CRITICAL CONNECTIONS

GETTING PEOPLE LEAVING PRISON AND JAIL THE MENTAL HEALTH CARE AND SUBSTANCE USE TREATMENT THEY NEED

What Policymakers Need to Know about Health Care Coverage

Executive Summary

BJA Bureau of Justice Assistance U.S. Department of Justice

the NATIONAL REENTRY RESOURCE CENTER

JUSTICE CENTER The Council of State Governments

Executive Summary

CRITICAL CONNECTIONS

GETTING PEOPLE LEAVING PRISON AND JAIL THE MENTAL HEALTH CARE AND SUBSTANCE USE TREATMENT THEY NEED

What Policymakers Need to Know about Health Care Coverage

January 2017

Martha R. Plotkin, J.D.
Alex Blandford, MPH, CHES

BJA Bureau of Justice Assistance U.S. Department of Justice
the NATIONAL REENTRY RESOURCE CENTER
JUSTICE CENTER The Council of State Governments

The Council of State Governments (CSG) Justice Center prepared this summary with support from the Bureau of Justice Assistance (BJA), U.S. Department of Justice, under grant number 2012-CZ-BX- K071. The opinions and findings in this document are those of the authors and do not necessarily represent the official position or policies of the U.S. Department of Justice or the members of the Council of State Governments. The supporting federal agency reserves the right to reproduce, publish, translate, or otherwise use and authorize others to use all or any part of the copyrighted material in this publication.

About the CSG Justice Center: The CSG Justice Center is a national nonprofit organization that serves policymakers at the local, state, and federal levels from all branches of government. It provides practical, nonpartisan advice and evidence-based, consensus-driven strategies to increase public safety and strengthen communities. For more about the CSG Justice Center, see www.csgjusticecenter.org.

About BJA: BJA is a component of the Office of Justice Programs, which also includes the Bureau of Justice Statistics, the National Institute of Justice, the Office of Juvenile Justice and Delinquency Prevention, the Office for Victims of Crime, and the Office of Sex Offender Sentencing, Monitoring, Apprehending, Registering and Tracking. Visit www.bja.gov for more information.

About NRRC: The National Reentry Resource Center (NRRC) was established in 2008 by the Second Chance Act (Public Law 110-199) and is administered by the U.S. Department of Justice's Bureau of Justice Assistance. The NRRC provides education, training, and technical assistance to state and local governments, tribal organizations, territories, community-based service providers, non-profit organizations, and correctional institutions working to improve reentry. To learn more about the NRRC, visit csgjusticecenter.org/nrrc.

Suggested citation and link to full report: Martha R. Plotkin and Alex M. Blandford, *Critical Connections: Getting People Leaving Prison and Jail the Mental Health Care and Substance Use Treatment They Need—What Policymakers Need to Know about Health Care Coverage* (New York, NY: Council of State Governments Justice Center, 2017).

For more information on related resources, see www.csgjusticecenter.org.

The Council of State Governments Justice Center, New York, 10007

Cover and interior design by Mina Bellomy.

Introduction

For decades, research and news headlines have driven home the fact that people with mental illnesses and substance use disorders are filling our nation's prisons and jails.[1] Their incarceration has a tremendous impact on their futures, their families, and their communities, as well as the corrections and health care systems. These individuals tend to have costly and complex chronic health problems,[2] stay incarcerated longer than those without behavioral health disorders,[3] and are more likely to be uninsured[4] and reincarcerated.[5] Millions return to their communities after incarceration each year (more than 2 million adults from jails alone)[6] in need of treatment and supports that can help put them on the path to wellness, recovery, and avoidance of the criminal justice system. Yet, while considerable work has been done in states and local jurisdictions across the country to address their needs, these efforts are often hampered by policy choices that limit this population's access to health care coverage and services.

At the same time, the health policy landscape is rapidly evolving, making it all the more important for state policymakers and criminal justice leaders to collaborate with Medicaid and other health authorities and behavioral health professionals to not only help reduce recidivism and improve lives, but also to use state and local resources more effectively.[7] * Medicaid is the single largest payer for community mental health services and also increasingly for substance use treatment.[8] In states that have expanded their Medicaid programs, a larger number of people leaving prison and jail are eligible for Medicaid. In states that have not expanded their Medicaid programs, the subset of people released from incarceration who have the most severe needs (i.e., those who meet Medicaid's categorical eligibility as "disabled") are eligible for Medicaid. State and county leaders, therefore, should be asking whether their state Medicaid programs are well positioned to address the distinct care needs of this population. All states have the opportunity to retool their programs and enrollment processes to facilitate these individuals' successful reentry from prison or jail.† There is also considerable value in ensuring that policies encourage linking qualified people to Veterans Affairs (VA) health care and benefits,‡ as well as to Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI) that provide critical income supports when people return to the community after incarceration.

Although it is clear that prisons and jails can be vital hubs for these activities, they are only able to succeed when they operate within a carefully crafted policy framework and have an adequate infrastructure with well-aligned resources. Putting these supports in place requires having the right people addressing the appropriate policy and implementation questions. *Critical Connections* raises those questions and provides the information needed to help guide focused discussions and planning efforts among state policymakers (including governors, legislators, corrections and health care leaders, and Medicaid and other benefit authorities), their professional staff, and county and community partners.

---

* Although the paper focuses on behavioral health (mental illnesses and substance use disorders), a "whole-person" approach to treatment must be considered to address the other complex health needs of people in prisons and jails. To affect recidivism rates (e.g., reincarceration) and related cost savings, Medicaid enrollment must be part of a comprehensive reentry plan.

† While the discussion paper is primarily centered on reentry strategies and goals, it also emphasizes the need to use diversion options to connect people to community-based care and supervision, when appropriate, while also permitting continued access to Medicaid and other benefits.

‡ Veterans health care and benefits are addressed within each of the five issue areas with suggested resources from the U.S. Department of Veterans Affairs (VA) for the criminal justice population, including Veterans Justice Outreach (for courts and jails), Health Care for Reentry Veterans (for prisons), and Veterans Reentry Search Service (for prisons, jails, and courts).

Roadmap to the Paper and Who Should Read It

The discussion paper outlines five important issue areas to consider when developing plans to improve access to publicly funded behavioral health care that can advance both health and public safety goals. Examples of state and local strategies are offered for all change agents interested in transforming systems and encouraging innovation.*

Five Issue Areas for Connecting People Leaving Prison or Jail to Behavioral Health Care

Issue 1: Identifying Enrollment and Eligibility Status

Issue 2: Maintaining Enrollment and Reactivating or Reenrolling in Benefits upon Release

Issue 3: Assisting with Applications

Issue 4: Examining Medicaid-Reimbursable Behavioral Health Services in the Community and Addressing Gaps

Issue 5: Tracking Progress

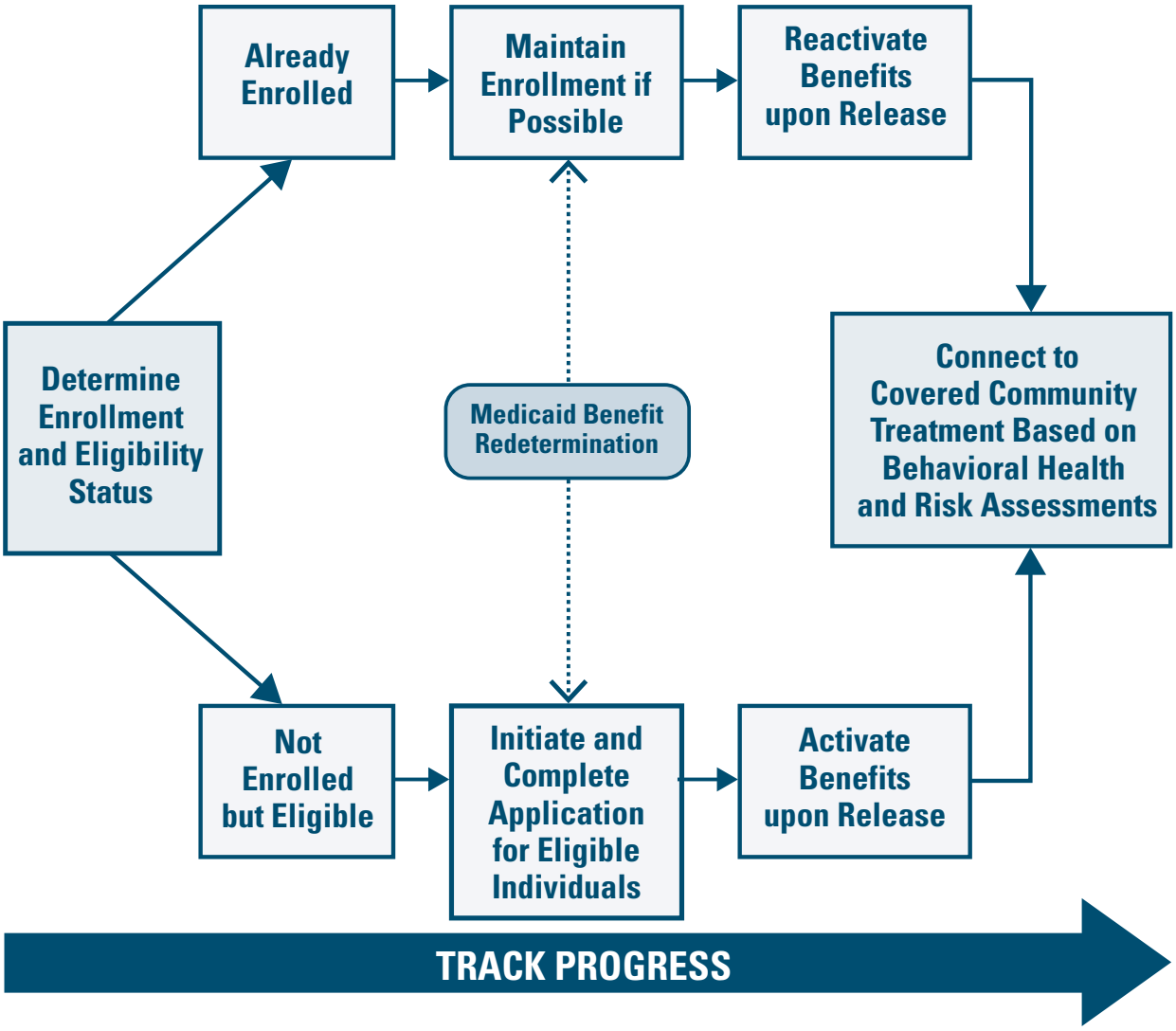
Within each of these issue areas, the discussion paper delves into relevant federal and state laws and guidance and the local implementation efforts of both. There are examples from prisons and jails and policies in more than 30 states that can help readers appreciate the wide range of approaches used to connect people to health care benefits and supports and better assess how their state's actions align with others across the nation.

* The examples in the discussion paper were selected to illustrate the range of policies and practices across states, but are far from exhaustive and are not meant as endorsements of any particular program or approach. They were compiled through a scan of the literature and feedback from expert reviewers. Although some examples have greater applicability in states with expanded Medicaid coverage under the Affordable Care Act (ACA), where there is a larger pool of eligible people in the criminal justice system, nonexpansion states can use many of the same strategies and are also highlighted.

How to Use the Discussion Paper

A group facilitator, policymaker, or liaison between criminal justice and behavioral health agencies should talk through the discussion paper's questions with key decision makers and stakeholders to assess where their state or jurisdiction stands on important policy issues and implementation strategies that can positively impact people with behavioral health needs leaving prison and jail.

The discussion paper takes readers through the five issue areas by describing the process steps below in greater detail. At each step, strengthening collaborations among criminal justice, behavioral health, and public health care/ benefit authorities should be emphasized, as well as developing measures to track and report on progress.



ISSUE 1: Identifying Enrollment and Eligibility Status

Issue 1 discusses the importance of developing the infrastructure and routine processes for determining whether people in prisons and jails are enrolled or are likely eligible for enrollment in Medicaid, SSI/SSDI, and VA health care and benefits. The discussion questions and examples help readers appreciate the wide range of screening strategies being used in prisons and jails and how their own efforts compare.

Consideration 1

What policies exist in your state to identify people who are enrolled in Medicaid, SSI, and SSDI when admitted to prison and jail, and those who are eligible to receive benefits upon release?

This section demonstrates how benefit screening policies and practices can influence the number of eligible people who are likely to be linked to continued health care and services in the community upon release. Among the factors considered are whether prisons and jails have mandated or voluntary screening, who will be screened (everyone or specified groups), by whom (corrections or health and human service staff), when (at intake or prerelease), and how (including access to benefit and correctional databases).

It also examines policies that affect the overall scope of the screening effort, including the impact of state decisions about expansion or nonexpansion of Medicaid coverage on the scale of prison and jail efforts; how strategies will accommodate varying lengths of stay for people who are incarcerated; and whether funding and data-system infrastructures needed for implementation have been prioritized. (Discussion paper pp. 8-19)

ISSUE 2: Maintaining Enrollment and Reactivating or Reenrolling in Benefits upon Release

Issue 2 examines how federal laws, state policies, and implementation efforts can significantly impact how Medicaid coverage for people in prisons and jails can be sustained in ways that promote recovery, help reduce recidivism, and make better use of correctional health care dollars. Whether coverage is suspended or terminated during incarceration, the discussion questions and examples focus on the need to develop processes that ensure access to reactivated or new benefits as quickly as possible upon release.

Consideration 1

For people who were enrolled in Medicaid when admitted to prison or jail, what policies does your state have in place to continue or reinstate enrollment so that they can access their benefits for allowable inpatient care while incarcerated, and fully upon release?

States have discretion to suspend benefits (often for limited periods of time) or terminate enrollment for all people incarcerated in prisons and/or jails. Whether a state suspends or terminates coverage impacts the ease with which eligible people are able to access benefits when they need them most—upon release (as well as during incarceration when hospitalized in the community under a limited "inpatient exception").*

Consideration 2

What policies or processes does your state have in place to facilitate reinstatement of SSI or SSDI when people are released from prison or jail?

Readers are also encouraged to examine how their states are implementing the federal requirement that Medicaid eligibility be periodically "redetermined,"† particularly for people in prisons and jails. State implementation examples, ex-parte redetermination processes, challenges related to data systems, and time-limited suspension issues are also reviewed. This information is meant to help corrections and their enrollment and reentry partners navigate the complexities of these issues and work with state Medicaid authorities to develop appropriate actions.

This section considers how requirements for maintaining SSI and SSDI benefits differ. It also examines the prerelease agreements that some states (or individual prisons and jails) have with the Social Security Administration. When these agreements are coupled with effective reapplication and reinstatement processes, they can help people who are eligible for benefits receive them quickly upon release. Also reviewed is the Social Security Administration's reporting incentive program for correctional facilities, as well as recipients' obligation to repay benefit payments if they are improperly received while incarcerated.[9] ‡

In 33 states plus the District of Columbia, an SSI disability determination can lead to Medicaid eligibility and enrollment.§ The discussion paper reviews how state policies and processes can help facilitate the swift reinstatement of benefits when either is suspended, and how Medicaid coverage can be maintained even when SSI is terminated if individuals qualify under other Medicaid eligibility criteria. (Discussion paper pp. 20-36)

---

* The inpatient exception allows Medicaid payments for eligible incarcerated people's allowable costs in authorized hospitals for inpatient stays expected to last at least 24 hours. (See 42 C.F.R. § 435.1009, 42 C.F.R. § 435.1010 and the index in full discussion paper.)

† Federal rules state that for people who are eligible for Medicaid [based on Modified Adjusted Gross Income (MAGI) criteria or non-MAGI criteria], eligibility must be redetermined at least once every 12 months (but no more frequently for eligibility based on MAGI criteria). (See 42 CFR § 435.916). For more information see "Redetermination" in the Index of the discussion paper.

‡ According to the Social Security Administration's Program Operations Manual System (GN 02607.400-Prisoner [Inmate] Reporting Agreements), correctional facilities can report inmate information to the Social Security Administration with or without a formal agreement, but will only receive incentive payments if a formal written agreement is in place.

§ This linkage is explored further in Issue 3 in regard to new applications and reenrollments.

ISSUE 3: Assisting with Applications

Issue 3 reviews who is authorized or permitted to complete applications on behalf of individuals who are incarcerated, the mandates related to accepting completed applications from people in prisons and jails, and information about Medicaid Administrative Claiming.*

Consideration 1

What policies and processes does your state have in place to help ensure that applications are appropriately filed so that eligible people will leave facilities with access to Medicaid and SSI/SSDI benefits?

As with screening for enrollment and eligibility status (Issue 1), many of the same questions arise for application processes, though the answers may differ. These questions include who should help applicants (e.g., trained corrections staff, health or human services personnel, other "assisters" in the community); when (e.g., at intake, for inpatient stays, or prerelease); how (e.g., automated, paper, telephone, applicant- or assister-driven), and with what funding. The examples in this section illustrate the many ways application processes are implemented and how they may be shaped by factors such as length of stay, available staffing, state and county data infrastructures, and the ability to access the necessary data systems while complying with privacy mandates.

Consideration 2

Does your state use presumptive eligibility provisions that allow entities other than hospitals to apply for temporary Medicaid enrollment for incarcerated people, with processes in place for full enrollment to follow?

Presumptive eligibility is a mechanism that states and local jurisdictions have used for qualified entities to enroll people who are likely to meet the eligibility criteria. It is used to ensure immediate, but temporary, access to health care coverage and is most often used by schools, clinics, hospitals, and local health departments. Application processes vary, but require a follow-up application for full, longer-term Medicaid coverage if one has not already been completed. This section examines how some states are exploring allowing corrections agencies to make these immediate eligibility determinations for time-limited coverage as well, particularly when people are poised to leave prison or jail and no final eligibility determination has been received prior to their release.†

An estimated 32 percent of people in state and federal prisons and 40 percent of those in local jails have at least one disability, underscoring the need to help ensure their enrollment in SSI and SSDI benefits.[10] The discussion paper outlines whether a state allows successfully enrolled SSI recipients to receive Medicaid coverage without submitting a separate application based on their SSI disability determination (see 50-state table). If an individual qualifies for Medicaid on the basis of a disability, not income, the

* Medicaid Administrative Claiming (MAC) provides federal reimbursement of a portion of administrative fees relating to Medicaid outreach, application assistance, and training if all criteria are met and an agreement is reached with the state Medicaid authority. See the Index in the full discussion paper for more information.

† See the Index in the full paper for more information on presumptive eligibility.

benefits offered are often more robust and are frequently accompanied by income supports. This may be of particular importance in nonexpansion states, where people may not qualify based on income criteria. This section also examines whether states facilitate enrollment in Medicaid while SSDI enrollees are waiting to be enrolled in Medicare.* Some eligible people may be reluctant to apply or are unaware of all of these benefits. As a result, a number of states are highlighted that provide health insurance and treatment literacy programs to encourage the completion of applications.† Training for parties who can help educate and enroll people in SSI/SSDI is also described.

Consideration 3

What policies, if any, does your state have to link SSI and SSDI determinations to Medicaid and Medicare enrollment?

In addition, Issue 3 addresses improving data systems and application processes; changing policies to allow sufficient time for eligibility determinations to be made; aligning benefit activations with release dates; and partnering with community groups, managed care organizations, and community supervision agencies when applications are not completed during incarceration or require follow up. States with the greatest successes in achieving high enrollment rates and coordinated benefit activation have dedicated liaisons at both Medicaid and corrections agencies, as well as prerelease agreements with the Social Security Administration and referral procedures for veterans. (Discussion paper pp. 37-55)

ISSUE 4: Examining Medicaid-Reimbursable Behavioral Health Services in the Community and Addressing Gaps

Issue 4 proposes that if policymakers, corrections leaders, and state agency professionals want to help people leaving prison and jail who have behavioral health needs and other health problems get the care they need, they should address:‡ (1) state plan design—ensuring that Medicaid state plans cover the types of behavioral health services and supports needed by people leaving prisons and jails; (2) service delivery—shaping service delivery to encourage a "whole person" integrated approach

Consideration 1

Are the treatments and services associated with positive outcomes for people with behavioral health needs leaving prison and jail covered by your state Medicaid program? If not, how can the benefit plan(s) be shaped further to cover gaps?

* All SSDI recipients are eligible for Medicare 24 months after their SSDI benefits have begun. While they are waiting for Medicare benefits, they may qualify for Medicaid and can complete a separate Medicaid application. This is possible because people who are dual-eligible for SSI and SSDI can also be eligible for both Medicaid and Medicare. Consequently, their Medicaid enrollment can continue even after their SSDI triggers Medicare enrollment.

† Education programs for helping people understand how to use their benefits once enrolled and when to properly access emergency care is covered in Issue 4.

‡ The focus of this section is on increasing access to comprehensive Medicaid-reimbursable behavioral health services and supports for people returning to the community as part of a reentry plan. (Several resources are cited in the discussion paper that directly address transition plans and care engagement.)

to health care; and (3) community capacity—inventorying and expanding services as well as the number, range, and availability of behavioral health treatment providers in the community who have the requisite skill set and experience to work with the reentry population.* States may consider using the complementary mechanisms outlined in Table 1 of the discussion paper (including State Plan Amendments, waivers, and financing options) and in related examples to improve state Medicaid benefit plans, service delivery, and treatment capacity.[11]

Although all states cover behavioral health services for certain Medicaid beneficiaries, the scope, duration, and intensity of services vary considerably, especially as a state may have multiple benefit packages.[12] The discussion paper calls for an examination of the state Medicaid benefit plans to determine which behavioral health treatments and related services are currently covered, and whether they employ evidence-based practices.

The discussion questions in this section are meant to stimulate thinking about how state plan amendments and waivers can be used to change Medicaid state benefit plans, within federal parameters, to address important gaps in covered behavioral health services. Examples illustrate how states have used these mechanisms together with legislation, regulations, and policies to help clarify and extend (consistent with the Centers for Medicare & Medicaid Services [CMS] requirements) coverage of behavioral health services under state Medicaid benefit plans. These mechanisms are highlighted for such services as Medication-Assisted Treatment (MAT), tele-psychiatry, peer support services, and longer inpatient psychiatric care.

Consideration 2

What mechanisms can your state use to improve the delivery of Medicaid-reimbursable behavioral health services for people who have returned to the community from prison and jail?

The discussion paper features a number of models used to coordinate and improve Medicaid service delivery, as well as to realize cost savings. Some of these models require changing the state plan. Other approaches effectively clarify which services are covered under benefit plans' existing allowable categories. For example, Health Homes (authorized by Section 2703 of the ACA) can be developed in both expansion and nonexpansion states.† They are used to integrate and coordinate the many treatments and services needed by people who have chronic, serious, and complex health problems, including behavioral health needs.

In addition, this section reviews the ways states can use financial mechanisms and payment models to improve coordination of care among all providers and better define reimbursable services, particularly through managed care organization (MCO) contracts,

---

* Federal and state law and local actions related to each of these efforts is reviewed, including (1) required and optional Medicaid benefits, Alternative Benefit Plans and Essential Health Benefits for expansion states, as well as new opportunities for inpatient services provided in "Institutions for Mental Disease" (IMDs); (2) improved service delivery by implementing mental health parity mandates, using Medicaid managed care systems, and creating health homes; and (3) access to care requirements and incentives for managed care organizations and providers.

† Health homes are not a physical place, but a team-based clinical approach offered in primary care or behavioral health care providers' offices. States have the flexibility to determine who is eligible to be a health home provider. According to CMS, "health home providers can be an individual provider, a team of health care professionals, or health team that provides the health home services and meets established standards and system infrastructure requirements." States can receive enhanced federal matching rates for specific health home services, which include comprehensive care management, care coordination, and transitional care/follow up. See CMS' "Health Homes (Section 2703) Frequently Asked Questions" and the full report for more information.

where applicable.* Medicaid agencies can enter into contracts in which MCOs agree to have network providers offer a specific suite of services to particular groups of people. Provisions in these managed care contracts can require health plans to engage with eligible people while they are still incarcerated to connect them to a managed care plan as part of their reentry preparation and to conduct outreach and coordination upon their release.[13]

The discussion paper considers two tiers of changes required to address community behavioral health treatment capacity: (1) systems-level change that focuses on the adequacy of provider networks (i.e., whether there are enough providers in all areas of the state to offer the range of needed services for the target population); and (2) qualified provider availability, particularly Medicaid providers who already have or will acquire the necessary skills and training to work with people with complex behavioral health and other needs.

Consideration 3

How can community-based treatment capacity be expanded at both the network and provider levels?

Recognizing that the onus should not rest solely on Medicaid agencies and providers or the behavioral health system to address the treatment and support needs of people returning to the community after incarceration, the discussion paper also examines how criminal justice agencies can serve as strong contributors and partners with the other systems. As a significant step toward breaking down system silos, criminal justice and health agencies can focus on tackling data systems and sharing health records to advance progress. The paper discusses federal funding that is available for improving Health Information Exchanges and some information-sharing resources that can enhance continuity of care. Collaborations with Social Security Administration offices and VA representatives can also help close gaps in the needed health care and income supports for eligible people leaving prison or jail.

The discussion questions in this section probe possible ways that states can increase community treatment capacity while promoting quality services through payment and service-delivery models, particularly MCO contracts.† States that have existing pay-for-performance models may encourage or require health plans to include a special focus on people with complex needs who require more intensive coordinated care. States can also explore how value-based incentives can be linked to providers' performance on a set of defined measures related to services for people in the criminal justice system.[14] Still, states will need to contend with the reality that Medicaid reimbursement rates and the requisite administrative infrastructure to participate in Medicaid programs present challenges to capacity building, particularly in rural areas. (Discussion paper pp. 56-86)

* MCOs typically have some discretion regarding the services they determine to be reimbursable within categories set out in the state Medicaid plan. MCOs can include a more detailed range of allowable services, provider types and settings, duration, and frequency than what is found in a state benefit plan.

† States with Accountable Care Organizations (ACOs) participating in a Medicaid-shared savings program could also include incentives in contracts to focus on achieving better outcomes or cost savings for people in the justice system (see http://www.chcs.org/media/ACO-Fact-Sheet-32515-ak.pdf).

Federal, State, and Local Funding Sources for Services Not Covered by Medicaid

Even after the most robust efforts are made to provide more Medicaid–covered behavioral health services in the community, there will inevitably still be gaps in needed care. However, there are federal, state, and local resources highlighted in the paper (see Table 5) that can be used to address those gaps. In some cases, grant programs and other sources have funded services that have been so effective in producing positive results, they have subsequently been added to a state Medicaid benefit plan's scope of covered services.

ISSUE 5: Tracking Progress

Data should be collected at each step in the enrollment/access-to-benefits process to guide resource allocations and comprehensive reentry planning. Much of the data identified in the discussion paper may already be collected by various agencies but might not be analyzed or used to inform policy and practice. Too often, policymakers, agency leaders, and professionals working directly with the reentry population receive information that is hard to interpret or lacks context for making meaningful decisions.

Tracking how many people in prisons and jails are screened for prior Medicaid and SSI/SSDI enrollment or eligibility, how many then submit applications, and how many are successfully enrolled or have remained enrolled in these programs (and referred to the VA if applicable) can be surprisingly complex—especially when states and counties lack adequate automated data systems or information-sharing processes. It has also been challenging for individuals trying to track progress to gauge if benefits are activated/reactivated on or soon after release dates. Taken together, data for these measures are often scattered across corrections, the Social Security Administration, Medicaid, VA, and health service agencies, underscoring the need to do an inventory of which agencies have information and how it might be more efficiently collected and analyzed. Prisons and jails consistently report that it is very difficult to get information about the application status and benefit reactivation efforts once a person has been released to the community, particularly if she or he is not on probation or parole.

Consideration 1

Does your state track how many eligible people in prison or jail are successfully enrolled in Medicaid and SSI/SSDI benefits that they can access upon release, as well as how many veteran referrals were made, when applicable?

It may also be useful to capture information on why applications have not been filed for individuals who likely meet Medicaid and other benefit eligibility criteria. For example, high rates of refusal to complete an application may be due, in part, to lack of information about the value of the benefits. Snapshots of progress-tracking efforts are provided from Massachusetts and Cook County, Illinois, to demonstrate how a state and county are monitoring their Medicaid enrollments to make improvements. Examples from Oklahoma and Miami-Dade County, Florida similarly illustrate how a state and county are tracking Social Security Administration benefit enrollments using the SSI/SSDI Outreach, Access, and Recovery (SOAR) program approach.*

Jurisdictions are encouraged to monitor systems-level changes and policy shifts in addition to individual-level data related to people who are being released from prison or jail. To inform treatment and placement decisions, a growing number of corrections agencies are using validated screening and assessment tools to identify people who have mental illnesses and co-occurring substance use disorders and higher risks of recidivism that can also help define priority populations for tracking. Although analyzing enrollment and access to benefit efforts is only the first step, it is foundational. With more people enrolled over time, correctional agencies' focus may expand to better gauge whether people are actually engaging in treatment and services that have been accessed through public benefits. These inquiries—which are the focus of a small number of intensive studies—will ultimately help determine whether improved access to publicly funded health care and benefits are helping to lower recidivism rates, improve individuals' recovery, and reduce health care costs for states. (Discussion paper pp. 87-99)

* SOAR is a national program with a presence in all 50 states that works to improve access to Social Security benefit programs for eligible adults facing homelessness, including those who have a mental illness, medical impairment, and/or a co-occurring substance use disorder. States, counties, and agencies can implement the SOAR approach for submitting and processing applications, train case managers to complete the applications, and track outcomes (e.g., number of approved applications).

Conclusion

States have widely varying policies on Medicaid suspension, termination, the scope of coverage, and benefit plans, but all can agree that continuity of coverage and care is critical for people with behavioral health needs who are returning to their communities from prisons and jails. Other public health care and income supports are similarly essential to advancing wellness and successful reentry to the community. *Critical Connections* provides the structure for conducting meaningful dialogues within states that can help advance innovative policies and practices by leveraging investments in Medicaid, SSI/SSDI, and VA health care and benefits.

The discussion paper is meant to help leaders navigate the policy decisions related to Medicaid and other health care reforms. It can help readers explore important issues and recognize the benefits of jumping in, wherever their state or county may be in its processes, to better connect people leaving prison and jail to needed community behavioral health care. Getting started involves putting policies and practices in place to identify people in prison and jail who are likely eligible for Medicaid and other public benefits; facilitating or reinstating their enrollment; and improving Medicaid coverage of behavioral health care in the community by increasing provider capacity so that quality care can be more easily accessed. By working through the discussion questions and related information provided in the paper, cross-systems planning can generate better outcomes for people in need of care and supportive services following incarceration and make better use of investments by the behavioral health and criminal justice systems.

Endnotes

1. Henry J. Steadman et al., "Prevalence of Serious Mental Illness Among Jail Inmates," *Psychiatric Services* 60, no. 6 (June 2009): 761-765 (based on jail admissions). Even greater numbers of individuals have mental illnesses that are not "serious" mental illnesses, but still require resource-intensive responses. Estimates of prevalence of mental illnesses in prisons and jails vary widely (from less than 20 percent to more than 50 percent) due to differences in definitions and methodologies. See, e.g., Council of State Governments Justice Center, "Frequently Asked Questions about New Study of Serious Mental Illness in Jails," (New York, NY: CSG Justice Center, 2009), Q.2, https://csgjusticecenter.org/wp-content/uploads/2012/12/Psy_S_FAQ.pdf; See also, Seth J. Prins, "Prevalence of Mental Illnesses in U.S. State Prisons: A Systematic Review," *Psychiatric Services* 65, no. 7 (March 2014). More than 50 percent of people in prisons and 68 percent of people in jails have known substance use disorders. See, e.g., Office of Justice Programs, Bureau of Justice Assistance, *Drug Use and Dependence, State and Federal Prisoners, 2004*, by Christopher J. Mumola and Jennifer C. Karberg, NCJ 213530, Special Report (Washington, DC: U.S. Department of Justice, 2006); Office of Justice Programs, Bureau of Justice Assistance, *Substance Dependence, Abuse, and Treatment of Jail Inmates,* by Jennifer C. Karberg and Doris J. James, NCJ 209588 (Washington, DC: U.S. Department of Justice, 2005). Alex Blandford and Fred Osher, *Guidelines for the Successful Transition of Individuals with Behavioral Health Disorders from Jail and Prison* (Delmar, NY: SAMHSA's GAINS Center for Behavioral Health and Justice Transformation, 2013), Table 1.

2. The Pew Charitable Trusts and the John D. and Catherine T. MacArthur Foundation, *State Prison Health Care Spending* (Washington, DC: The Pew Charitable Trusts, 2014); Jeffrey W. Swanson et al., *Costs of Criminal Justice Involvement Among Persons with Severe Mental Illness in Connecticut* (Durham, NC: Duke University School of Medicine, 2011); KiDeuk Kim, Miriam Becker-Cohen, and Maria Serakos, *The Processing and Treatment of Mentally Ill Persons in the Criminal Justice System* (Washington, DC: The Urban Institute, 2015).

3. Office of Justice Programs, Bureau of Justice Assistance, *Mental Health and Treatment of Inmates and Probationers*, by Paula M. Ditton, NCJ 174463, (Washington, DC: Department of Justice, 1999); The Council of State Governments Justice Center, *Improving Outcomes for People with Mental Illnesses Involved with New York City's Criminal Court and Correction System*, (New York, NY: The Council of State Governments Justice Center, 2012); E. Fuller Torrey, Aaron D. Kennard, Don Eslinger, Richard Lamb, and James Pavle, *More Mentally Ill Persons Are in Jails and Prisons than Hospitals: A Survey of the States*, (Arlington, VA: Treatment Advocacy Center, 2010).

4. This has been attributed, in part, to people in incarceration lacking access to employer-sponsored insurance, the means to purchase insurance in the individual market, and the qualifications for Medicaid. See The Pew Charitable Trusts, *How Medicaid Enrollment of Inmates Facilitates Health Coverage After Release*, (Washington, DC: The Pew Charitable Trusts, 2015).

5. KiDeuk Kim, Miriam Becker-Cohen, and Maria Serakos, *The Processing and Treatment of Mentally Ill Persons in the Criminal Justice System* (Washington, DC: Urban Institute, 2015); Jacques Baillargeon et al., "Psychiatric Disorders and Repeat Incarcerations: The Revolving Prison Door," *American Journal of Psychiatry* 166, no. 1 (January 2009): 103-109.

6. Henry Steadman, et al., "Prevalence of Serious Mental Illness Among Jail Inmates."

7. See, e.g., Catherine McKee et al., *State Medicaid Eligibility Policies for Inmates Moving Into and Out of Incarceration* (Menlo Park, CA: The Henry J. Kaiser Family Foundation, 2015); The Pew Charitable Trusts and the John D. and Catherine T. MacArthur Foundation, *State Prison Health Care Spending* (Washington, D.C.: The Pew Charitable Trusts and the John D. and Catherine T. MacArthur Foundation, 2014). Deborah Bachrach, Patricia Boozang, and Mindy Lipson, *The Impact of Medicaid Expansion on Uncompensated Care Costs: Early Results and*

Policy Implications for States (Princeton, NJ: The Robert Wood Johnson Foundation, June 2015); The Council of State Governments Justice Center, *Medicaid and Financing Health Care for Individuals Involved with the Criminal Justice System* (New York, NY: The Council of State Governments Justice Center, 2013); Washington State Department of Social and Health Services, Research and Data Analysis Division, *Chemical Dependency Treatment, Public Safety: Providing chemical dependency treatment to low-income adults results in significant public safety benefits*, by David Mancuso and Barbara E.M. Felver, Report 11.140 (Seattle, WA: 2009).

8. "Behavioral Health Services," U.S. Department of Health & Human Services, Centers for Medicare & Medicaid Services, accessed May 5, 2016, https://www.medicaid.gov/medicaid-chip-program-information/by-topics/benefits/mental-health-services.html; Vikki Wachino to State Health Officials, "To Facilitate successful re-entry for individuals transitioning from incarceration to their communities," SHO #16-007 (Baltimore, MD: Centers for Medicare & Medicaid Services, April 28, 2016); Substance Abuse and Mental Health Services Administration, *Medicaid Handbook: Interface with Behavioral Health Services*, SMA-13-4773 (Rockville, MD: U.S. Department of Health & Human Services, 2013).

9. U.S. Social Security Administration, *Incentive Payments for State and Local Institutions*, SSA #05-10088 (Washington, DC: October 2003); U.S. Social Security Administration, "GN 02607.160 Title II Prisoner Suspension Provision," *SSA's Program Operations Manual System*.

10. U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics, *Disabilities Among Prison and Jail Inmates, 2011—12*, by Jennifer Bronson, Laura M. Maruschak, and Marcus Berzofsky, NJC 249151, Special Report (Washington, DC: December 2015); See also, Rebecca Vallas, *Disabled Behind Bars: The Mass Incarceration of People with Disabilities in America's Jails and Prisons* (Washington, DC: Center for American Progress, July 2016), https://cdn.americanprogress.org/wp-content/uploads/2016/07/15103130/CriminalJusticeDisability-report.pdf.

11. For additional information on different types of mechanisms that states can use to change how their Medicaid programs are structured, see U.S. Department of Health & Human Services, Centers for Medicare & Medicaid Services, "*At-a-Glance" Guide to Federal Medicaid Authorities Useful in Restructuring Medicaid Health Care Delivery or Payment,*" (Baltimore, MD: April 2012), https://www.medicaid.gov/State-Resource-Center/Medicaid-State-Technical-Assistance/Health-Homes-Technical-Assistance/Downloads/At-a-glance-medicaid-Authorities.pdf.

12. See, Veronica Guerra, Christian Heiss, and Shannon M. McMahon, *Key State Considerations for Selecting an Essential Health Benefit Benchmark for Medicaid and the Exchange* (Hamilton, NJ: Center for Health Care Strategies, Inc., July 2012), http://www.chcs.org/media/EHB_for_Medicaid_and_the_Exchange2-1.pdf; and "Alternative Benefit Plan Coverage," U.S. Department of Health & Human Services, Centers for Medicare & Medicaid Services, accessed July 20, 2016, https://www.medicaid.gov/medicaid-chip-program-information/by-topics/benefits/alternative-benefit-plans.html.

13. U.S. Department of Health & Human Services, Centers for Medicare & Medicaid Services, *Coverage and Delivery of Adult Substance Abuse Services in Medicaid Managed Care*, by Patricia Boozang, Deborah Bachrach, and Andrew Detty (Baltimore, MD: March 2014), https://www.medicaid.gov/medicaid/benefits/downloads/cms-adult-substance-abuse-services-coverage.pdf.

14. For examples of how states have pursued Medicaid provider incentive programs, see Diane Hasselman, *Provider Incentive Programs: An Opportunity for Medicaid to Improve Quality at the Point of Care* (Trenton, NJ: Center for Health Care Strategies, Inc., March 2009), http://www.chcs.org/media/P4P_Resource_Paper.pdf.

www.csgjusticecenter.org

BJA
Bureau of Justice Assistance
U.S. Department of Jus ı

the NATIONAL REENTRY
RESOURCE CENTER

JUSTICE CENTER
THE COUNCIL OF STATE GOVERNMENTS