



# Transitioning From Incarceration to the Community: Approaches and Lessons Learned for States and Health Plans

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# Questions for the Audience

How many of you are in states that have:

- Expanded Medicaid eligibility following the enactment of the ACA?
- Designated prisons and or jails as “qualified entities” for purposes of determining presumptive eligibility for the jail/prison population?
- Started using the option of suspending eligibility for this population rather than terminating it for the duration of Medicaid eligibility?
- Developed or planned to develop programs aimed at smoothing the transition from incarceration back to the community?
- Delayed planning and developing programs for this population due to uncertainties about the ACA and Medicaid expansion?

# Agenda for Today

- NORC's study
- Background on this population
- Federal policy levers on state programs
- State approaches
- Lessons learned and challenges
- Maryland's approach
- New Mexico's approach
- Questions, comments, and thoughts from the audience



# NORC at the University of Chicago - Study

- Molina Healthcare Inc. contracted with NORC at the University of Chicago to profile programs operating in different states
- Literature review
- 8 leadership interviews with:
  - MD, NM, and OH Medicaid staff
  - National thought leaders
  - Molina Healthcare New Mexico and Ohio staff
  - Metropolitan Detention Center, Albuquerque NM

# General Background on the Justice-Involved Population

- **11 million people** cycle through the United States' justice system each year<sup>1</sup>
- A disproportionately large number are **young, nonwhite, low-income males**
- They are **7x more likely** to suffer from mental illness, substance abuse, infectious disease, and chronic conditions than the rest of the population<sup>2</sup>
- In the first two weeks after release, these individuals have a **mortality rate that is 12 times higher** than the general public's

# Importance of Transitions from Incarceration to Community-Based Services

Given the rates of substance use, mental health concerns, and chronic conditions prevalent in justice-involved populations, connection to community-based services are essential.

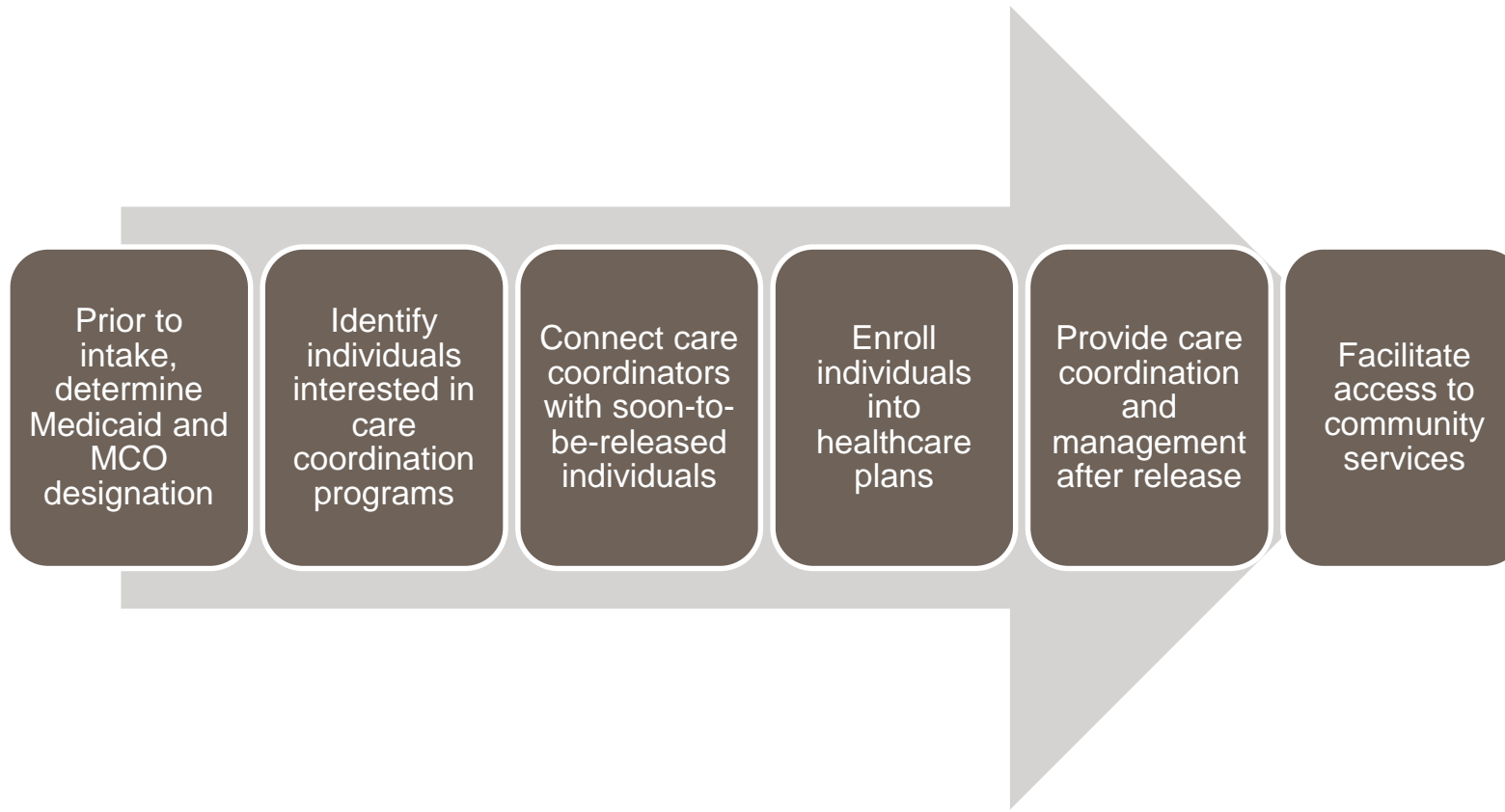
- Medicaid enrollment facilitates coverage for community-based services
- Pre- and post-release care coordination helps establish connections with community providers

# Background on Federal Policy Levers

- ACA changed the landscape for the justice-involved population
  - Medicaid expansion for low income adults
    - 32 states and the District of Columbia have implemented an expansion
  - Presumptive eligibility definition expanded to new “qualified individuals”
- Medicaid eligibility suspension for the jail/prison population
  - 16 states plus the District of Columbia allow for suspension of eligibility for the duration of an individual’s incarceration

# Generally Similar Approaches to Connect the Justice-Involved with Community-Based Services

## Collaborative pre-release programs



### Goals:

- Increase access to services
- Improve health outcomes
- Foster successful reentry into community
- Reduce recidivism
- Reduce criminal justice and healthcare costs



# Comparison of State Programs

**EXHIBIT 2. PRE-RELEASE PROGRAM CHARACTERISTICS IN MARYLAND, NEW MEXICO, AND OHIO**

State Program	Program Location	Implementation Date	Justice Facility	Pre-enrollment Education	Transition Services Offered	MCOs Involved	Enrolled Members
Maryland: Presumptive Eligibility for Correctional Facilities	Statewide	July 2017	Jail	N	Care coordination, substance abuse, mental health*	No	N/A
New Mexico: Care Coordination Program for Jail-Involved Members	Bernalillo County	June 2016	Jail	Y	Care coordination, substance abuse, mental health, pharmacy, transportation, Education on Medicaid-covered benefits (dental and vision)	1 MCO	250 (July 2017)
Ohio: Medicaid Pre-Release Program	Statewide	Sep 2014	Prison	Y	Care coordination, transportation, and assisting with addressing other social determinants of health (housing, financial assistance, etc.)	All (5 total)	15,000 (August 2017)

\*The development of these services is taking place under the Connecting Criminal Justice to Health Care initiative, awarded in the spring of 2016. This initiative will support care coordination and post-release services, once implemented.

# Similarities and Differences in State Approaches

- Stakeholder involvement in planning
- State and local partnerships
- Role of managed care plans
- Roll out and implementation
- Staffing and Training
- Role of jail and prison staff
- Use of prisons/jails for direct engagement
- Care management responsibilities, risk assessment, and care plans
- Data sharing
- Program funding



# Key Takeaways

- Garnering **buy-in from all partnering entities** is key
- **Communication** is vital
- Having **the right staff to educate, engage and gain the trust of incarcerated individuals** is essential
- Programs should be **tailored to specific areas/populations/environment**
- **Data sharing** is difficult and takes time, but **is necessary**
- Sustainability and funding support **relies on data** that highlights a program's impact
- Medicaid coverage plus care **coordination assists transition back into the community**

# Program Findings

- To date **reports are anecdotal.**
- Programs are in early stages and **findings are not available.**
- Molina Healthcare of New Mexico has **some initial findings.**
- **Ohio is reviewing its program data** for potential release.
- **More studies are needed** as these programs evolve on the programs' costs, impacts, challenges and lessons learned.

# References

1. Wagner, P. (2015, August 14). Jails matter. But who is listening? Retrieved from <http://www.prisonpolicy.org/blog/2015/08/14/jailsmatter/>
2. Dorn, S., J.D., & Jannetta, J., M.P.P. (2015, November 30). Connecting Criminal Justice to Health Care Initiative (CCJH): Request for Proposals [PowerPoint Slides]. Retrieved from [http://www.urban.org/sites/default/files/bja\\_urban\\_manatt\\_bidders\\_webinar\\_presentation\\_11\\_30\\_15.pdf](http://www.urban.org/sites/default/files/bja_urban_manatt_bidders_webinar_presentation_11_30_15.pdf)
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**Thank You!**



**NORC**  
*at the UNIVERSITY of CHICAGO*

 insight for informed decisions™



**Maryland Medicaid**  
**Management of the Jail-Involved**  
**Population: Eligibility and Service**  
**Delivery**

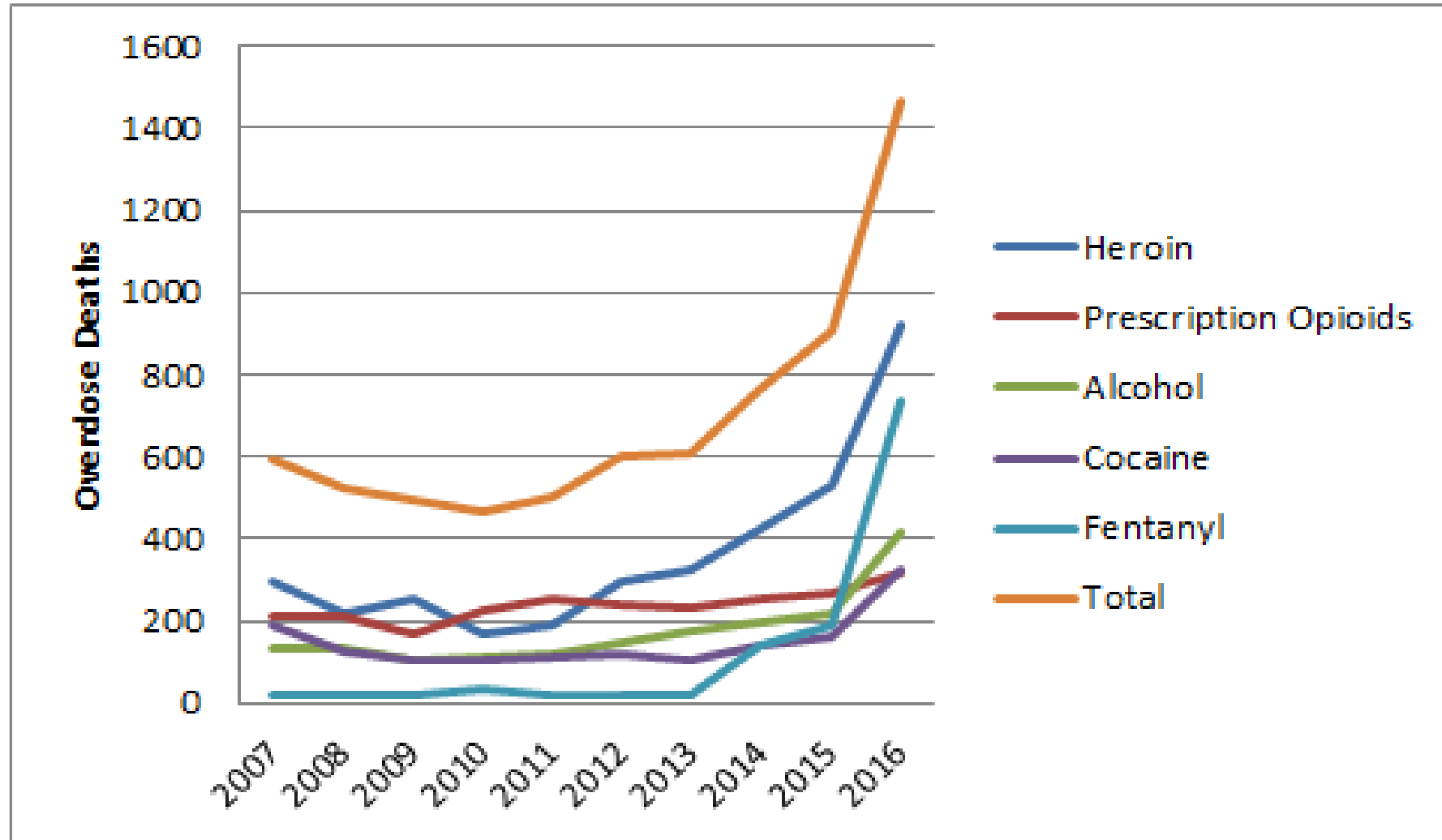
Shannon McMahon  
Former Deputy Secretary for Health Care Financing  
Maryland Department of Health  
August 29, 2017

A photograph of a person's hands holding a large quantity of pills and syringes. The person's face is blurred in the background. The scene is dimly lit, with a strong light source from the left creating a lens flare effect. The pills are of various colors (white, blue, orange) and shapes. The syringes are clear plastic with orange plunger caps. The overall mood is somber and clinical.

# Opioid Overdose Epidemic Overview



# Maryland Overdose Deaths by Drug Class 2007-2016\*



# Why Target Medicaid?

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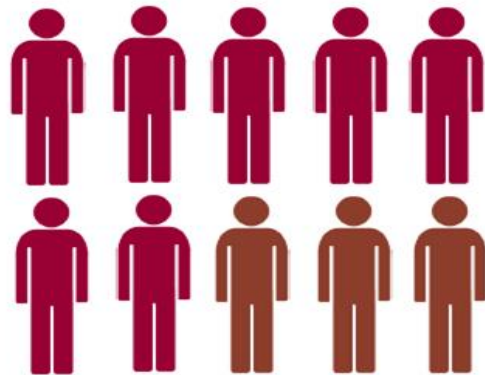
- Over 20% of Marylanders enrolled in Medicaid
- Statewide reach
- 6 of 8 MCOs are integrated provider and payer networks
- 816 (65%) of opioid overdose deaths in 2015 were enrolled in Medicaid at any point after January 1, 2011. Of that amount 691 were enrolled in Medicaid at some point during CY 2015.
  - 67.5% of participants were male
  - The majority of participants were white (61.9%) or African American (29.2%).
  - Most participants lived in suburban Baltimore (35%), Baltimore City (33.1%), and Western Maryland (10.5%)

# Prescription Drugs and Heroin

Prescription opioid misuse is a major risk factor for heroin use



**3 out of 4 people**  
who used heroin in the  
past year misused  
opioids first



**7 out of 10 people**  
who used heroin in the  
past year also misused  
opioids in the past year

Jones, C.M., Heroin use and heroin use risk behaviors among nonmedical users of prescription opioid pain relievers – United States, 2002–2004 and 2008–2010. *Drug Alcohol Depend.* (2013).



MARYLAND  
Department of Health



# Maryland Medicaid SUD Initiatives

# Residential SUD Treatment

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- December 2016, CMS approved Maryland Medicaid 1115 waiver renewal, which included its request to provide IMD services for substance use disorder treatment
  - Waives Medicaid IMD exclusion and allows Maryland Medicaid to offer SUD services in IMDs with more than 16 beds
- With this addition, the program covers ASAM's full continuum of care for SUD treatment
- Effective July 1, 2017, Maryland Medicaid will provide reimbursement for up to two nonconsecutive 30-day stays in a rolling year for ASAM levels 3.7 WM, 3.7, 3.5, and 3.3.
- The Department intends to phase in coverage of ASAM level 3.1 beginning on January 1, 2019.



# Care for Justice-Involved

# Medicaid Initiatives in Correctional Facilities

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- Medicaid presence in all 24 jurisdictions in Maryland
- Local health departments important partners in this effort
- Full Medicaid enrollment in full swing in over 80% of detention centers
  - LHD provide enrollment staff and IT resources
  - Detention centers identify space for conducting determinations and inmates that need enrollment assistance; also conduct orientation and training for LHD enrollment staff
  - Remaining 20% are finalizing resources and processes prior to launch

# Presumptive Eligibility for Correctional Facilities

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- Maryland Medicaid launching “Presumptive Eligibility for Correctional Facilities” (CPE) in 2017
  - CMS approved MD’s SPA to allow correctional facilities to be “qualified entities” for its Presumptive Eligibility program
  - CPE allows incarcerated individuals to undergo a simplified application to enroll into temporary Medicaid coverage
  - CPE is designed to be a safety net for individuals that have challenges enrolling into full Medicaid, PEDs are required to attempt a full application first
  - In the process of finalizing state regulations
  - Comments all positive from advocates



# The Need for Data

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- An important part of this process is to ensure Medicaid is accurately “turned on” and “turned off” for individuals as they go in and out of correctional facilities.
- For an incarcerated individual to obtain access to their Medicaid coverage, the Department must be notified when the individual has been released from jail or prison so that their coverage may be activated as quickly as possible.
- When Medicaid is activated, the individual will be able to use and navigate their coverage.
- The Department currently receives data from DPSCS for correctional facilities under its jurisdiction to conduct such activities.
- DPSCS sends the Department electronic data reports daily that the Department matches with MMIS data

# Medicaid Enrollment MOUs

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- There has been a long-lasting data exchange agreement between DHMH and DPSCS. However, no such arrangement with detention centers presently exists.
- With the tremendous uptake on enrollment activities in detention centers, the Department hopes to have an agreement with each of our counties.
- DHMH has put together a draft MOU for our counties. It includes language regarding (1) data exchange – same format and process as with DPSCS facilities and (2) enrollment activities – both full Medicaid and CPE.
- The MOU is a three-way agreement between (1) DHMH, (2) local health department, and (3) local detention center.

# Care Coordination Strategy: MCO “Real Time Enrollment”

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- Part I: Enrollment and Data Sharing
  - Shore up enrollment workforce – make full enrollment a priority
  - Make community connections (MH, SUD, MCOs)
  - Identify point persons from local health departments and local detention centers to manage the data sharing MOU
- Part II: Care Coordination
  - MCO Auto-enrollment
    - Beneficiaries in Maryland Medicaid MCOs receive care coordination
  - Greater local health departments involvement
    - Majority of LHDs also facilitate connections to behavioral health and social support services

**Thanks!**

***Any questions?***

# Jail Involved Care Coordination Pilot

8/29/2017

Amir Wodajo, MS, CCM Director of Case Management & Behavioral Health

# Agenda

- **Program Overview**
- **Pilot Program**
- **Successes**
- **Opportunities**
- **Success Stories**

# Medicaid for Incarcerated Populations in New Mexico

GOAL: Help inmates make a successful reintegration into their communities and reduce recidivism

Over 1,200 NMCD inmates were enrolled into Medicaid in 2015

After 30 days of incarceration, Medicaid is suspended until release

MIIP allows inmates enrolled into Medicaid to keep their eligibility while in prison/jail and have their benefits reactivated when released

This allows for timely access to the following services:

- Physical health services
- Behavioral health services
- LTSS services
- Pharmacy/prescriptions

# Jail Involved Care Coordination Pilot

- Molina entered into a partnership with the Metropolitan Detention Center (MDC) in September of 2015
- Molina Care Coordinators (Case Managers), entered into the jail on June 1, 2017
- **Care Coordination Intervention Defined as:**
  - Assisting with understanding healthcare benefits
  - Complete a Health Risk Assessment and Comprehensive Needs Assessment
  - Coordinate Medical, Behavioral and Long Term Care, dental, vision services
  - Educate about non-emergent medical transition (Medicaid benefit)
  - Educate on telemedicine services
  - Identifying community resources
  - Completion of a comprehensive care plan



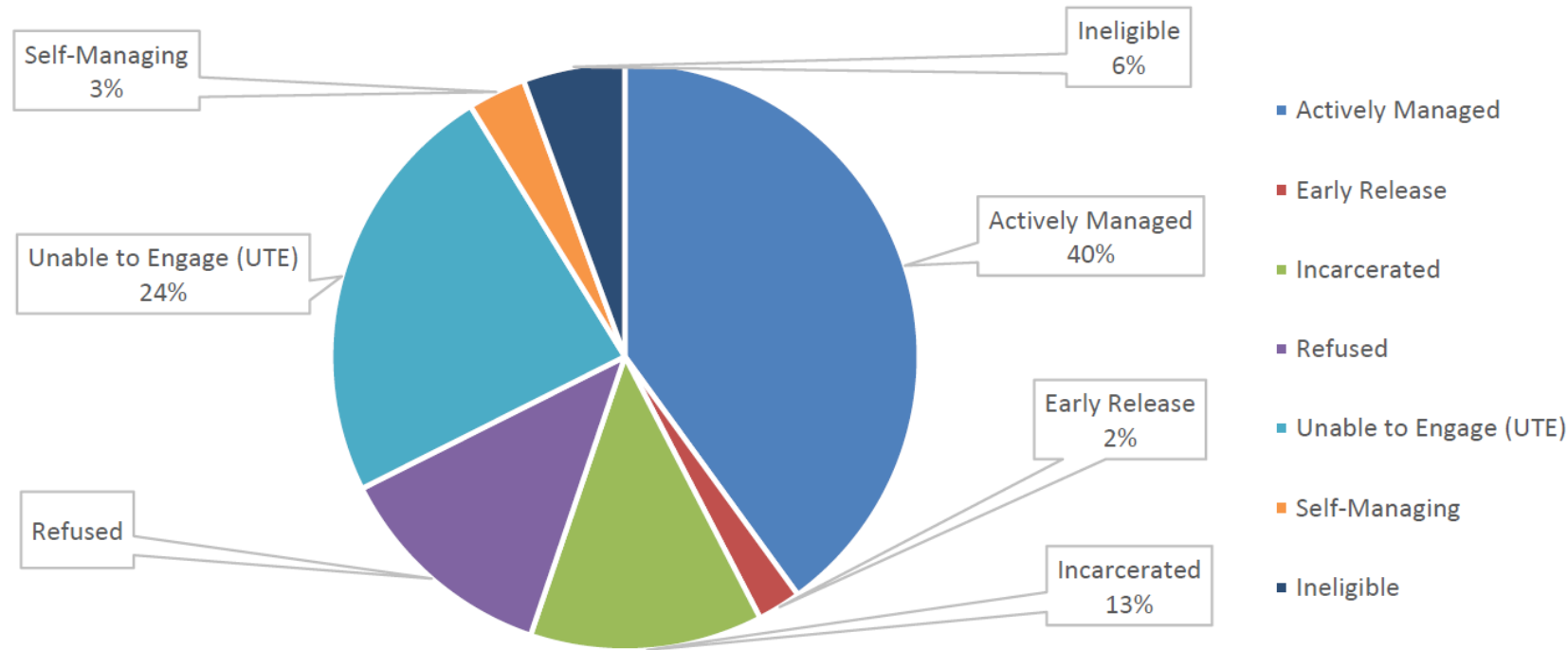


# Jail Involved Care Coordination Pilot

- **Year to Date Referrals**

- 250 members agreed to participate in this project
- 20 Refused with MDC; 11 refused with the Care Coordinator

Total Members Agreed to Participate in Care Coordination (n=250)



# Pilot Successes

**24% Decrease in ED use upon Care Coordination intervention**

- On average, those that received the intervention had 8 ED claims per month compared to those that did not receive the intervention had an average of 23 ED claims per month

**35% Decrease in BH services among members engaged**

- Data show a significant pattern of appropriate use as trends begin to stabilize post intervention

**14% Decrease in PH services among members engaged**

- Inclusive of urgent care and specialist services. Data also illustrates a consistent pattern of PCP engagement

**4% Decrease in inpatient utilization for those that received the Care Coordination intervention**

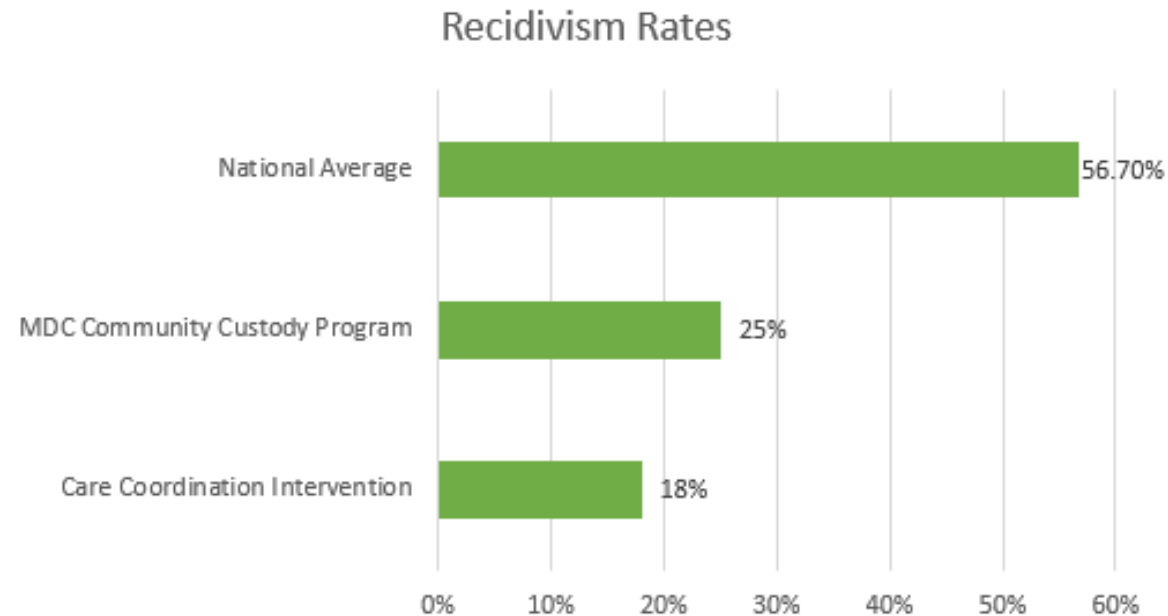
- Inclusive of BH inpatient stays, admissions through the ED as well as planned inpatient stays

**Decrease in Pharmacy claims/Improved Medication Adherence**

- Attributed to overall increase in health, increase in access to appropriate primary care services and 90 day Rx fills

# Pilot Successes: Recidivism Rates

- National Institute of Justice (NIJ): More than half (56.7%) of inmates who are released are re-incarcerated within 1 year of release
- Individuals involved in the Community Custody Program (ankle monitoring) show a rate of 25%
- Members that received the Care Coordination Intervention show a rate of 18%



# Pilot Opportunities

- Notification of Release
- Re-approaching those members that are re-incarcerated
- Medicaid benefit suspension and reinstatement monitoring
- Continued data and claims analysis
- Expansion of Care Coordination to 27 additional detention centers, statewide

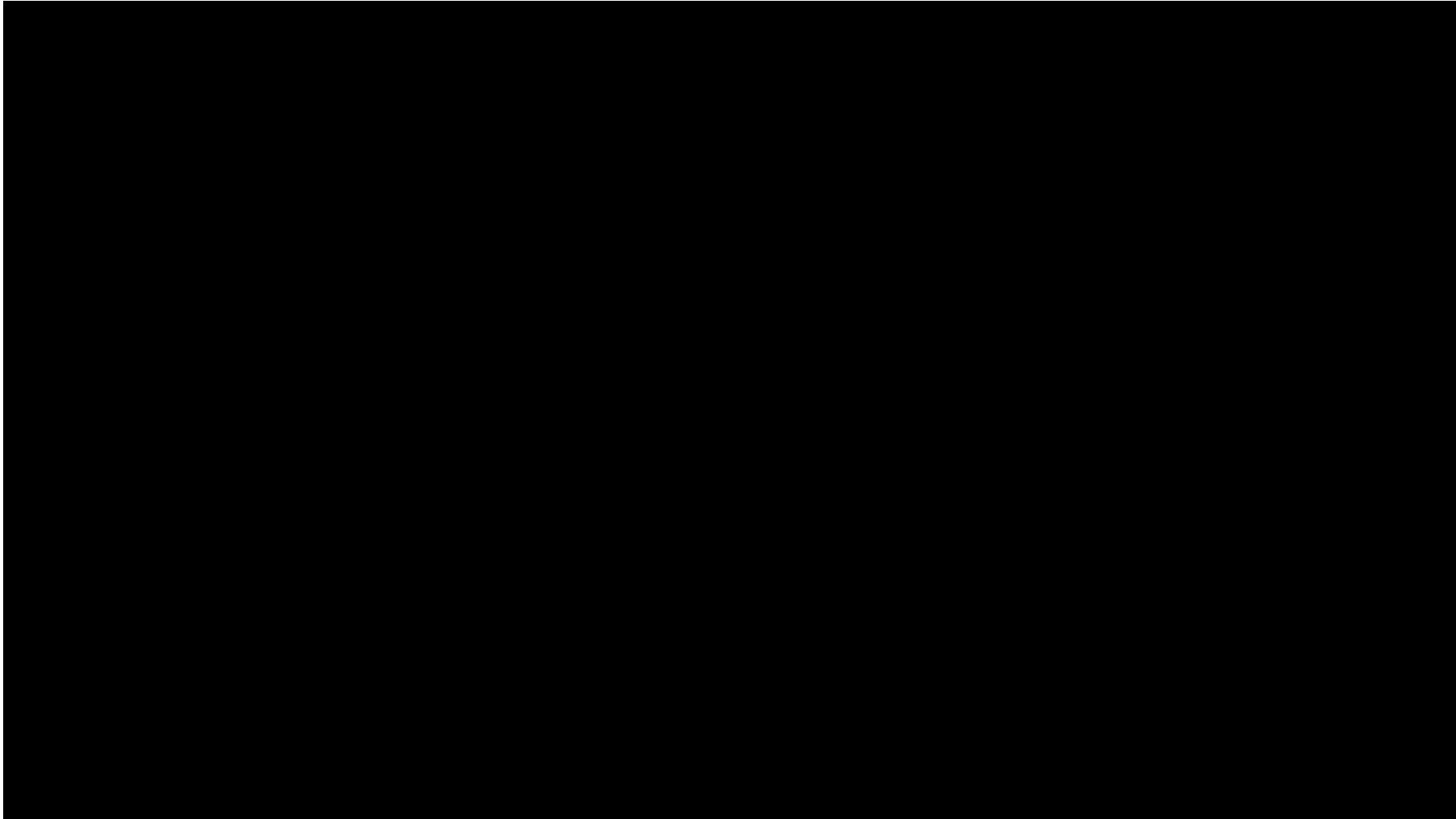


# Success Stories

## Care Coordination in Action

On a visit to the Metropolitan Detention Center, MHNM met a man who was incarcerated for burglary, aggravated battery, and possession of narcotics, among other infractions. He agreed to complete a Health Risk and Comprehensive Needs Assessments at MDC. While undergoing the assessments, this man shared that he had used illegal drugs for 20 years and contracted HIV and Hepatitis C. Up to that point, he had received only sporadic medical care. Upon his release, an MHNM CC helped the man establish contact with an Intensive Outpatient Program (IOP) for substance abuse. The CC also assisted him in reestablishing a relationship with a medical provider for treatment of HIV and Hepatitis C. The member has continued ask his MHNM CC questions about his health and about community resources. As of March 2017, he graduated from his IOP program and continues attending behavioral health and physical health appointments regularly. The man also happily reports that he recently found employment.

# Success Stories



# Questions

