 50 percent MAC for time spent by justice staff (e.g., deputy sheriffs) enrolling incarcerated people into Medicaid, and if those staff interaction with the Medicaid Eligibility and Enrollment system, they may qualify for 75 percent MAC. Those agencies would need to certify their expenditure of public dollars to enable the state Medicaid program to claim matching federal MAC dollars. The Medicaid program, in turn, would transfer those federal funds to justice agencies, defraying the latter agencies' Medicaid enrollment costs.
- State or local governmental behavioral health agencies could station staff in jails or prisons to take Medicaid applications from incarcerated people with serious mental health or substance use disorders (MH/SUDs). As with justice agencies, mental health agencies would need to certify public expenditures, enabling the Medicaid program to claim 50 percent MAC, which would then be transferred to the mental health agencies. To the extent these activities required the use of trained and skilled medical staff—for example, in cases where psychologists were needed to determine meeting criteria for targeted enrollment efforts—they could qualify for 75 percent Skilled Professional Medical Personnel MAC.

[25] The Centers for Medicare and Medicaid Services has specified that such call center activity can qualify for 75 percent funding. See Centers for Medicare and Medicaid Services (2013b).

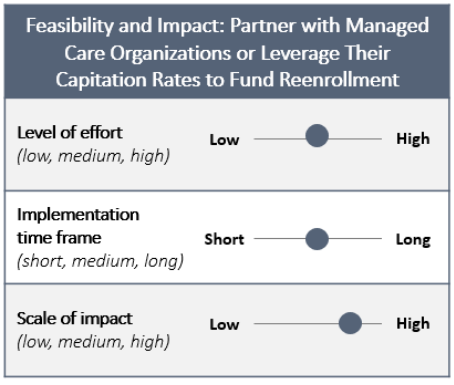
TABLE 5

Implementation Considerations for Different Approaches to Using MAC for Public Employee Enrollment Efforts

Approach	Level of effort	Implementation time frame	Scale of impact
Pursue MAC for call center staff that process Medicaid applications submitted by incarcerated people	Low	Short to medium	High
Outstation Medicaid eligibility workers in correctional settings	Low to medium *Low for 50% match; medium for 75% because of possible need for internet connection*	Short to medium *Short for 50% match; medium for 75% match*	Moderate to high
Pursue MAC for justice agency staff	High *Must allot hours by function; build CPE or I/G transfer system. For 75% match, training and data rules, internet access*	Medium to long	High
Pursue MAC for mental health staff stationed in correctional settings	Medium to high *High for SPMP match, because must allot hours*	Medium to long	Moderate to high

Note: CPE = certified public expenditures; I/G = intergovernmental; MAC = Medicaid Administrative Claiming; SPMP = skilled professional medical personnel.

Strategy 3.2: Partner with Managed Care Organizations or Leverage Their Capitation Rates to Fund Reenrollment



State Medicaid agencies could contract with Medicaid managed care organizations to conduct "in-reach" to reenroll their former members into coverage as they are nearing reentry. States receive FMAP to cover MCOs monthly capitated payments, including for the MCO's administrative

expenditures. But MCO contracts can devote no more than 15 percent of total funding to cover administrative costs. Medicaid MCOs can voluntarily agree, without payment, to undertake specified activities through their contracts with the state. Additionally, when multiple MCOs are competing for Medicaid enrollees, they are forbidden from engaging in cold-call marketing activities. Regulations define such activities as "unsolicited personal contact…that can reasonably be interpreted as intended to influence the beneficiary to enroll in that particular MCO's…Medicaid product, or either to not enroll in or to dis-enroll from another MCO's…Medicaid product."[26]

For example, New York has for many years used its Medicaid MCOs to provide facilitated enrollment (FE).[27] Managed care organizations participate at community education events to help inform consumers about Medicaid eligibility and to help them apply for coverage. The state assures compliance with federal cold-calling restrictions by forbidding MCOs from using FE to recruit MCO members. Compliance with this and similar prohibitions is enforced through "secret shopper" visits and inspection of MCO education materials. This example illustrates, outside the criminal justice context, states' ability to claim full FMAP for administrative expenses included in managed care contracts. In such cases, no federal matching funds are claimed, and the above prohibitions on the use of federal funds do not apply.

The first financing strategy would leverage the administrative portion of the capitated rate to cover costs associated with reenrollment. These are administrative costs, not service costs, and are not subject to the prohibition against federal funding for medical care provided to the incarcerated. Because they would be funded through the MCO contract, standard FMAP could be claimed.[28] Although this approach appears consistent with federal statutes and regulations, it has not yet been tried, so the extent of CMS support is unknown.

Another possibility is to request that MCOs use their own resources to support in-reach efforts that reinstate their members' coverage and links to care before they re-enter the community. Such efforts are likely to yield net cost savings for MCOs because they reduce the likelihood that members will go without essential care soon after reentry and quickly experience costly health emergencies. Both approaches create continuity of care during a person's transition from incarceration to community residence.

States face several considerations in deciding whether and how to implement this approach:

[26] Marketing Activities, 42 C.F.R. 438.104 (2009).
[27] For an example of a request for applications for organizations to do this work, see DCE (2011).
[28] See also "Matching Rates," MACPAC, accessed October 20, 2017, https://www.macpac.gov/subtopic/matching-rates/; and Costs Under Risk and Nonrisk Contracts, 42 C.F.R. 438.812 (2011).

- Effective and timely data exchange mechanisms are likely to be important. Managed care organizations need to know when their members have been incarcerated and when they are scheduled for release, which would have to be facilitated through the state Medicaid agency (see strategy 1.6).
- If in-reach is funded through MCO administrative funding, the Medicaid agency will need to work with MCOs to ensure that total administrative dollars do not exceed the maximum percentage allowed by federal law.
- Jails and prisons do not necessarily need to provide staff to support enrollment efforts, but they may need to spend money to make it possible for incarcerated people to meet with their MCOs, either in-person, by videoconference, or telephonically.
- This approach prioritizes inmates based on prior Medicaid coverage status, not their need for health care. Incarcerated people who were not previously enrolled in Medicaid likely need a different approach to funding enrollment efforts. With incarcerated people who were not members at incarceration, MCOs may face challenges conducting outreach because of the prohibition against cold-call marketing.
- To maximize its ability to continue coverage from a justice-involved person's preincarceration MCO, a state may need to continue Medicaid eligibility at incarceration, reclassifying coverage to avoid improper payments without ending eligibility outright. As discuss in box 15, Arizona used this approach to avoid the new enrollment-choice opportunities that may have been required, under federal regulations, if incarcerated people simply lost their Medicaid eligibility.

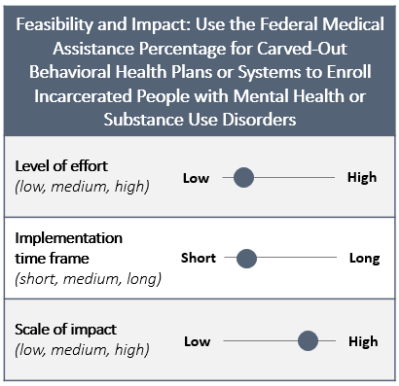
BOX 15

Arizona's Requirement That MCOs Reenroll Former Members upon Release

In Arizona, a recent amendment to the state's MCO contract requires MCOs to do in-reach to the jail population to reenroll their former members into coverage. The MCOs agreed to take on this new task without requesting an increase in their capitated rate. The MCOs decided that in-reach and reenrollment assistance to their former members to ensure continuity of care would create net financial gains by preventing medical emergencies and hospitalizations. The state received a waiver, under Section 1115 of the Social Security Act, permitting the automatic reenrollment of beneficiaries within 90 days of losing Medicaid eligibility, which goes beyond the more typical two-month re-enrollment limit specified in federal law.[a] Because the state does not terminate Medicaid eligibility at incarceration, it can reenroll incarcerated people at community reentry without running afoul of the waiver's 90-day limit. A similar approach could presumably be used by states that do not pursue such a waiver.

Source: "Transitions out of the Criminal Justice System," Arizona Health Care Cost Containment System, accessed October 24, 2017, https://www.azahcccs.gov/AHCCCS/Initiatives/CareCoordination/justiceinitiatives.html.
[a] Social Security Act, H.R. 7260, 74th Cong. (1935), §1903(m)(2)(H); and Disenrollment: Requirements and Limitations, 42 C.F.R. 438.56(g) (2010).

Strategy 3.3: Use the Federal Medical Assistance Percentage for Support Carved-Out Behavioral Health Plans or Systems to Enroll Incarcerated People with Mental Health or Substance Use Disorders



In many states, MCOs provide physical health care, and separate agencies or systems are responsible for "carved out" behavioral health care. Often, beneficiaries can choose between multiple MCOs but have only one available behavioral health program that covers all residents of a particular geographic area. In such cases, states could consider using the behavioral health agency or system to enroll incarcerated people with mental health and substance use disorders into Medicaid. These costs could

be covered as administrative expenses under the behavioral health contract. So long as the behavioral health agency is at risk financially for providing covered services, the same FMAP applies to health care and to administrative costs furnished under such a contract.[29]

When behavioral health agencies are not competing for enrollment, Medicaid's cold-call marketing prohibition does not apply. In such cases, this approach can be used with incarcerated people who were not enrolled in Medicaid before incarceration.

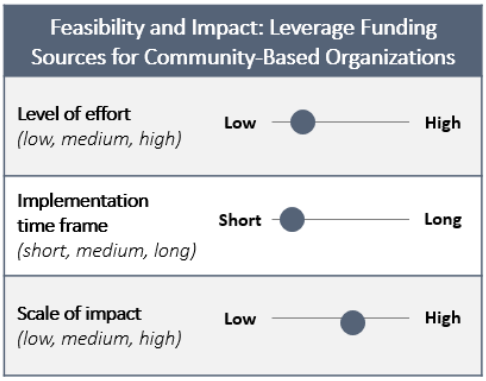
This approach has the advantage of targeting groups of incarcerated people for which health care might have a significant impact on recidivism. But states should consider several factors:

- This approach is not possible in geographic areas where competing MCOs offer behavioral health care.
- Medicaid agencies must ensure that administrative costs do not exceed the maximum 15 percent of managed care contracts allowed by federal law.
- States will need to designate the MH/SUDs that trigger the incarcerated people's links to Medicaid behavioral health agencies.
- Justice agencies need not provide enrollment assistance under this approach. But they ensure the operation of routines for identifying uninsured incarcerated people with relevant MH/SUDs. In addition, jails and prisons would have to create spaces and opportunities within the facility for incarcerated people to meet with staff of Medicaid behavioral health agencies.
- In many states, separate behavioral health agencies serve Medicaid beneficiaries who live in different areas. To connect departing incarcerated people to the appropriate behavioral health agency, justice agencies would need to screen them to learn where they plan to live upon release. This is likely to be an important concern with prisons that house people from across the state.
- Federal law protects privacy of personal information involving MH/SUDs. States may have additional confidentiality protections. Policymakers must ensure that the process of linking incarcerated people with behavioral health agencies does not involve unlawful disclosure of confidential information under federal or state law. Among other things, state agencies may need a system for obtaining the person's informed consent to information disclosure.
- A Medicaid agency could include behavioral health contract obligations that go beyond enrollment into Medicaid. Behavioral health agencies or systems could work with people

[29] Costs under Risk and Nonrisk Contracts, 42 C.F.R. 438.812 (2011).

before release and ensure links to appropriate providers capable of treating incarcerated people's MH/SUDs. These administrative services might include scheduling of initial appointments. See also the discussion of strategy 3.4.

Strategy 3.4: Leverage Funding Sources for Community-Based Organizations



Community-based organizations (CBOs) could use Medicaid funding or private grant funding to support enrollment efforts in jails and prisons. Under this approach, staff members from CBOs—as opposed to public employees or health care vendor staff—connect with incarcerated people to offer enrollment assistance. Several funding sources are possible.

State Medicaid agencies can use MAC to help fund CBO contracts. At least 50 percent of federal funding is claimable, but states may be able to access 75 percent Medicaid administrative funding match if a 90-10 match was used to upgrade an IT system and CBO staff working to enroll incarcerated people are linked to Medicaid's "back-end" eligibility and enrollment system. The eligibility and enrollment system, or state employees hired on the basis of merit, must make the final eligibility determination, but CBO enrollment efforts can still qualify for MAC, potentially at the 75 percent level.

States must identify the nonfederal share of the CBO enrollment costs. They could consider requesting that justice agencies pay part or all of the state's share for justice-involved enrollment activities. Such agencies could forward the necessary funds to the Medicaid agency through an intergovernmental transfer.

Navigator grants may be an option, depending on the state. Navigators are generally funded by Marketplaces that offer private insurance to people with incomes too high for Medicaid. But when recipients of navigator funding provide Medicaid enrollment services, Medicaid may contribute to the cost of the navigator program. In that case, the federal government provides MAC to help with the Medicaid program's share of navigator costs, consistent with federal cost-allocation principles noted

earlier. To the extent that these expenses involve the justice-involved population, the justice agency could use intergovernmental transfers to cover the non-federal portion of such responsibilities.

Finally, CBOs may have other resources, including foundation grants, to help cover enrollment costs. Community-based organizations vary greatly in their access to such funds. Generally, foundation funding is time-limited, rather than ongoing, which can limit the duration and scope of the enrollment efforts they support.

As with some of the approaches discussed earlier, this strategy relieves justice agencies of the need to provide enrollment assistance directly. But work is required to create space and opportunities within jails and prisons for CBOs to provide enrollment assistance. Also, justice agencies may need to identify incarcerated people who will receive assistance, ideally based on an assessment of priority populations.

BOX 16

Rhode Island's Use of Navigator Funding to Support Jail-Based Enrollment Efforts

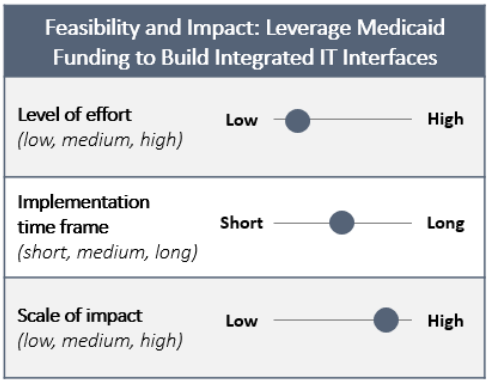
Though the initiative has since been discontinued, Rhode Island's Executive Office of Health and Human Services temporarily allocated funding from the state's Navigator Program to staff corrections facilities with mobile navigators who answered questions and assisted incarcerated people in applying for coverage.

Source: "Rhode Island: State Strategies to Enroll Justice-Involved Individuals in Health Coverage," National Academy for State Health Policy, December 17, 2015, http://www.nashp.org/rhode-island-state-strategies-to-enroll-justice-involved-individuals-in-health-coverage/.

Funding IT Development

This section explores how state and local officials might claim 90 percent federal Medicaid funding to support IT development that links the justice-involved population with a state Medicaid agency's eligibility and enrollment system. Information technology links between previously disparate electronic systems serving Medicaid and justice agencies could streamline Medicaid enrollment and renewal processes for eligible, justice-involved, low-income youth and adults.

Strategy 3.5: Leverage Medicaid Funding to Build Integrated IT Interfaces



Medicaid programs could seek 90 percent MAC matching funds to help build an electronic interface between justice and Medicaid IT systems that supports Medicaid enrollment, eligibility status adjustment, and renewal. Such an interface could include the following features:

- The justice system automatically sends data showing the identities of people who have been incarcerated, transferred, or released.
- The Medicaid system automatically sends a response informing the jail or prison about newly incarcerated people's current and former Medicaid status (including MCO enrollment) and adjusts the Medicaid status of beneficiaries entering and leaving custody.

The frequency with which justice agencies send data to the Medicaid program would depend on the size of the applicable facility and incarcerated people's turnover rates. Medium-sized and large jails, for example, could send batch files daily or several times a day.

The Medicaid agency could program its IT system to automatically perform several key functions:

- **Terminate MCO capitation payments when a beneficiary is incarcerated, and change the beneficiary's status** (e.g., by changing eligibility categories or suspending benefits). A Medicaid agency could consider limiting these changes to people after they have been incarcerated for a minimum number of days or hours. Many people in jail remain for brief periods, including people who are detained pretrial.
- **Consistent with any applicable confidentiality requirements regarding incarceration status, notify the beneficiary's MCO of the beneficiary's incarceration,** including information about where the beneficiary is housed. Such notice can facilitate steps by the MCO to prevent gaps in care when the beneficiary leave incarceration and reenters the community.

- **Restore full benefits when the beneficiary is released from custody.** This can include reinstatement of the beneficiary's prior MCO status as long as the beneficiary did not have his or her eligibility end while incarcerated.

- **Intervene to prevent incarcerated Medicaid beneficiaries from losing eligibility at redetermination**. The Medicaid agency's IT system could flag incarcerated beneficiaries who are approaching their coverage redetermination date and coordinate with the justice agency to facilitate renewal.

The jail or prison can make several uses of the data it receives from Medicaid:

- **Focus application assistance on inmates who are not Medicaid beneficiaries at admission.** Information from the Medicaid agency on which newly incarcerated people are already enrolled in Medicaid can help the justice agency identify those who lack coverage and would need to complete an application from scratch to have Medicaid coverage at the time of community reentry.

- Claim Medicaid reimbursement for inpatient or other institutional care furnished for at least 24 hours off the jail or prison grounds. When the jail or prison knows that someone is already eligible for Medicaid, claiming Medicaid reimbursement can be simplified because no new Medicaid application is required.

Claiming 90 percent federal match requires the Medicaid agency to submit a Medicaid Eligibility and Enrollment (EE) Implementation Advance Planning Document (IAPD)[30] and obtain CMS approval. Officials must consider two questions in framing such an IAPD:

- **Administrative effort.** Is the work involved in preparing the IAPD and obtaining CMS approval justified in view of the magnitude of the IT investment? Some jurisdictions with modernized Medicaid eligibility and enrollment systems may find that the effort involved is modest and can be completed by agency staff without going through an IT procurement process. In such jurisdictions, it may be simpler—and relatively inexpensive—for the Medicaid agency to do the work and claim the standard 50 percent MAC. In other places, the effort required may be sufficiently great that 90 percent IT funding could be essential to making the necessary investments.

[30] An IAPD template is available at "Medicaid Eligibility and Enrollment (EE) Implementation Advanced Planning Document (IAPD) Template," Medicaid.gov, accessed October 20, 2017, https://www.medicaid.gov/affordable-care-act/provisions/downloads/medicaid-eligibility-and-enrollment-iapd-template.pdf.

- **Cost allocation.** How much of the IT infrastructures' benefits would help the criminal justice agency, and how much would they help the Medicaid agency? Most benefits accrue to Medicaid: faster termination of capitated payments that are no longer appropriate, more efficient enrollment and retention of eligible people, and improved MCO ability to meet contractual obligations. But criminal justice agencies benefit from an improved capacity to bill Medicaid for inpatient and other institutional services furnished off jail or prison grounds. Whatever portion of the IT investment that is allotted to the criminal justice agency could not qualify for Medicaid funding, including either the federal 50 percent or 90 percent matching payments.

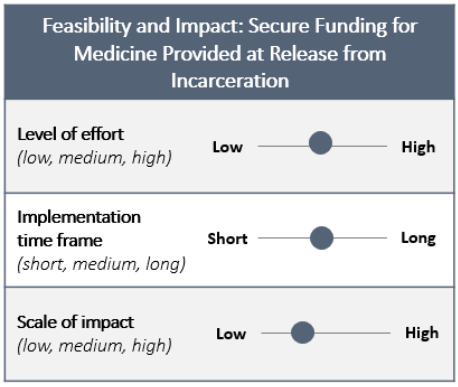
Several considerations are important to keep in mind as officials decide whether and how to move forward with financing and building an electronic interface between justice agencies and Medicaid:

- Matching the incarcerated person's identity with identity information in Medicaid case files is an inherently imperfect process, for many reasons. The kinds of data-matching arrangements discussed here will identify most Medicaid beneficiaries within the jail or prison population.
- Policy and legal changes are likely to be required. This includes data use agreements and policies and procedures that safeguard privacy and data security. The latter will involve proper practices for credentialing people who have access to confidential and personally identifiable information that flows through the justice agency–Medicaid IT interface. If the IT development cannot be handled in house by Medicaid agency staff, formal IT procurement may be needed to select a vendor or expand the scope of work under a contract with an existing vendor.
- Jails and counties with limited IT capacity could consider using simple Excel files to communicate information to and from the state Medicaid agency, should the Medicaid agency be willing to do so.

Funding Transition Services

The policy strategies in this section (3.6–3.8) suggest how state and local officials could tap federal funding for services that help incarcerated people transition towards receiving necessary care after community reentry. The options in this section do not help people in jail or prison receive care while incarcerated; rather, their objective is to facilitate the receipt of essential health services after community reentry. The strategies discussed in this section, like many explored elsewhere in this guide, could be implemented in stages. Officials could consider beginning with the highest-need populations, including people with substance use disorders, severe mental illness, or conditions such as HIV.

Strategy 3.6: Secure Funding for Medicine Provided at Release from Incarceration



People leaving custody with a prescription in hand may not fill it. To prevent such gaps in care, many jurisdictions provide needed prescription drugs at discharge by giving departing people bottles of medicine or by administering long-acting doses. One potential option for seeking Medicaid coverage for such medication is to dispense the prescription drugs after people are free to leave but are briefly remaining on-site to obtain their medicine. In such circumstances, people might no longer be considered incarcerated, under federal Medicaid law. Under 42 CFR §435.1010, "An individual is not considered an inmate if… (b) He is in a public institution for a temporary period pending other arrangements appropriate to his needs."[31]

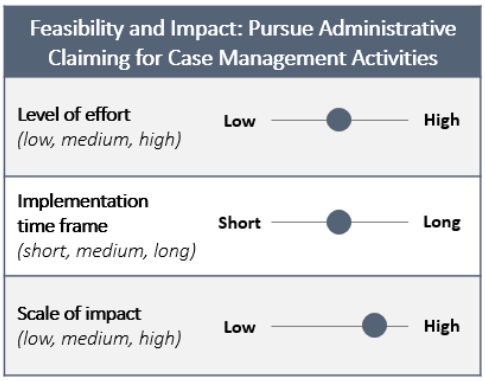
States have not yet tried this approach for claiming federal financing, but Los Angeles County is defining a process to do so through the pharmacy in its jail. Relevant considerations are likely to include the following:

- State and local justice agencies would need to develop and implement clear procedures for
  - » designating a person as no longer being involuntarily confined and
  - » documenting that the prescription was dispensed during a brief, voluntary stay.
- Many people will not want to remain in custody for any appreciable period. Procedures for dispensing medication during voluntary stays thus need to provide prescription drugs rapidly.
- A key issue is defining the when and where the service is provided. Prescriptions can be dispensed while a person is voluntarily remaining in custody for a brief period. Officials would need to clarify that the Medicaid-covered prescription drug is provided when it is dispensed, not when the prescription is filled.

[31] Definitions Relating to Institutional Status, 42 C.F.R. 435.1010 (2010).

- Officials must ensure that a Medicaid-qualified provider is furnishing the medication. Jail- or prison-based pharmacies may have to be certified by the state Medicaid agency, as Los Angeles County is doing. Moreover, CMS may have questions about jail- or prison-operated pharmacies that serve only incarcerated people.

Strategy 3.7: Pursue Administrative Claiming for Case Management Activities



State Medicaid agencies could explore using administrative claiming for case management activities to fund transitional services that facilitate postrelease care. Federal law permits states to use federal matching funding for administrative expenses incurred in operating Medicaid programs, which can include costs of many activities typically performed by case managers, such as intake, assessment, service planning or arranging Medicaid services (O'Keefe et al. 2010, 113–14). Under this approach, case management would be provided as a Medicaid administrative function, rather than as a covered service. If allowed by CMS, it might thus be exempt from the prohibition against funding health care services for the incarcerated. Medicaid case management services can link beneficiaries to both medical and nonmedical services. Such costs can be covered as a Medicaid benefit—targeted case management—in which case FMAP provides financing. Alternatively, they can be provided as a Medicaid administrative function. The former approach provides 90 percent or greater funding when beneficiaries are newly eligible, low-income adults, but the latter involves administrative costs that are not subject to denial of federal funds because of incarceration.

For this to happen, a state Medicaid agency must amend the state's cost-allocation plan to specify this use of administrative claiming. Several factors are important for officials to consider if pursuing administrative claiming for case management activities:

- Case management functions can be performed by public employees or by contractors. The latter category includes Medicaid MCOs, behavioral health plans, and other vendors.

- Case management services qualify, at minimum, for a 50 percent administrative match. If those services require "skilled medical training" and are furnished by a "skilled medical professional" with two or more years of training, case management costs can qualify for the 75 percent skilled professional medical personnel match.
- If case management services are part of a risk-bearing contract between the state and either an MCO or a behavioral health agency, the state may claim the full applicable FMAP amount. Federal law forbids administrative costs from exceeding 15 percent of the risk-bearing contract.
- States have not yet tried this approach. The Centers for Medicare and Medicaid Services' attitude toward the strategy is thus unknown.

References

Bandara, Sachini N., Haiden A. Huskamp, Lauren E. Riedel, Emma E. McGinty, Daniel Webster, Robert E. Toone, and Colleen L. Barry. 2015. "Leveraging the Affordable Care Act to Enroll Justice-Involved Populations in Medicaid: State and Local Efforts." *Health Affairs* 34 (12): 2044–51.

Binswanger, Ingrid A., Marc F. Stern, Richard A. Deyo, Patrick J. Heagerty, Allen Cheadle, Joann G. Elmore, and Thomas D. Koepsell. 2007. "Release from Prison—A High Risk of Death for Former Inmates." *New England Journal of Medicine* 356 (2): 157–65.

Brooks, Tricia, Karina Wagnerman, Samantha Artiga, Elizabeth Cornachione, and Petry Ubri. 2017. *Medicaid and CHIP Eligibility, Enrollment, Renewal, and Cost Sharing Policies as of January 2017: Findings from a 50-State Survey*. Washington, DC: Kaiser Family Foundation.

CMS (Centers for Medicare and Medicaid Services). 2013a. "Medicaid and CHIP FAQs: Enhanced Funding for Medicaid Eligibility Systems." Washington, DC: US Department of Health and Human Services, Centers for Medicare and Medicaid Services.

———. 2013b. "Affordable Care Act: State Resources FAQ." Washington, DC: US Department of Health and Human Services, Centers for Medicare and Medicaid Services.

Clemans-Cope, Lisa, Cybele Kotonias, and Jeremy Marks. 2017. "Providing Medications at Release: Connecticut and Rhode Island: Medicaid Areas of Flexibility to Provide Coverage and Care to Justice-Involved Populations." Washington, DC: Urban Institute.

Davis, Lois M., and Sharon Pacchiana. 2004. "Health Profile of the State Prison Population and Returning Offenders: Public Health Challenges." *Journal of Correctional Health Care* 10 (3): 303–31.

DCE (Division of Coverage and Enrollment). 2011. "Request for Applications: Facilitated Enrollment Program." Albany: New York State Department of Health, Office of Health Insurance Programs, DCE.

Florida Agency for Health Care Administration. 2013. *Health Plan Model Contract Attachment II—Core Contract Provisions*. Tallahassee: Florida Agency for Health Care Administration.

Hagen, Elizabeth. 2016. *Medicaid Suspension Policies for Incarcerated People: 50 State Map*. Washington, DC: Families USA.

Heiss, Christian, Stephen A. Somers, and Mark Larson. 2016. "Coordinating Access to Services for Justice-Involved Populations." New York: Milbank Memorial Fund.

Howard, Jhamirah, Madeleine Solan, Jessica Neptune, Linda Mellgren, Joel Dubenitz, and Kelsey Avery. 2016. "The Importance of Medicaid Coverage for Criminal Justice–Involved Individuals Reentering Their Communities." Washington, DC: US Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation.

Jannetta, Jesse, Jane B. Wishner, and Rebecca Peters. 2017. "Ohio's Medicaid Prerelease Enrollment Program: Medicaid Areas of Flexibility to Provide Coverage and Care to Justice-Involved Populations." Washington, DC: Urban Institute.

Karberg, Jennifer C., and Doris J. James. 2005. "Substance Dependence, Abuse, and Treatment of Jail Inmates, 2002." Washington, DC: US Department of Justice, Bureau of Justice Statistics.

Louisiana Department of Health. 2017a. "Healthy Louisiana: Justice Involved Prerelease Enrollment Program Manual." Baton Rouge: Louisiana Department of Health.

———. 2017b. *Informational Bulletin 12-16: Algorithm for Auto-Assignment to a Health Plan for Specialized Behavioral Health Services*. Baton Rouge: Louisiana Department of Health.

Mallik-Kane, Kamala, and Christy A. Visher. 2008. *Health and Prisoner Reentry: How Physical, Mental, and Substance Abuse Conditions Shape the Process of Reintegration*. Washington, DC: Urban Institute.

MLC (Medicaid and CHIP Learning Collaborative). 2015. "Medicaid/CHIP Renewals: State Practices, Lessons Learned, and Opportunities." Presentation at the Coverage Expansion Learning Collaborative, Baltimore, August 13.

Morrissey, Joseph P., Henry J. Steadman, Kathleen M. Dalton, Alison Cuellar, Paul Stiles, and Gary S. Cuddeback. 2006. "Medicaid Enrollment and Mental Health Service Use following Release of Jail Detainees with Severe Mental Illness." *Psychiatric Services* 57 (6): 809–15.

Office of Management and Budget. 2014. "Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards," 2 C.F.R. 200 . Washington, DC: Office of Management and Budget.

O'Keefe, Janet, Paul Saucier, Beth Jackson, Robin Cooper, Ernest McKenney, Suzanne Crisp, and Charles Moseley. 2010. *Understanding Medicaid Home and Community Services: A Primer (2010 Edition)*. Washington, DC: US Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation.

Ryan, Jennifer, Lucy Pagel, Katy Smali, Samantha Artiga, Robin Rudowitz, and Alexandra Gates. 2016. "Connecting the Justice-Involved Population to Medicaid Coverage and Care: Findings from Three States." Menlo Park, CA: Kaiser Family Foundation.

Spillman, Brenda, Lisa Clemans-Cope, Kamala Mallik-Kane, and Emily Hayes. 2017. "Connecting Justice-Involved Individuals with Health Homes at Reentry: New York and Rhode Island." Washington, DC: Urban Institute.

Steadman, Henry J., Fred C. Osher, Pamela Clark Robbins, Brian Case, and Steven Samuels. 2009. "Prevalence of Serious Mental Illness among Jail Inmates." *Psychiatric Services* 60 (6): 761–65.

Trestman, Robert L., and Rob H. Aseltine Jr. 2014. "Justice-Involved Health Information: Policy and Practice Advances in Connecticut." *Perspectives in Health Information Management* 11.

Visher, Christy, Sara Debus, and Jennifer Yahner. 2008. "Employment after Prison: A Longitudinal Study of Releasees in Three States." Washington, DC: Urban Institute.

Wang, Emily A., Clemens S. Hong, Shira Shavit, Ronald Sanders, Eric Kessell, and Margot B. Kushel. 2012. "Engaging Individuals Recently Released from Prison into Primary Care: A Randomized Trial." *American Journal of Public Health* 102 (9): e22–29.

Wang, Emily A., Yongfei Wang, and Harlan M. Krumholz. 2013. "A High Risk of Hospitalization following Release from Correctional Facilities in Medicare Beneficiaries: A Retrospective Matched Cohort Study, 2002 to 2010." *JAMA Internal Medicine* 173 (17): 1621–28.

Wishner, Jane B., and Kamala Mallik-Kane. 2017. "Information Sharing between Medicaid and Corrections Systems to Enroll the Justice-Involved Population, Arizona and Washington: Medicaid Areas of Flexibility to Provide Coverage and Care to Justice-Involved Populations." Washington, DC: Urban Institute.

Zemel, Sarabeth, Chiara Corso, and Anita Cardwell. 2015. "Toolkit: State Strategies to Enroll Justice-Involved Individuals in Health Coverage." Washington, DC: National Academy for State Health Policy.

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