

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



BJA
Bureau of Justice Assistance
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RESOURCE CENTER

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THE COUNCIL OF STATE GOVERNMENTS

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Websites, examples, and resources referenced in this publication provided useful information at the time of this writing. The authors do not, however, necessarily endorse the information or sources.

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Introduction

State legislators, corrections directors, and health systems administrators often face significant challenges in helping connect the large number of people with behavioral health disorders who are leaving prisons and jails to health care and supportive services.* Much of this difficulty lies in determining the policies and practices that can be the most effective in helping people obtain the health insurance and other federal benefits they need to access appropriate and affordable care upon their return to the community. These are longstanding problems that have taken on new dimensions as an increasing share of treatment and services needed by the reentry population are covered under Medicaid if eligible individuals are enrolled.†

As the single largest payer of mental health services and increasingly of substance use treatment,¹ Medicaid is a system becoming more focused on care management, service coordination, and treatment for people with complex needs. Any state that wants to make an impact on addressing the behavioral health needs of people who are in frequent contact with the justice system should consider how Medicaid and other federal programs can be leveraged. A coordinated state response involves knowing how to:‡

- Identify people in the criminal justice system who are likely eligible for Medicaid and other publicly funded benefits such as Social Security Administration benefits and U.S. Department of Veterans Affairs (VA) health care and benefits;
- Facilitate or reinstate enrollment of people in prisons and jails in Medicaid and other benefits; and
- Engage in cross-sector collaborations to
 - Review and revise Medicaid state plans to cover the types of behavioral health care and supportive services needed by people leaving prisons and jails§
 - Shape service delivery to encourage a “whole person” integrated approach to health care and supportive services.
 - Inventory and expand needed community care and supportive services, including the number, range, and availability of behavioral health treatment providers who have the requisite skills and experience to work with the reentry population.

* “Behavioral health disorders” refers to mental illnesses and substance use disorders (alone or co-occurring). The Diagnostic and Statistical Manual of Mental Disorders, 5th Edition, defines mental illness as “a syndrome characterized by clinically significant disturbance in an individual’s cognition, emotion regulation, or behavior that reflects dysfunction in the psychological, biological, or developmental processes underlying mental functioning.” For the purposes of this paper, people who are incarcerated refers to all detainees and sentenced individuals in jails and prisons. “Adults” refers to people who are age 19 and older (i.e., those who no longer meet the Medicaid Children’s Health Insurance Program [CHIP] definition of “child”). (See 42 C.F.R. § 457.10.) Although this paper focuses on addressing behavioral health disorders, any actions should be part of larger efforts to coordinate care for adults leaving prison and jail with complex health needs and recidivism risk factors.

† Medicaid is a joint federal-state health care program to help low-income families or individuals pay for medical care costs. Federal mandates and guidance allow states flexibility in how they shape their own programs, such as eligibility criteria and benefit design, which accounts for significant variation across states. States and the federal government share the costs. For more information on state Medicaid programs, see [Medicaid.gov](#) and [Issue 4](#).

‡ This report focuses on state policies and actions that affect both prisons and jails, recognizing that some states have a unified correctional system, and in others, jail administration may be with counties, municipalities, or regional authorities. Even if a state agency does not effect change, local agencies often can act if there are no mandates to the contrary.

§ This includes addressing both behavioral health needs and criminogenic risk/needs. Criminogenic risk and needs are determined by factors that contribute to the likelihood of reoffending and requires that intervention type and intensity be aligned to each individual’s assessed levels of risk and need (see Fred Osher, et al., *Adult with Behavioral Health Needs under Correctional Supervision: A Shared Framework for Reducing Recidivism and Promoting Recovery*, New York: The Council for State Governments Justice Center, 2012).

Report Summary and Companion Discussion Questions

A concise summary of this paper and the key questions that can stimulate discussions and assessments of progress at the state, local, and agency levels on helping individuals leaving prisons and jails with behavioral health needs access public health care, benefits, and covered treatment are available at the CSG Justice Center website.

THE REENTRY POPULATION: UNINSURED WITH COSTLY COMPLEX NEEDS

A significant barrier to connecting people to community behavioral health services upon release from a correctional institution has been the large number of people who lack any health insurance.² Of the nearly 10 million people released from correctional facilities each year, as many as 70 percent leaving prison³ and 90 percent leaving jail⁴ were estimated to be uninsured prior to the enactment of the Affordable Care Act (ACA) in January 2014. Under the provisions of the ACA, many of these people are eligible for Medicaid simply based on their income status. States that have elected to be Medicaid “expansion” states,^{*} which broadens coverage to all adults who make less than 133 percent of the federal poverty level,[†] may identify as many as 80–90 percent of people leaving prisons eligible for Medicaid.⁵ Although there is little data on the number of people leaving jails who are eligible for Medicaid post-ACA,[‡] experts in the field and recent reports suggest that approximately 60 percent of people exiting jails could qualify for Medicaid in expansion states based on their income.⁶ Adding this group to those who are in jail and were previously eligible for Medicaid based on traditional categories (i.e., pregnant, women with children, aged, blind and disabled), the estimated total percentage of Medicaid-eligible people leaving jails may be equivalent to that of people leaving prisons.⁷ In nonexpansion states, the percentage of people leaving jails and prisons who are eligible for Medicaid is much lower—sometimes less than five percent of the incarcerated population.⁸

* The June 2012 Supreme Court decision in *National Federation of Independent Business vs. Sebelius*, 567 U.S. 1 (2012) made Medicaid expansion an option under the ACA—not a requirement. States may expand their coverage to a larger pool of individuals by allowing a higher cap on the income level permitted for participation. As of July 2016, there were more than 30 states, plus the District of Columbia, that have broadened their Medicaid eligibility criteria. The Henry J. Kaiser Family Foundation maintains an up-to-date list and map reflecting the changing status of Medicaid expansion decisions at <http://kff.org/health-reform/slide/current-status-of-the-medicaid-expansion-decision>. See also the State Reform updates at <http://www.nashp.org/states-stand-medicaid-expansion-decisions>.

† The federal poverty level (FPL) is a measure of income that is issued every year by the U.S. Department of Health & Human Services and used to calculate eligibility for Medicaid. In 2016, a family of four would be eligible for Medicaid in expansion states with an annual income of \$32,319 or less, and a single adult would be eligible with an annual income of \$15,800 or less. (Some sources cite the eligibility threshold as 138 percent of the FPL in expansion states, which accounts for the five percent that is effectively added as part of an income calculation methodology introduced through the ACA: Modified Adjusted Gross Income, or MAGI.) Department of Health & Human Services, Office of the Secretary, Notice, “Annual Update of the HHS Poverty Guidelines,” Federal Register 81, no. 15 (January 25, 2016): 4036, <https://www.gpo.gov/fdsys/pkg/FR-2016-01-25/pdf/2016-01450.pdf>.

‡ People “leaving jails” does not refer to people who are being moved from jail to prison, as the individual’s incarceration status does not change for purposes of Medicaid eligibility.

Racial Disparities and the Need for Health Equity

Although health care reform has supported and stimulated significant progress in reducing the racial disparities in health care coverage, health equity continues to be an issue of deep concern within corrections settings as well, given the overrepresentation of people of color in prisons and jails and higher rates of chronic conditions, infectious diseases, mental illnesses, substance use disorders, and disabilities among incarcerated people when compared with the general population.^{9*} Health problems can also be exacerbated by common conditions of incarceration, such as overcrowding, violence, trauma, and solitary confinement.¹⁰ Upon release, people have many barriers to quality health care, particularly people of color. Research shows that people of color have historically had lower health literacy rates¹¹ and have been less likely than white Americans to have health insurance¹² or be connected to a personal doctor or health care provider.¹³

When making policy decisions for people returning to the community from prisons and jails, health equity must be considered in determining the scope of enrollment efforts (such as focusing on groups with lower rates of coverage) and improving connections to health plans with health care providers that are able to deliver high-quality services to people in ways that are responsive to social and cultural characteristics such as those associated with their race, gender, ethnicity, and language. Providers that practice cultural competence may also be willing, able, and capable of meeting the distinct needs of particular populations such as people involved in the criminal justice system.[†] States can also leverage the many efforts at the federal level to reduce racial disparities in access to quality health care.[‡]

Access to behavioral health care is critical for people who are in or are being released from correctional facilities. More than 50 percent of people in prisons¹⁴ and nearly 70 percent of people in jails have known substance use disorders.¹⁵ The prevalence of serious mental illnesses among people in prisons and jails is also three to six times greater than in the community,¹⁶ and many of these individuals have co-occurring substance use disorders.¹⁷ People with mental illnesses are more likely to return to prison and jail¹⁸ and stay longer than those who do not have these disorders.¹⁹ This overrepresentation of people with behavioral health disorders in the criminal justice system comes with considerable costs to corrections²⁰— spending on adults with mental illnesses alone is two to three times higher than for those without mental illnesses.²¹

The weeks immediately following reentry are also when people are most vulnerable to relapse and recidivism.^{22§} Research indicates that people who are enrolled in health care coverage when released are more likely to use community-based services that can help

* Policymakers should review the research related to state and local policies and practices that contribute to racial disparities among people with health needs in prisons and jails and the lack of health equity for those seeking quality, covered treatment when returning to their communities. These policies and practices include guidelines for psychiatric evaluations, criteria for diversion, arrest policies for drug offenses, sentencing guidelines, and how these and other directives are being implemented.

† For example, [Transitions Clinic programs](#) provide patient-centered care for people returning to their communities from prison, and each program is committed to providing culturally competent services that take into account the needs of this population. In addition, the programs include community health workers who have histories of incarceration as part of integrated medical teams.

‡ See, e.g., U.S. Department of Health & Human Services, *A Nation Free of Disparities in Health and Health Care: HHS Action Plan to Reduce Racial and Ethnic Health Disparities* (Washington, DC: U.S. Department of Health & Human Services, 2011), http://minorityhealth.hhs.gov/npa/files/plans/hhs/hhs_plan_complete.pdf.

§ Although the emphasis here is 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.

reduce their chances of recidivating.^{23*} For example, a two-year study of all jail releases in King County, Washington, and Pinellas County, Florida, found that for detainees with severe mental illnesses, having Medicaid coverage and receiving behavioral health services were associated with a 16 percent reduction in recidivism.²⁴ A Washington State study found that indigent, substance-dependent adults with recent arrests who received publicly funded substance use treatment were 18 percent less likely to be rearrested in the year following treatment.²⁵

States can realize significant savings through connections to care and effective recidivism-reduction strategies,²⁶ as well as leverage Medicaid coverage to avoid more costly, uncompensated health care (like emergency room visits) for adults who might not otherwise be insured.²⁷ States can also draw on federal Medicaid contributions toward inpatient hospitalizations of longer than 24 hours for incarcerated individuals,[†] which makes up an estimated 20 percent of correctional health costs (see [page 27](#) for examples).²⁸

Medicaid Expansion States' Share for People Newly Eligible

In order to incentivize and assist states with the expansion of Medicaid eligibility, the federal government has been providing an enhanced Federal Medical Assistance Percentage (FMAP, sometimes referred to as the federal “matching rate”) for people newly eligible to enroll. The state share has been set by federal law at 5 percent in 2017, 7 percent in 2018, 8 percent in 2019, and 10 percent in 2020 and in the years following.²⁹ Typically these state match amounts under Medicaid expansion are much lower than traditional state Medicaid match requirements for newly eligible individuals.^{‡30} Still, some states have expressed concerns about the amount of money needed to meet this requirement³¹—particularly in states that underestimated the actual number of enrollees or the related costs following expansion.³² Studies have, however, indicated that a combination of decreased spending on uncompensated health care costs; the use of Medicaid funds in place of general state funds; and other gains in revenue related to expansion will result in overall cost savings for expansion states,³³ even at the highest 10 percent match level if states allocate the savings for this purpose.³⁴

Whenever appropriate, people should be [diverted](#) from the criminal justice system to supervision or treatment programs in the community, which will also help maintain their benefits.[§] When that is not possible, steps should be taken at the earliest opportunity to enroll all eligible individuals in Medicaid to help increase connections to treatment and services. Early interventions can better support recovery and reduce the risk of deeper involvement in the criminal justice system and recidivism. States that have expanded their Medicaid coverage are able to enroll and cover a larger proportion of the prison and

* However, recent research suggests that to affect recidivism rates and related cost savings, Medicaid enrollment must be part of a comprehensive coordinated care plan that also addresses risk factors related to reoffending such as lack of family supports and unemployment. Enrollments can increase use of treatment services, but to impact recidivism, direct interventions are needed that target the underlying causes of recidivism instead of relying on the indirect effects of Medicaid enrollments. (Joseph P. Morrissey, Marisa E. Domino, Gary S. Cuddeback, “Expedited Medicaid Enrollment, Mental Health Service Use, and Criminal Recidivism Among Released Prisoners With Severe Mental Illness,” *Psychiatric Services*, (online version March 15, 2016) at <http://dx.doi.org/10.1176/appi.ps.201500305>).

† This is referred to as the “inpatient exception” that applies to “inmates of a public institution” and is discussed in detail (along with relevant language from the federal law) under [Issue 2](#) on sustaining enrollment and related cost savings and [Issue 3](#) on application processes associated with inpatient hospitalizations.

‡ The federal matching percentage (FMAP) for traditional Medicaid varies by state, ranging from a floor of 50 percent to just under 75 percent. This means that states are required to finance their share for traditional Medicaid ranging from 50 percent of costs to just over 25 percent.

§ When determining whether diversion is appropriate, criminal justice professionals must consider any public safety concerns, policies governing release following arrest, and the availability of options that can address the person’s needs.” For more on diversion, see text box in [Issue 2](#) on [page 21](#) and [Index](#).

jail population than nonexpansion states. However, there are also opportunities to increase enrollment in nonexpansion states that meet the set criteria. For both expansion and nonexpansion states, there are multiple points along the criminal justice continuum where personnel—including court, corrections, and community corrections professionals (probation and parole)—can help people enroll in public health care coverage (Medicaid, Medicare, and VA health care programs) and other benefits (such as critical income supports for individuals who qualify for Social Security disability and veterans benefits).³⁵ Prisons and jails play a pivotal role in this process at a time when states across the nation are intensely scrutinizing their approaches to health care.³⁶ States and counties can support these efforts by pursuing collaborative policy strategies to maximize enrollment, as well as reduce disruptions in coverage.

Health Care and Other Resources for Veterans

Information on veterans health care and benefits is included throughout the paper in distinctly formatted text boxes, such as this one, to pull out information that is relevant to that population within prisons and jails. The resources and processes for screening and enrollment differ from those used for Medicaid and SSI/SSDI and should not be overlooked. Suggested resources from the U.S. Department of Veterans Affairs (VA) for the criminal justice population include Veterans Justice Outreach, Health Care for Reentry Veterans, and Veterans Reentry Search Service.

WHY IS THIS IMPORTANT NOW?

The state and federal health policy landscape is constantly changing. This paper proposes a series of questions and considerations that can guide discussions about where states currently stand and how future health policy options may impact efforts to promote successful reentry from prison and jail. State leaders continue to assess whether to expand Medicaid eligibility and the scope of covered services. Particularly following national and gubernatorial elections, states tend to examine their expansion decisions—and may reconsider the parameters of their plans through waivers and other means.³⁷ At the federal level, court decisions and legislative actions can lead to important changes, and the U.S. Department of Health & Human Services and its Centers for Medicare & Medicaid Services (CMS) periodically offer clarifications and direction for administering Medicaid provisions that directly and indirectly impact people in the criminal justice system. For example, CMS issued guidance in April 2016 to update decades-old policies relating to Medicaid coverage for people who are involved in the criminal justice system.³⁸ Among the clarification provided in the guidance, states received assurance they are able to use Medicaid dollars for residents of halfway houses*—including for people transitioning from prison and jail—if they have freedom of movement consistent with CMS requirements. CMS also released rules in March 2016 to implement the Mental Health Parity and Addiction Equity Act (MHPAEA) requirements for Medicaid managed care organizations† and state Medicaid Alternative Benefit Plans (ABPs), including those provided to people newly eligible for Medicaid.³⁹ States need to ensure that limits on Medicaid coverage under ABPs and managed care for behavioral health services,

* This policy applies to both expansion and nonexpansion states and is estimated to impact some 96,000 people nationwide in expansion states at the time of the guidance release. Jhamirah Howard, Madeleine Solan, Jessica Neptune, Linda Mellgren, Joel Dubenitz, and Kelsey Avery, *The Importance of Medicaid Coverage for Criminal Justice Involved Individuals Reentering Their Communities*, (Washington, DC: U.S. Department of Health & Human Services, Office of the Assistant Secretary for Planning and Evaluation, April 2016).

† Managed care is a health care delivery system that uses contracts between state Medicaid agencies and managed care organizations (MCOs) that set per member per month (capitation) payment for Medicaid benefit services. These MCOs are expected to better manage Medicaid program costs and the use of health services in ways that will also improve health care quality. For more information, see <https://www.medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/managed-care/managed-care-site.html>.

including those used by people leaving prison and jail, are no more restrictive than for physical health services (medical and surgical).⁴⁰ In October 2016, the Mental Health and Substance Use Disorder Task Force (established in March 2016) issued a series of actions and recommendations to help improve the implementation of the MHPAEA Act, as well as compliance with and enforcement of the act's provisions.* In April 2016, CMS issued final rules for enrollees in Medicaid managed care, which allow federal payments for previously disallowed short stays for adults in inpatient mental health and substance use treatment when services are otherwise not available and meet CMS criteria.⁴¹ As policymakers and practitioners navigate this evolving health care environment, they will need to decide how they will use these and other opportunities to better address the mental health and substance use needs of the millions of people leaving prisons and jails each year to help keep them on a path to recovery and out of the criminal justice system.[†]

Although there appear to be a growing number of prisons and jails whose personnel and partners are interested in identifying and enrolling eligible people in public health care and benefits, many facilities do not yet have processes in place. A 2015 National Association of Counties (NACo) survey found that while 73 percent of its 282 respondents from "county jail jurisdictions" are working to reduce the prevalence of mental illnesses in jails, nearly half reported facing challenges in coordinating treatment,⁴² and only about one quarter (28%) screen for Medicaid eligibility.⁴³ A 2016 survey indicated that 16 state prison systems have no formal procedure to enroll people in Medicaid upon release and nine have small programs in either specific facilities or for limited groups of people, such as individuals with disabilities.⁴⁴ The scope of these efforts varies significantly and reflects the need for additional support from policymakers to advance efforts nationwide.

HOW TO USE THIS DISCUSSION PAPER

This discussion paper should be used to help guide conversations and planning between state policymakers—primarily governors, legislators, and correctional agency directors—and their staff in collaboration with state and county behavioral health and state Medicaid agency administrators on issues at the intersection of public health and safety policy. Specifically, it may be used to advance discussions on how to better connect people who are in prisons and jails to public health insurance and other benefits, with a particular emphasis on Medicaid, to support their care upon release. The paper also outlines the key issues that must be addressed to achieve these goals.[‡] Readers are encouraged to use the policy questions provided in the paper as a starting point for engaging the right mix of leaders and stakeholders in focused discussions about where progress can be made. The paper is also meant to encourage the policy and infrastructure changes needed to advance this work in all prisons and jails, regardless of variations in approaches. Examples of what is being done in states and counties are presented in the sections that follow to encourage systems change in both expansion and nonexpansion states.[§]

* For more information, see <https://www.whitehouse.gov/the-press-office/2016/10/27/fact-sheet-mental-health-and-substance-use-disorder-parity-task-force>.

† This paper provides information on federal laws and related regulations, rules, and guidance at the time of this writing. Readers should visit Medicaid.gov, the [CSG Justice Center health policy page website](#), and other sites found in the references to monitor updates. Information can also be received by registering for The Council of State Governments Justice Center behavioral health and reentry newsletters at csgjusticecenter.org/subscribe.

‡ Many of the policy options discussed will apply more to Medicaid expansion states for newly eligible individuals than to nonexpansion states because so many more individuals in the criminal justice system are covered through Medicaid expansion. Whenever possible, examples from and options for both are highlighted.

§ The examples included were selected to illustrate the range of possible policies and practices, and the variation 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.

A ROADMAP TO THIS PAPER

There are five important issues for state policymakers and correctional and health care administrators to consider when examining how to improve access to publicly funded behavioral health care for people leaving prisons and jails.* Within each of these issue areas, the paper explores relevant federal and state laws and policies, as well as state and local implementation efforts.



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

Prisons and jails are vital hubs for enrolling and reenrolling people who are eligible for Medicaid or Social Security Administration disability benefits—i.e., Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI)—so that benefits can be accessed upon release.[†] These programs are the primary focus of this paper. When relevant, Qualified Health Plans (QHPs), which are certified Health Insurance Marketplace (Marketplace) plans that can be subsidized through tax credits, are also considered, and may be of particular interest for nonexpansion states where eligibility for Medicaid is more restrictive than eligibility criteria in expansion states.[‡] VA health care and benefits are also reviewed when applicable. This paper takes the readers through the process steps needed to help eligible people in prison and jails with behavioral health needs enroll in these programs and improve the range and capacity of covered services in the community.

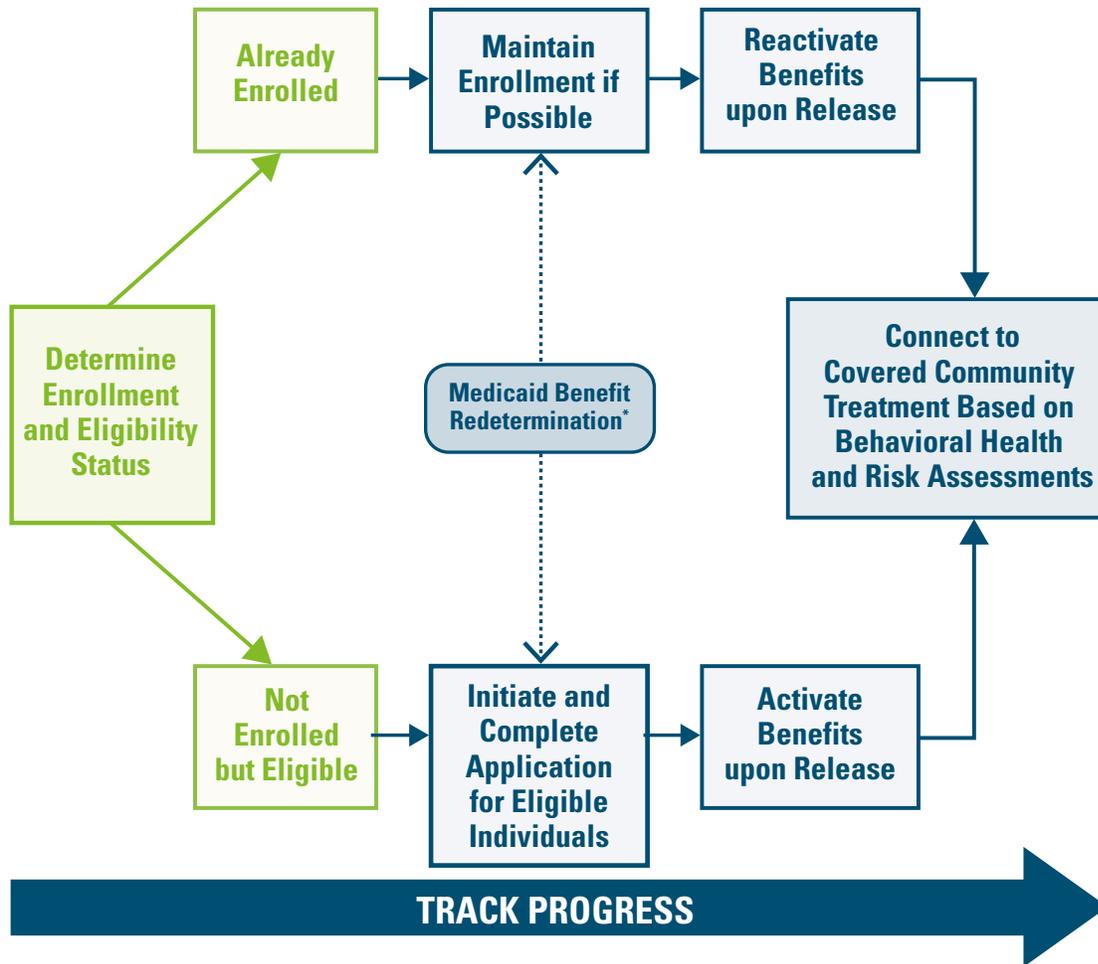
* Probation and parole agencies also play a critical role in helping with health care coverage enrollment and connections to services, but this paper's inclusion of community corrections is limited. There are other corrections settings in which individuals could be linked to health care coverage and treatment (such as residential reentry centers, otherwise known as halfway houses), but this paper focuses on jails and prisons—recognizing that jail personnel may have more implementation challenges with typically shorter lengths of stay for individuals who are incarcerated.

† SSI and SSDI not only provide vital income supports but, in many states, provide access to Medicaid (through SSI) and/or Medicare (through SSDI after 24 months). Although there is no direct link between SSDI eligibility and Medicaid, many people who qualify for SSDI may qualify for Medicaid while they wait to become eligible for Medicare. These mechanisms are discussed in more detail in [Issue 3 \(pages 52-53\)](#), "Assisting with Applications."

‡ QHP benefits can be received by pretrial detainees (i.e., people incarcerated pending disposition of charges) but not by people who have been convicted. Convicted individuals can enroll or reenroll in QHPs after release from prison or jail. (People leaving jail and prison also qualify for a 60-day special enrollment period outside of the Marketplace open enrollment period to sign up for health care coverage through the Marketplace—including QHPs—if ineligible for Medicaid.)



ISSUE 1: Identifying Enrollment and Eligibility Status



OVERVIEW

The first step to increasing access to community-based treatment and services for people leaving correctional facilities is to maximize their enrollment in Medicaid or other public health insurance and benefit programs, which are becoming the primary financing sources for treatment and services.[†] It is useful for state policymakers and prison and jail officials to be familiar with the key provisions of their state Medicaid plans and federal benefit criteria to have a sense of their potential eligible population.[‡] Screening for Medicaid and SSI/SSDI eligibility and prior enrollment will set in motion the steps needed for people to have health care coverage and benefits when released.

* Federal policy requires that an individual's eligibility for Medicaid be redetermined at least every 12 months. Federal rules also state that for those who are eligible for Medicaid [based on Modified Adjusted Gross Income (MAGI) criteria or non-MAGI criteria], eligibility may not be redetermined more frequently than every 12 months. (See 42 CFR § 435.916). An administrative renewal using information already available to the Medicaid agency could be conducted (an ex-parte renewal) to redetermine eligibility for individuals while incarcerated to avoid termination when possible. See the [Index](#) for more information on redetermination and incarceration.

† Qualified health plans that are subsidized can also be useful for individuals leaving prisons and jails who may qualify for the tax credits (even if not otherwise filing). In addition, some individuals can be directed to the U.S. Department of Health & Human Services' Indian Health Service, the federal health program for American Indians and Alaska Natives, when appropriate.

‡ This paper often refers to a state's Medicaid benefit plan, recognizing that in many states this is a suite of benefit plans or packages, each covering services CMS specifies as mandatory and optional. In expansion states, there may be an Alternative Benefit Plan (ABP) for newly eligible adults that is not pegged to the traditional state Medicaid plan, and there may even be multiple ABPs for different groups of beneficiaries. For more information on state Medicaid benefit plans, see [Issue 4](#) and the Legal Action Center 50-state resource at <http://lac.org/resources/state-profiles-healthcare-information-for-criminal-justice-system/>.

Checks for all benefit enrollment and eligibility may be part of intake or prerelease planning, and may also be incorporated into existing health and behavioral health (mental health, substance use, or co-occurring) screens.*

Veteran Screening

Identifying veterans can open the door to benefits both during and after their incarceration. Veterans can enroll in the VA health care system while incarcerated, but cannot receive treatment until release. They also can apply for VA financial and educational benefits while incarcerated, but eligibility is dependent on the specific type of benefit.⁴⁵ Veterans should be encouraged to contact their closest VA Regional Office.

Medicaid Eligibility

Federal law requires that state Medicaid benefit plans cover specified groups (mandatory eligibility groups) in order to receive federal matching funds. States can also receive matching funds when extending coverage to other allowed groups (optional eligibility groups), such as low-income adults with higher incomes who have very high medical expenses (i.e., individuals who are “medically needy”), or who have particular diagnoses (e.g., tuberculosis) or participate in specified federal programs (e.g., Medicaid “Buy-In,” in which workers with disabilities can have higher earnings in excess of traditional Medicaid rules so that they can maintain employment and still receive benefits).^{46†}

States set eligibility criteria for Medicaid coverage within minimum federal requirements:⁴⁷

- **Categorical eligibility (mandatory):** Covered groups must include pregnant women, people who are disabled by medical conditions, older adults, children, and adults with dependent children.⁴⁸
- **Income eligibility:** Assistance is limited to people in financial need. Federal law determines income eligibility thresholds that vary by category and are defined for particular groups.
- **Non-financial eligibility:** People must meet criteria that include state residency and U.S. citizenship or satisfactory immigration status.

States can expand Medicaid coverage (including categories or thresholds) beyond the minimum eligibility requirements by submitting waivers or state plan amendments to CMS (see Issue 4, table 4 on page 62 and Appendix B).

Prior to the passage of the ACA, states largely limited Medicaid eligibility to people who only met categorical eligibility requirements. The ACA allowed states to expand Medicaid coverage to include adults at or below 133 percent of the federal poverty level.‡ These expansion states must calculate income eligibility for most people who are eligible for Medicaid using a modified adjusted gross income (MAGI) calculation.⁴⁹

* Behavioral health screening results not only help guide assessment and treatment decisions within the correctional facility but will also inform subsequent connections to specific Medicaid treatment providers in the community that can meet individuals’ distinct needs and diagnoses. Similarly, any assessments completed for risk of reoffending or reincarceration should be considered in determining type and level of intensity of supervision and treatment, as discussed in [Issue 4](#), “Examining Medicaid-Reimbursable Behavioral Health Services in the Community and Addressing Gaps.”

† For an overview of Medicaid mandatory and optional eligibility groups, see “List of Medicaid Eligibility Groups” on [Medicaid.gov](#).

‡ States that have elected to expand Medicaid coverage can also retain the categorical eligibility requirements.

FEDERAL LAW AND GUIDANCE

Medicaid

There are no federal requirements stipulating that prison or jail officials must screen for Medicaid enrollment or eligibility upon admittance. CMS's April 2016 guidance makes clear that Medicaid screening and enrollment can occur during incarceration.^{50*} Generally, however, states are prohibited from requesting federal Medicaid payments—federal financial participation (FFP), sometimes referred to as the “federal match” or “federal share”—for treatment and health care costs assumed during an individual's incarceration, unless it is for allowable inpatient services.⁵¹ (See box below, “Inpatient Exception.”)

Correctional facilities that identify people who are enrolled in Medicaid at the time of admission can help their state comply with the mandate that federal payment cannot be issued for health services provided during incarceration. They may also assist these people with reactivating or reapplying for benefits upon release.[†]

Inpatient Exception

An exception to the law prohibiting federal Medicaid payments for services provided to people in prison or jail (the “inmate exclusion”) occurs when an incarcerated individual is admitted to a medical institution generally open to the public for inpatient care that is expected to last 24 hours or more.⁵² Under 42 CFR § 435.1010, “inpatient” refers to someone who is “admitted to a medical institution as an inpatient on recommendation of a physician,” and who receives, or is expected to receive, “room, board and professional services for a 24-hour period or longer even if it later develops that the patient dies, is discharged, or is transferred to another facility and does not actually stay in the institution for 24 hours.” Costs, therefore, can be recouped for the state share for an incarcerated individual's eligible inpatient services even if that person is released from the medical institution before 24 hours—as long as the stay was expected to last at least that long. Services must be covered by the state's Medicaid plan and provided by a certified or enrolled provider in a setting and manner that meets all federal requirements.⁵³ The inpatient exception and information on related savings are discussed in Issue 2.[‡]

Supplemental Security Income and Social Security Disability Insurance

SSI provides payments to people of low income who are more than 65 years old, blind, or have other disabilities (without regard to work history or Social Security contributions). In most states, eligibility for SSI disability benefits grants eligibility for Medicaid. (See Issue 3, [pages 52-53](#).)

* Screening for Medicaid eligibility generally entails staff in correctional facilities asking questions related to health status and income to help them determine who would likely be eligible for benefits. Screens performed at the correctional facility level do not replace formal *eligibility determinations* by Medicaid (or disability determinations by the Social Security Administration for SSI and SSDI). Individuals ineligible for Medicaid may still be referred to QHPs if they qualify for the subsidy, or to Navigators to access coverage through the Marketplace.

† This federal law disallowing states to recoup any federal payment for Medicaid services for people while incarcerated impacts enrollment in Medicaid managed care systems, as its capitation payments—a fixed amount of money paid to a medical professional in advance, per patient per unit of time, for the delivery of health care services—are not allowed for incarcerated individuals. (See Issue 4, “Examining Medicaid-Reimbursable Behavioral Health Services in the Community and Addressing Gaps” for more on [managed care contracts](#) as they relate to financing behavioral health services.) As clarified in the April 2016 CMS guidance, states should make every effort to prevent capitated payments from being made while enrollees are incarcerated. This could include specifying in managed care contracts that enrollees be disenrolled when incarcerated and excluding enrollment of people into managed care plans while they are still incarcerated. States may opt to enroll individuals into fee-for-service Medicaid programs during incarceration and transfer them to managed care upon release, as long as appropriate restrictions are in place to prevent the use of federal funds while they are incarcerated.

‡ For more information on which agency is reimbursed for inpatient stays when an individual is sent to a correctional facility in another state (in response to overcrowding, for example), along with other issues involving another state, see CMS guidance from April 28, 2016, found at [medicaid.gov/federal-policy-guidance/downloads/sho16007.pdf](https://www.medicare.gov/federal-policy-guidance/downloads/sho16007.pdf).

Social Security Disability Insurance (SSDI) provides payments to people with disabilities and some family members if those individuals meet the work history criteria and have paid Social Security taxes. However, under specific circumstances, a person may still qualify for SSDI even if he or she doesn't have sufficient or relevant work credits.⁵⁴ After two years, recipients are eligible for Medicare.*

There is no federal requirement that correctional facilities screen people upon admission to determine if they are enrolled in SSI or SSDI. Despite the lack of a requirement, many facilities do seek to determine if people are enrolled in either one to help the Social Security Administration monitor allowable benefits and to identify unenrolled people who could apply for benefits—particularly those who have serious mental illnesses.

Veterans Benefits and Outreach Programs

Although the overall number of veterans in prisons and jails has decreased, their numbers remain significant—more than 180,000 veterans were reported incarcerated in U.S. prisons and jails in the U.S. between 2011 and 2012.⁵⁵ Moreover, nearly half (48 percent) of veterans in prison and about 55 percent of those in jails reported having been previously told by a mental health professional that they have a mental illness.⁵⁶

The following resources from the VA can be used alone or in combination with Medicaid, Medicare, SSI and SSDI benefits to help policymakers and staff identify and respond to veterans in the criminal justice system.†

Veterans Reentry Search Service (prisons, jails, and courts): This data service helps correctional personnel identify veterans within their system who may be eligible for benefits and care. Users go to the secure Veterans Reentry Search Service (VRSS) website and upload the list of everyone in custody, identified by name, Social Security number, date of birth, corrections identification number, location, and release date. VRSS then compares the list with military service records, and sends users and VA outreach specialists a list of veterans in the system. This information helps correctional facility staff make more informed decisions related to addressing veterans' needs and benefits. For example, more than seven states assign veterans to the same housing units,⁵⁷ which can be designed to reflect the disciplined, cooperative environment that veterans experienced during their time in military service.⁵⁸ Some facilities also provide targeted programming designed to address veterans' treatment needs.⁵⁹ The screening can also help connect identified veterans to other outreach services for the transition to the community.

This search service is particularly useful because people who are incarcerated tend to under-report their military service. In the California state prison system, for instance, less than 3 percent of people self-identified as veterans, but VRSS found that just under 8 percent had actually served in the military—a difference of 5,000 people. The search service is in use by a growing number of prison, jail, and court personnel nationwide. There is no fee for use.

* The 24-month calculation for activating Medicare eligibility begins at the Social Security Administration's disability determination date. There are also exceptions; for example, people with end-stage renal disease and amyotrophic lateral sclerosis (ALS) do not need to wait for Medicare eligibility.

† For a resource for caseworkers on enrolling veterans in prisons and jails at risk for homelessness in SSI/SSDI benefits, see *SOAR Works to End Veteran Homelessness: VA Caseworker's Guide*, Version 1, Winter 2016; U.S. Department of Veterans Affairs, Homeless Veterans Program at va.gov/homeless/docs/VA_SOAR_Guide.pdf.

Veterans Justice Outreach (courts and jails): The VA administers the Veterans Justice Outreach (VJO) program to avoid the “unnecessary criminalization of mental illness and extended incarceration” of veterans by facilitating access to treatment. Every VA medical center has at least one VJO specialist dedicated to providing direct outreach and case management to veterans, as well as facilitating access to Veterans Health Administration services. More than 90 percent of veterans who have a mental health diagnosis and were seen by a VJO specialist received VA mental health services within the following year.⁶⁰ A state-by-state listing of contact information for VA VJO specialists is available at va.gov/HOMELESS/VJO.asp.

Health Care for Reentry Veterans (prisons): Specialists with the VA’s Health Care for Reentry Veterans (HCRV) program provide prerelease outreach, assessment, linkage, and post-release case management services for veterans leaving state and federal prisons. It connects soon-to-be-released veterans with a range of VA services including health care, housing assistance, educational assistance, vocational counseling, and training. HCRV serves about 80 percent of prisons in the nation. More than 90 percent of veterans with a mental health diagnosis who were seen by an HCRV specialist entered VA mental health services within the following year.⁶¹ A state-by-state listing of contact information for VA HCRV specialists is available at va.gov/homeless/reentry.asp.

STATE APPROACHES

Some states legislatively mandate or authorize the screening of people in correctional facilities to determine enrollment and eligibility status for public health care coverage and benefits.* Provisions may also be part of state Medicaid plans or prison and jail-based efforts to integrate benefits screening into the intake process at the same time that other screenings are conducted, during an inpatient stay, or during the release planning process.⁶² State laws and policies might focus on specific correctional facilities (i.e., jails or prisons, but not both) or may target particular populations (e.g., people with mental illnesses).⁶³

✓ *How are Some States Authorizing or Mandating Health Care Coverage Eligibility Screening?*

- In Minnesota, a statute requires that sheriffs ensure that all people are screened at jail intake for enrollment in health care coverage. Those who identify as insured must provide the necessary information for the sheriff to obtain specific coverage information.⁶⁴
- In Washington State, SB 5593 allows personnel to screen individuals for Medicaid eligibility at the time of booking into jail and enroll them, if they choose to, in the program if found to be eligible.⁶⁵
- The Illinois Department of Corrections (IDOC) established a policy in which jail medical providers conduct benefit verifications during the intake process. If people are not enrolled in health care coverage, jail staff members assist them in completing a screening questionnaire to determine eligibility for coverage through Medicaid or the health insurance Marketplace. Upon transfer to prison, IDOC

* This is often performed in conjunction with helping people fill out applications for health care coverage. See [Issue 3](#), “Assisting with Applications.”

staff members receive individuals' health and benefit records and conduct benefit verifications. Records are flagged when individuals were previously enrolled in Medicaid or Marketplace coverage, are currently enrolled, or are newly eligible.⁶⁶

The section that follows outlines different state policy considerations and approaches that can help personnel working in correctional facilities identify people who are enrolled in or are eligible for Medicaid, SSI, and SSDI.

KEY CONSIDERATIONS AND EXAMPLES

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?

States that have expanded Medicaid have a greater pool of potential enrollees than nonexpansion states, particularly among people leaving prison and jail. This fundamental policy choice drives many of the decisions that follow related to making investments in screening for Medicaid eligibility. That said, there remains a need in nonexpansion states to screen for both Medicaid and SSI/SSDI benefit eligibility that can, together, make a significant impact on a person's ability to secure housing, food, and behavioral health care services upon release from prison or jail. Decisions about who should be screened for Medicaid enrollment and eligibility status, what mechanisms (e.g., automated data-matching processes) should be used to do so, when to conduct screenings, and who should conduct them—all can involve coordination across a variety of authoritative entities.* These determinations may be made through some combination of legislation, state Medicaid agency policies (including state eligibility criteria), and correctional policies. There are many reasons one might see variety in these policies across and within states, including differences in available resources and average lengths of stay across jail and prison facilities.

✓ *Who gets screened?*

Ideally, everyone entering prisons and jails is screened for their eligibility for, or enrollment in, Medicaid, SSI, and SSDI.† In jails with rapid turnover, it may be necessary to prioritize particular populations for screening.‡ For example, a special focus may be on people with behavioral health disorders, adults with chronic or acute medical problems, veterans, or other people who are in the facility long enough to be screened.⁶⁷ A 2015 study supported by the Laura and John Arnold Foundation found that of 64 jail, prison, and probation or parole enrollment programs, 17 percent targeted a specific population.⁶⁸ Programs

* Many of these same decisions come into play when determining processes for helping with applications (discussed in Issue 3). In some cases, the same personnel who are screening for enrollment status and eligibility are completing the applications, and at a single point in time. In other cases, screenings and applications are bifurcated—particularly when enrollment and eligibility checks are part of routine medical and behavioral health screenings.

† Screenings for eligibility or prior enrollment are not the same as the “notifications” prisons and jails may provide to Medicaid and SSA when people are incarcerated to avoid unallowable federal benefit payment. These notifications, to the extent that they are being done, are typically made by providing batches of names with identifying information to federal benefit administration offices. Those offices can then suspend benefit payments until they are notified of a person's release, or they can terminate them. In contrast, eligibility screenings focus on a single individual's ability to meet specific criteria for coverage.

‡ Because recidivism rates tend to be higher for people with behavioral health disorders, correctional facilities may be able to identify those with a history of mental illness, substance use, and other health needs based on prior diagnoses recorded in their own systems. That said, disorders can go undiagnosed and conditions may vary over time, making it necessary to re-assess people returning to prison or jail. [Health information exchanges](#) involving information sharing with community treatment providers is addressed in Issue 4.

operating prior to the expansion of Medicaid or those in nonexpansion states screened for individuals who fall within traditional eligibility categories such as people who are low income and have qualifying disabilities.⁶⁹ In contrast, expansion states have likely been screening a larger population of people who qualify under the broadened income levels.

In Practice

Screening All or Most People

- At the Cook County Jail in Illinois, enrollment and eligibility screening is integrated into the intake process as part of a larger health care enrollment initiative. The initiative includes a partnership among the Cook County Health and Hospitals System, the Cook County Sheriff's Office, and Treatment Alternatives for Safe Communities (TASC), which is a community-based organization that connects people with health care services.⁷⁰ For eight hours each day, seven days a week, TASC staff screen people for Medicaid eligibility at jail intake. People who are not already enrolled in Medicaid, private insurance, SSI, or SSDI move forward to the screen for whether they are likely eligible. If a person appears to meet the basic criteria, then Medicaid applications are completed by TASC staff and are submitted online on behalf of the individual with that person's consent. To help ensure online security, TASC staff use computers that can only access the Medicaid application website and other related websites needed to verify eligibility. In addition, TASC staff have also tracked information related to the status of applications.^{71*}

The Illinois Criminal Justice Information Authority provided the initial funding to support data collection efforts and the Cook County Health and Hospitals System continues to fund the application assistance services.

- The Ohio Department of Rehabilitation and Correction (ODRC) has a process to identify all people enrolled in Medicaid in state prisons and to engage those who are not enrolled but are potentially eligible at least 90 to 120 days prior to their release (in order to initiate the application process).[†] People in Ohio's prisons attend a pre-enrollment class and are informed of what is required for enrollment, followed by a review several days later of the state Medicaid forms. ODRC then submits their information to the Medicaid portal for eligibility screening.⁷²
- Bernalillo County, New Mexico, is working toward screening everyone who is detained longer than three days for prior Medicaid coverage by Metropolitan Detention Center (MDC) social services staff who compare the jail census to the state Medicaid database. Detainees who are not covered, but may be eligible, are informed that they can apply for coverage while at MDC.⁷³

Veterans Screening Example

As part of the screening process for all incoming individuals, staff at the Los Angeles County Jail provide the names of identified veterans to the VA's Community Reentry Program. The VA responds with case management staff who can facilitate veterans' enrollment in VA health care, help locate housing, and determine financial support payments.⁷⁴

* This is not an electronic sharing of information between two systems but it does accomplish the purpose. This approach is not uncommon and has the advantage of avoiding some significant issues (e.g., developing user authentication and access controls, creating business associate agreements or MOUs, saving the technology costs to build interfaces, and others). Sometimes this approach is more desirable, faster, and less costly as long as the staff are available to fulfill this role (correspondence with Robert May, IJIS Institute, July 6, 2016).

† This process was being used in four facilities, with plans underway to expand its use in all 27 facilities. (See <http://www.drc.ohio.gov/Portals/0/Reentry/Reports/Annuals/Annual%20Report%202015.pdf?ver=2016-08-03-152549-077>.)

Screening Specific Populations

- The Department of Corrections in Oklahoma screens people with mental illnesses six to nine months prior to release as part of the reentry planning process.* The screen includes determining whether the individuals were enrolled in Medicaid, SSI, or SSDI prior to incarceration and if they will be eligible for these benefits upon release.⁷⁵
- In Minnesota Department of Corrections' facilities, a health services manager identifies people who have "significant" physical and mental health needs that will extend beyond their release dates and sends these cases to a social worker assigned to the health services unit. This social worker, also known as a medical release planner, identifies people who need health care coverage upon release and if eligible, assists them with filling out Medicaid application forms and submitting them via mail at the prison's expense.⁷⁶

How is screening performed?

Some states or jurisdictions match data from a prison or jail roster against the Medicaid or Social Security Administration's data (alone or in combination with other screening efforts) to identify individuals who were receiving benefits when admitted. Previous enrollment is a strong indicator of continued eligibility upon release. The U.S. Department of Health & Human Services (HHS) also operates a data services hub in which the state Medicaid agency verifies citizenship, income, and tax information to process all Medicaid applications, including those submitted for people in a correctional facility.⁷⁷

The Social Security Administration operates the Prisoner Update Processing System (PUPS) to verify the incarceration status of SSI or SSDI recipients using information sent from federal, state, and local correctional facilities to facilitate the suspension and reinstatement of benefits. Although some experts have cautioned against using this system because of inaccuracies reported on the incarceration status, according to a February 2016 GAO report, PUPS information could be used to help identify individuals for follow up.⁷⁸

Eligibility and enrollment checks can be done using paper processes or electronically and must comply with privacy mandates that govern the access to or exchange of protected health (HIPAA) or substance use treatment information (42 CFR Part 2).

Data matching across systems is not without challenges—in addition to a potential time lag in sending and receiving information, some people lack the proper identification while incarcerated and have to collect necessary information from family members (or determine how to pay the related costs to obtain or replace identification documentation) to use these systems.⁷⁹ Automated data matching is more efficient but also requires significant technology upgrades and information-sharing agreements that many states do not currently have in place. Screening for previous enrollment and eligibility is typically done through a coordinated effort between corrections and contacts at the state Medicaid agency and the Social Security Administration office that have authorization to access the required information.[†]

* Many of the examples in this report are from states that have expanded Medicaid and have a larger pool of eligible individuals. In states that have not expanded Medicaid such as Oklahoma, the focus is often on using traditional eligibility criteria for people with disabilities, including serious mental illnesses, as well as people who were previously enrolled in Medicaid and other public benefits to advance reentry efforts.

† As mentioned previously, the VA has set up such a system using the Veterans Reentry Search Service (VRSS). Any corrections agencies that have entered incarcerated individuals' information into VRSS are notified of who is a veteran within their prison or jail population.

In Practice

- Using an online portal, the Oregon Health Authority (OHA) created a process for county jails and prisons to screen—for Medicaid eligibility—anyone under the age of 65 who is scheduled for release from custody or an in-patient hospitalization lasting 24 hours or more.⁸⁰ Jail personnel have screened individuals by entering their last names, first names, dates of birth, and inquiry dates into the online portal.⁸¹ Medicaid records appear for current and past beneficiaries. Individuals with no records are still considered potentially eligible.⁸²
- In North Carolina, the Department of Public Safety (DPS) and the Division of Medical Assistance (DMA) have been doing a daily match for all people in prison since 2011.⁸³ They examine both past and current eligibility for Medicaid by cross-referencing data from the DPS Division of Adult and Juvenile Facilities with data from the DMA to identify people in prison who have a history of Medicaid enrollment and whose enrollment may have been suspended or terminated by DMA.⁸⁴
- Rhode Island’s Executive Office of Health and Human Services (EOHHS) partnered with the state’s Department of Corrections (DOC) to improve the accuracy and accessibility of data related to incarceration status, identity, and income verification.* Specifically, the DOC and EOHHS implemented system changes to improve the accessibility of the DOC’s databases and provide real-time data on incarceration status. EOHHS developed a form that people can use to indicate their low-income levels and issued guidance to health insurance exchange staff and Navigators to accept this as a valid document.^{85†}

☑ Who conducts screenings?

Decisions related to who conducts screenings may be tied to funding and training for those positions—as well as who can have direct access to the required health information and data systems. Prisons and jails may use the same personnel to screen and provide application assistance, or they may use different staff for each task.

In Practice

- Jails in Denver, Colorado, and in California’s Santa Cruz and Imperial Counties are moving toward screening everyone for Medicaid eligibility at the time of booking but use different agencies’ personnel to do so. Denver uses Human Services agency employees to screen for Medicaid eligibility; Santa Cruz relies on trained jail staff; and Imperial County uses the support of Catholic Charities.⁸⁶
- In New York City, the Department of Health and Mental Hygiene (DOHMH) has used state-funded discharge planning staff to conduct Medicaid screening for incarcerated people with mental illnesses.⁸⁷ In May 2015, DOHMH finalized a plan to expand eligibility identification and enrollment efforts to people with substance use disorders and chronic medical problems.⁸⁸

* Rhode Island has a unified corrections system for its prison and jail populations. States with unified systems have integrated their state prison and local jail systems. For more information on how unified correctional systems operate, see National Institute of Corrections, *A Review of the Jail Function within State Unified Corrections Systems*, (Washington, DC: U.S. Department of Justice, September 1997). Those states with unified systems are 1) Alaska, 2) Connecticut, 3) Delaware, 4) Hawaii, 5) Maine 6) Rhode Island, and 7) Vermont.

† As discussed more fully in Issue 3 regarding who can assist with Medicaid applications, Navigators can be individuals or organizations trained to provide assistance with screening and enrollment in Marketplace insurance, and sometimes Medicaid. For more information, see <https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/Downloads/marketplace-ways-to-help.pdf>. States may have additional designations for people who can assist with screening and applications with related criteria.

✓ **When are screenings conducted?**

Screenings may be conducted at intake, as part of health or behavioral health screenings, for the provision of inpatient health services, or as part of the reentry or prerelease planning process. Early screenings can allow more time for the development of treatment plans, in addition to helping position correctional facilities to take advantage of Medicaid's exception for covering allowable inpatient services. Some prerelease screenings for eligibility comply with statutes or policies and procedures established to ensure that applications and eligibility determinations are completed before release, and ideally with time for insurance cards to be provided to successfully enrolled applicants. These screenings often occur 30–90 days before release.

In Practice

- The Illinois Department of Corrections (IDOC) matches its list of people who will be released within 90 days against the Department of Healthcare and Family Services' list of all incarcerated people whose Medicaid enrollment is coming up for redetermination.⁸⁹ This helps IDOC staff determine whose enrollment is still valid and who may need to reapply. Under Illinois law (HB 3270), prisons also must assist with Medicaid applications for uninsured eligible individuals 45 days prior to release.
- In California's Inyo County Jail, people are screened for Medicaid eligibility both within the first 30 days of booking and again 30–60 days before release. A staff member from the county Health and Human Services' Behavioral Health division performs the eligibility screening.⁹⁰

IMPLEMENTATION ISSUES

The advantages associated with facilitating health care coverage are clear: when policymakers and health care and corrections officials develop structures and processes for identifying people who were previously enrolled in or are eligible for public health care and benefits, they greatly increase the likelihood that these individuals will be enrolled and able to access critical treatment services quickly upon release. Without these processes, investments made behind the walls may be lost due to a lack of continuity of care. Many of the key implementation concerns—when determining who should be screened, when, how, and by whom—center around length of stay and available resources (including staffing and information technology).

Length of Stay

Length of stay most directly affects when screening is done and for what segment of the population in the facility. People admitted to jails, in particular, tend to have shorter lengths of stay and as a result, assigned personnel may screen upon intake. Because a significant number of jail detainees leave the facility within 48 hours,⁹¹ incorporating benefit screening into the intake process (particularly as part of behavioral health screens) is an effective way to make an impact on connecting the largest possible group of eligible individuals to public health care. It can also help to guide any referrals to a treatment provider that participates in a Medicaid network.⁹²

People who leave jail within a short period of time and are uninsured can be referred to a community-based group that assists with enrollment if the jail does not have the time or capacity to do so.⁹³ In addition, community supervision agencies (e.g., probation/parole) may also be engaged in these efforts.⁹⁴ In some cases, screeners can request a Social Security card be sent to the individual, if time allows, for people who are likely to need them to complete their applications outside of the facility.

For people who are incarcerated for longer periods,* benefit eligibility may be determined during intake or admission or for inpatient care, and then again during the prerelease stage as enrollment or eligibility status may have changed. These repeated screenings provide additional opportunities to educate people—including those initially reluctant to enroll—about what the Medicaid program and other benefits can offer, and it may help ensure that people, particularly those who enter the facility in crisis, have the time they need to make thoughtful enrollment choices. It may be most helpful, however, to complete full Medicaid eligibility checks for people with known release dates at times closer to their release, because enrollment may be terminated during longer stays, depending on the state’s legislation and policies regarding termination upon admission or after a set time period (e.g., some states currently terminate after 12 months, or at an individual’s redetermination date).† Ultimately, a combination of state policies may need to be adjusted to support maximum enrollment among individuals leaving after longer stays.

Resources and Information Technology Infrastructure

Policymakers should examine whether it is possible for criminal justice professionals to use existing data systems to access Medicaid enrollment status information while complying with privacy mandates. If they cannot, corrections leaders will need to partner with behavioral health or Medicaid professionals that have this access to adhere to privacy rules and avoid relying on information obtained through self-reports.

Prisons and jails may train existing personnel to conduct benefit screenings to see if people are enrolled when admitted or likely eligible and can collaborate with personnel who have access to the needed data, such as protected health information.⁹⁵ They may also leverage staff from behavioral health and health care partners or contractors to complete these screenings. Navigators, assistors, and others who do screening and application assistance may be given an orientation about working in a correctional setting. The best staffing options depend on the circumstances of each agency and can be largely affected by whether enrollment and eligibility status checks are performed at intake, as part of behavioral health screenings or medical care while incarcerated, or during the prerelease stage. Funding support is also a critical issue. Depending on the level of expertise needed or restrictions that exist on accessing data systems, administrators should consider the costs of training screeners and staffing these functions. Administrators also need to consider which agency might best fund these positions or seek reimbursement for certain administrative costs.‡

Data matching is particularly helpful for people being screened who do not know whether they are enrolled in health care coverage. Unfortunately, delays and glitches with existing systems and a lack of funding to upgrade agency technology infrastructures is a real issue in some states and jurisdictions. A December 2015 federal rule broadened the types of systems and activities that qualify for a 90 percent federal match (up from 50 percent) to help with the expense of upgrading states’ Medicaid Management Information Systems (MMIS) to improve state Medicaid programs’ overall eligibility and enrollment processes. This funding could help with eligibility and enrollment status determinations in addition to the processing of applications,⁹⁶ but it may require that corrections facilities also make improvements to their IT systems in order to implement effectively.

* Some states have enacted policies that result in placing people in jails who previously would have gone to state prisons, which can lead to longer than usual jail stays.

† Additional information about redetermination, ex-parte/administrative reviews, and termination is covered in Issue 2, ([Index](#) for pages.) “Maintaining Enrollment and Reactivating or Reenrolling in Benefits upon Release.”

‡ For a discussion of reimbursable administrative costs under the [Medicaid Administrative Claiming \(MAC\)](#) program, see pages [38](#) and [44-45](#).

A CMS “State Medicaid Director” letter released in May 2016 also indicates that states may be able to claim a 90 percent federal match for expenses related to coordinating information sharing through Health Information Exchanges (HIEs) involving eligible health care providers and other Medicaid providers,* including correctional health care providers and community behavioral health treatment providers.⁹⁷ Although much of the focus is on using funds to improve information sharing for guiding treatment decisions and providing continuous care (discussed in Issue 4, page 83), it is important to note that these improvements can be useful for correctional facilities’ health care providers to be given electronic health record information kept by health care providers in the community that can help identify people with behavioral health disorders who should be screened for possible enrollment in Medicaid and for other benefits.^{98†} Federal funding is also available for state Medicaid programs at a 75 percent match rate for ongoing operations of these improved systems.⁹⁹

While technology improvements are essential, ultimately the challenges faced by corrections and Medicaid agencies in performing eligibility and prior enrollment checks are best met through interagency coordination and a shared commitment to increasing enrollments to advance public safety and health outcomes.

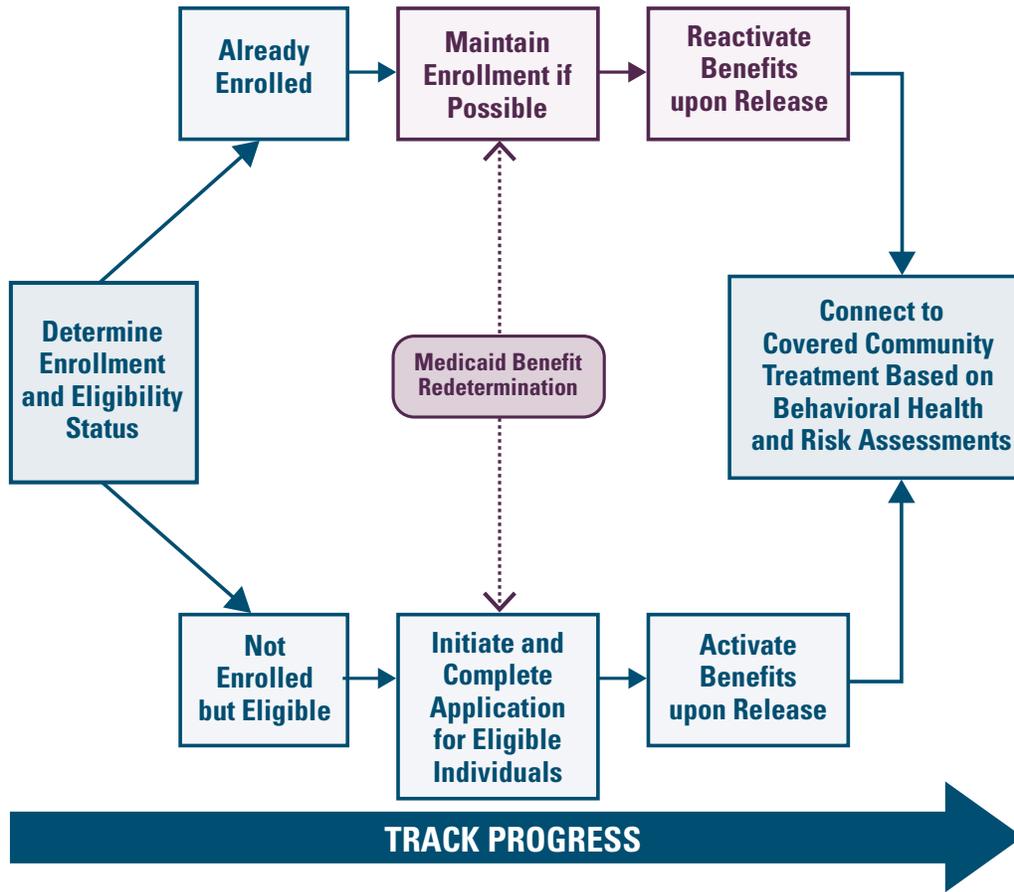
* CMS issued this letter to expand the activities and expenses eligible for the federal match related to encouraging partnering among and within states for exchanging electronic health records and related communications. It relates that, “Subject to CMS prior approval, States may thus be able to claim 90 percent [...] match for expenditures related to connecting Eligible Providers to other Medicaid providers, including behavioral health providers, substance abuse treatment providers, long-term care providers (including nursing facilities), home health providers, pharmacies, laboratories, correctional health providers, emergency medical service providers, public health providers, and other Medicaid providers, including community-based Medicaid providers”[...] in order to further the objectives of Meaningful Use, which includes “the use of certified [electronic health record] technology in a meaningful manner (for example electronic prescribing); ensuring [...] the electronic exchange of health information to improve the quality of care; and that in using certified ... technology the provider must submit to the Secretary of Health & Human Services (HHS) information on quality of care and other measures.” For more information, see <https://www.medicaid.gov/federal-policy-guidance/downloads/SMD16003.pdf>.

Corrections agencies should talk with their state Medicaid agency contacts to explore using federal matching funds to improve community HIEs to better take into consideration the needs of individuals in prisons and jails and how correctional care providers can access information for screening, treatment, and continuity of care. (See, e.g., <http://perspectives.ahima.org/health-information-exchange-between-jails-and-their-communities-a-bridge-that-is-needed-under-healthcare-reform/>.)

† This can be a complicated effort in many jurisdictions both for screening and reentry planning discussed in later sections: In addition to mental health and substance use treatment records will not always being kept with other physical health records, many electronic health record systems may not keep substance use treatment information with mental health and physical health care records because privacy mandates are stricter for substance use than they are for mental health services. For more information and guidance, see Ben Butler, *New HIE Funding Opportunities for Corrections* at cochs.org/files/CMS/New-HIE-Funding-Opportunities.pdf.



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



OVERVIEW

For people who are incarcerated in prisons and jails, a state’s policy related to terminating or maintaining their enrollment in Medicaid is a critical factor affecting continuity of coverage and care. Suspending Medicaid coverage is preferable to terminating for three reasons: (1) it requires less time to reactivate covered benefits than to complete new applications, resulting in fewer administrative costs; (2) it positions corrections agencies to take advantage of Medicaid payments for allowable inpatient expenses (often resulting in the saving of millions of dollars);^{100*} and (3) if enrollment is maintained for the length of stay, the quick reactivation of benefits can help to avoid lapses in health care. Many states pursue suspension or termination through legislative efforts, but others have done so through administrative processes.

Opportunities to reactivate suspended Medicaid and SSI benefits will have a significant impact on jails, as well as on prisons that incarcerate people for short stays or are in states that allow for long suspension periods. Reactivation may be affected by state policies on termination, time-limited suspensions, and redetermination processes.[†]

* See pages 26-27 for examples of several states’ correctional cost-savings and the corresponding endnote for more resources.

† New York State, for example, does not count days of incarceration toward Medicaid redetermination dates under the provision that “a State can periodically redetermine eligibility as required by 42 CFR 435.916, but use simplified procedures to do so.” States may also be able to conduct redeterminations during incarceration through ex-parte/administrative renewals (or completing renewal documentation) as detailed in the state implementation section.

Alternatives to Incarceration

Medicaid and SSI/SSDI enrollment and benefits can remain intact for people who are diverted from incarceration to programs offering community-based treatment and supervision as long as they are not “inmates of a public institution” and meet other Medicaid requirements.* These programs can include pretrial, prosecutor diversion programs, or court-based programs that focus on people with specific needs, such as veterans or people with substance use disorders, mental illnesses, or both.¹⁰¹ Jails may also petition judges for the release of sick patients on pretrial detention.¹⁰² When an appropriate diversion program is available, the individual’s need for continuity of health care coverage and treatment can be among the placement consideration factors.

Some experts feel, however, that states do not need to have a formal “suspension/suspended status”[†] or termination policy if they can put the real-time systems in place to avoid submitting inappropriate claims for federal Medicaid payment while people are incarcerated. For example, as of August 1, 2016, Ohio’s Medicaid system allows for enrollees who are incarcerated to remain on the Medicaid rolls (and suspension is no longer required).¹⁰³ Still, suspension and termination are the primary mechanisms that states are using at this time.

Reinstating Veterans Benefits and Qualified Health Plan Coverage

Veterans enrolled in VA health care benefits do not need to reapply upon release; those whose VA disability compensation or pension benefits were reduced or discontinued while they were incarcerated just need to provide the release documentation provided by the correctional facilities to the VA to prove that they are no longer incarcerated so that full coverage can be reinstated.

Federal law does not require termination of a QHP until a person has been convicted of a crime.¹⁰⁴ Therefore, people who are held pending disposition (on pretrial detention) are still eligible for QHPs. However, people who are incarcerated without a conviction may choose to terminate their QHPs to avoid paying for coverage of services they cannot access.¹⁰⁵ People who are convicted of a crime are not eligible to enroll in or maintain a QHP while incarcerated, but they may submit an application to reenroll within a 60-day special “enrollment period” following release.¹⁰⁶

* Social Security Act § 1905. This applies to individuals who have a criminal justice-involved status but are not determined to be “inmates” under the law. The CMS 2016 guidance to state health officials confirms that matching federal Medicaid payments or FFP can be available for Medicaid-covered services provided to individuals who are on probation, parole, or awaiting trial in the community. Matching federal Medicaid funds can also be available for individuals receiving care who are on home confinement. The guidance states that the federal share of Medicaid can be paid for individuals’ treatment in “corrections-related, supervised community residential facilities” (halfway houses) where residents meet CMS criteria for having “freedom of movement.” The guidance also clarifies that services provided in hospitals, nursing facilities, or other medical facilities that exclusively serve “inmates” are considered correctional institutions and are ineligible for federal Medicaid payments.

† In the CMS Guidance to State Health Officials, *To facilitate successful re-entry for individuals transitioning from incarceration to their communities*, CMS suggests that [...] “states should consider placing the eligibility of a Medicaid-enrolled inmate in a suspended status upon incarceration and/or setting up claims processing markers and edits to ensure that services are limited to only inpatient services.” (See Q12 on page 7.)

FEDERAL LAW AND GUIDANCE

Medicaid Suspension, Termination, and Payment Restrictions

As stated previously, federal law and regulations do not require states to terminate Medicaid enrollment when a person is incarcerated, but the law does prohibit federal payments for that person's health care costs while he or she is in prison or jail (excluding the inpatient exception).^{*} Guidance from the Centers for Medicare & Medicaid Services (CMS) in April 2016 clarifies that states must accept applications from people who are incarcerated and enroll or reenroll them if determined eligible. It encourages states to suspend enrollment or coverage by using markers or other indicators in the claims processing system that help ensure that claims submitted by states are denied for disallowed services provided to people in prisons and jails. Whatever method is used, CMS states that a suspension must be lifted when this exclusion no longer applies—for example, upon a person's release, or when he or she is admitted to a medical institution for treatment that falls within the inpatient exception.¹⁰⁷

Medicaid Inpatient Exception

As discussed in Issue 1, one of the values of maintaining enrollment in Medicaid—but suspending benefits—is positioning corrections to use the inpatient exception that allows for Medicaid to cover permitted inpatient treatment services for an eligible incarcerated person receiving care in an authorized facility in the community. In such cases, inpatient benefits can be “turned on” for states that suspend Medicaid coverage. For states that terminate Medicaid coverage, new applications must be submitted, though often using streamlined processes. Medicaid payment is made when an eligible recipient experiences a stay in a hospital or other authorized facility that lasts, or is expected to last, longer than 24 hours. CMS has defined these facilities as “a hospital, nursing facility, juvenile psychiatric facility, or intermediate care facility.”¹⁰⁸ The April 2016 CMS guidance on justice-involved people also makes it clear that the medical institution providing care must be one that can generally be accessed by the public; it does not include correctional medical facilities.[†] Federal payment for these services is available retroactively for up to three months prior to application, if the individual would have been otherwise Medicaid-eligible at the time of receiving care.¹⁰⁹

Periodic Redetermination of Medicaid Eligibility

Federal law requires states to review enrollees' eligibility for Medicaid at least every 12 months (known as “redetermination of Medicaid eligibility”).¹¹⁰ This raises issues in nearly all states for people who will be incarcerated for more than a year or whose redetermination dates arise while they are in prison or jail.[‡] There is no federal law or policy prohibiting redetermination for enrollees who are detained or incarcerated. Although not specifically directed to people in prison or jail, CMS has issued guidance to state Medicaid agencies that first an ex-parte renewal should be considered for anyone facing Medicaid redetermination, which includes the verification/review of information that is already available to the Medicaid agency, to the extent possible.¹¹¹ Provisions

^{*} Incarceration—and not sentence status—has an impact on an individual's Medicaid enrollment and SSI eligibility. SSDI eligibility, however, is based on conviction status.

[†] The CMS Guidance to State Health Officials, *To facilitate successful re-entry for individuals transitioning from incarceration to their communities* states, “Hospitals, nursing facilities, or other medical institutions operating primarily or exclusively to serve inmates are considered correctional institutions and FFP would not be available for services.” This includes using the same staff, areas of the facility, and services as for other patients who are not from prisons and jails. (See other requirements for an allowable medical institution at 42 CFR §435.1010.)

[‡] However, certain states have implemented federal [redetermination](#) mandates to effectively extend the 12-month period in practice, and examples are included in the pages that follow. See the state section below regarding redetermination practices, as some states terminate Medicaid enrollment at admission or at 12 months (or less) of incarceration or as of the date of redetermination.

were included in the ACA to help establish these streamlined renewal processes and to facilitate the completion of ex-parte renewals.¹¹² States should explore using ex-parte/administrative renewals to the extent possible for this population, as there will be no change in many individuals' income and other factors that relate to eligibility status during incarceration. Where additional information is needed, state Medicaid agencies could send a pre-populated renewal form to enrollees.¹¹³

SSI and SSDI Benefits and Reporting Incentives

Although there are many similarities between the SSI and SSDI programs, the Social Security Administration oversees different rules under each program for people who are incarcerated.

SSI Suspension and Reinstatement

The Social Security Administration suspends SSI benefits for individuals who are incarcerated for longer than a full calendar month.¹¹⁴ Suspension can last for 12 consecutive calendar months. During this time, the individual should still be considered as a person living with a disability. People who are released before serving 12 consecutive calendar months can reinstate their benefits upon release, without reapplying, by providing proof of their release to the Social Security Administration, and verifying an address in the community.^{115*}

After 12 consecutive months of incarceration, SSI benefits are terminated. When the person loses SSI benefits, federal requirements prohibit states from terminating a person from Medicaid without first performing a redetermination and exhausting all possible ways of retaining eligibility.¹¹⁶

SSDI Suspension and Reinstatement

SSDI recipients (and some family members) remain entitled to receive benefits as long as they meet the federal definition set out in the Social Security regulations for a person with a disability.¹¹⁷ SSDI benefits are not terminated after 12 months of incarceration, while SSI benefits are terminated. With SSDI, benefits are *suspended* if recipients are convicted of a crime and are incarcerated for more than 30 continuous days.[†] Therefore, people receiving SSDI benefits who are incarcerated while awaiting trial will continue to receive benefits until they are convicted.¹¹⁸ The Social Security Administration provides clear guidance on when SSDI should be suspended, including how to calculate when to begin counting 30 continuous days of incarceration, taking into account pretrial release, dates for reporting to facilities, and more.¹¹⁹ Upon release, the applicant must provide the Social Security Administration with proof of release before SSDI benefits can be reinstated.

The Social Security Administration has agreements with many, but not all, correctional facilities to identify SSI or SSDI enrollees who are incarcerated and whose benefits should be suspended or terminated, depending on the criteria outlined above.¹²⁰ As part of this process, participating prisons and jails submit monthly reports to the Social Security Administration with identifying information on people who have been admitted, along with conviction and release information. The Social Security Administration then performs a data match to determine who was enrolled prior to incarceration and who has met the criteria for suspension or termination. As part of a reporting incentive program, the Social Security Administration pays a facility as much as \$400 for each recipient whose benefits

* There is no requirement that the recipient's living arrangement be designated as "stable;" the address provided could be a shelter. The Social Security Administration requires that a person's living arrangement be specified and some kind of contact information be provided.

† The Social Security Administration and the VA use data-matching to identify incarcerated veterans who are receiving veterans' pension or compensation payments. The Social Security Administration shares the identifying information it receives from jails and prisons with the VA to help the agency appropriately alter payments to veterans who failed to report their incarceration.

are suspended as a result of the information provided.^{121*} If Social Security benefit payments are not discontinued during periods of ineligibility, the individual is obligated to repay them.¹²²

As discussed in [Issue 3](#) on completing new applications for SSI/SSDI benefits or reinstating those terminated during incarceration, states and/or their individual correctional facilities can have agreements to not only identify individuals who have been previously receiving benefits,[†] but to also help facilitate applications for people who require new/renewed benefits upon release.¹²³ Although the Social Security Administration is a federal agency, there is some local control through its regional, area, district, and field offices, providing the flexibility for these offices to have prerelease agreements with one or more correctional facilities or with a state's Department of Corrections.

STATE APPROACHES

Medicaid Termination or Suspension with Reactivation

States are in various stages of implementing strategies and technology to ensure that claims for federal Medicaid reimbursement are not inappropriately submitted once an individual is incarcerated in prison or jail. A state generally indicates within its Medicaid data system that any claims for the federal share cannot be approved for services a person enrolled in Medicaid receives while incarcerated, unless it meets the inpatient exception.¹²⁴ States that suspend Medicaid have different processes but a similar outcome: Incarcerated people remain on Medicaid rolls (subject to any relevant redetermination decisions) and are positioned to have Medicaid coverage reactivated quickly upon release or for a qualifying hospitalization while incarcerated.

Describing a state as a “[termination](#)” or “[suspension](#)” state can mask the complexities of this categorization. First, the status of the states is constantly changing, so classifications may be based on information that becomes quickly outdated. Second, suspension policies themselves vary, and the extents to which Medicaid and correctional systems—and prison and jail facilities—can implement them also differ significantly. For example, some states suspend enrollment for prisons, but not jails, or for some combination of prisons and jails within a state. Some state policies have limited the suspension to particular lengths of time, for example 30 days, or up to an individual's redetermination date, or 12 months, whichever comes first. At this writing, at least one state has passed legislation that allows for a two-year suspension during incarceration. In other cases, details on time limits are unavailable, unspecified, or unlimited.¹²⁵ To further complicate matters, there are variations in how certain systems are structured. For example, unified state corrections systems may implement these suspension or termination policies differently than states whose jails are under county authority.

There have been several recent efforts to advance the understanding of suspension and termination policies in states. [Appendix A](#) helps to reveal some of the nuances and complexities of classifications. Variations among the sources of this information are due, in part, to differences in methodologies, dates of publication, and the definitions discussed above, making it difficult to get an authoritative picture of a constantly shifting landscape.

* 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. See also the August 2, 2014 Executive Briefing by Open Minds, [Another Reason Why States Terminate Medicaid Benefits When Enrollees Become Incarcerated](#), for more information on the incentive program.

† In some cases, local agreements complement state agreements to ensure that staffing and other issues address local needs and concerns for implementation. These may be verbal or written. For more information and samples of these agreements, see pages [35](#), [49](#), and the [Index](#) for Social Security Administration prerelease agreements).

States that terminate coverage generally do so to avoid any disallowed federal billing or because historically Medicaid was automatically terminated when a person's SSI/SSDI enrollment was suspended or terminated, even if not required by federal law. Some states terminate because of inadequate data systems to track suspensions.¹²⁶ In addition, there has been some confusion over federal requirements, as well as a desire to eliminate the per-member, per-month capitation payments that the state makes to health plans for keeping a person enrolled in a managed care program.^{127*} In states that terminate, a person must be reenrolled to activate his or her health coverage upon release from incarceration.

During this paper's development, the number of states that suspend rather than terminate Medicaid has grown.¹²⁸ HHS and several state- and county-focused policy organizations have identified the benefits of suspending when possible, recognizing that for some states, implementation has been slowed by technology challenges.^{129†} Suspension can be imposed through legislation but may also be employed through other mechanisms.

☑ *How Can Legislation, Policies, and Other Mechanisms Be Used to Facilitate Suspended Benefits for People in Prisons and Jails?*

In addition to legislative and executive actions, it is also possible to have a suspension policy using only the authority of the state agency that administers Medicaid, without amending a state Medicaid plan or seeking CMS approval before implementation.¹³⁰ Examples of several of these approaches include the following:

- On January 1, 2014, California passed legislation requiring all of its prisons and jails to suspend rather than terminate Medicaid benefits for all incarcerated people. Suspension is limited to one year or the period of incarceration, whichever is shorter, provided that the individual remains eligible for Medicaid. Upon release within the one-year period, Medicaid benefits are restored for people who are eligible. Regular redetermination requirements apply regardless of incarceration status, and failure to meet these requirements during incarceration results in a termination of Medicaid benefits.¹³¹
- The state of Arizona uses intergovernmental agreements to suspend benefits for people who are incarcerated in state prisons and in jails in Cochise, Coconino, Maricopa, Mohave, Navajo, Pima, Pinal, Yavapai, and Yuma counties. Benefits are terminated for people in other county jails, per the policy from the state's Medicaid agency, the Health Care Cost Containment System.¹³² A 2016 brief indicates that about 9,000 Medicaid enrollees are in suspended status in Arizona in any given month. Coverage is reactivated without the need for reapplication upon release.¹³³
- In North Carolina, benefits are only suspended for people in state prisons. Benefits are terminated for people in local jails, per North Carolina Department of Health and Human Services policy that states, "Medicaid beneficiaries who are incarcerated in a federal prison, juvenile justice facility, county or local jail must have their eligibility terminated. Inmates who are incarcerated in a North Carolina prison facility must have their eligibility placed in suspension, provided they remain eligible for Medicaid."¹³⁴ The policy also allows for incarcerated people whose Medicaid

* The April 2016 CMS guidance makes clear that states can enroll people who are incarcerated but should work to prevent making capitated payments while enrollees are incarcerated. Managed care contracts can provide for disenrollment during incarceration and preclude new enrollment until release. States may enroll individuals into fee-for-service Medicaid programs during incarceration and transfer them to managed care upon release, but they should have safeguards to prevent the use of federal funds during incarceration.

† For example, the National Academy for State Health Policy (NASHP) found in 2015 that although Colorado has a suspension policy, "[...] the department has not yet implemented a function within its systems to suspend Medicaid upon incarceration. Therefore correctional facilities are still required to terminate coverage for those individuals who are enrolled in Medicaid and become incarcerated." Efforts have been underway to address those problems. CMS, in its April 28, 2016 guidance to state health officials, indicated that there are federal funds available to develop or enhance systems that will support suspension policies.

enrollment has been suspended to be covered for hospital stays that qualify for federal payment under the inpatient exception.

States that have chosen not to terminate Medicaid use various mechanisms to maintain enrollment, with the goal of using automated data-matching systems to help ensure compliance with the law; quick reactivation of full Medicaid coverage upon release when applicable; and reductions in staff time related to Medicaid application assistance. Adopting strategies to maintain Medicaid coverage instead of terminating can open the door to significant time and cost savings, particularly to obtain Medicaid reimbursements under the inpatient exception. Note that counties can arrange with their state Medicaid agency to suspend individuals' Medicaid enrollment even if the state policy is to terminate.^{135*}

The Medicaid Inpatient Exception: State and Local Implementation

At least 15 state prison systems—in both suspension and termination states—have capitalized on the [exception](#) that allows Medicaid to be billed for the federal share of eligible inpatient services when incarcerated people are hospitalized for more than 24 hours.^{136†}

County Jails' Use of the Inpatient Exception

Like state corrections authorities, counties can take advantage of the [inpatient exception](#). The National Association of Counties (NACo) states, “because each state has its own unique Medicaid program, counties should be sure to work with their state Medicaid authority, insurance commission, and department of health or comparable agency to understand the applicable laws and establish appropriate and effective processes.”¹³⁷

For states that terminate Medicaid enrollment, state procedures would need to include an immediate enrollment process for people who are eligible in order to be able to direct costs to Medicaid. For states that suspend Medicaid enrollment, correctional agencies can use a reactivation process or the hospital's presumptive eligibility authority[‡] to benefit from the use of federal Medicaid contributions and state reimbursements for eligible inpatient stays.¹³⁸ For all states, hospitals can directly bill Medicaid for the federal share of eligible individuals' care. Correctional agencies and health or social service agencies may coordinate how the state share is paid, with the Medicaid rate frequently lower than the non-Medicaid rates that corrections typically pays to hospitals for inpatient care.[§]

* This may be possible where there are no legislative or other state mandates to the contrary regarding termination of Medicaid enrollment for individuals in jails.

† There are states that have [termination](#) policies and yet enroll people who are incarcerated in a “limited Medicaid benefit” that permits billing only for services that are allowable under the inpatient exception. For example, the Pennsylvania Department of Human Services developed a process to implement legislation (2011 Public Welfare Code, Act 22) allowing for the processing of claims for inpatient services received by individuals during incarceration. As part of the process, a flag is included on applications completed through the Medicaid application portal to signal that the individual is currently incarcerated and should only be enrolled in a limited benefit for allowable inpatient services if eligible. (See “Criminal Justice in Pennsylvania” under “Programs and Services” at pacounties.org for a number of resources, but note that Pennsylvania has adopted legislation in July 2016 [HB 1062 to amend Act 62] to become a suspension state.) Massachusetts, a suspension state, has also developed a fee-for-service limited inpatient benefit but reactivates full benefits upon release. See Jennifer Ryan et al., *Connecting the Justice-Involved Population to Medicaid Coverage and Care: Findings from Three States*, The Kaiser Commission on Medicaid and the Uninsured, June 2016.

‡ [Presumptive eligibility](#) allows authorized entities to quickly, but temporarily, enroll individuals who meet the criteria in Medicaid for specified benefits. (See pages 30-31 for more information.)

§ Medicaid can often negotiate lower provider rates than correctional agencies can. For various payment and reimbursement strategies, see the GAO report from Carolyn L. Yocom, Director, Health Care to U.S. Reps. Fred Upton and Joseph Pitts, *Medicaid: Information on Inmate Eligibility and Federal Costs for Allowable Services*, GAO: Washington, DC, September 5, 2014, at <http://gao.gov/assets/670/665552.pdf>, page 4.

Correctional Health Care Savings and the Inpatient Exception

Many states—regardless of whether they terminate or suspend Medicaid enrollment or whether they are expansion or nonexpansion states—have realized significant savings in correctional health care expenditures by taking advantage of the inpatient exception.^{139*}

- Ohio reduced prison health care spending by \$10.3 million in FY2014 compared to FY2013 because of “savings attributable to Medicaid-covered inpatient hospitalizations.”¹⁴⁰
- An April 2015 study by the Robert Wood Johnson Foundation found that Arkansas, Colorado, Kentucky, and Michigan reported combined FY2014 and FY2015 savings of \$2.8 million, \$10 million, \$16.4 million, and \$19.2 million, respectively.¹⁴¹
- A Massachusetts audit of inpatient costs from 2011 and 2012 revealed that state DOC facilities could have saved about \$4 million in federal matching funds if they utilized the inpatient exception, while county jails could have saved \$7.5 million.¹⁴²
- Kentucky has estimated savings of \$5.4 million in State Fiscal Year (SFY) 2014[†] and projected \$11 million in SFY2015.¹⁴³
- North Carolina reported that it saved \$10 million in the first year of billing Medicaid for eligible inpatient services, while California saved about \$30 million by doing so in FY2013.¹⁴⁴

State Implementation of Redetermination Requirements

States that suspend Medicaid enrollment typically allow people with sentences of less than 12 months to reactivate their enrollment upon release—although as discussed earlier, some states have shorter periods of suspension before benefits are terminated. All states, however, are subject to the federal requirements of [redetermination](#), with some flexibility in how redetermination will be implemented. There is no law prohibiting that redetermination be conducted while people are incarcerated. The Substance Abuse and Mental Health Services Administration (SAMHSA) reported that historically, one of the main reasons why many people who remain in correctional facilities for a year or longer lose Medicaid coverage is that the necessary paperwork for redetermination was not completed.¹⁴⁵ Ultimately, state policies may need to be adjusted to support maximum enrollment among individuals leaving after longer stays.

States that have not already done so should establish processes to facilitate coordination between corrections agencies and state Medicaid agencies to help ensure that redetermination is completed during incarceration when appropriate. It is unclear which policies and procedures states are now using to conduct eligibility redeterminations for enrollees while they are incarcerated, including ex-parte renewals.[‡] To conduct these administrative renewals for people who are incarcerated on or around their redetermination

* For additional examples of savings by individual jails, see Kathy Rowings and Andrew Whitacre, *Health Coverage & County Jails: Inpatient Exception*, (Washington, DC: National Association of Counties, July 2016), at www.naco.org/inpatient-exception-2016.

† Kentucky's State Fiscal Year is from July 1 to June 30.

‡ Information was not found for how many states are now using ex-parte renewals for individuals who are incarcerated, and it appears that few prisons or jails are tracking or being notified systematically of these dates.

dates, state Medicaid agencies can review information that they already have access to, which may obviate the need to request updated information from the individual.

The following considerations can help state leaders appreciate how their termination, suspension, and data-matching policies and practices related to Medicaid can affect both correctional facilities' bottom line and their ability to facilitate access to needed health care services for people who are returning to their communities after incarceration. The questions raised by each of these considerations also increase awareness of policies and practices that can facilitate the use of the inpatient exception and reactivation of Medicaid and other publicly funded benefits.

KEY CONSIDERATIONS AND EXAMPLES

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?

There are many ways in which states can implement a [suspension](#) for people who are incarcerated. Some states are taking a stepped up approach in which they roll out suspension policies and practices in a number of prisons and jails, but not all, as they work to improve their data systems in order to be able to accommodate new processes. Other states are working to implement universal suspension policies and reactivation processes.

Does your state use non-termination policies and processes (such as suspension with data-matching) to facilitate the reactivation of benefits upon release?

Although there has been a push for states to adopt suspension policies that are only affected by annual redetermination-related terminations for ineligibility, there are states that have limited the period of suspension to less than 12 consecutive months of incarceration. Many states are struggling to implement their suspension policies given the need for effective data systems and efficient processes for activating and deactivating benefits. Because completing new applications for Medicaid coverage is typically more time consuming than reactivating benefits, states should factor the related cost savings into their policy decisions.

In Practice

- In August 2016, Ohio transitioned to a system that permits people who are incarcerated to remain enrolled in Medicaid by using a real-time data system, without requiring suspension.¹⁴⁶ Prior to that time, Ohio had a system to suspend enrollment during incarceration. Ohio's data system, the Reinstatement of Medicaid for Public Institution Recipients (RoMPIR), allowed staff from the departments of youth services, corrections, and mental health to notify one another when individuals enter and exit prisons.¹⁴⁷ Staff within the state prison entered a person's identifying information into RoMPIR within 72 hours of incarceration to determine if he or she was currently enrolled in Medicaid. If so, Medicaid was suspended and the correctional facility received confirmation of the suspension. To reinstate a person's benefits upon release, authorized staff ran a daily report from the RoMPIR Tracking

Database that provides the names of the people being released whose benefits were suspended and who had been incarcerated for less than 12 months. Staff submitted required information on the person being released into the RoMPIR portal for reinstatement of benefits, and no further action was required within RoMPIR.¹⁴⁸

- Maryland has suspended rather than terminated Medicaid coverage for incarcerated people entering facilities that are overseen by the Maryland Department of Public Safety and Correctional Services.¹⁴⁹ To suspend benefits, the state's Department of Health and Mental Hygiene (DHMH) conducts a daily, automated match of people in the Medicaid claim system against a list of people who are incarcerated in those facilities to detect if someone enrolled in managed care should be temporarily shifted to the "fee-for-service system,"¹⁵⁰ so that the state can avoid managed care fees.¹⁵¹ When people are released, they must be reenrolled into managed care.¹⁵¹
- According to a policy established in 2013, North Carolina has detailed instructions for suspending (or terminating in specified settings) enrollees through a data match between the state prison's records and the Department of Health and Human Services' (DHHS) Eligibility Information System, the automated system that is used to track Medicaid applications and enrollment status.¹⁵² DHHS receives a daily file from the state Department of Public Safety's Division of Prisons (DOP) that lists people who are being released from incarceration. DHHS runs this file against its list of suspended enrollees, and when there is a match in the DOP's file with the person's release date, DHHS automatically reinstates Medicaid benefits, and coverage becomes effective as of the first day of the month of release.¹⁵³
- In Monroe County, New York, the jail's contracted health services provider conducts screening upon intake to determine a person's health insurance enrollment status. The Monroe County Department of Human Services (DHS) then uses an electronic jail census to cross reference the information gathered through screening against the Medicaid rolls. DHS staff use this information to reinstate individuals upon release.¹⁵⁴
- The Fayette County, Kentucky, jail is acquiring a new data management system that will interface with the state Medicaid system to automatically suspend benefits when individuals are incarcerated and reactivate them upon their release. This system will help sustain health care coverage for those who are Medicaid enrollees.¹⁵⁵

Does your state terminate Medicaid but have policies to expedite reenrollment when people are released from incarceration?

The challenge for states that **terminate** Medicaid is that there may be months-long delays in checking applicants' eligibility and processing applications for reenrollment before release. Many termination states are working to streamline the process and ensure that, at minimum, people with the greatest needs are being reenrolled in Medicaid:

- Wisconsin correctional staff help people apply by phone for Medicaid coverage at the end of the month prior to the month of their release. Coverage goes into effect on the first day of the month in which they return to their communities. To facilitate the process, applicants can provide consent on the phone in lieu of a written signature on the application.¹⁵⁶ There is no verification required for income if wages are limited to prison work. Arrangements are made for enrollment cards to be provided or forwarded to enrollees.¹⁵⁷

* In a fee-for-service payment model, health care providers are paid for each service rather than the managed care plan payments of a per member per month fee. More information on how [contracts with managed care organizations](#) and other strategies can help connect individuals to appropriate care in the community that is covered by Medicaid is addressed in Issue 4, "Examining Medicaid-Reimbursable Behavioral Health Services in the Community and Addressing Gaps."

- Previously in Pennsylvania, Medicaid enrollment was terminated upon intake but the Department of Corrections prioritized assisting with reenrollment for prior enrollees and enrollment for eligible people who have “serious illnesses,” which include serious mental illnesses. At this writing, the DOC is manually suspending people in state prisons with sentences of less than two years, and is moving towards an automated system.¹⁵⁸

Additional information on reenrollment can be found in Issue 3, “Assisting with Applications.”

☑ ***Is the inpatient exception for incarcerated people used to access Medicaid funds for qualifying hospital stays? If so, how do related processes affect the eligible individuals’ ongoing enrollment status?***

Presumptive Eligibility

Presumptive eligibility (PE) is a mechanism that allows people to be immediately enrolled in Medicaid, for at least limited benefits, on a temporary basis as long as they attest to basic information that helps establish eligibility: name, household size, and estimated monthly income, and at state option, state residency and citizenship, or satisfactory immigration status.* A full Medicaid eligibility determination can later be made if the individual submits a full Medicaid application. States are required to allow hospitals to determine presumptive eligibility for all populations covered in that state. States may choose to permit other entities to make PE determinations, and those have typically included clinics, schools, and local health departments.†

The Kaiser Family Foundation found that many states do not address in their policies how to make use of the inpatient exception, which may indicate that it is being underused.¹⁵⁹

Both suspension and termination states may use Medicaid to finance qualifying inpatient care provided to individuals during incarceration. In order to do so, states that have suspended Medicaid will need to reactivate it for the hospital stay. Termination states will need to have the individual reenrolled at least temporarily (often for limited benefits). By working with its state Medicaid authority, a [county](#) may be able to access federal Medicaid reimbursement for inpatient care for an enrolled individual in a county jail even if the state does not seek reimbursement for enrolled individuals in a state prison.

For immediate, but temporary, coverage, [presumptive eligibility](#) can be used to facilitate reimbursement for qualifying inpatient hospital stays. States are required to put policies and procedures in place to allow hospitals to elect to be qualified entities for determining PE.¹⁶⁰ A person may start (or complete) a full application with assistance from staff in order for coverage to continue.¹⁶¹ If a full application is not submitted, an individual’s temporary enrollment will end within a specified period of time following the hospitalization.¹⁶²

* Note that “presumptive eligibility” for Medicaid differs from the Social Security Administration’s presumptive disability or blindness payments. For SSI benefits for disability or blindness, payments may be made for up to 6 months while the applicant is waiting for the Disability Determination Services (DDS) to make a final decision. The decision to grant payments is based on the severity of the condition and the likelihood that the claim will be ultimately approved and is not based on financial need.

† For more information, see Enroll America’s Fact Sheet, “Presumptive Eligibility: New Options in 2014.” For a table of which states provide presumptive eligibility, see <http://kff.org/health-reform/state-indicator/state-adoption-of-presumptive-eligibility-for-eligible-individuals-enrolling-in-medicaid-chip>. Not all states have pursued the state PE option to allow for temporary enrollment in settings other than hospitals.

In Practice

- In New Jersey, as of January 2015, Medicaid has been tasked with data-matching using daily inmate files from both the Administrative Office of the Court and the Department of Corrections. According to the policy memorandum issued by the state Medicaid agency, any person identified as Medicaid-eligible at the time of incarceration will have a Special Program Code (SPC) added to their eligibility data. There will be code designations for people incarcerated in county correctional facilities and state prisons. The SPC will limit Medicaid coverage to fee-for-service inpatient services received during acute care hospitalizations only. Applications, including those completed by hospitals certified to use presumptive eligibility, should be processed for a full eligibility determination. Upon an individual's release, the "incarceration" program code will be removed from their Medicaid records. County correctional facilities are requested to work with their local county welfare agencies to ensure that full Medicaid eligibility checks and applications are completed for people not otherwise enrolled so that they can access benefits upon release.¹⁶³
- In California, when an incarcerated person receives inpatient hospital care and is found Medicaid-eligible during that stay, the Department of Health Care Services (DHCS) will submit a follow-up, full application on his or her behalf (with benefits suspended during the remainder of the term of incarceration). DHCS will notify the person's county of residence when he or she is being released from prison. As this constitutes a "change in circumstances," the county will then do a check to ensure that the person is still eligible for Medicaid and should remain enrolled. If the individual is still eligible, the county changes his or her Medicaid billing code to allow for Medicaid coverage in the community. Benefits remain active throughout the full application review process.¹⁶⁴
- A 2015 Indiana law coupled with clear guidance from the state Medicaid authority (Indiana Family and Social Services) allows the state to take advantage of the inpatient exception using PE mechanisms. The state has developed a process for hospitals recognized as qualified providers to enroll eligible individuals in temporary Medicaid coverage for inpatient hospitalization services through the use of a web-based tool. PE allows for an eligibility determination to occur the same day an individual applies. However, an application using PE must be completed by the hospital on the day of admission, as Indiana does not permit retroactive coverage. Once enrolled through PE people receive temporary coverage for limited benefits related to the inpatient hospitalization. Claims are paid through the fee-for-service system. If a full application is submitted and approved, the coverage for inpatient hospitalization services is available for one year from the date of the PE application or until notification of an individual's release. Indiana follows up with a full application, as needed, as part of the reentry process. Indiana's jails participate by signing an agreement with the state to work with this process.¹⁶⁵

Regardless of what strategy a state uses to secure coverage for inpatient care, a process for ensuring these stays are covered and claims are properly paid is necessary. Correctional agencies and facilities should examine any existing contracts with health care service providers to determine whether federal reimbursement is allowed for inpatient stays that are covered within these contracts.¹⁶⁶ Reimbursement strategies have often been complicated, causing many states to work on streamlining their processes (such as centralizing reimbursements in the state through a single county or a single agency).¹⁶⁷

☑ **How does your state's implementation of the federal requirements for redetermination of Medicaid eligibility affect maintaining enrollment for incarcerated adults?**

The length of time an individual can remain enrolled in Medicaid during incarceration and when they are subject to eligibility [redetermination](#) can vary by state because, as mentioned earlier, states have the authority to determine their own suspension/termination policies as well as processes for implementing federal redetermination requirements.*

In Practice

- Like many other states, Iowa allows incarcerated individuals to remain enrolled in Medicaid for up to 12 months.¹⁶⁸ Iowa's Department of Human Services (DHS), however, as of 2016, is in the process of removing the 12-month limit, which will allow the suspension to continue during the entire period of incarceration. DHS must review an individual's continued eligibility for the suspension on an annual basis and will use available data matches to perform this review.¹⁶⁹
- The New York State Social Services code states that a person incarcerated in a state or local correctional facility who is eligible for Medicaid at entry to the system remains eligible during their incarceration and upon release, until such time as an eligibility redetermination finds that they are no longer eligible. New York has legislated: "To the extent permitted by federal law, the time during which such person is an inmate shall not be included in any calculation of when the person must recertify his or her eligibility for medical assistance in accordance with this article."¹⁷⁰

Consideration 2

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

As mentioned previously, some states have [prerelease agreements](#) with the Social Security Administration that, when coupled with reapplication and reinstatement processes, can help ensure that people who are eligible for benefits receive them at the time of their release from prison or jail.¹⁷¹

☑ **What prerelease agreement(s), if any, does your state or its prisons and jails have with the Social Security Administration to expedite reinstatement of SSI or SSDI benefits for eligible people upon release?**

The Social Security Administration can have prerelease agreements with state departments of corrections that either apply to all prisons and jails or can be made with just specific facilities. There can also be state agreements with complementary local implementation agreements. These prerelease agreements can facilitate reinstatement of SSI and SSDI for people who were previously enrolled in the programs and whose release falls within the reinstatement timeframe (see [Table 1](#)).

While the general purpose of prerelease agreements is to initiate new SSI/SSDI applications prior to release for people who are leaving jails and prisons, they can also be used to reinstate benefits for people who had previously been enrolled.¹⁷² Facilities that identify people who were previously enrolled in SSI and are eligible to have benefits reinstated can save hours of staff time and facilitate individuals' access to benefits upon release from prison or jail.

* No inventory of how states handle redetermination during incarceration was found.

TABLE 1. ELEMENTS OF A PRERELEASE AGREEMENT¹⁷³

The Correctional Agency or Facility Might Agree to:	The Social Security Administration Might Agree to:
<ul style="list-style-type: none"> • Notify the Social Security Administration if an applicant appears likely to qualify for disability benefits and is expected to be released soon (e.g., within 90 to 120 days); • Provide current medical evidence and non-medical information to process the [application]; • Identify the applicant’s expected release date and update the Social Security Administration if there is a change; and • Alert the Social Security Administration when the applicant is released. 	<ul style="list-style-type: none"> • Provide guidelines for requested information; • Process the [application] or reinstatement as quickly as possible; • Notify the DOC or facility promptly regarding the decision on the [application]; and • Offer a contact person to assist in prerelease procedures.

In Practice

- The Oklahoma Department of Corrections has a memorandum of understanding with the Social Security Administration to streamline SSI and SSDI benefit activation for people with mental illnesses in three of its prisons. This MOU is an outgrowth of a collaborative reentry program that was funded by the Oklahoma Department of Mental Health and Substance Abuse Services. Approximately 120 days prior to release, a member of the person’s treatment team or a discharge manager located in the prison facilitates an application by telephone and provides medical information to the Social Security Administration, which then flags the application as one originating from a correctional facility.¹⁷⁴ The DOC is also working to develop a system that identifies people coming into prisons who are already enrolled in SSI and SSDI benefits.

Does your state allow SSI recipients with a qualifying disability to be eligible for enrollment in Medicaid using that same SSI disability determination?

As detailed in Issue 3 (pages 52-53), “Assisting with Applications,” nearly 80 percent of states allow an SSI disability determination to result in Medicaid eligibility and enrollment (this occurs in 33 states plus the District of Columbia, while a separate application is required in 7 states). Yet this relationship between SSI and Medicaid adds a level of complexity regarding suspension, termination, and reactivation or reinstatement. The length of time a person is incarcerated is the factor that distinguishes whether his or her SSI benefits are suspended (after a full calendar month of incarceration) or terminated (after 12 calendar months of incarceration), requiring reapplication upon release. When SSI eligibility is suspended due to incarceration, states have the option to suspend Medicaid coverage as well.¹⁷⁵ If both Medicaid and SSI are suspended, these benefits can be reinstated relatively quickly, but the exact process and timeframe may differ from state to state. If the state suspends Medicaid pending reinstatement of SSI, Medicaid will—once reinstatement is official—cover services for up to three months retroactive to the date of SSI eligibility. Termination of SSI enrollment in these cases, however, most often results

in Medicaid termination.¹⁷⁶ If SSI is terminated because the person has been incarcerated for more than 12 months, he or she must reapply for SSI benefits, which can result in a lag time in the resumption of benefits. In the interim, the person can complete a new application for Medicaid, if eligible, and then transition to the Medicaid plan associated with the SSI approval, which may be more robust depending on the state.

IMPLEMENTATION ISSUES

Medicaid Termination vs. Suspension

States that lack [policies to suspend](#) Medicaid at the time of incarceration are somewhat hampered from realizing a number of advantages, including saving staff time and resources to enroll people in Medicaid; promoting continuity of health care by being able to reactivate benefits when possible upon release; and positioning corrections to more easily avoid costs that can be partially paid for by federal Medicaid under the inpatient exception. Taken together, these factors can translate into significant cost savings, improvements in individuals' recovery, and may help lower the risk of recidivism. States that do suspend benefits during incarceration will need to consider any limitations on that suspension (e.g., suspending only for 30 days of incarceration) to determine what impact they hope to have on the eligible population. They also need to take into consideration how they will implement redeterminations with regard to incarceration within federal law parameters.

Suspending Medicaid during incarceration requires close coordination between correctional systems or facilities and state Medicaid agencies. There are practical problems, such as trying to time the [benefit activation](#) to begin precisely on an individual's release date, which can change due to good time credits or other factors. Many states also face significant technology challenges (discussed below) that hinder their ability to efficiently track suspensions, implement redetermination processes for people who are incarcerated, and activate benefits.

States that terminate Medicaid enrollment don't run the risk of improperly billing for the federal match. There are often significant delays, however, in enrolling individuals with behavioral health needs in Medicaid and connecting them to covered treatment quickly upon release to the community—when they are most likely to recidivate or relapse if not given the proper treatment and services. Estimates suggest that reenrollment processes can cause lapses in critical treatment that last for weeks or even months.¹⁷⁷ In some cases, even when applications can be completed on time, state policy may be to only [activate benefits](#) on the first day of the month of release or some other designated interval. This can undermine continuity of care efforts, particularly if weeks or months pass before benefits are in place, and care providers require they be active before appointments can be scheduled. Corrections leaders will need to work with state Medicaid agencies to develop processes for timely reenrollment and activation of benefits.

Data Systems for Termination or Suspension

The ability to effectively activate or reactivate benefits is inextricably linked to the quality of data systems and efficient processes for [data-matching](#). Many states are working toward automated systems so that suspension can be triggered upon admission to a correctional facility and then lifted upon release. In the interim, states are upgrading their systems and designing workarounds that address their distinct processes and systems. Because systems are so tailored to local needs and approaches are continually evolving, it can be difficult to find models or to try to replicate and implement strategies in such

a rapidly changing environment. For example, New York State uses monthly electronic notifications from state prisons and local jails to run against its Medicaid enrollment data.¹⁷⁸ Pennsylvania, a termination state at this writing, has been using a manual data match but is moving toward an automated system as state leaders are planning their implementation of a law passed in July 2016 to suspend Medicaid coverage during individuals' incarceration. The automated system will increase capacity to complete applications for more than just priority populations. In Rhode Island, a state with a unified correctional system, the Executive Office of Health and Human Services has made advances in being able to access the DOC's databases for real-time data on incarceration status to help address errors in release dates.¹⁷⁹ States need to consider that unless they have a unified correctional system, county jails often do not share the same information technology (IT) network as the state corrections system, which will make it unlikely that a single system would be used for both prisons and jails without significant coordination.

Social Security Administration Prerelease Agreements

Prerelease agreements between correctional facilities and the Social Security Administration can help ensure that people who were previously enrolled in SSI or SSDI, and are still in a suspended status, have benefits quickly reinstated upon release (or facilitate the processing of new applications if SSI benefits were terminated, as discussed in [Issue 3](#)). SSI and SSDI recipients tend to be particularly vulnerable, with high rates of mental illnesses and unemployment, making the immediate income support provided by SSI or SSDI crucial to successful reentry.

Interagency agreements are not required for correctional facilities to file prerelease applications with the Social Security Administration for people whose SSI benefits are terminated, but they have been found to streamline the work processes for both.¹⁸⁰ Because the Social Security Administration provides a model prerelease agreement that outlines its core elements and offers completed examples online,¹⁸¹ the time correctional facilities need to invest in the development of an agreement has been reduced.

The processes to maintain enrollment or quickly reactivate Medicaid coverage and Social Security benefits can seem overwhelming and complex. However, many states report that implementing these processes provides people with improved access to health care coverage upon release, particularly for those with shorter periods of incarceration.

Appendix A. Variations in Key Resources: State Suspension and Termination Policies

RESOURCE	FINDINGS
<p>Families USA, Medicaid Suspension Policies for Incarcerated People: 50-State Map (updated July 2016), at http://familiesusa.org/product/medicaid-suspension-policies-incarcerated-people-50-state-map</p>	<p>This resource provides a color-coded map of all 50 states indicating which states terminate and suspend, and differentiates between states with policies that specify a limit on the duration of suspension and those that do not. According to the map, 19 states terminate Medicaid enrollment upon incarceration, while 15 states suspend for a specified period of time before terminating (e.g., 30 days to 12 months). An additional 16 states and the District of Columbia suspend Medicaid during incarceration, but people whose Medicaid enrollment is suspended are subject to redetermination, at least annually.*</p>
<p>American Correctional Association and U.S. Department of Justice's Bureau of Justice Assistance, Health Care Reform—The Patient Protection and Affordable Care Act: A Practical Guide for Corrections and Criminal Justice Professionals (July 2016), at: www.aca.org/ACA_Prod_IMIS/DOCS/OCHC/HealthCareReform.pdf.</p>	<p>This paper highlighting research by the American Correctional Association shows 14 states—Arizona, California, Colorado, Connecticut, Florida, Iowa, Louisiana, Maryland, Massachusetts, Minnesota, New York, North Carolina, Ohio, and Oregon—that currently suspend benefits, with Texas as a state that suspends benefits for 30 days and then terminates.</p>
<p>Kaiser Family Foundation, Medicaid Eligibility Processes for Individuals Moving In and Out of Incarceration (August 2015), at http://kff.org/report-section/state-medicare-eligibility-policies-for-individuals-moving-into-and-out-of-incarceration-issue-brief/#endnote_link_160166-10</p>	<p>This brief provides a summary of suspension policies for eight selected states; it is not intended to be a full inventory. These states are Arizona, Florida, Indiana, Iowa, Nevada, New Mexico, North Carolina, and Oregon (with Arizona and North Carolina having some facilities, but not all, covered by suspension policy).</p>
<p>National Association of Counties, Health Coverage and County Jails: Suspension vs. Termination (December 2014), at http://www.naco.org/sites/default/files/documents/Suspension-termination-DEC2014%20(2).pdf†</p> <p>National Conference of State Legislatures Legisbrief: Providing Health Care Coverage for Former Inmates (April 2014), at http://www.ncsl.org/documents/health/lb_2215.pdf</p> <p>The Council of State Governments Justice Center, Medicaid and Financing Health Care for Individuals Involved with the Criminal Justice System (December 2013), csgjusticecenter.org/wp-content/uploads/2013/12/ACA-Medicaid-Expansion-Policy-Brief.pdf.</p>	<p>These sources list 12 states. There is slight variation in terms of the specific states that are listed.‡</p>

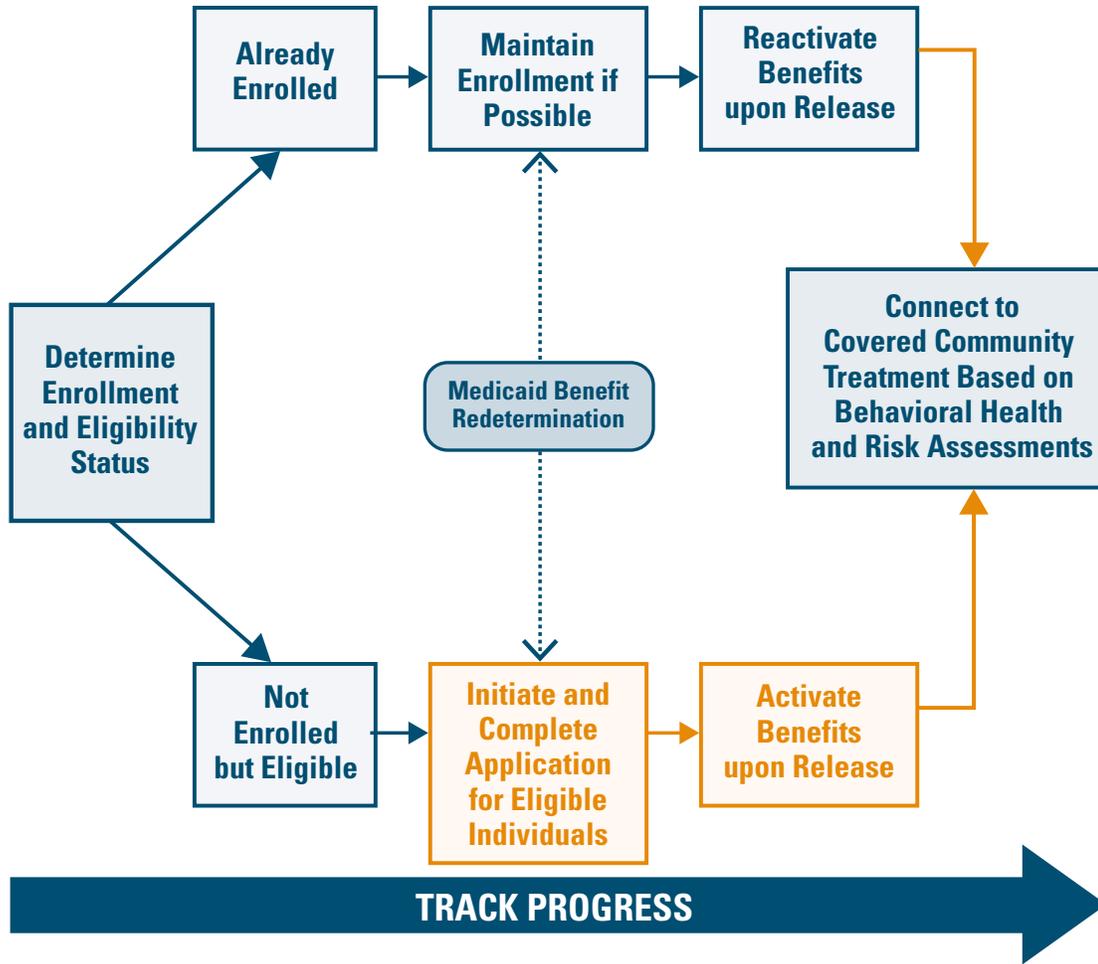
* Information accessed from Families USA website July 21, 2016; however, at this writing, several states were moving forward with suspension policies for individuals incarcerated in prisons and jails not yet reflected on the map. For example, Alabama passed legislation not yet implemented (Senate Bill 268 passed May 2016, see <http://www.alsenaterepublicans.com/updates/opinion/new-medicare-law-could-save-state-money/>) Other states have changed their length of suspension.

† NACO updated this brief in July 2016, which includes references to the Families USA map as the resource for suspension/termination. *Health Coverage & County Jails: Suspension vs. Termination* (Washington, DC: National Association of Counties, July 2016): 4, www.naco.org/suspension-termination-2016.

‡ The last 3 resources all list 12 states, but they differ (e.g., some list Massachusetts, but not Washington, and others the reverse).



ISSUE 3: Assisting with Applications



OVERVIEW

Successfully increasing the number of people in prisons and jails who are enrolled in Medicaid and other benefits requires a concerted effort by state policymakers, correctional leaders, behavioral health agency administrators, and Medicaid agency and Social Security Administration officials. These leaders are needed to formulate and promote the policies and processes that will ensure eligible individuals receive help in applying for available benefits before they reenter their communities.* Like screening for enrollment and eligibility status, many questions arise related to which entity or person should assist with completing the applications, when and where, and with what funding. The processes for Medicaid enrollment differ from those associated with Social Security benefits, and yet even Medicaid processes alone are highly variable. There are many permutations of how application processes are implemented, in part because they are shaped by state and local policies, available staffing, data structures, access to the Medicaid application system, and privacy mandates.

The examples in this section are meant to demonstrate the many approaches taken by correctional facilities to assist incarcerated people with completing their benefit applications.¹⁸² Many correctional facilities that provide application assistance report

* Eligible individuals include people who meet the Medicaid plan criteria and were previously enrolled but terminated, opted not to previously apply, or are newly eligible under ACA criteria (a particularly large pool in expansion states).

the need for close working relationships with the state Medicaid agency and the Social Security Administration to help facilitate eligibility determinations.* They also often rely on the help of community organizations and other external entities willing to assist with the application process and to help ensure that people leave incarceration with Medicaid cards and alternative forms of documentation and benefits information.

FEDERAL LAW AND GUIDANCE

Medicaid Enrollment

Under federal law, people are allowed to file applications for and enroll in Medicaid at any time while they are incarcerated.^{183†} April 2016 CMS guidance called on states and local correctional agencies to assist with or facilitate applications for Medicaid prior to release using methods agreed upon with their state Medicaid agency. Federal guidelines require state Medicaid authorities to accept applications that are submitted online, through the mail, or by phone.¹⁸⁴ A range of options is available to help ensure that applications are properly filled out, from using Navigators and application assisters to “authorized representatives.” Correctional facility employees and others “working on behalf of incarcerated individuals” who have given them consent to do so are allowed to act as an authorized representative for the purposes of submitting a Medicaid application.¹⁸⁵ Correctional facilities do not need to be certified by the state Medicaid authority to submit applications on behalf of incarcerated individuals.¹⁸⁶ In some states, anyone can help a person who is incarcerated apply for Medicaid—including by signing-up to serve as a “community partner” on state Medicaid websites.¹⁸⁷

Medicaid Administrative Claiming

Under a program called [Medicaid Administrative Claiming \(MAC\)](#), both nonexpansion and expansion states may receive federal reimbursement for certain activities that are essential for the administration of their state Medicaid programs. According to CMS, states can receive a federal match for up to 50 percent of the cost for activities, “as found necessary by the Secretary for the proper and efficient administration of the state plan.”^{188‡} These activities can include, but are not limited to, outreach, application assistance, and staff development and training.^{189§} The state Medicaid agency must submit all claims for federal reimbursement for these activities under the MAC program. Consequently, state and local criminal justice agencies seeking reimbursement for their Medicaid administrative activities need to develop an agreement with the state Medicaid authority to process their claims.¹⁹⁰ There is, however, little federal guidance regarding how MAC can be used by corrections agencies, specifically prisons and jails, to support activities related to Medicaid enrollment.**

* Corrections can help identify individuals who are likely to meet eligibility criteria, and can help facilitate the completion of applications, but only a Medicaid authority can make the eligibility determination resulting in successful enrollment. Similarly, only the Social Security agency can make the “disability determination” based on medical criteria, and the verification of other non-medical criteria (including age, marital status, employment status) to determine if the applicants should receive payments. Successful applications are referred to as “allowances.”

† States and agencies may further prescribe when applications should be completed (e.g., not more than 120 days prior to release).

‡ Reimbursement for activities under MAC is based on Federal Financial Participation (FFP) and not the Federal Medicaid Assistance Percentage (FMAP). States must use non-federal (i.e., state, county, and local) funding to meet the match.

§ In addition to MAC reimbursements, information is provided on [page 83](#) on other federal supports for enhancing technology and ongoing operations of enrollment and eligibility systems.

**The most recent federal guidance (April 2016) regarding justice-involved people says only that “federal Medicaid matching funds are available for application assistance and eligibility determination, assuming all other qualifications are met.” Although this guidance is directed to state health officials, see resources by the Community Oriented Correctional Health Services (COCHS) that reports that in addition to probation and parole agencies, prisons and jails can use MAC for enrollment activities (http://www.cochs.org/files/medicaid/cochs_medicaid_Public_Safety.pdf and http://www.cochs.org/files/medicaid/cochs_medicaid_MAC.pdf).

SSI/SSDI Enrollment

Congress mandated that the Social Security Administration provide a way for people to apply for SSI and SSDI benefits before release from incarceration.¹⁹¹ To implement this mandate, the Social Security Administration provides information to correctional facilities on how to facilitate [prerelease processes through interagency agreements](#) (for reinstatements, as discussed in [Issue 2](#), and for new applications). The agreements do not result in an expedited review but do allow for applications to be processed up to 120 days in advance of release (as opposed to 30 days when submitted without a prerelease agreement).¹⁹² Benefits do not start until the day of release, with or without a prerelease agreement in place, but having one increases the likelihood that a decision is obtained prior to community reentry and payments can start shortly thereafter. Each application reflects what an individual's income, disability, and housing situation will be after reentering the community, when they can begin receiving benefits.¹⁹³

STATE APPROACHES

Processes for assisting with benefit applications vary widely both across and within states, as [counties](#) do not tend to share an IT structure (unless on a regional jail network or as part of a unified system) in the same way that many state correctional facilities do. In addition, Medicaid application processes may be managed at the state level, by counties, or other local entities. Which entity or person will assist with Medicaid, SSI, and SSDI applications often depends how much funding and other support is provided to prisons and jails for this purpose, and whether this activity is contracted out, centralized for some or all facilities, or conducted by individual correctional facility staff. Correctional facilities use a variety of personnel for application assistance, including prison or jail staff, personnel from other government agencies such as health or human services departments, and community-based organizations or universities, among others.* However, the people assisting with applications may not always be the same personnel as those who conduct initial screenings for enrollment and eligibility status.¹⁹⁴

Even though federal law allows people who are incarcerated to apply for Medicaid at any time during their stay, many states specify that Medicaid applications can only be submitted within a certain time frame prior to release, or that applications may not be approved until a time closer to or upon release.

States report that an increasing number of facilities in expansion states are providing enrollment assistance. For example, a 2014 California survey of 44 responding counties indicated that 70 percent (31 counties) already provide enrollment assistance in their local jails, and the remaining 30 percent (13 counties) had plans to offer this enrollment assistance in their local jails by the end of 2015.¹⁹⁵ By December 2015, all 44 [counties](#) confirmed that they were actively providing or still planning to provide application assistance to people in their jails.¹⁹⁶

Mandates and authorization for representatives to complete applications for people in prison or jail may be spelled out in state legislation or policy but may also be part of a state Medicaid plan, county jail operating procedures, or other administrative or executive actions.

* The type of available consumer assistance programs that help enroll people in health care coverage depends on the state (particularly for the kind of Marketplace model the state has). Among the different types of assisters, Navigators and Certified Application Counselors (CACs) are individuals or organizations trained to provide assistance with enrollment in Marketplace insurance and sometimes Medicaid as well. For more information on differences in funding and range of duties for these positions, see <https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/Downloads/marketplace-ways-to-help.pdf>. States may have additional designations and may require additional certification for assisters beyond the federal requirements.

☑ **Are There State Laws and Other Actions That Promote or Mandate Application Assistance for People in Correctional Facilities?**

- A 2015 New Mexico law (SB 42) specifies that for all prisons and jails in the state, people who are not enrolled in Medicaid when their incarceration begins will be allowed to submit a Medicaid application during their incarceration.¹⁹⁷
- A 2015 Illinois law (HB 3270) requires state prisons to provide Medicaid application assistance for those not already insured at 45 days prior to release.¹⁹⁸
- A 2015 Indiana law (HEA 1269) requires sheriff's departments to assist people who are incarcerated for more than 30 days in applying for Medicaid prior to discharge or release from county jail.¹⁹⁹
- Under a 2013 memorandum of understanding (MOU) between the Connecticut Department of Corrections (DOC) and the Department of Social Services (DSS), DSS provides dedicated staff to process Medicaid applications that have been completed by the DOC's discharge planners.²⁰⁰ The positions are funded by the DOC, the Judicial Branch, and the Department of Mental Health and Addiction Services. Initially, prerelease enrollment efforts focused on people with serious mental illnesses; they have since expanded to include everyone being released.²⁰¹
- Washington State's Health Care Authority (HCA) accepts applications for Apple Health benefits (the state's Medicaid benefits) for people who are incarcerated no more than 45 days before the expected release date. To facilitate the timely processing of applications prior to release, interested correctional facilities can sign an MOU with the HCA to define the exact roles and responsibilities of the facility and the HCA and the timeline for the submission and processing of applications.²⁰²

It is unclear just how many states require correctional agencies to provide prerelease assistance with Medicaid applications. States such as New Mexico and Indiana are undertaking universal, system-level approaches to increasing enrollment for people leaving prisons and jails, whereas other states have chosen to authorize staff to check for eligibility and file applications on behalf of consenting individuals without a specific state mandate, leaving the choice of whether and how to provide assistance in the hands of correctional and local officials. Other states require staff to help with applications only in particular prisons or jails.

KEY CONSIDERATIONS AND STATE EXAMPLES

The following questions and examples are intended to help state leaders identify policy and implementation options to improve the chances that eligible people will be enrolled in Medicaid and able to access benefits upon release from prison or jail.*

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?

Applying to Medicaid is voluntary, and some eligible people may be reluctant to apply or are unaware of its benefits. As a result, there are a number of states that provide [health insurance and treatment literacy](#) programs.† Literacy programs educate people about the value of health care benefits so they can make an informed decision about whether to apply for coverage. Who engages in these health education efforts (peers, health professionals, jail personnel) varies, but there is growing recognition that, to the extent possible, people who are eligible for benefits should be given information about the importance of and processes for enrollment at multiple points during their incarceration. The importance of applying for benefits and health care coverage can also be bolstered by prison and jail health care professionals when providing treatment in the facility. These visits provide an opportunity to encourage follow-up in the community for any health conditions addressed during incarceration (see also Issue 4, [page 75](#)). The information can be reinforced using several complementary formats, including written resources, awareness posters, in-person classes, and videos.

In Practice

- In partnership with the Colorado Center on Law and Policy, the Colorado Criminal Justice Reform Coalition has developed Take Care–Health Matters, a comprehensive website with archived webinars and resources for criminal justice professionals, health care providers, and people involved in the criminal justice system in Colorado. The resources include many that discuss the value of obtaining and using health insurance. While the site was developed specifically for Colorado, the site and its resources may be useful for people from any state.²⁰³
- Kentucky uses videos that explain the advantages of Medicaid enrollment for people leaving prison and jail, and information about how to apply. It features personal accounts from people who have been helped by having health care coverage.²⁰⁴
- SAMHSA's SOAR Works website (<https://soarworks.prainc.com>) provides information and training for case managers and others who assist with completing applications for SSI/SSDI benefits, including resources and content in the free online training course about conveying the value of connecting people facing homelessness to SSI/SSDI benefits and health care coverage, including Medicaid. The website also contains a section focused specifically on the criminal justice population.²⁰⁵

* These applications are for individuals who are newly eligible or previously chose not to apply, as well as those whose benefits were terminated. (In contrast, Issue 2 focuses on only reactivations for suspended benefits.)

† Literacy programs in this section focus on informing people about the benefits of enrollment. Issue 4 examines how these programs can help enrollees better understand how to use their benefits in the community and avoid unnecessary emergency care.

Some states or their facilities allow people to apply for Medicaid at any point during incarceration (at intake, as part of behavioral health screenings in the prison or jail, for an inpatient stay in a medical institution during incarceration, or as part of reentry planning), and other states allow them to apply at a set point prior to release (e.g., no more than 45 days prior).

The level of effort dedicated to providing assistance with applications within prisons and jails seems largely determined by the available technology, procedural issues, political concerns, and funding for staffing. Assistance can range from providing minimal guidance to people who complete their Medicaid applications themselves, engaging trained individuals to provide some application assistance, and using trained or certified enrollment staff from community-based organizations or health or social service agencies to guide applications and work with Medicaid staff on eligibility determination issues. Some correctional facilities have staff trained to complete forms or become certified application counselors to aid with public health care enrollment²⁰⁶ (or enrollment in Qualified Health Plans [QHPs] or Marketplace options for people who are ineligible for Medicaid). States such as Indiana provide general guidance to correctional facilities on how to select and support the staffing needed to complete applications.²⁰⁷ In terms of SSI/SSDI, there is training for both corrections and other personnel on completing SSI/SSDI applications using a standardized approach.* The best configuration for facilities to provide enrollment assistance depends on the circumstances of particular jails or prisons, and may include a mix of funding sources and staff from numerous state, local, or community-based agencies.

VA Benefits and Medicaid

Staff working within prisons and jails can not only identify and refer veterans who are eligible for VA health care benefits upon release, but they can also assist eligible veterans in applying for Medicaid to guard against gaps in covered care and to enable access to a broader range of providers and services.

Qualified Health Plans

Correctional facilities can capitalize on the fact that when a person leaves incarceration it is considered a “qualifying life event,” which opens the door to applications being accepted outside of the regular open enrollment period. Prison and jail personnel who assist with applications may also act as facilitators for QHP enrollment for people who are eligible for tax credits to subsidize Marketplace health plans.²⁰⁸

According to Families USA, for 2016 Marketplace coverage, “individuals enrolling through the federally facilitated marketplace cannot apply ahead of their release. For 2017 and beyond, however, individuals will be able to notify the marketplace ahead of their release in order to obtain health care coverage as soon as possible following their release.”²⁰⁹

* SSI/SSDI Outreach, Access, and Recovery (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. Under the program, 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). For more on what the SOAR process entails, see <https://soarworks.prainc.com/content/what-soar> and click on “SOAR process.” Also, see “The SSI/SSDI Outreach, Access, and Recovery (SOAR) Model” text box on [page 50](#) for additional information, including more on the SOAR Technical Assistance Center.

☑ **What person or entity provides Medicaid application assistance, and how is that work funded?**

According to the Arnold Foundation study of 64 programs,²¹⁰ state-level programs are more likely than county-level programs to use correctional staff (76 percent versus 21 percent) to provide application assistance. The majority of programs overall, however, use personnel from public health or social service agencies, as well as staff from community-based agencies or nonprofit groups, to conduct enrollment.²¹¹ Many correctional facilities use a combination of staff from criminal justice and health agencies and organizations. For example, in the Monroe County (NY) Jail, jail staff, personnel from the County Office of Mental Health, and community-based health care providers all enroll people in coverage.²¹² In other facilities, non-correctional staff are paid by corrections or a health care partner to help with applications.²¹³ Existing correctional staff in still other facilities are trained by Medicaid or health care partners to assist with applications.

In Practice

- The following jurisdictions are among those that use nurses and other health care professionals from public health departments and other health/social service agencies to assist with applications: Colorado Department of Corrections,²¹⁴ Butte County, CA, San Diego County, CA, Santa Barbara County, CA, Sutter County, CA, and New York City, NY.²¹⁵ See also El Paso County, CO.²¹⁶
- In Rhode Island, interns from Brown University's Center for Prisoner Health and Human Rights, along with prerelease planners from the state Department of Corrections, help people complete applications while they are incarcerated.²¹⁷
- In Louisville, KY, Navigators funded through the state health benefit exchange work in jails on weekdays during business hours to enroll people in Medicaid and other health insurance plans.²¹⁸
- Imperial County, CA, uses personnel from a local Catholic Charities organization to assist with applications.²¹⁹
- In the Denver County (CO) jail, enrollment specialists from Denver Human Services screen people coming into the jail and complete applications for them if they are hospitalized or nearing release. The effort is paid for with savings from the Sheriff's Department's medical budget due to hospitalization billing to Medicaid for allowable services under the inpatient exception.²²⁰
- Enroll America is a nonprofit organization whose volunteers focus on enrollment activities across the nation through the *Get Covered America* campaign.²²¹ Correctional facilities, probation and parole offices, and reentry coalitions across the country have partnered with Enroll America to help connect people who are leaving jails and prisons with health care coverage, including Maricopa County, AZ, the Health Re-Entry Coalition of Kentucky, and Santa Cruz County, CA.²²²

Some enrollment personnel are permanent, in-house staff members within the corrections facility (e.g., corrections personnel trained by Medicaid or health care agencies or application assistants and case managers assigned within correctional facilities), as is the case for the Napa County Department of Corrections, CA, the Massachusetts Department of Correction, Thurston County, WA,²²³ and Multnomah County, OR.²²⁴ Corrections staff often work in concert with health care partners.

In Practice

- In Washington State, an MOU between the Health Care Authority (the state agency that oversees Medicaid) and state prisons and some of the state's larger jails clearly delineates roles and responsibilities with regard to enrollment. The jail facility is responsible for identifying people who are eligible and helping them apply for Medicaid at least 30 days before release. The jail is also responsible for securing documentation that confirms the consent of the applicant, including acknowledgement of their rights and responsibilities. The Health Care Authority, in return, gives the jail access to a streamlined online application, provides technical assistance, connects the jail with local organizations that can assist with applications, and offers training on Medicaid eligibility issues.²²⁵
- New Hampshire state prison and county jail staff help people apply for Medicaid prior to their release by either using an online application portal (known as NH EASY) or submitting the necessary forms by mail to the Department of Health & Human Services.²²⁶
- Santa Clara County, CA, uses general fund discretionary resources to support an initiative to submit a particular number of Medicaid applications daily at two local jails. As a part of this initiative, the Department of Correction and the Social Services Agency's Department of Employment and Benefit Services work together to screen people 30 to 60 days prior to their release date to identify potential applicants, with the goal of activating Medicaid benefits upon release.²²⁷

Medicaid Administrative Claiming: A Potential Funding Source for Staffing

States may receive federal reimbursement under Medicaid Administrative Claiming (MAC) for certain activities that are essential for the proper and efficient administration of their state Medicaid programs. MAC is often used by schools and mental health and social services agencies, in conjunction with their state Medicaid agency, to reimburse a portion of the costs incurred when performing allowable administrative activities such as outreach and eligibility intake. Its use, however, has been recommended for probation, parole, courts, and other criminal justice agencies that are becoming increasingly aware of its potential to help support Medicaid eligibility checks and applications.^{228*} To explore participation in MAC, jurisdictions should contact their state or local Medicaid agency. Public safety agencies may be able to seek reimbursement for some expenses under MAC, depending on their agreement with the state Medicaid agency.²²⁹ For example, prisons and jails may have the opportunity to use MAC for Medicaid enrollment activities performed in the 30 days prior to a person's release. The Legal Action Center points out that state Medicaid agencies may also consider stationing their staff members directly in jails and prisons to help train criminal justice staff on state eligibility and enrollment requirements and may claim MAC for these activities.²³⁰

* MAC is often discussed in conjunction with another federal program on Targeted Case Management (TCM). Prisons and jails are not typically positioned to access these reimbursements, as they do not oversee community-based care and are unable to meet all of the requirements.

Select counties and state authorities in Ohio, Illinois, New Mexico, Indiana, and California are among those in various stages of investigating the viability of obtaining reimbursement through the MAC program to help cover Medicaid-related administrative activities conducted by prisons, jails, and other criminal justice agencies.²³¹ In California, for example, the state's Medicaid Administrative Claiming Plan was amended in 2013 to authorize the claiming of administrative reimbursement for Medicaid application assistance. Administrative activities associated with Medi-Cal eligibility intake for people who are incarcerated and soon to be released was found to meet the necessary criteria, and the federal share (federal financial participation or FFP) could be used for those activities (but not other services for people in prison or jail).²³² In Bernalillo County, New Mexico, the Human Services Department's Medicaid Division is making MAC available to the county's Metropolitan Detention Center (MDC). This will allow some federal funds to be available for MDC's staff time spent on Medicaid-related activities, such as eligibility screening, application assistance, and educating people who are detained on the Medicaid program. If successful, these funds can be used to expand the MDC workforce conducting these efforts.²³³

There are, of course, MAC requirements for documenting time spent on Medicaid enrollment activities (for example, documenting billable time by activity code using time studies).^{*} Some agencies, such as the Alameda County (CA) Sheriff's Office's Youth and Family Services Bureau, have contracted with firms that track all time and activities for claims submitted by the state for reimbursement under MAC.²³⁴ Other agencies have investigated using apps for mobile devices that can track authorized personnel's time spent on billable activities.²³⁵ Costs can only be recognized as allowable Medicaid administrative expenditures to the extent that they are claimed consistent with federal cost-allocation principles.

Correctional agencies would benefit from a manual provided by the state Medicaid authority to guide them through such documentation requirements (similar to what states have done for schools that participate in MAC), as well as to describe other oversight and monitoring responsibilities of the state and its partner. Though the documentation duties may be too burdensome for small jails and some current data systems, the potential for significant funding for these activities may be realized by states that can take it to a large enough scale, even when billing responsibilities are taken into consideration.²³⁶

When are Medicaid applications completed?

The timing for completing applications can be influenced by the typical length of stay in the facility, the state's policies on suspension versus termination, and the ability of data systems to track the status of eligibility determinations and enrollments. It can also be influenced by the length of time it takes for benefits to be activated after release.²³⁷ State policies regarding when to begin the application process should take into account how much time is required to complete the application, how far in advance Medicaid and Social Security Administration agencies will accept applications prior to release, and how much time these agencies need to make eligibility determinations and process the applications so that benefits can be accessed on or soon after a person's release from prison or jail.

^{*} According to Community Oriented Correctional Health Services (COCHS)'s May 2015 FAQ, if only one service code is being used, "direct charging" is allowed for that tracked activity. States can otherwise conduct a time study (either a random moment time study or perpetual time study) to demonstrate claims.

Upon Intake

Some states may require, or correctional leaders have decided, that in order to reach the largest possible eligible population Medicaid applications should be completed at intake. This makes the most sense for people whose period of incarceration is short, most often in jails.

In Practice

- In Cook County, IL, enrollment is incorporated into the jail intake process in order to reach as many people as possible coming in and out of the facility.* Staff from Treatment Alternatives for Safe Communities, Inc. (TASC) meet with each person at intake to collect basic eligibility information if they want to apply for Medicaid and are not already covered by another form of insurance. Eligible individuals then verify their identities through fingerprint-based booking information in lieu of the usual required documentation, such as state identification cards or drivers licenses that they may not be able to provide.²³⁸ Staff use computers at the jail intake facility that have access to the jail's information system, the state Department of Human Services' website, the county's application site, and the U.S. Post Office's zip-code look-up to verify addresses. The entire application process takes 10 to 15 minutes per person.²³⁹ As of January 2016, more than 15,000 people had successfully enrolled in Medicaid in Cook County since the program's inception in 2013.²⁴⁰

For Inpatient Hospitalizations

Some states, including those that terminate Medicaid upon incarceration, enroll people who require inpatient hospitalizations in the community that meet the criteria to receive federal payment under the [inpatient exception](#). Applications can be filed at the time of the hospitalization or, in some cases, immediately afterward, with benefits and reimbursement payments applied retroactively within a specified time limit.†

In Practice

- Virginia's Department of Corrections (DOC) has worked to identify people who may be eligible for coverage before an inpatient hospitalization occurs.‡ The Department of Medical Assistance Services, the Virginia Department of Social Services, and the DOC have developed procedures for submitting applications to specific local departments of social services for eligibility determinations. As of 2013, applications were being submitted after an individual left the hospital. If all eligibility requirements were met, the individual was enrolled for a "closed" period of coverage that began on the date of the inpatient admission and ended with the date of discharge.²⁴¹
- The North Carolina Department of Public Safety (DPS) screens people with inpatient hospitalizations and facilitates applications for those eligible for Medicaid. In addition, DPS social work staff help people eligible for Medicaid in the correctional facility to apply within 90 days prior to their release.^{242§}

For more on inpatient enrollments that use presumptive eligibility mechanisms, see Issue 2, [page 30](#).

* While the majority of applications are completed at intake, some are also completed at discharge.

† As discussed in Issue 2, states can receive federal payment for services that incarcerated individuals receive during eligible inpatient hospital stays. In some cases, states choose to enroll people in a "limited benefit" and may also use presumptive eligibility processes to do so quickly. A full application may not have been completed if presumptive eligibility processes were used.

‡ Virginia is a Medicaid nonexpansion state that terminates benefits for individuals during incarceration.

§ North Carolina is a nonexpansion state that suspends Medicaid in state prisons during periods of incarceration.

As Part of Prerelease Planning

For some facilities, reentry planning begins soon after intake and is a continuous process. As part of this planning, many states and their facilities begin the benefit enrollment process a specified number of days prior to a person's release. The timing of applications is often meant to take into account eligibility determinations by benefits agencies, processing periods, and the goal of getting an insurance card or other proof of coverage into people's hands as they walk out the door.

In Practice

- In Ohio, the Department of Rehabilitation and Correction uses trained peer educators, or Peer-to-Peer Medicaid Guides, who conduct pre-enrollment classes under the supervision of facility staff to educate their peers about Medicaid, review the enrollment process, and provide assistance. These peer guides can also serve as a point of contact for follow-up. The enrollment process begins at least 90 days prior to release. Following the class, attendees connect directly to an Ohio Medicaid Consumer Hotline representative via a dedicated phone line. The representative completes the Medicaid application through a series of questions and helps individuals select a managed care plan.²⁴³
- In Wisconsin prisons, correctional staff screen people to see if they fall into any of the following categories that might warrant application assistance: people with mental health needs, developmental disabilities, lower reading scores, and language barriers.²⁴⁴ Social workers determine if people need help completing applications over the phone, a process that takes place on or after the 20th day of the month prior to the month of release. The Department of Corrections employs social workers and three contract benefits specialists who rotate among six facilities to provide assistance.²⁴⁵
- The Arnold Foundation's 2015 study revealed that Connecticut's unified Department of Correction (DOC) jail and prison system has had six DOC staff members acting as full-time discharge planners. They help incarcerated individuals fill out Medicaid applications prior to release. In all prisons and jails, the enrollment process begins when people are classified by level of health needs 60 to 90 days prior to release. Medical and behavioral health staff under contract through the University of Connecticut support Medicaid eligibility and enrollment activities for people identified as having more significant health needs, while people with lesser health needs are assisted by correction and reentry personnel. Applications are completed by the discharge planners and are then sent to the Department of Social Services (DSS) for processing.²⁴⁶ Through an MOU with the DOC, the DSS has a dedicated Pre-Release Entitlement Unit to only process applications received from the DOC. The DOC, the Judicial Branch, and the Department of Mental Health and Addiction Services fund the positions in the unit.²⁴⁷ The Department of Social Services has access to the DOC's roster that identifies which people are discharged daily, so that DSS can activate a person's Medicaid coverage upon release.²⁴⁸ *
- Colorado requires correctional facility personnel to provide application assistance to any person in a correctional facility who was receiving SSI, Medicaid, or both immediately prior to entering the correctional facility, or is expected to meet eligibility criteria upon release.²⁴⁹ Application assistance begins at least 90 days prior to release.

* For information on an Urban Institute pilot project in Connecticut that used an intake process in order to address the short stays of pretrial detainees, see the December 2016 report at <http://www.urban.org/research/publication/using-jail-enroll-low-income-men-medicaid>.

- In California, the Department of Corrections and Rehabilitation provides Medi-Cal, SSI/SSDI, and VA benefits application assistance to everyone released to parole or post-release community supervision* approximately 90 to 120 days prior to release.²⁵⁰

For more examples of states that incorporate benefit enrollment into prerelease planning, see for instance, Washington State (applications are completed as part of prerelease planning no more than 30 days prior to release), Arizona (people can apply before release but applications cannot be approved until actual date of release), and Michigan (eligible people can apply and be enrolled while incarcerated).²⁵¹

☑ **How are Medicaid applications processed?**

Most states have online applications that may be accessed through mechanisms provided within the jail or prison system. If paper applications are used, then the enrollment assisters follow state-specific requirements for submitting applications, as well as all dictates for having the individual's written consent to apply on his or her behalf.²⁵² In a case where an authorized representative is assisting with an application, the applicant's written consent is required, whereas an application assister who is not serving as an authorized representative does not need to secure written consent from the applicant.²⁵³ There are states and facilities using automated, semi-automated, and paper-based systems that are often in flux as system improvements are made. There are also personnel configurations, such as dedicated, centralized state corrections and Medicaid liaisons to help facilitate eligibility determinations for people leaving prison and jail. Some processes rely on trained assisters to complete most of the applications, whereas others depend on the applicants' ability to fill out most of the application themselves, with hotline or in-person staff to help with questions.

In Practice

- The California Department of Corrections and Rehabilitation (CDCR) submits completed Medicaid applications (as authorized by the applicant) to the county agencies where the person's release is scheduled to take place. Counties expedite the eligibility determination—to the extent possible—if the release is scheduled within 30 days, and the county notifies CDCR prerelease staff of the outcome or if additional information is needed. Counties notify CDCR at least 10 days before release if the Medicaid determination will not be completed by the release date, such as when the individual needs to be contacted for additional information in order to determine eligibility.²⁵⁴ For people in county jails, the county board of supervisors, in consultation with the county sheriff, can designate an entity or entities (including a community-based agency) to assist people who are incarcerated with their Medicaid enrollment. Only designated entities that are county human services agencies, however, can make eligibility determinations.²⁵⁵
- The Colorado Department of Health Care Policy and Financing (HCPF) and the DOC have developed application processes that include the hiring of two full-time nurse case managers through the DOC that process prerelease applications. Case managers at the correctional facilities send permission forms that have been signed by the applicants to the nurse case managers at a central DOC office. The nurse case managers complete applications electronically based on information they access in the DOC's database.²⁵⁶ HCPF has given DOC limited access to PEAKPro, an online tool to track the status of applications. Most determinations are made in real time.²⁵⁷

* Post-release community supervision applies to the population who, under California's "realignment" legislation, are being supervised in the community by the county authority instead of the state even when they are released from prison.

- In Massachusetts, correctional staff used an electronic, online application for MassHealth (the state’s combined Medicaid and CHIP program) prior to the passage and implementation of the ACA. As of January 1, 2014, the DOC was instructed to submit paper MassHealth applications because the online application portal was not fully aligned with post-ACA requirements. As of March 2016, correctional facilities submitted all MassHealth applications to Medicaid using paper forms to be processed for eligibility.²⁵⁸ There are 58 DOC employees who are trained as Certified Application Counselors. The DOC’s Reentry Services Division also helps oversee the application and data-tracking processes. A DOC liaison helps to manage the process in coordination with a liaison from MassHealth to keep successful enrollment determinations rates high. (For more about the data Massachusetts collects, see Issue 5, [page 92](#).)²⁵⁹
- In Pennsylvania, the Department of Human Services uses a web-based application called COMPASS that allows for online Medicaid applications—and applications for other types of benefits administered by the state—that can be electronically submitted for people in state correctional institutions.²⁶⁰

There are both high- and low-tech options that prisons and jails are using to help process applications. These are constantly evolving as electronic systems are improved and efforts are taken to scale.*

How are SSI/SSDI applications completed?

Issue 2 discussed how state prisons and jails have used written [prerelease agreements](#) with the Social Security Administration to expedite benefit reinstatement. However, they can also be used for people applying for the first time for SSI/SSDI or applying anew because their SSI enrollment was terminated after 12 continuous months of incarceration. The time between starting a new SSI and SSDI application and receiving Social Security Administration approval and enrollment in benefits can take at least three to five months, due in part to the complex and multistep process involved in making a determination about a person’s disability.²⁶¹ Prerelease agreements can facilitate and improve application processing and eligibility determinations for SSI/SSDI among people returning to their communities after incarceration.²⁶² These agreements can be applied to one or more facilities.²⁶³

[Prerelease agreements](#) should be reviewed annually and updated to reflect operational changes within institutions. The review also creates an opportunity to inform new staff of their responsibilities under the agreement.²⁶⁴ State prisons and local jails that hold sentenced populations for longer terms and do not currently have arrangements with the Social Security Administration can particularly benefit from formal written agreements.

* For example, Cook County, IL uses PCs to enroll at booking; Denver uses kiosks for individuals to use for enrollment; Alameda County, CA uses automated enrollment based on booking data (Resources and additional examples are available at *Health Reform and Public Safety Series: New Opportunities, Better Outcome* at <http://info.nicic.gov/hrps/?q=node/27>).

The SSI/SSDI Outreach, Access, and Recovery (SOAR) Model

The SSI/SSDI application process is complex and challenging to navigate. To increase approvals, the Substance Abuse and Mental Health Services Administration (SAMHSA) funded the SSI/SSDI Outreach, Access and Recovery (SOAR) Technical Assistance Center,* which focuses on providing training to facilitate the submission of SSI/SSDI applications. The SOAR approach has been successfully implemented into benefit application processes as part of transition and reentry planning in jails and prisons across the country. In 2015, criminal justice facilities in 20 states were using the SOAR process.²⁶⁵ † Staff assisting in the completion of applications can take a free, online course to learn the SOAR process. ‡ National technical assistance is available through SAMHSA's SOAR Technical Assistance (TA) Center, and each state has a SOAR lead.

In Practice

- Initiated in September 2005, the Center for Urban and Community Services (CUCS) provides an “entitlements liaison” at the Community Orientation and Reentry Program unit at New York State’s Sing Sing Correctional Facility. In 2015 alone, CUCS reported 96 percent of 47 adults were approved for disability benefits in an average of 31 days.²⁶⁶
- The Georgia Department of Behavioral Health and Developmental Disabilities began a SOAR pilot project in 2009 at the Fulton County Jail. The behavioral health staff were given jail access cards to work with potential applicants. Staff received referrals from social workers in the public defender’s office, interviewed potential applicants, completed SSI/SSDI applications, and hand-delivered them to the Social Security Administration. The positive results prompted the Georgia Department of Corrections to provide SOAR training to 33 correctional officers to work on SSI/SSDI applications in Georgia’s prisons.²⁶⁷

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 (PE) is a mechanism that states and local jurisdictions have used to enroll individuals in Medicaid to ensure immediate but temporary access to health care coverage for people who are likely to meet Medicaid eligibility criteria. In addition to securing immediate health care coverage, PE can put people on a path to full, longer-term enrollment—particularly in states that do not have quick determination processes.

* From 2006 to 2015, SOAR reached all 50 states and reported 27,226 approvals on initial application, with a national approval rate of 65 percent in an average of 81 days. See SAMHSA’s SOAR TA Center, <https://soarworks.prainc.com/article/2015-national-soar-outcomes>.

† The SOAR application process can be used in prisons and jails, as well as in community supervision agencies and specialty courts to achieve better outcomes. For individuals with shorter jail stays, the application process can be started at prerelease with a hand off to community partners for completion.

‡ This free, online course, estimated to take about 16 hours, is available at <http://soarworks.prainc.com/course/ssissdi-outreach-access-and-recovery-soar-online-training>.

Presumptive eligibility is usually a state option that allows designated entities, such as federally qualified health centers, hospitals, and schools to immediately enroll individuals in Medicaid for the short term. (Even without state action, health care reform expanded the allowable use of PE to all hospitals that opt to use it and accept Medicaid.²⁶⁸) States may designate any entity, including a correctional facility, to presumptively determine eligibility for Medicaid if the state determines the entity is capable of making such decisions (subject to federal approval).²⁶⁹

Application processes can vary for presumptive eligibility, including whether the full Medicaid application is used. If a full Medicaid application is not used, individuals will need to complete one at a later date to be fully enrolled.²⁷⁰

☑ *Are there hospitals that use presumptive eligibility to temporarily enroll people who are incarcerated?*

For corrections, presumptive eligibility is most often used in the context of hospitalizations that fall within the [inpatient exception](#). At that time, hospitals can file full applications or determine that a person is presumptively eligible to ensure enrollment for the hospital event. Sometimes enrollment will cover subsequent hospitalizations within a set length of time during incarceration as long as these events fall within the PE period. Correctional facilities should be aware of which hospitals in their area, if any, have adopted PE mechanisms for temporary enrollment, in addition to knowing the limits of those benefits. (See examples in Issue 2: Maintaining Enrollment [pages 30-31](#).)

☑ *Does your state provide presumptive eligibility authority to correctional agencies?*

Some states are looking to authorize correctional agencies as “qualified entities” to employ [presumptive eligibility](#), which is not traditionally how it has been used. Some correctional facilities have explored this approach to ensure immediate Medicaid coverage for people leaving prisons and jails.²⁷¹ This is particularly useful for jails, where the length of stay is typically short, as it can encourage full enrollment.

In Practice

- New Mexico has broad [presumptive eligibility](#) policies and systems in place.²⁷² In 2013, New Mexico’s Human Services Department (HSD) submitted an amendment to its Medicaid state plan to allow for PE use in its correctional facilities.²⁷³ Jail personnel report that PE facilitates coverage for people leaving jails for post-release medical and behavioral health care.²⁷⁴ Presumptive eligibility includes a rapid review of the full Medicaid application. If an applicant is determined to be likely eligible for Medicaid, benefits will be approved for 30 days. If the applicant’s full application has not been reviewed within 30 days, benefits can be extended for an additional 30 days.²⁷⁵ Applications are submitted through the state’s electronic Medicaid application system, with review for PE conducted immediately and approval promptly provided via the same electronic system.²⁷⁶ To be eligible for coverage through PE, the applicant cannot have had PE coverage within the past year. For this reason, jail personnel check the applicant’s Medicaid status and history in the state’s electronic system prior to completing the application. In Bernalillo County, jail staff have been developing new processes to complete full applications as soon as possible and to reserve PE only for those people who are within a week of being released and have not yet received full Medicaid enrollment determination. Previously, personnel waited until the person was released to submit the PE application and full application so as to maximize the number of days that the individual was covered, and thus have access to care.²⁷⁷

Consideration 3

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

A report from the U.S. Department of Justice’s Bureau of Justice Statistics indicates that an estimated 32 percent of people in state and federal prisons and 40 percent of those in local jails reported having at least one disability, which underscores the need to enroll incarcerated people in SSI and SSDI.²⁷⁸ These monthly payments are critical for rent, food, clothing, and other essentials needed by people leaving prison and jail. In most states, Social Security benefit determination for a disability leads to Medicaid or Medicare eligibility (and most likely enrollment). It is preferable for a person to qualify on the basis of a disability, not income, because the benefits offered through categorical Medicaid are often more robust and are frequently accompanied by income supports. This may be of particular importance in nonexpansion states where individuals may not qualify based on income criteria. In these states, unless single adults qualify for Medicaid based on categorical eligibility, they can only gain access to Medicaid coverage through eligibility for SSI. It is more difficult to obtain access to Medicaid and Medicare through eligibility for Social Security benefits, however, as eligibility determinations for SSI and SSDI are more complex and require many sources of information and documentation.

Does your state allow successfully enrolled SSI recipients to qualify for Medicaid coverage without a separate application required?

As of 2016, in most states (33) and the District of Columbia, qualified SSI recipients can also access Medicaid coverage. In these states, the SSI application has the dual purpose of also serving as the application for Medicaid.²⁷⁹ In another seven states, the eligibility requirements used by the Social Security Administration for SSI are also used for Medicaid, but they require a separate application. (If both applications are filed and SSI eligibility is allowed, the applicant is also Medicaid eligible, but not vice versa.*) Ten states require separate applications for Medicaid and SSI; as there are additional criteria for Medicaid eligibility, it is not tied to SSI application approval.²⁸⁰

* The Social Security Administration will not adopt the disability decision of another agency or program. A person can be found by the VA to be “disabled,” for example, yet the Social Security Administration will conduct an independent disability determination.

TABLE 2. MEDICAID ELIGIBILITY FOR PEOPLE ENROLLED IN SSI²⁸¹*(Nonexpansion states are indicated in italics as of September 2016).*

States (33 plus the District of Columbia) that allow Medicaid eligibility and enrollment for SSI recipients* (SSI recipients do not need to take any other action.)	Alabama Arizona Arkansas California Colorado Delaware District of Columbia Florida Georgia Indiana Iowa Kentucky	Louisiana Maine Maryland Massachusetts Michigan Mississippi Montana New Jersey New Mexico North Carolina New York Pennsylvania	Rhode Island South Carolina South Dakota Tennessee Texas Vermont Washington West Virginia Wisconsin † Wyoming
States (7) that allow Medicaid eligibility for SSI recipients, but need additional action (SSI recipients must file separate Medicaid applications.)	Alaska Idaho Kansas Nebraska	Nevada Oregon Utah	
States (10) that do not allow Medicaid eligibility or enrollment for SSI recipients (States elected to use their own criteria in determining Medicaid eligibility for SSI recipients.)‡	Connecticut Hawaii Illinois Minnesota Missouri	New Hampshire North Dakota Ohio Oklahoma Virginia	

☑ Does your state facilitate enrollment in Medicaid while SSDI recipients are waiting to be enrolled in Medicare?

All SSDI recipients are eligible and enrolled in 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 eligible for both SSI and SSDI may also be eligible for both Medicaid and Medicare. Consequently, their Medicaid enrollment can continue even after their SSDI triggers Medicare enrollment.

IMPLEMENTATION ISSUES**Prioritizing Populations with Health Needs and Streamlining Processes**

Medicaid applications are generally more straightforward for single adults without dependents, and as a result, many prisons and jails routinely help to complete them. However, even these applications can be confusing and time consuming to complete if the required documentation and information are not readily on hand,²⁸² unless information is verifiable electronically. Policies that can reduce this burden—such as removing the income verification requirement for people who have been incarcerated for long periods of time—should be explored with state Medicaid agencies. Applications for individuals with dependents may need to be referred to county or state health agencies or application assisters in the community, as these applications tend to be more complex.²⁸³

* These states are known as “1634 states” as they elect to complete an agreement with the Social Security Administration outlined in Section 1634 of the Social Security Act that allows the administration to (1) determine eligibility for Medicaid using SSI criteria and (2) enroll SSI recipients.

† Wisconsin covers individuals up to 100 percent of the federal poverty level but did not adopt expansion.

‡ These states are known as “section 209 (b)” states as they opted to use more restrictive criteria to determine Medicaid eligibility for SSI recipients under Section 209 (b) of the 1972 amendments to the Social Security Act.

If resources are limited, it's important to prioritize who will be screened for benefit eligibility (Medicaid, SSI/SSDI, and for veteran status) and assisted with applications. The need to prioritize people with health problems—physical, mental health, and substance use—underscores the importance of conducting effective behavioral health assessments in prisons and jails, together with other assessments that gauge the risk of reoffending, which may affect a person's treatment options (e.g., the need for cognitive behavioral therapy or other interventions at higher doses to address criminal thinking as well as to promote recovery).²⁸⁴

Technology Challenges

The most common challenges reported by states regarding implementation are related to the lack of interoperability across **information management** systems, problems with access to other agencies' data and systems, inadequate functionality of existing systems, and other related information-sharing obstacles. It is also difficult to navigate issues related to privacy, implementation policies, and addressing the cost of technology. Some states' systems used by corrections agencies for Medicaid applications also have not been fully aligned with the ACA requirements, and while they are being redesigned, require paper-based or hybrid systems that are inefficient, costly, and increase the likelihood of human error. In addition, allowing assisters and applicants to access these systems from inside prison or jail has raised concerns about online security—leaving some systems to rely on telephone enrollment or other processes. Other sections of this paper address problems with data systems that can make it difficult to match who is incarcerated with who was previously enrolled in Medicaid, as well as issues related to being able to automatically turn benefits on and off for periods of incarceration. An increasing number of states report that they are getting closer to automated systems, which will improve coordination and integration across systems.

Selecting and Funding Personnel to Complete Applications

At the crux of some of the technology challenges are concerns about complying with privacy mandates associated with protected health information, including mental health and substance use treatment information. There are often misperceptions about what information can be shared and accessed that can be addressed through education efforts and role-based access. In most cases, application forms can be filled out by assisters who do not need to access protected information, particularly if they do not have to also do eligibility checks, or the information for the form is retrievable without needing to access protected health information. In all cases, assisters should be trained to work with people in prisons and jails so that they can be sensitive to their needs and perspectives, and receive the necessary training to efficiently and effectively complete applications to secure the highest possible success rates.

The selection of application assisters may be influenced as well by how their positions are funded. If, for example, individuals outside the prison and jail are able to receive MAC funding more easily or have alternative funding sources, those factors should be considered. Some facilities have helped to fund personnel by offsetting some of the costs from savings realized from **inpatient hospitalizations**, as mentioned in Issue 2: Maintaining Enrollment. All states can take advantage of this option—regardless of whether they have elected to expand Medicaid or not, and whether or not they suspend or terminate Medicaid upon incarceration.

As also discussed earlier, for states that still have longer determination processes, **presumptive eligibility** is a consideration for expedited (although temporary) enrollment and immediate access to care if correctional facilities are authorized.* It will be necessary, however, to determine what the process and associated costs are in doing any follow up regarding full enrollment when required for people whose interim enrollment lapses after

* This is particularly important for individuals experiencing a health crisis who cannot wait for a full determination to begin accessing treatment. (See e.g., http://healthaffairs.org/healthpolicybriefs/brief_pdfs/healthpolicybrief_106.pdf.)

they are released to the community, particularly if they are not going to be under community supervision. Some hospitals have expressed reluctance to use presumptive eligibility and to do the paperwork for inpatient exception patients—both because of the perceived additional workload and because the Medicaid reimbursement rates (which would apply to a larger pool of eligible individuals coming from corrections) tend to be lower than the rates corrections has historically paid hospitals for the care of individuals who are incarcerated. To alleviate some of these concerns, more states and corrections agencies are moving toward establishing systems that help ensure seamless, longer-term coverage.

Timing and Coordination

The most important challenge seems to be trying to develop data systems and processes that allow people to complete the enrollment process and leave prison or jail with active Medicaid benefits and the documentation and information they need to access treatment and services immediately upon release. This requires that any state policies provide sufficient time for eligibility determinations to be made and that states address other [barriers to benefit activation](#). For example, several state correctional officials stated that the period available to complete applications prior to an individual's release was shortened by state mandates, which has made it difficult to complete the process in time. Others have said that they have had to change policies related to determining release dates, such as the date by which all "good time credit" was calculated or reevaluate other factors that can influence release dates in order to pinpoint with more certainty when benefits could be activated or reactivated. How states deal with redetermination processes can also influence whether full applications or more simple reactivations will be needed, particularly for people who have been incarcerated for a long period of time. Some suspension states are exploring whether [redetermination](#) dates can be tracked with other applicant data and whether policy changes might extend these periods or ensure that ex-parte/administrative processes are used effectively. States that reported the highest enrollment rates and coordinated benefit activation were those that had dedicated liaisons at both the Medicaid and corrections agencies.

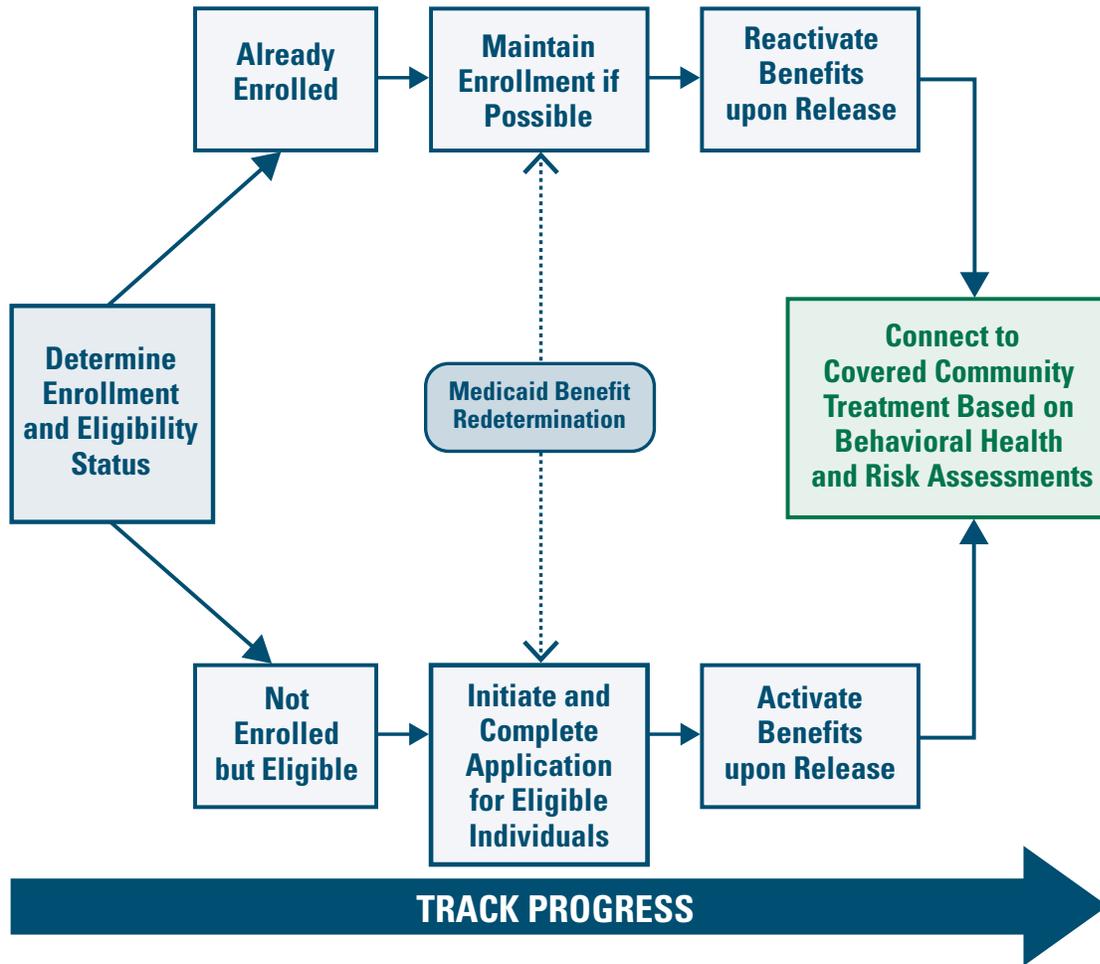
SSI/SSDI Applications

Because jails generally hold people for shorter lengths of time, it is likely that [jails](#) would assist with more benefit renewals and significantly fewer new applications than prisons. Partnerships with community groups that can help facilitate transitions for people leaving facilities with pending applications are an important component of successful reentry. Ideally, corrections agencies would have prerelease agreements or other memoranda of understanding (MOUs) in place with the Social Security Administration that outline agency responsibilities for both prisons and jails to enable new applications. In the absence of formal, written agreements, these agencies should establish standard protocols to ensure that SSI/SSDI benefits are in place upon release, whenever possible. It is important to have staff properly trained to assist with applications through appropriate programs. Submitting properly completed applications can significantly increase approval rates and decrease processing time for SSI/SSDI applications.

The role of corrections agencies does not need to end at the completion of applications. Staff may work with probation and parole agencies, [managed care](#) organizations, and other partners to help ensure that people are successfully enrolled in Medicaid or other health care coverage and understand their options, including (if available) enrollment in health plans with culturally-competent providers. In many cases, if a person does not pick a plan, one may be auto selected that is not well suited for that person.²⁸⁶ As discussed in Issue 4 that follows, for Medicaid, Social Security, and veterans benefits, it is also important that people released from prison and jail [understand how to access those benefits](#) and where to find Medicaid-covered health care and services once released to the community.



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



OVERVIEW

A large number of people leaving prisons and jails have serious behavioral health disorders, frequently combined with physical illnesses, that need to be addressed within the context of a comprehensive reentry plan—a plan that builds on correctional agencies’ investments in an individual’s treatment during incarceration. It is critical to ensure that there is continuity of care, particularly in the vulnerable period immediately following a person’s release.* With Medicaid increasingly becoming the primary payer of behavioral health services in the community, enrollment is only an important first step in accessing those services. The next step is to ensure that the state Medicaid benefit plans cover and pay for the types of services most relevant to people with behavioral health needs who are leaving prisons and jails.

If state agency professionals, policymakers, and corrections leaders want to ensure that people get the help they need to advance recovery and reduce recidivism, there are three significant challenges that need to be met:

* The extent to which corrections can provide treatment or help stabilize an individual depends on many factors, including how long the person is incarcerated.

- 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 to health care
- 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

Behavioral Health Services: Just One Component of Reentry

Many resources exist that delve into the full range of reentry strategies that can be used to meet the needs of people with behavioral health disorders leaving prisons and jails. A good number of these are beyond the scope of this paper. The focus of this section is on increasing access to comprehensive behavioral health care services covered by Medicaid as part of a reentry plan for people returning to the community after incarceration. As a starting point, for more information on reentry issues such as employment, housing, and other key supports, please see the National Reentry Resource Center (csgjusticecenter.org/nrrc); the SAMHSA GAINS Center for Behavioral Health and Justice Transformation’s Guidelines for Successful Transition of People with Behavioral Health Disorders from Jail and Prison;²⁸⁷ and the Center for Advancing Correctional Excellence at George Mason University’s Risk-Needs-Responsivity Simulation Tool portals that can help assess community programs and resource capacity (gmuace.org/research_rnr.html).

FEDERAL LAW AND GUIDANCE

There are a number of federal laws and guidelines that have traditionally affected the structure of state Medicaid programs and the range and types of services that can be covered. States establish and administer their own Medicaid programs, deciding the type, amount, scope, and duration of services offered within these broad federal guidelines. Federal guidance that is periodically released to state officials helps interpret what is allowable. Guidance provided by the Centers for Medicare & Medicaid Services (CMS) in 2016, for example, has helped to effectively expand some Medicaid-covered services by clarifying what treatment and supports may be covered within allowable categories or provisions, including some behavioral health services that are often needed by people leaving prisons and jails.

1. Benefit Design and Covered Services

All state Medicaid programs are required to provide a suite of mandatory services and can choose to offer a range of optional services as well (see Table 3, “Mandatory and Optional Medicaid Benefits”). In addition, states may offer different combinations of benefits to people who fall within various Medicaid eligibility categories. As a result, there can be considerable variation among benefit plans, even within a state.

TABLE 3. MANDATORY AND OPTIONAL MEDICAID BENEFITS*

Examples of Required Benefits	Examples of Optional Benefits
<ul style="list-style-type: none"> • Inpatient hospital services • Outpatient hospital services • Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services • Medicaid Nursing Facility (NF) services • Home health services • Physician services • Rural health clinic services • Federally qualified health center services • Laboratory and X-ray services • Transportation to nonemergency medical care 	<ul style="list-style-type: none"> • Prescription drugs • Clinic services • Occupational therapy • Other diagnostic, screening, preventive, and rehabilitative services • Case management • Intermediate Care Facility services for Individuals with Intellectual Disability (ICF/ID) • State plan Home and Community-Based Services (HCBS) 1915(i) • Inpatient psychiatric services for people under the age of 21 • Health homes for people with chronic conditions

For states that have expanded Medicaid eligibility for all adults below 133 percent of the federal poverty level[†] (which includes many people in the criminal justice system), covered services for the expansion population are outlined through an “Alternative Benefit Plan (ABP).” Within any given state, the ABP for the Medicaid expansion population can differ from the benefit plan provided to traditional Medicaid-eligible groups. All ABPs must include Essential Health Benefits, which are broad categories of services that all private Marketplace plans are required to provide.[‡] These Essential Health Benefits include mental health and substance use disorder services, although the law does not define the specific services that these benefits must include.²⁸⁸ States may also implement multiple alternative plans tailored for particular expansion populations[§] through the submission of a state plan amendment (SPA).²⁸⁹

Some Medicaid expansion states have aligned their ABPs with the benefit plan for the traditional Medicaid populations within their state. For example, Michigan added substance use treatment—including peer support specialists—to its ABP to mirror traditional state plan coverage.²⁹⁰ Other states have done the reverse, adding benefits to their traditional state Medicaid plans that are in their ABPs. Kentucky, for instance, expanded substance use treatment services to all traditional state plan enrollees, which matches the level of coverage in its alternative plan.²⁹¹

* For a full list of covered services, see CMS “Benefits,” U.S. Department of Health & Human Services. Accessed June 8, 2016. at <https://www.medicare.gov/medicaid-chip-program-information/by-topics/benefits/medicaid-benefits.html>.

† As mentioned previously, the federal poverty level (FPL) is a measure of income that is issued every year by the U.S. Department of Health and Human Services and used to calculate eligibility for Medicaid. In 2016, a family of four would be eligible for Medicaid in expansion states with an annual income of \$32,319 or less, and a single adult would be eligible with an annual income of \$15,800 or less. (Some sources cite the eligibility threshold as 138 percent of the FPL in expansion states, which accounts for the 5 percent that is effectively added as part of an income calculation methodology introduced through the ACA: Modified Adjusted Gross Income, or MAGI). Department of Health & Human Services, Office of the Secretary, Notice, “Annual Update of the HHS Poverty Guidelines,” Federal Register 81, no. 15 (January 25, 2016): 4036, <https://www.gpo.gov/fdsys/pkg/FR-2016-01-25/pdf/2016-01450.pdf>. For more information for families, see Families USA, “2016 Federal Poverty Guidelines,” at familiesusa.org/product/federal-poverty-guidelines.

‡ Although Essential Health Benefits do not apply to traditional Medicaid plans, some states have chosen to align them.

§ States could conceivably create an Alternative Benefit Plan specifically for the criminal justice population. (Interview with Chris Heiss from CHCS.)

Institutions for Mental Diseases Exclusion

The [Institutions for Mental Diseases \(IMD\) exclusion](#) has prohibited federal Medicaid payment for any services provided to otherwise eligible people between the ages of 21 and 64 who are patients in any “hospital, nursing facility, or other institution of more than 16 beds, that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases.”^{292*} It has been interpreted to apply to residential and inpatient facilities providing care to people with mental health and substance use disorders.

CMS has been working to increase access to inpatient behavioral health services for Medicaid beneficiaries.[†] Given the high number of people with mental illnesses and substance use disorders leaving prisons and jails, these actions can have a meaningful impact on that population. For example, [a July 2015 letter was issued](#) from CMS to state Medicaid directors permitting states to use demonstration waivers to provide residential substance use treatment services within facilities that are determined to be IMDs as part of a state’s comprehensive, evidence-based transformation of its substance use treatment system. (The improvements must meet a detailed list of CMS criteria.)²⁹³ The waiver would allow for federal share payments to cover Medicaid services that are received for a specified period of time in such IMD facilities.

CMS also released in 2016 [a final rule on Medicaid managed care organizations \(MCOs\)](#) that allows a state to work with MCOs to substitute services or settings for those covered in the state plan when they are cost-effective and medically necessary (i.e., the “in lieu of” provision).²⁹⁴ This provides managed care organizations the flexibility to use IMD facilities to ensure that appropriate care is provided.[‡] Therefore, if a residential substance use treatment benefit is included in the state plan and the managed care contract, and an individual leaving jail or prison needs this level of care but this treatment option is unavailable or there is insufficient capacity locally except for in an IMD facility, that facility can be used to provide those services if doing so is cost-effective and a necessary medical service.

2. Service Delivery

States and care management entities are increasingly working to achieve parity in behavioral health care as set out in both federal law and in more recent CMS rules. The parity mandates are meant to ensure that mental health and substance use treatment benefits are consistent with coverage for other physical health services. In addition, various payment and service delivery models, including managed care and health home approaches, are structured to improve care coordination and enhance health benefits for people with complex or chronic conditions:

* “Primarily engaged” refers to the activities of a facility in which more than half of the patient population is admitted for care attributed to mental illnesses or substance use disorders.

† CMS offered an innovation model authorized by Section 2707 of the ACA (the Medicaid Emergency Psychiatric Demonstration) for participating states to improve access to psychiatric care and reduce strain on general hospital emergency departments. Specifically, 11 states (Alabama, California, Connecticut, Illinois, Maine, Maryland, Missouri, North Carolina, Rhode Island, Washington, West Virginia) and the District of Columbia piloted whether reimbursing private psychiatric hospitals for certain services that are typically non-reimbursable would improve care quality and better control costs. The demonstration concluded in December 2015 and a final evaluation report will be posted upon completion at innovation.cms.gov/initiatives/medicaid-emergency-psychiatric-demo/.

‡ Under the final rules, MCOs can receive a capitation payment from the state for up to 15 days in a month for enrollees aged 21 to 64 who are receiving crisis residential services for behavioral health disorders in an IMD.

Parity Protections for Mental Health and Substance Use Treatment

The 2008 federal [Mental Health Parity and Addiction Equity Act \(MHPAEA\)](#) requires group health plans and health insurance issuers to make certain that financial requirements (such as co-pays and deductibles) and treatment limitations (such as medical management tools and day/visit limits) related to mental health and substance use treatment benefits are not substantially more restrictive than requirements for other medical/surgical benefits covered by the plan. In 2016, CMS released a final rule on how the parity law applies to MCOs and to Medicaid Alternative Benefit Plans within states expanding Medicaid coverage.^{295*} In the rule, CMS requires that parity protections apply to all managed care enrollees regardless of how services are delivered.† The rule also requires that every approved Alternative Benefit Plan is compliant, even if services are delivered through fee for service. State Medicaid agencies and, where applicable, MCOs share the responsibility for compliance.²⁹⁶ In October 2016, the Mental Health and Substance Use Disorder Task Force (established in March 2016) issued a series of actions and recommendations to help ensure the implementation of parity, including resources and guidance to help ensure appropriate oversight and compliance with parity protections and to help consumers, providers, and health plans understand the implications of parity.‡

Medicaid Managed Care

Whereas most states had traditionally used a fee-for-service model for delivering health care, in which providers were paid for individual services rendered,[§] state Medicaid programs are increasingly [contracting with MCOs](#) to coordinate and deliver Medicaid-covered services.** Thirty-nine states (expansion and nonexpansion) now contract with MCOs that are responsible for services for more than half of the nation’s Medicaid beneficiaries.²⁹⁷ These organizations are paid a monthly capitated fee for each enrolled Medicaid beneficiary and are responsible for providing the full range of covered services outlined in their contract with the state.

Health Homes

The Medicaid Health Home for Enrollees with Chronic Conditions provision, authorized by the ACA, allows both expansion and nonexpansion states the option of creating “health homes” as a state plan benefit to better integrate and coordinate care.²⁹⁸ These “homes” are not a physical place, but a team-based clinical approach offered in primary care or behavioral health care providers’ offices. According to CMS, health home providers “integrate and coordinate all primary, acute, behavioral health, and long-term services and supports to treat the whole person.”²⁹⁹ Eligible people must have either a serious and persistent mental health condition, two chronic conditions, or one condition with the risk of a second.³⁰⁰ State Medicaid programs implementing this model receive enhanced matching rates —90 percent for health home services for the first two years—

* At this writing, the federal parity law does not apply to traditional Medicaid fee for service or Medicare.

† The parity rules apply to both “carved-in” managed care arrangements (i.e., physical health and behavioral health services are managed within the same health plan by contracted MCOs using a capitated—per person/per month—rate) and “carved-out” managed care arrangements (behavioral health services that stay within traditional fee-for-service or state contracts with another provider outside of the health plan). For more about these approaches, see, e.g., National Council for Behavioral Health (2014), thenationalcouncil.org/wp-content/uploads/2014/11/14_Managed-Care-2.pdf and National Alliance on Mental Illness (NAMI) (2011) “[Managed Care, Medicaid, and Mental Health: Resource Guide](#).” Although there are different agencies, regulations, and guidance for commercial insurance plans versus Medicaid plans, the framework for conducting a parity analysis applies to both.

‡ For more information on the recommendations of the Federal Parity Task Force, see The Mental Health & Substance Use Disorder Parity Task Force Final Report at <https://www.whitehouse.gov/the-press-office/2016/10/27/fact-sheet-mental-health-and-substance-use-disorder-parity-task-force>.

§ In a fee-for-service delivery model, Medicaid agencies pay participating treatment providers who bill for each service they deliver to eligible patients, subject to reimbursement caps that vary by the type of service given.

** States’ movement toward managed care has been largely driven by the potential for cost savings, budget predictability, and a more coordinated approach to care, but additional research on the effectiveness of these models is still needed.

and can define their own target population in keeping with eligibility criteria. Although not targeted specifically at the criminal justice population, a significant number could qualify for services if they meet the state's Medicaid health home chronic condition criteria.

3. Treatment Capacity

Federal authorities require there to be an adequate number of Medicaid providers in a state in order to deliver quality services. Recognizing that there will always be needed services that cannot be entirely met through a Medicaid program, there are also some federal grant programs, such as grants from the U.S. Department of Health & Human Services (including those administered by SAMHSA and CMS) and the U.S. Department of Justice (including those administered by BJA) that provide support to states to increase behavioral health treatment capacity (see [Table 5, page 78](#)). States can use these funds to complement or create a bridge to Medicaid-covered services.

Access to Care Requirements

While the federal government defers implementation of Medicaid programs to the states, it maintains standards for access to care that ensure that enrolled people receive the care to which they are entitled. These requirements include meeting criteria for the availability of treatment and service providers. CMS actively monitors access to care through the review of provider reimbursement rates, network adequacy, and consumer surveys. States that contract with MCOs remain responsible for meeting federal access-to-care requirements and incorporating these expectations into their managed care contracts.

STATE APPROACHES

Despite these federal requirements with which all states must comply, states still have considerable flexibility in shaping their Medicaid programs, including determining which behavioral health services are covered, in what amount/duration, and how they are provided. The range of behavioral health services found in state Medicaid programs and the various mechanisms that can be used to improve service coverage, delivery, and availability are important considerations addressed in this paper.

No current benefit analyses were found that synthesize and compare various states' Medicaid plans for covered behavioral health services.³⁰¹ There are, however, a number of resources and ongoing research in this area that can put states on the path to understanding how their Medicaid benefit plans compare to other states.* Criminal justice, Medicaid, and behavioral health oversight agencies also are increasingly working together to determine if the scope of services included in a state's Medicaid benefit plans for both traditional and expansion populations is adequate to meet the needs of the reentry population. Services identified by researchers for this population that can advance recovery and help reduce recidivism include integrated treatment for co-occurring mental health and substance use disorders, cognitive behavioral interventions, and intensive clinical case management.³⁰² In addition, there must be a clear focus on how these services are delivered and whether the pool of providers is adequate and qualified.

* For example, the Legal Action Center (LAC) has a 50-state map that links to each state's health system and insurance options. It includes information on key contacts in the state, which health care services and medications are available to Medicaid recipients, which providers bill Medicaid, and how to connect with mental health and addiction treatment providers. It can serve as a good starting point for understanding the health policy landscape in a state. See lac.org/resources/state-profiles-healthcare-information-for-criminal-justice-system. Although not Medicaid-specific, a useful resource for finding behavioral health treatment providers can be found at <https://findtreatment.samhsa.gov>.

States can consider using the many complementary mechanisms and related Medicaid legal authorities reviewed in the table below to improve state Medicaid benefit plans, service delivery, and treatment capacity.³⁰³ The appropriate choices should be dictated by the specific problem(s) a state has identified and what solutions best fit its fiscal and political context.

TABLE 4. STATE AND LOCAL MECHANISMS TO EXPAND BENEFITS, IMPROVE SERVICE DELIVERY, AND INCREASE TREATMENT CAPACITY³⁰⁴

State Plan Amendments: The state plan is an agreement between the state and the U.S. Department of Health & Human Services' Centers for Medicare & Medicaid Services (CMS) on how the Medicaid program will be implemented within the parameters of existing CMS regulations. States can use state plan amendments (SPAs) to make changes to their Medicaid program for myriad reasons, including to:

- Expand Medicaid eligibility;
- Pursue new delivery system models or plan options targeted to people with behavioral health needs (such as health homes,³⁰⁵ managed care, or the Home and Community-Based Services state plan option*);
- Pursue federal funding to help cover certain case management services, including those that are not tied to a diagnosis;
- Use Medicaid Administrative Claiming (including application assistance); and
- Obtain the federal match for certain services for adults through Medicaid by adding these services to the state Medicaid plan as optional services, which would otherwise be paid for with general revenues.³⁰⁶

After a SPA is approved, it becomes a permanent part of the state plan and typically does not require further CMS approval or renewal until such time that it is amended again.³⁰⁷ SPAs often use “pre-prints” or templates provided by CMS that spell out the choices available to states and may have predefined approval timelines.

Waivers: A state can submit a waiver to CMS to request that the state be exempt from certain provisions of federal Medicaid laws and regulations.³⁰⁸ Waivers provide a vehicle for states to request and receive CMS approval to make changes beyond what is provided in existing federal Medicaid regulations. As such, waivers can allow a state the flexibility to make changes to its Medicaid program and improve coverage for people with behavioral health disorders.¹³⁰⁹

Expansion and nonexpansion states can use the following types of waivers to increase the number of people able to receive a greater range of Medicaid-covered mental health and substance use services.

* States can add the Home and Community-Based Services (HCBS) 1915(i) option to their state Medicaid plans to offer at-home and community services to specified groups of enrollees. This state plan option can be used in place of a more lengthy and complicated waiver process. (See <https://www.medicaid.gov/medicaid-chip-program-information/by-topics/long-term-services-and-supports/home-and-community-based-services/downloads/1915i-fact-sheet.pdf>.) Note that states can include HCBS services in their Medicaid State plans through multiple authorities, including the 1915(i) state plan option and the 1915(c) HCBS waiver option.

† States most often seek to waive requirements of comparability, freedom of choice, and “statewide” (so they can do pilot programs with particular populations or roll out a program by geographic area, enhance benefits to a vulnerable group, or change service delivery [such as to managed care systems]).

Waivers are an important mechanism to promote innovation and improve access to care, but the process can be lengthy and complicated.* CMS requires that proposed initiatives be cost-effective or budget neutral. Waivers also require renewal and public notice. Once approved, the waiver represents a contract between the state and the federal government, typically for a period of five years.

- *The Section 1115 Demonstration Waiver* can be used to expand Medicaid eligibility and to include services not typically covered by a plan³¹⁰ or to implement innovative models to improve quality of care and service delivery systems. These waivers include a required research or evaluation component.[†]
- The *1915(b) Managed Care Waiver* allows for the creation of Medicaid managed care delivery systems and can be used to provide an enhanced benefit package to specific beneficiaries. These must be determined by CMS to be cost-effective and efficient.[‡]
- The *1915(c) Home and Community-Based Services Waiver* allows a state to provide services in the community to enrollees who would otherwise qualify for institutional level care.[§] A state may tailor the services to the needs of specific groups of enrollees, which could include people with serious mental health and substance use disorders. For example, of particular importance for people leaving prison and jail, this waiver can help provide supported employment and housing-related activities and services.^{**}

State Legislative Action may be helpful, or in many cases required, to amend benefits provided through Medicaid or to change the spending authority. Legislation can prompt a SPA or waiver or can help qualify the range of services or delivery options available within an allowable category set out in the state Medicaid benefit plan.

Rules and Regulations provide the opportunity to implement programmatic changes authorized by state law. These rules provide additional guidance on the implementation of the Medicaid state plan and any related legislation, and can also effectively broaden services by clarifying what is covered within general allowable categories of care and the use of particular facilities.

Executive Action and Agency Policy and Protocol Changes can also make clear when Medicaid covers particular services—so long as they are consistent with the state Medicaid plan—and how these services are delivered. Strong partnerships between local corrections and behavioral health agencies or providers (such as those formalized in memoranda of understanding) can also expand services by making explicit which services are available within allowable categories. These agreements can help increase efficiency and effectiveness, coordinate care, and ensure that intensive interventions are prioritized for people with the greatest need.

* For more information about how waivers differ from SPAs see Appendix B and 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, Module 9).

† Some states have also transitioned from a waiver to a SPA to expand Medicaid eligibility (e.g., Pennsylvania), which reflects a more permanent change to the state Medicaid plan.

‡ Note that SPAs can also be submitted to implement managed care delivery systems.

§ States can combine the waivers for Managed Care, 1915(b), and Home and Community-Based Services, 1915(c), to implement a mandatory or voluntary managed care program that includes home and community-based services in the contract. The waiver allows for selective contracting with providers. However, because this combined option requires meeting the requirements of two separate waivers, few states are pursuing this.

** For more information on what falls within the parameters of “housing-related activities and services,” see <https://www.medicaid.gov/federal-policy-guidance/downloads/cib-06-26-2015.pdf>.

Payment Models/Financial Incentives can be structured so that administering entities (e.g., MCOs) (a) determine which services are allowable and cost-effective; (b) require coordinated service delivery; and (c) help to increase capacity by providing incentives to ensure quality managed care and encourage treatment providers to work with populations with complex needs.

- » **Managed Care Contracts** outline specific services that are reimbursable by Medicaid within permitted categories (e.g., substance use treatment might be defined as “including Medication-Assisted Treatment” when medically necessary).*
- » **Pay-for-Performance** payments can be used to provide a financial incentive to providers to meet specific quality measures. Payments can be attached to a range of processes or outcome measures and can be targeted to specific populations. These could include people in the justice system.
- » **Shared Savings** programs can facilitate data-driven care coordination and delivery by holding Accountable Care Organizations (ACOs) or similar entities financially accountable for the health outcomes of the population they address. Based on identified quality measures, ACOs participating in a Medicaid shared savings program might have incentives to focus on achieving better outcomes or cost savings for people in the justice system.† These programs may increase benefits or care coordination (through the use of home visits, for example) in order to reduce unnecessary, siloed care. As of 2015, there were eight states with ACOs.³¹¹
- » **Global Budgets and Capitated Payments** provide a fixed dollar amount or monthly payment rate, respectively, for the provision of a defined set of services for a specified group of Medicaid enrollees. These payment models can provide broad flexibility to providers in how they deliver services, giving providers the ability to spend more time coordinating care for complex patients. Examples include managed care contracts involving capitated per-member-per-month payments and global hospital budgets.

* States that instead use fee-for-service models can contract with Administrative Services Organizations (ASOs) to coordinate services provided under the state Medicaid benefit plan. For example, Connecticut uses an ASO model in which “an entity is contracted to administer the [state’s] Medicaid program and coordinate services, though claims are submitted to the Department of Social Services on a fee-for-service basis.” (See NASHP Toolkit at <http://www.nashp.org/connecticut-804/>.)

† Shared savings is a payment strategy that offers incentives for providers to reduce health care spending for a defined patient population by offering them a percentage of net savings realized as a result of their efforts. (See http://www.commonwealthfund.org/~media/Files/Publications/Issue%20Brief/2011/Aug/1539_Bailit_key_design_elements_sharesavings_ib_v2.pdf.)

KEY CONSIDERATIONS AND STATE EXAMPLES

Despite the many mechanisms for expanding which behavioral health services are covered by Medicaid in a state's benefit plan, there can be significant challenges in delivering these services and ensuring that there are sufficient treatment providers in the community to meet service needs. Even when a state's Medicaid benefit plan covers a particular behavioral health treatment service typically needed by people leaving prison and jail, it does not mean that these services are readily available to them upon release. Many people experience long periods on waiting lists and delays in initiation of services as treatment providers are already overextended. In most jurisdictions, there are fewer treatment providers prepared to work with the criminal justice population as part of their client base than are needed. The reality is that most states and counties continue to see declining or consistently low mental health and substance use treatment funding* or are attempting to build up systems that have been recovering from decades of cuts.†

There are many reasons for the inability to adequately respond to the demand for treatment, including treatment providers' dissatisfaction with Medicaid reimbursement rates, administrative/billing burdens that discourage plan participation, and inadequate training or experience in addressing the complex needs of the criminal justice population, with a resultant lack of bandwidth among the available qualified professionals.‡ Also, before parity mandates and passage of the ACA, substance use treatment services in particular were not well covered by Medicaid, so there may still be a shortage of Medicaid-participating providers to serve the criminal justice population.³¹²

The onus should not rest solely on state Medicaid programs and the behavioral health system to address the treatment and support needs of people returning to communities after incarceration, but should rather be a collaborative effort that leverages the expertise of criminal justice professionals—such as probation and parole officers—to directly address some clinical needs (e.g., drug use monitoring or cognitive behavioral interventions) while coordinating access to other effective community-based interventions.§ Given the impact that expanding coverage and improving reimbursements has on various budgets, the active involvement of legislators is important.

Increasingly, services provided in jails and prisons are being thought of as part of the larger community behavioral health care system. “In-reach” services that address people's specific risk and treatment needs can help ensure that “behind the walls” investments in care are not wasted, and that people are provided with a path to recovery.** Even though they are often not close to the communities to which people are released, prisons can play a critical role in ensuring continuity of care upon release through prerelease planning.

* NAMI states in a December 2015 report that fewer than half the states increased their mental health budgets in 2015 (in part making up ground from previous cuts), and only 11 states have consistently increased funding from 2013 to 2015. (See more at <https://www.nami.org/About-NAMI/Publications-Reports/Public-Policy-Reports/State-Mental-Health-Legislation-2015#sthash.CMumFcqG.pdf>; Declines have also been experienced in substance use federal funding sources. (See, e.g., <http://nasadad.org/wp-content/uploads/2015/02/SAPT-Block-Grant-Fact-Sheet-2016-1.pdf>.)

† In examining reductions in behavioral health budgets, it is important to consider to what extent treatment services have been leveraged through Medicaid budgets, particularly with Medicaid expansion and mental health parity requirements.

‡ As health systems and agencies make changes to Medicaid payment and reimbursement systems, treatment providers continue to seek assistance and resources to address associated infrastructure issues and challenges. Recognizing this need, SAMHSA launched BHBUSINESS Plus, a technical assistance program to help providers implement changes to their business practices and increase capability. Focus areas include designing and improving billing systems, enhancing eligibility and enrollment processes, and accurately costing out services. (See <https://nc-bhpublic.tenzo.io/home/>.)

§ This is not to suggest that the criminal justice system should create a parallel behavioral health system of care, but instead that some corrections professionals be trained to work with people with behavioral health needs and coordinate with a range of existing and emerging treatment partners to improve capacity and access to effective community-based interventions.

**With in-reach services, service providers engage with people in the prison or jail to help with their transition and continuity of care and make linkages to community resources (e.g., employment counselors, managed care organizations, housing specialists, and treatment providers).

Probation and Parole

Although community supervision issues are largely beyond the scope of this paper, it is important to note that among the array of services historically provided through and funded by corrections in the community, there are some that may now be eligible for Medicaid reimbursement (such as drug treatment). Medicaid providers and community corrections administrators should work collaboratively to transition from contracted service mechanisms to newer payer sources even though prior contracted reimbursement rates may have been higher and administrative burdens lower. Treatment providers may need to be actively encouraged to accept Medicaid payments. Directing payment for behavioral health services away from general funds to Medicaid funds can result in significant corrections and overall state savings that could be reinvested in increasing treatment capacity in the community.

In conjunction with benefit administrators, reentry coordinators, and their behavioral health partners, state policymakers should discuss the key considerations and questions that follow. State Medicaid benefit plans should be examined to determine which behavioral health treatments and related services are currently covered and therefore eligible for Medicaid reimbursement. In many cases, if a state elects to cover treatment services for mental health and substance use disorders, this coverage will include many of the behavioral health services needed by people returning to the community from prisons or jails. Several factors to consider in the benefit review process are discussed below, including whether states have multiple benefit plans and how states define which mental health and substance use services are covered and to what extent.

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?

Although all states cover behavioral health services for certain Medicaid beneficiaries, the scope of services, duration, and intensity vary considerably, especially as a state may have multiple benefit packages (traditional and alternative) under its state Medicaid program.³¹³ A 2015 study of four state Medicaid programs conducted by the Kaiser Family Foundation found that Medicaid coverage of behavioral health services is generally more comprehensive than Marketplace qualified health plans (QHPs).^{*} The study also found traditional plans in nonexpansion states were comparable to those in states that expanded Medicaid to a larger pool of newly eligible individuals.³¹⁴ More comprehensive analyses on the range of behavioral health services typically covered in state plans and related issues are needed.[†]

* All four states covered the following specialty behavioral health services: psychiatric hospital visits, case management, day treatment, psychosocial rehabilitation, psychiatric evaluation, psychiatric testing, medication management, individual therapy, group therapy, family therapy, inpatient detoxification, methadone maintenance, and smoking and tobacco cessation services.

† There continue to be discussions around differences in behavioral health coverage for traditional Medicaid state plans versus ABPs. In expansion states, for example, newly eligible adults who meet the federal definition of “medically frail” (individuals with disabling mental or chronic substance use disorders) are exempt from requirements that they enroll in an ABP. Instead, they have the option of enrolling in the ABP or accessing the full Medicaid state benefit package to the extent it differs. (See <http://kff.org/health-reform/issue-brief/the-affordable-care-acts-impact-on-medicare-eligibility-enrollment-and-benefits-for-people-with-disabilities/>.)

Court-Ordered Treatment

Policymakers should be aware that court-ordered services mandated by a judge and frequently provided by corrections or their treatment providers (based on assessed risk of reoffending and behavioral health needs) may not necessarily meet the requirements for payment with Medicaid funds. Although these services may be covered by the state Medicaid benefit plan, they must be deemed “medically necessary,” based on a medical diagnosis, to be eligible for Medicaid funding.

The duration of treatment ordered by the court must also meet criteria associated with medical necessity. Additionally, the treatment provider must be enrolled as a Medicaid provider for costs to be covered.³¹⁵ States can work with Medicaid medical directors, or chief medical directors can collaborate with correctional medical directors, to maximize the alignment of benefits with prescribed treatment. State and local officials can also work with judges to ensure court-ordered services meet Medicaid definitions of “medically necessary” and that the Medicaid plans and contracts cover court-ordered services.³¹⁶ Policymakers can also work to make the process easier for treatment professionals to enroll as Medicaid providers.

☑ What mental health and substance use treatment services and supports, in particular, does your state Medicaid program cover?

Research demonstrates that there are a number of services and supports that are effective in addressing the complex behavioral health and criminogenic needs of people involved in the criminal justice system.* These evidence-based practices can be used to mitigate the likelihood of an individual’s return to custody and have been shown to help advance recovery. Medicaid programs, in continuing their push for whole-person-care approaches, are examining important reimbursable supports for people with such complex needs. Some covered services go beyond medical or psychiatric treatment. For example, state Medicaid programs can help cover certain housing-related activities and services to assist people with disabilities, and who are chronically homeless, to find and keep permanent housing.³¹⁷ Still, there are services that are disallowed by Medicaid’s coverage exclusion for “inmates of public institutions” (such as certain in-reach services by community service providers) that prison and jail personnel would like to be federally reimbursed by Medicaid. These services would be important inclusions since correctional facilities are increasingly considered part of the health care continuum.³¹⁸ The following services are frequently needed by people involved in the criminal justice system:†

- Mental health treatment services
- Substance use treatment services³¹⁹
- Provision of psychiatric medication upon release
- Structured cognitive-behavioral and skill-building interventions, including those focused on criminogenic risk

* For more on the research about effective behavioral health services that addresses criminogenic needs, see Fred Osher, et al., *Adults with Behavioral Health Needs under Correctional Supervision: A Shared Framework for Reducing Recidivism and Promoting Recovery*, New York: The Council of State Governments Justice Center, 2012. For a detailed list of services and supports associated with positive outcomes for people with behavioral health needs leaving jail or prison, see “A Checklist for Implementing Evidence-Based Practices and Programs for Justice-Involved Adults with Behavioral Health Disorders.” See also, Crime Solutions at <http://www.crimesolutions.gov/> and the National Registry of Evidence-Based Programs and Practices at <http://www.samhsa.gov/nrepp> for justice-involved populations.

† The precise combination of treatment and services provided for a person must be guided by validated assessment tools and a thoughtful determination of his or her needs.

- Case management, including forensic assertive community treatment (FACT)*
- Integrated mental health and substance use services
- Medication-assisted treatment (MAT)
- Supported employment³²⁰
- Supportive housing services
- In-reach services³²¹
- Peer support services†

Various state agencies have initiated an inventory of behavioral health treatment services and supports that are covered by their state plans and are identifying their options to expand covered services as needed through authorized mechanisms. No comprehensive analyses or inventories were found at the time of this writing, however, which can place these into context or offer comparisons.³²²

In Practice

- California’s Department of Corrections and Rehabilitation (CDCR) currently funds mental health and substance use services for people who are on parole. However, the state is exploring whether it can instead enroll these individuals in Medicaid and access these services through Medi-Cal providers—which allows them to access federal matching dollars for these services. California is in the process of identifying whether there are sufficient behavioral health providers participating in the Medicaid program to serve this population. If so, this change is expected to translate into savings for both the CDCR and the state and potentially improve outcomes for people on parole.³²³
- West Virginia has been working to leverage its Medicaid program expansion to help residents successfully return from jails and prisons. The West Virginia Department of Military Affairs and Public Safety has worked closely with the state Medicaid authority to compare services provided in its treatment supervision program with services covered by Medicaid, to see where opportunities exist to qualify these services for reimbursement. In doing so, the state hopes to be able to focus on improving access to care and making more effective use of corrections’ resources.³²⁴

Changing the State Plan to Fill Gaps in Services

Once gaps in covered services have been identified, the two primary ways that states can make changes to their Medicaid plans to increase the scope of covered behavioral health services for people released from prison or jail are through a state plan amendment or a waiver (see Appendix B for a side-by-side comparison). These mechanisms often accompany or precede legislation. In addition, as state Medicaid agencies work to bring their mental health and substance use coverage into compliance with the federal parity law, this represents an important opportunity to ensure that the behavioral health treatment and medications needed by people in the criminal justice system are covered and accessible.

* For more information on FACT, see <http://www.prainc.com/wp-content/uploads/2015/10/fact-sheet-forensic-assertive-community-treatment-updating-evidence.pdf>.

† Like most other types of in-reach services, peer support is often not covered by state Medicaid plans. For more information on peer support, see <http://nashp.org/wp-content/uploads/2016/01/Peer-Supports.pdf>. For services for people with serious mental illness, also see <http://www.prainc.com/wp-content/uploads/2015/10/peer-support-criminal-justice-settings-role-forensic-peer-specialists.pdf>.

☑ **Are there changes that can be made to the state Medicaid plan through an approved state plan amendment?**

As noted in Table 4, state plan amendments (SPAs) address services that have already been deemed permissible under existing federal regulations but may not be currently covered under a state's Medicaid program benefit plans. SPAs approved by CMS can be used to make permanent changes to state Medicaid plans to cover specific services that are needed by people with behavioral health disorders who are in the criminal justice system. States can also use an amendment to pursue an Alternative Benefit Plan (ABP) targeted specifically to this population or to add specific benefit options authorized by CMS to their state plans. A SPA can be prompted by a state's budget revision and approval process or to enact a policy change dictated by legislation. States have also submitted SPAs to adopt Section 1945 of the Social Security Act that allows the addition of the Medicaid Health Home option to their state plans, which can enhance benefits and improve care coordination and management for people with chronic conditions who are enrolled in Medicaid. (See Consideration 2 on [page 72](#) for more on service delivery models.)

In Practice

- CMS approved a SPA for Pennsylvania that added peer support services to its Medicaid benefit plan for any beneficiary who meets the medical necessity criteria (and is not considered an "inmate of a public institution"). The Pennsylvania DOC also established a program that allows qualifying incarcerated people to become certified peer support specialists to help others in the facility identify and meet recovery goals.³²⁵ Although the activities of these peer support specialists are not paid for by Medicaid while they are incarcerated, the peer specialists can be paid by Medicaid if they become employed after release by Medicaid providers that offer peer support services, because their certification is recognized by the state agency that authorizes all certifications.³²⁶
- In 2016, the Texas Department of State Health Services broadened the scope of its 1915(i) Home and Community-Based Services (HCBS) program to focus on people with serious mental illnesses with histories of institutionalization, including extended inpatient psychiatric stays, frequent emergency room visits, and incarceration.^{*327} A trained recovery manager coordinates services among all agencies—including criminal justice agencies—involved in the person's care. Of particular interest in relation to participating people in the criminal justice system are services such as supported employment, peer support, and transition assistance (including set-up expenses for people leaving institutional settings). At the time of this writing, the health services agency is continuing to work with CMS to clarify the specific parameters of the amended HCBS program.³²⁸

* The 1915(i) changes were made at the direction of the state legislature in 2015 and implemented through a SPA that CMS approved in October 2015. Among those impacted are people with serious mental illnesses with "three or more discharges from correctional facilities during the three years prior to enrollment." Other eligibility criteria include an income of 150% of the federal poverty level or less. Individuals may also qualify for the benefit if they have had a long-term hospitalization in an inpatient psychiatric hospital within 5 years prior to Medicaid enrollment or if they have had 15 or more emergency department visits while enrolled in Medicaid and a history of inpatient psychiatric hospitalization or outpatient mental health treatment during the 3 years prior to enrollment. See Texas Department of State Health Services, Home and Community-Based Services—Adult Mental Health: Provider Manual, page 9

☑ *Can you use waivers to expand the range of services covered by your state Medicaid plan?*

There are a variety of Medicaid waiver authorities that can be used to expand the range of services covered under a state’s Medicaid plan. Waivers are typically used to obtain flexibility not provided under existing federal regulations and therefore require approval. They can be submitted to CMS to test new approaches (i.e., demonstration projects) or to replicate a successful approach on a larger scale. For example, waivers can help states provide people with behavioral health disorders with a broader range of needed services than those allowed under existing federal regulations, which can have a significant impact on people in the criminal justice system.

In Practice

- In August 2015, California received approval for a demonstration project for its five-year pilot, “Drug Medi-Cal Organized Delivery System.” It was the first state to submit a proposal in response to the July 2015 CMS guidance on using section 1115 demonstration projects to improve Medicaid substance use disorder treatment systems. California’s demonstration project provides for broad coverage of treatment services—with an emphasis on evidence-based care—organized by levels of care per the American Society of Addiction Medicine (ASAM) criteria within a managed care system.³²⁹ Notably, residential treatment providers that deliver care consistent with the ASAM criteria and that exceed the 16-bed capacity limit imposed by the IMD exclusion can receive federal Medicaid funding to treat Medi-Cal recipients with substance use disorders. Under the demonstration project, Medi-Cal covers two noncontinuous 90-day residential stays each year for beneficiaries, with the possibility of one 30-day extension if medically necessary—the average length of stay for residential services is 30 days.³³⁰ The criminal justice population may be eligible for locally funded longer lengths of stay if treatment is also found to be medically necessary.³³¹

☑ *Is there state legislation or regulation that can be used to facilitate state Medicaid plan changes and support the enhancement of behavioral health services in your state?**

State Medicaid programs pursue SPAs and waivers to receive federal approval for changes to their state Medicaid plan. State legislation can help facilitate this expansion of coverage for behavioral health services by demonstrating legislative support and statutory authority for revisions, consistent with CMS requirements. These forms of support are key factors that CMS considers when reviewing state requests. For example, Ohio passed HB 123 in 2014, which requires the state Medicaid program to establish standards to bill Medicaid for telehealth; and also passed HB 83, which requires the Ohio Board of Psychology to adopt rules to govern the use of telepsychology, with the intent to protect people who receive those services.³³² State regulations or rule making can also provide important clarifications about how a covered service will be delivered and any strategies for managing how resources may be employed.

* Changes can also be made by executive order and implemented at the agency level. See the Ohio example in the Medication-Assisted Treatment sidebar.

Medication-Assisted Treatment Coverage: How Various Mechanisms Come Together

The way that some states have ensured that medication-assisted treatment (MAT) and screening for co-occurring mental health and substance use disorders are part of their Medicaid-covered services exemplifies how various mechanisms can be used to initiate expansion of behavioral health care treatment options.*

- In 2015, Illinois passed legislation that required Medicaid managed care companies to eliminate prior authorization requirements and lifetime benefit limits for medications that treat drug dependence.³³³
- Vermont's MAT and related opioid treatment program was incorporated into its Global Commitment for Health waiver and then expanded through a health home state plan amendment in 2014. Spending authority was also incorporated through the state budgeting process.³³⁴
- Rhode Island also received state plan amendment approval for MAT through a health home proposal, which focused on opioid-dependent Medicaid beneficiaries who meet the requisite criteria.³³⁵
- Texas passed legislation in 2011 that allowed certain providers and facilities to use medication to manage "withdrawal/intoxication from all classes of abusable drugs."³³⁶ The state established procedure codes and billing guidance for MAT providers.
- In February 2011, the Ohio governor signed an executive order authorizing specified providers to use FDA-approved medications to treat opioid addiction.³³⁷ In 2012, the Ohio Medicaid program began to cover MAT for particular providers and settings.³³⁸ The Ohio Department of Mental Health and Addiction Services developed protocols for MAT implementation.³³⁹

CMS suggests that states "may consider reviewing their benefits coverage, service utilization, and other data to assess if Medicaid enrollees with opioid use disorder have sufficient access to MAT services," and offers technical support in making these assessments.³⁴⁰

Even using SPAs, waivers, legislation, regulations, or rule making, there are additional strategies that may be used to make certain that specific services—those that fall within allowable categories of benefits—are reimbursable. For example, some benefits can be more clearly defined in managed care contracts and other approaches that are consistent with state plans.

Remaining Gaps in Services

Even using all available mechanisms, however, there will inevitably be a need for behavioral health services that are not covered by Medicaid or that serve populations not eligible for Medicaid. For a discussion of other federal, state, and local sources of funding that may be leveraged to help fill these gaps, see page 78.

* According to CMS, MAT is the use of FDA-approved medications together with evidence-based behavioral therapies to provide a whole-patient approach to addressing substance use disorders. CMS states that, "providers offering substance use treatment can screen for mental health issues and provide services onsite (with appropriate mental health professional supports in place), along with referrals to community providers, depending on the illness severity and onsite mental health capacity." (See [medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-07-11-2014.pdf](https://www.medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-07-11-2014.pdf), page 6.)

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 following are models used to coordinate and improve Medicaid service delivery, as well as to realize cost savings. Some of these models rely on both changing the state Medicaid plan and implementing other approaches that do not require plan revisions.

Has your state considered a health home model to enhance the integration of treatment services?

Health homes (Section 1945 of the Social Security Act, as described in the Federal Law section on [page 60](#)) can be developed using a SPA.* Health homes are used to integrate and coordinate the many treatments and services needed by people who have chronic, serious, and complex health problems.

In Practice

- Rhode Island was among the first states to implement the Medicaid health home model, which focused on people with serious and persistent mental illnesses. Its health home services have included comprehensive care management, health promotion, individual and family support services, referrals to community and social support services, and transitional care follow up. People in the criminal justice system who meet the diagnostic criteria for health home services can be enrolled with the help of the behavioral health organizations that serve as transition planning contractors for the Department of Corrections.³⁴¹
- New York State has created a criminal justice pilot within five of its Medicaid health home programs that considers the needs of the criminal justice population and targets a broad range of services for chronic disorders.³⁴² Pilot participants eligible for health home services upon leaving jail and prison in the state are referred to the program and meet with health home providers while still incarcerated to learn how they will be able to access care, avoid improper emergency department use, and make appointments with community treatment providers.³⁴³ In designing the project, New York established a criminal justice committee that includes representatives from the Department of Corrections and Community Supervision. Some health home providers include sheriffs, parole officers, and others from the criminal justice system on their boards. With its ensuing evaluation plan, New York has been collecting data and outcome measures designed to determine whether health home services result in improvements in both health and public safety.³⁴⁴ Its efforts to identify and address issues specific to the criminal justice population have also increased health home enrollment in the state.

* 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." (See page 3 of CMS' "Health Homes (Section 2703) Frequently Asked Questions" for more information.)

✓ **Can your state use financial mechanisms or payment models to improve coordinated care and better define reimbursable services for people coming out of prison and jail who have mental illnesses and substance use disorders?**

Medicaid Managed Care Contracts

Medicaid managed care health plans have a considerable amount of flexibility in the way in which they engage beneficiaries and the specifics of which services will be reimbursable within allowable categories. States should ensure through their managed care contracts that they are getting the most effective and cost-efficient range of treatment options for the payments made to MCOs. These contracts can also have provisions that create appropriate financial incentives for coordinating the care needed for people coming out of prisons and jails.

Provisions in 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 reentry efforts and to conduct outreach and coordination upon their release.³⁴⁵

In Practice

- The Ohio Department of Medicaid, in partnership with the Ohio Department of Rehabilitation and Correction (ODRC), piloted the Medicaid Managed Care Prison Transition Program in the summer of 2014 to help enroll eligible people into Medicaid managed care plans prior to release.³⁴⁶ The enrollment process begins approximately 90 days prior to release when representatives from one of the state's five managed care plans connect with eligible people in the prison through ODRC's telemedicine system.³⁴⁷ If enrollees have two or more chronic health conditions (including mental illnesses and substance use disorders) and qualify for the state's health home program, they receive an enhanced level of case management. Case managers help them develop a transition plan, which includes scheduling appointments and organizing transportation.³⁴⁸ Due to efforts undertaken by ODRC staff, people now typically have both their Medicaid card information and their managed care plan information card in hand upon release from prison.³⁴⁹

Managed Care and Covered Services

In addition to shaping service delivery, managed care organizations (MCOs) typically have some discretion regarding the services they determine to be reimbursable within categories set out in a 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. Medicaid also can enter into contracts where MCOs agree to have network providers offer a specific suite of services to Medicaid beneficiaries or particular groups of beneficiaries. Because a state Medicaid program can refine the parameters of behavioral health care provision in the contract, the state and MCO could conceivably consider, in consultation with corrections and behavioral health professionals, whether the services meet the range of needs of people leaving prisons and jails. MCOs may be willing to cover additional services if they are a cost-effective alternative to paying for a state Medicaid plan's covered health services that would otherwise need to be provided.

Some managed care contracts advance both service coordination and benefit expansion.

In Practice

- In Rhode Island, the state negotiated new contracts in 2015 following its adoption of Medicaid expansion to incorporate specific changes to benefits for newly eligible adults. Among the modifications, the Executive Office of Health and Human Services added a stipulation requiring that providers within Medicaid health plans “conduct outreach and health risk assessments for individuals being released from incarceration.”³⁵⁰
- Florida included contract provisions stating that MCOs must reach out to plan enrollees to help them avoid, when possible, future inpatient services or their deeper involvement in the criminal justice system.³⁵¹ Outreach focuses on people who are homeless or at risk of involvement/already engaged with the criminal justice system to improve access to care. As part of this outreach, MCOs must use prevention measures, including connecting people to pre-booking sites that perform screenings and assessments, and link them to behavioral health treatment.³⁵²

Other Payment Models

It is beyond the scope of this paper to catalog and explain the policies associated with the many permutations of various payment models and financing mechanisms. Shared Savings and Global Payment models from Table 4 are important to highlight, however, because participating providers receive a flat amount per enrollee, rather than payment per service. Rather than volume driving payment, these models seek to reward value to encourage health care systems to deliver coordinated care in a way that improves quality and reduces costs. Accordingly, providers need to be concerned about which services are provided and how they are delivered.

☑ Are there other state and local approaches that you can use to improve the delivery of services and better define the range of Medicaid benefits?

In some cases, waivers can create other models of coordinated care. Executive orders, legislation, and other mandates—carried out through policies or protocols at the state, county, or facility level—can help define how services are delivered. Informal agreements can also be used by health plan administrators and behavioral health professionals to improve the quality of services that are tailored to the criminal justice population’s complex needs.

In Practice

- California has proposed creating a Whole Person Care (WPC) pilot program under a section 1115 demonstration waiver in order to give counties new options to provide coordinated care for vulnerable, high-utilizing Medicaid recipients.* The overarching goal of the WPC pilots would be to better coordinate health, behavioral health, and social services, as applicable, in a patient-centered manner, with the goals of improved beneficiary health and wellbeing through the more efficient and effective use of resources. As proposed, “this program will help communities address social determinants of health, and offer vulnerable beneficiaries innovative and potentially highly effective services on a pilot basis.”³⁵³

* At this writing, a decision has not been made regarding its approval/denial/revision.

- A 2014 Iowa state law requires that multiple state agencies, including the Iowa Department of Corrections and the Department of Human Services, develop a process to “address the medical and psychosocial needs* of individuals upon release from a correctional facility.” Specifically, the law requires “cross-disciplinary prerelease preparation.”³⁵⁴
- In accordance with state legislation and state Medicaid regulations, the New Mexico Human Services Department (HSD) included language in its policies for MCOs that says that care plans must be revised to help meet the health needs—including behavioral health—of people who become involved in the criminal justice system.³⁵⁵ MCO contracts require compliance with these and other HSD policies.³⁵⁶

Providing People with Documentation and Information for Accessing Benefits

Although reentry transition issues are largely beyond the scope of this paper,[†] two reentry-related challenges must be met before services can be delivered: (1) ensuring that people who leave jail and prison understand how to use their benefits to receive appropriate care in the community and (2) providing them, before their release, with any Medicaid, SSI/SSDI, or other enrollment documentation or identification needed to access treatment or benefit payments.

To help people leaving prisons and jails make appropriate use of services covered by Medicaid, and to use nonemergency services whenever possible, many states have developed health literacy programs.[‡]

- The Massachusetts Department of Corrections (DOC) employs three medical discharge planners who meet with every person scheduled for release who has a mental health diagnosis to arrange outpatient appointments with behavioral health care providers in the community. As part of reentry planning, the DOC educates people on how to access health services through the Medicaid program. Biannually, a MassHealth representative visits each DOC facility to answer people’s questions. A 2011 study of the Medicaid claims of 2,400 released individuals found that more than 70 percent had a medical visit within the months following their release. These people also accessed preventive care at nearly twice the rate of the general Medicaid population and had lower rates of inappropriate use of the emergency department.³⁵⁷

States are also pursuing various ways to ensure that people enrolled in benefits have the proof of insurance they need upon their release so they can access care, whether that includes physical benefit cards, policy numbers, or alternative workarounds.

- In Colorado, most people who are enrolled in Medicaid prior to release leave DOC facilities with a Medicaid benefit card in hand. For people who do not receive a card, the DOC ensures that they have the enrollment number and contact information for a nurse case manager if they have any questions after their release.³⁵⁸

* Psychosocial needs are psychological, social, spiritual, and environmental factors that contribute to wellbeing.

† A list of questions is provided in [Appendix C](#) as a starting point for state leaders to continue conversations that relate to the larger category of transition and reentry issues. See also the National Reentry Resource Center at csgjusticecenter.org/nrrc.

‡ CMS has a series of health literacy resources that may be helpful for reentry planning purposes, including videos called “From Coverage to Care.” DVDs can be ordered on the CMS website. Many states have also developed their own resources tailored to the specifics of their state systems and policies.

- States, such as Connecticut, are also developing processes for people who do not receive Medicaid documentation before release so they can access medication until their full enrollments are completed. Under the Medicaid Prescription Voucher program, people leaving prisons are given a voucher with their prescription for a 30-day supply of their medications at any Medicaid community pharmacy.³⁵⁹ Similarly, in New York City jails, if people have not received a prerelease Medicaid determination, they can get temporary pharmacy cards for needed medications.³⁶⁰

Consideration 3

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

There are several components to building community treatment capacity to help ensure that people returning from prison and jail can access needed services and supports. The first is systems-level change that focuses on the adequacy of provider networks (for example, whether there are enough providers in all areas of the state to deliver the range of needed services for the target population). The second component focuses on incentivizing providers, 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. Finally, states must contend with the fact that Medicaid reimbursement rates and the requisite administrative infrastructure to participate in Medicaid programs are among the greatest obstacles to capacity building.

Building Capacity in Rural Areas

There are many smaller or rural counties that lack the capacity to meet the needs of people who have behavioral health disorders. In these areas, regional behavioral health authorities and care providers can work with regional jails to share resources.

- The Merrimack County, New Hampshire, Department of Corrections is in the process of converting an old jail facility into a community corrections reentry center for men and women that will offer work release programming, gender-specific treatment and services, and assistance with SSI/SSDI enrollment. These are part of a greater effort to better connect people leaving jail to behavioral health services in the community.³⁶¹
- New River Valley, Virginia, has a regional partnership that created a therapeutic crisis assessment center where law enforcement officers can transfer custody of people having a mental health crisis to receive immediate evaluation in a therapeutic setting instead of in police custody.
- Six counties in Minnesota formed a regional partnership to provide mobile behavioral health services throughout the region and train law enforcement officers on how to access these services when responding to mental health crisis situations.

Network Adequacy and Performance Criteria

In order to increase community treatment capacity and promote quality services, states that contract with MCOs can include performance measures in their agreements that tie to specific quality standards.* For example, contracts may include specific expectations related to (1) having enough qualified care providers within the coverage area (often called a network adequacy requirement), (2) the timeliness of appointments (being able to see a provider within a specified number of days from request), and (3) required screenings for particular disorders to guide treatment prioritization decisions and make the best use of provider capacity. Meeting these performance measures can be tied to specific quality payments (such as “quality withholds” or performance incentives)† that allow states to encourage a level of performance from health plans.

States that have existing pay-for-performance models for health plans may include a special focus on people with complex needs who require more intensive coordinated care. These pay-for-performance contracts may include metrics that are tied to quality payments for working with people with complex needs, including people who have significant behavioral health problems and are at a higher risk for reoffending upon leaving prisons and jails.

- In Pennsylvania, to receive payment from the state, the MCOs that oversee physical health services and behavioral health organizations are required to demonstrate collaboration on such activities as identifying and prioritizing people who have the most serious mental illnesses and physical health needs, care plan development, real-time notification of hospitalizations, and pharmacy management.³⁶² The program was initially a two-year pilot in two regions. As of January 2016, the state has expanded the program statewide.³⁶³

Provider Financial Incentives

There will always be workforce issues related to provider capacity (including recruitment, training, certification, retention, and oversight), which are largely beyond the scope of this paper. Still, states can explore how value-based incentives can be linked to providers’ performance on a set of defined quality, cost, and efficiency measures related to services for people involved in the criminal justice system.³⁶⁴

Just as incentive payments can be provided for MCOs (e.g., through higher per-person capitation rates for enrollees with specific chronic conditions, including behavioral health disorders), states and MCOs can also provide incentives for providers to work with the reentry population. For example, a state might offer an increased billing rate to providers that use evidence-based treatment and delivery strategies that meet the specified criteria to serve people coming out of prisons and jails.

The goal of all service delivery efforts is to achieve improvements that result in quality coordinated care that is cost efficient and helps meet the needs of people with behavioral health disorders.³⁶⁵

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

† Under a quality withhold, the state retains a percentage of the established capitated rate that will be released to the health plan only if specified performance or outcome measures are achieved. (See <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/InformationandGuidanceforPlans.html>.)

☑ **What other federal, state, and local resources can your state use to address gaps in services and promote evidence-based practices that are not covered by Medicaid?**

Even after the most robust efforts to expand Medicaid-covered behavioral health services, there are sure to be gaps in needed treatment. However, there are federal, state, and local resources that can be used to address those gaps. In some cases, related grant programs have funded services not otherwise covered under a state’s Medicaid plan that, after demonstrating effectiveness, have been added to the state plan’s scope of covered services. To help states position themselves to use their Medicaid dollars most effectively and then fill gaps in services using other funding sources, it is important to catalog which sources can help achieve these purposes. The examples provided in Table 5 highlight some of the larger or more commonly used funding mechanisms that can be used to round out community behavioral health services for people leaving prison and jail and may also serve as bridges to Medicaid coverage. These are meant to provide a starting point for creating an inventory of available resources beyond general discretionary funding.

TABLE 5. Resources for Expanding Behavioral Health Treatment Capacity

FEDERAL
U.S. Department of Health & Human Services (HHS)
<p>Block Grants</p> <p>Authorized by the Public Health Services Act,³⁶⁶ block grants from the Substance Abuse and Mental Health Services Administration (SAMHSA) play a large role in supporting mental health and substance use treatment services.</p> <ul style="list-style-type: none"> <p><i>Community Mental Health Services Block Grant (MHBG):</i> The MHBG program provides funding to all 50 states, the District of Columbia, and most territories. Grants are administered by state mental health agencies and have traditionally been used to support mental health services for low-income adults (and children) who are not covered by other insurance (e.g., employment and housing services, peer support, and case management). This funding can help launch services that, once successfully implemented, could subsequently qualify for Medicaid reimbursement. In Michigan, for example, MHBG funds were used to create a statewide network of Assertive Community Treatment teams, and then secured Medicaid funding for ongoing sustainability.³⁶⁷</p> <p><i>“Community Mental Health Services Block Grant,” samhsa.gov/grants/block-grants/mhbg</i></p> <p><i>Substance Abuse Prevention and Treatment Block Grant (SABG):</i> SABG has historically been the primary source of funding for substance use treatment services and prevention for many states. Funds are administered by the state’s substance use treatment services agency responsible for planning, delivering, and monitoring efforts.* The program focuses on certain populations such as women who are pregnant and intravenous drug users as well as categories of services such as prevention. States retain flexibility, however, in how to use funds that have included substance use treatment services for uninsured low-income adults.</p> <p><i>“Substance Abuse Prevention and Treatment Block Grant,” samhsa.gov/grants/block-grants and “2016 Annual Meeting Presentations, SSAs in Criminal Justice Reform,”† National Association of State Alcohol and Drug Abuse Directors, nasadad.org/2016/06/2016-annual-meeting-presentations</i></p>

* These agencies are known as “single state agencies,” and have been funded in large part through SABG funds. State mental health agencies are primarily funded through Medicaid, and to a lesser extent, MHBG funds (See store.samhsa.gov/shin/content/SMA15-4926/SMA15-4926.pdf, page 3).

† The National Association of State Alcohol and Drug Abuse Directors (NASADAD) presentations highlight how state substance use agencies in New York, Pennsylvania, and Utah administer their funding, including but not limited to SABG funding, to address the needs of individuals with substance use disorders in the criminal justice system.

Certified Community Behavioral Health Clinics Demonstration Program

Planning grants were awarded to 24 states from SAMHSA in 2015 to develop Certified Community Behavioral Health Centers (CCBHCs).³⁶⁸ These CCBHCs are federally qualified health clinics that specifically serve individuals with behavioral health needs in the community. Eight planning states have been selected to participate in a two-year demonstration program from 2017-2019. These health clinics are eligible for higher Medicaid match rates for providing needed services such as targeted case management and crisis mental health services.³⁶⁹

“Section 223 Demonstration Program for Certified Community Behavioral Health Clinics,” samhsa.gov/section-223 and “CCBHC Resource HUB,” thenationalcouncil.org/topics/certified-community-behavioral-health-clinics/

Federally Qualified Health Center Grants and Enhanced Medicaid Reimbursement

Facilities considered Federally Qualified Health Centers (FQHCs)—which are often community health centers—provide care on a sliding-fee-scale to underserved populations and locations. FQHCs must meet quality assurance mandates and provide care even for patients who are unable to pay.³⁷⁰

These centers qualify to receive higher Medicaid reimbursement rates,³⁷¹ and grants from the Health Resources and Services Administration (HRSA) help cover uncompensated costs.³⁷² They can seek reimbursement from state Medicaid agencies for behavioral health services that are not included in the state Medicaid plan as long as the providers are “practicing within their scope of services.”³⁷³ FQHCs play a vital role in providing care³⁷⁴ and may be one of the few available and accessible providers in some geographic areas (e.g., rural areas that experience provider shortages). They can also be particularly responsive to individuals returning from jail and prison who may not be eligible for Medicaid.³⁷⁵

“Health Center Program,” bphc.hrsa.gov

Grants for Integrated Primary and Behavioral Health Care

Under the Primary and Behavioral Health Care Integration (PBHCI) program, SAMHSA provides grants to communities to coordinate and integrate primary care and behavioral health services in publicly-funded care settings. People with serious mental illnesses have higher morbidity and mortality rates compared to the general population and limited access to primary care services.³⁷⁶ Emerging models of care that integrate primary and behavioral health care have demonstrated improved health outcomes for this population.³⁷⁷

“SAMHSA PBHCI Program,” integration.samhsa.gov/about-us/pbhci

Innovation Center Grants and Technical Assistance

Authorized through the Affordable Care Act, CMS provides funding and technical assistance (TA) to states through its multiple programs to develop and evaluate state-led, innovative payment and service delivery models to improve system performance and quality of care and reduce costs.

- State Innovation Models (SIM) Program: States (often their Medicaid authority or public health agency) have received awards under the SIM program to test the implementation of new payment and care delivery models (such as integrated care models and health homes) within existing multi-payer systems (those using public and/or private insurance) to advance system reform. States must bring a range of stakeholders into the design process and “use the full range of their executive and legislative authority to facilitate and support new health care delivery models.”³⁷⁸ From 2013 to 2015, 38 awards were made across 34 states.

“State Innovation Models Initiative: General Information,” innovation.cms.gov/initiatives/state-innovations

- Health Care Innovation Awards: These complement the SIM program by funding projects at a more local level to test specific payment and delivery models for Medicaid and other beneficiaries. These approaches could then be implemented on a larger scale as part of a broader system-level change effort—which is the focus of the SIM program. From 2012 to 2015, 29 awards were made across 27 states.

“Health Care Innovation Awards Round Two,” innovation.cms.gov/initiatives/Health-Care-Innovation-Awards/Round-2.html

Medicaid Innovation Accelerator Program

The Innovation Accelerator Program (IAP) also complements the SIM program, described above. CMS launched the IAP in July 2014 to provide federal tools and resources to selected states, including opportunities for states to learn from one another and to support reforms of system-level payment and service delivery. Areas of focus include substance use service delivery systems, beneficiaries with complex needs, community integration through long-term services and supports, and physical and mental health integration.

“Medicaid Innovation Accelerator Program (IAP),” medicaid.gov/state-resource-center/innovation-accelerator-program/innovation-accelerator-program.html and for “News and Activity,” see medicaid.gov/state-resource-center/innovation-accelerator-program/news-and-activity/news-and-activity.html

U.S. Department of Justice

Justice and Mental Health Collaboration Program Grants

The Bureau of Justice Assistance’s Justice and Mental Health Collaboration Program (JMHCPC) grants provide funding to states, localities, and tribal organizations to facilitate coordinated initiatives among the criminal justice, juvenile justice, and mental health and substance use treatment systems.³⁷⁹ Grantees receive technical assistance to plan and implement system reform efforts and programming to address the needs of people with mental illnesses who are involved in the criminal justice system and improve public safety.³⁸⁰

“Justice and Mental Health Collaboration Program,” [bj.gov/ProgramDetails.aspx?Program_ID=66](http://bja.gov/ProgramDetails.aspx?Program_ID=66) and csgjusticecenter.org/mental-health/projects/justice-and-mental-health-collaboration-program/

Second Chance Act Grant Programs

These grant programs, administered by the Bureau of Justice Assistance and the Office of Juvenile Justice and Delinquency Prevention, support state, local, and tribal governments and nonprofit organizations in their work to reduce recidivism and improve outcomes for people returning from state and federal prisons, local jails, and juvenile facilities. Second Chance Act grant programs support the improvement of corrections and supervision practices that aim to reduce recidivism, as well as the provision of vital services—including employment training and assistance, substance use treatment, education, housing, family programming, mentoring, victims support, and other services. One grant program focuses specifically on improving connections to behavioral health treatment in the community as well as other supportive services for people with co-occurring mental illnesses and substance use disorders who are reentering their communities. Some grantees’ efforts have included connecting individuals to Medicaid and other benefits.

“Second Chance Act,” bj.gov/ProgramDetails.aspx?Program_ID=90 and csgjusticecenter.org/nrrc/projects/second-chance-act/

* FQHCs obtain approval from the HRSA’s Bureau of Primary Health Care for their “scope of service,” which is the basis of the prospective payment rate received from Medicaid. To change the amount the FQHC receives from Medicaid for a visit, the FQHC must submit a revised scope of services. (See http://www.integration.samhsa.gov/Financing_BH_Services_at_FQHCs_Final_7_23-12.pdf.)

State-Level Grants to Encourage Innovation

States may offer innovation grants to stimulate promising approaches at the state and local levels that can be used to bolster behavioral health community-based services for people leaving prisons and jails:

- *The Innovative Programs Component of the California Mental Health Services Act:* Counties can use these grants to expand community mental health services by providing treatment and other support services that are not otherwise covered to underserved groups.³⁸¹ Some counties are using this funding to focus on the criminal justice population. Los Angeles County, for example, is developing information-sharing structures among jail personnel, mental health navigators, and treatment providers to support people with mental illnesses leaving jail by helping with the scheduling of exact release dates and then increasing the number of people who are successfully connected to services in the community.³⁸²

"Mental Health Services Act," dhcs.ca.gov/services/mh/Pages/MH_Prop63.aspx

- Florida Criminal Justice, Mental Health, and Substance Abuse (CJMHS) Reinvestment Grant: Authorized by the 2007 Florida legislature (ss. 394.656, F.S.) and administered by the Department of Children and Families, this grant program gives awards to counties to plan, implement, or expand initiatives to address the overrepresentation of people with mental illnesses and substance use disorders in the criminal and juvenile justice systems. Grant recipients obtain TA to help execute activities outlined in their grant applications.

"Florida Criminal Justice, Mental Health, and Substance Abuse Technical Assistance Center," www.floridatac.com

- Indiana Recovery Works Program: Indiana passed legislation in 2015 (HEA 1006) that allows behavioral health treatment providers to receive vouchers to provide treatment and support services to people with behavioral health needs who lack health care coverage and have been diverted from incarceration or are leaving correctional facilities.³⁸³ Participating providers are expected to enroll participants in the state's Medicaid program and all other programs for which they are eligible, and the vouchers are intended to cover the cost of services not otherwise covered by Medicaid. The intent is to integrate multiple funding sources within the state. The legislature allocated \$10 million for the first year (SFY2016, from July 2015–June 2016) and \$20 million for the second year.

"Recovery Works," in.gov/fssa/dmha/2929.htm

Criminal Justice Agency Contracts

Criminal justice agencies (such as community corrections) can include a requirement in their contracts with health care providers that Medicaid be billed first for covered services, and then contract dollars can be used to help fill in the gaps for needed behavioral health services.

Justice Reinvestment

From 2010 to 2016, approximately 30 states have engaged in justice reinvestment, a data-driven approach designed to reduce corrections spending and reinvest a portion of the savings in strategies, such as providing mental health and substance use treatment services, which can decrease recidivism and increase public safety.³⁸⁴ For example, Alabama reinvested \$12 million to expand and improve community-based behavioral health treatment for people on supervision in FY2016 and FY2017.³⁸⁵ Kansas invested \$8 million between FY2014 and FY2016 in behavioral health treatment resources for people on supervision as well.³⁸⁶ Idaho

has invested \$2.5 million in enhancing substance use treatment for individuals on supervision as part of its efforts to safely reduce its prison population.³⁸⁷ West Virginia has also invested \$11 million in grants from FY2014–2017 to expand substance use treatment and services for community-based substance use treatment, with a particular focus on people at risk of failing on probation or parole.³⁸⁸

“Justice Reinvestment Initiative,” bja.gov/programs/justicereinvestment/index.html and csgjusticecenter.org/jr

Criminal Justice Coordinating Entities and Technical Assistance Centers

Some states have councils or committees composed of state-level officials and policymakers who drive systems change that will improve responses to people with mental illnesses and co-occurring substance use disorders in the criminal justice system. These entities may be created for a time-limited period to develop recommendations or have a long-term presence to also provide implementation guidance and oversight.³⁸⁹

Some states have also created TA centers (including Criminal Justice and Mental Health Centers of Excellence) that assist local jurisdictions with implementing recommendations and promoting promising practices. Many state centers of excellence also train their staff on effective approaches in order to train others or provide direct guidance to agencies.³⁹⁰ For example, the Florida legislature designated the Louis de la Parte Florida Mental Health Institute as the state’s Criminal Justice, Mental Health, and Substance Abuse Technical Assistance Center. The center conducts research and provides training and TA to counties.*

COUNTY

Counties may also have dedicated funding to support local system-level planning efforts and to fund specific services or programs for people with behavioral health needs who are leaving jails and prisons. For example, many counties have tax initiatives that generate revenue that can be used to help fund mental health services for local county residents.

- A 2005 Washington state law addressed the large number of people with mental illnesses who are facing homelessness, high psychiatric inpatient admission rates, and limited treatment options by allowing counties “to exercise a one-tenth of one percent sales tax to support mental health and chemical dependency and therapeutic court services.”³⁹¹ The action was meant to reduce incarceration and the inappropriate use of emergency rooms. Several counties used these funds to develop or expand court systems to include drug, mental health, and family therapeutic courts, as well as augment Medicaid and state funding by expanding mental health services for co-occurring disorders and restoring previously terminated services.³⁹²
- Following California’s Public Safety Realignment, passed in 2011, counties have received a dedicated and permanent revenue stream, which is constitutionally guaranteed through the 2012 passage of Proposition 30, for local public safety programs using vehicle license fees and a portion of the state sales tax.³⁹³ Many counties use a portion of these funds to provide people in the justice system with behavioral health services not covered by Medicaid.³⁹⁴

* Other similar TA Centers include Ohio’s Criminal Justice Coordinating Center of Excellence, Pennsylvania’s Mental Health and Justice Center of Excellence, and Illinois’ Center of Excellence for Behavioral Health and Justice.

IMPLEMENTATION ISSUES

There have been significant strides in breaking down silos that have traditionally existed within (and among) the criminal justice, mental health, and substance use systems. There is still a need, however, for these systems to develop stronger partnerships with state Medicaid authorities to enable services for their shared populations.

Information Technology

Investments in improved health information technology (IT) and policies to promote effective sharing between systems that provide care to people in the justice system can facilitate these partnerships, but in many places, costly IT changes to modernize Medicaid and other systems take several years and may be difficult to sustain as a priority project.³⁹⁵

A February 2016 CMS letter to state Medicaid directors expanded the scope of expenditures for which states could obtain funding (for the 90/10 federal match) to make improvements to their health information exchanges (HIEs).³⁹⁶ That funding can now be used to better connect correctional health care providers with community-based Medicaid and other care providers, and emergency care facilities so that information can be more readily shared across systems. There are resources that provide examples of how correctional agencies can make use of this funding match, recognizing that in many places information exchanges are complicated by behavioral health records being kept separately from physical health records.^{397*} As states explore ways to enhance these systems, they should also examine how improvements in connectivity can advance enrollment activities. These efforts need to be paired with effective information-sharing protocols with corrections agencies that meet all the privacy mandates and help ensure that people receive uninterrupted care when they return to their communities after incarceration.

Funding is also available for state Medicaid programs at a 75-percent match rate for ongoing operations of these improved systems.³⁹⁸ Corrections administrators should explore the possible availability of “meaningful use” incentive funds when addressing electronic health record systems, whether through a vendor or internally.³⁹⁹

Driving Innovation through Criminal Justice-Medicaid Systems Collaboration

Much of the focus in this section has been on state Medicaid plans, but it is important to remember that Medicaid is a tremendously complex system with diverse beneficiaries and a long list of priorities related to the quality of services, cost containment, and avoidance of fraud. Going forward, it will be important to demonstrate how the broadening of Medicaid services that benefit people in the criminal justice system also help to achieve Medicaid program goals.

The Medicaid system has increasingly targeted particular models of care to groups of people that share certain health needs. There is also a strong emphasis on serving a “whole person’s needs” in the ongoing movement to more effectively coordinate care where chronic or multiple treatment and service needs exist. In keeping with those trends, there are opportunities to provide more tailored service-delivery approaches

* The COCHS’ March 2016 resource by Ben Butler reviews four options that corrections’ administrators can consider: (1) Querying patient health data from an HIE; (2) Querying and adding data from corrections’ electronic health records to an HIE; (3) Sharing data among multiple health care providers that use the same electronic health record system on an exchange; (4) Contacting specified private entities to request information through the “Direct” messaging service using secure emails. (See cochs.org/files/CMS/New-HIE-Funding-Opportunities.pdf, page 2.)

for the people in the criminal justice system who have an array of often difficult and expensive physical and behavioral health needs.

It takes time and commitment to master the levers that can help move state Medicaid policy and funding to align with criminal justice system needs and meet public health, safety, and cost-saving goals. Yet, innovative states and counties that have increased Medicaid service capacity and improved access to care often share similar origin stories: criminal justice, behavioral health, and Medicaid staff sat down together (along with other key stakeholders) to work through how to address eligibility and enrollment, benefit plan design, service provision, and the capacity among community providers to offer quality treatment and supports.

APPENDIX B

Because Medicaid programs are so varied, states interested in making changes to their program regarding behavioral health services should contact CMS for technical assistance on the best approach. As background, the information below has been compiled to provide a starting point for understanding some of the differences between state plan amendments and waivers.

Diving Deeper on Changing State Plans: When to Use State Plan Amendments vs. Waivers

	STATE PLAN AMENDMENTS (SPAs)	WAIVERS
What Do States Submit to CMS	Proposed change to state Medicaid plan. SPAs allow for the implementation of benefits and services that are within existing federal regulations, which involves choosing from an “always acceptable” menu of changes.	Formal request to have specified federal Medicaid requirements waived. Waivers allow states to make changes not always reflected in federal regulations. Some waivers have become increasingly standardized, such as some of the managed care and “home and community-based waivers” (1915 waivers), while demonstration waivers (1115 waivers) tend to require negotiations around the distinct approach.
What States Can Request	Changes to any aspect of Medicaid program administration (eligibility, benefits, services, provider payments, etc.), but those changes must comply with federal Medicaid requirements.	Request to waive specific requirements in the Medicaid statute (Title XIX of the Social Security Act 1902). ^{400*} These can help states focus on particular groups in need of specific services, promote demonstration pilots, use managed care structures, and perform other actions that permit exclusion from mandates of comparability, freedom of choice, and “statewideness.”
Budget Requirements	No cost or budget requirements. [†]	Must be cost-effective or cost-neutral; calculations depend on the waiver type.
Approval Process	90-day clock that can be suspended if CMS requests information from the state. Tends to have a less rigorous stakeholder engagement and public response process than waivers.	90-day clock for 1915(b) and 1915(c), but no required timeframe for CMS approval for 1115. ⁴⁰¹ The process for 1115 waivers must be transparent; other waivers can be posted on Medicaid.gov but are not subject to transparency requirements. More extensive review processes tend to lengthen the process.
Duration of Approval	Permanent	Time limited (generally three to five years) depending on waiver type, but can be renewed

The foundation for this table was taken, with permission, from Families USA. Additional content was provided by the Center for Health Care Strategies and other reviewers.⁴⁰²

* Main waiver types include 1915(b) Managed Care waivers; 1915(c) Home and Community-Based Care waivers; Combined 1915(b) and (c) waivers; and 1115 Demonstrations

† Although SPAs may not require budget neutrality, some states may have their own requirements.

APPENDIX C

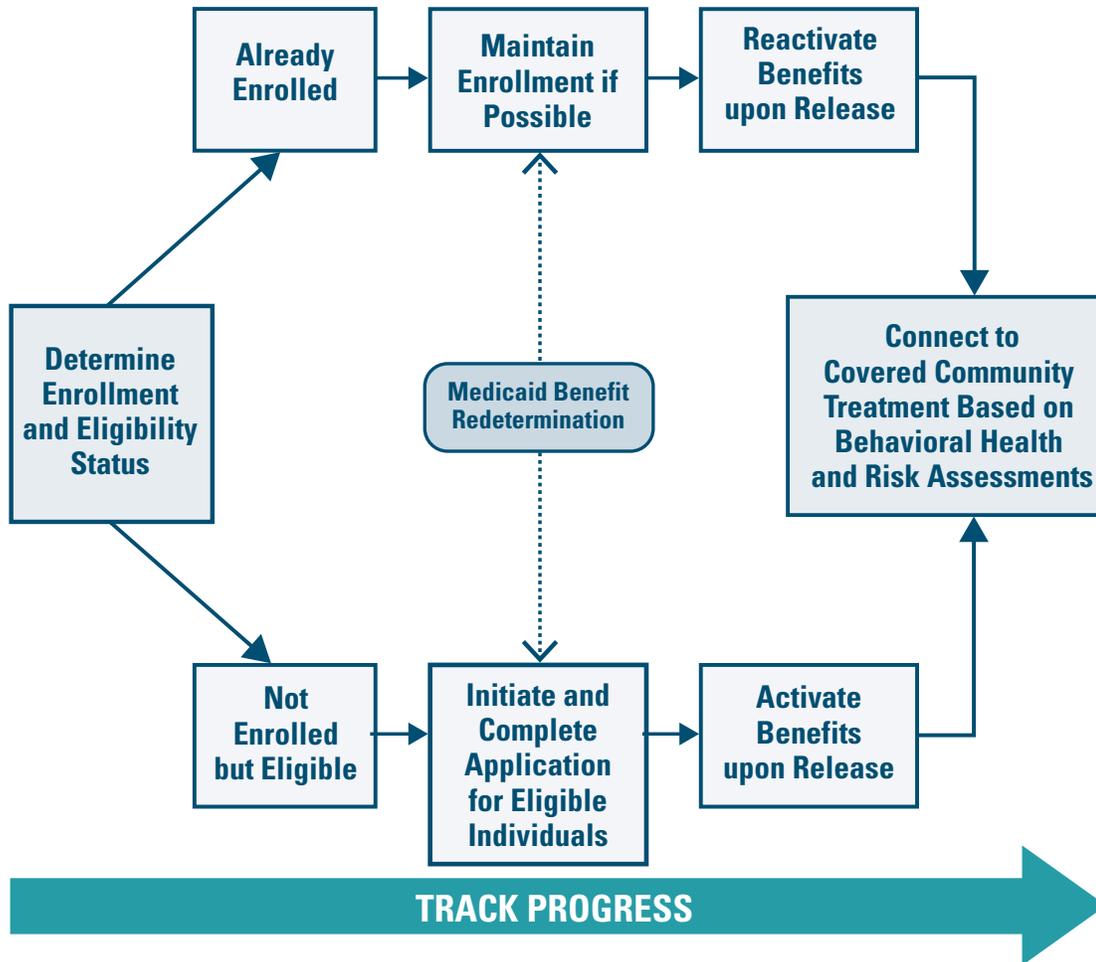
Questions Regarding Health Care Integration in Reentry Planning

Policymakers may want to explore questions similar to those posed below to generate discussions among behavioral health, corrections, and other agency leaders to determine the extent to which health care issues are being addressed as part of overall transition planning for people being released from prisons and jails:

- What health care, including behavioral health care, is provided inside the facility that requires consideration as people transition to the community?
- What health education (including information on health care coverage) is provided to people in prison or jail, particularly as part of parenting/fatherhood and risk-reduction programs?
- Are behavioral health and insurance/benefit screenings integrated into reentry planning activities?
- Are assessments helping to guide decisions about connections to services?
- Are people with prescribed medications leaving jail or prison with an appropriate supply of or prescriptions for those medications?
- In states that have managed care programs, how are people enrolled in those plans upon their release?
- How are discharge plans set up to coordinate behavioral health, physical health, and other services when people are transitioning to the community, and who is responsible for overseeing that work?
- How can financing models help improve access to care, care coordination, and a focus on reentry outcomes?
- How are prisons and jails coordinating with community supervision agencies and work release programs to ensure continuity of care, health care coverage, and benefit enrollment?



ISSUE 5: Tracking Progress



OVERVIEW

To gauge progress on all of the activities associated with improving access to benefits and covered health care for people leaving prisons and jails (see figure above), data can be collected at each step to drive a series of important decisions that will advance a comprehensive reentry plan. Much of this data may already be collected by various agencies, but not analyzed or used to inform policy and practice. Tracking how many adults in prisons and jails are eligible for Medicaid and SSI/SSDI benefits, and how many of them are then successfully enrolled in these programs, can be a complicated process—particularly for states and counties with inadequate automated data systems or information-sharing processes. Data are often scattered across corrections agencies, the Social Security Administration, state Medicaid authorities, and health service agencies. Despite these challenges, many states are collecting at least some data in recognition that assessing enrollment efforts will help inform changes to reentry staffing, partnerships, and connections to behavioral health care and services. Tracking enrollment activities can help policymakers and practitioners align their efforts and determine if they are increasing access to care in cost-effective ways.

But where should correctional agencies start? Increasingly, prisons and jails are working with behavioral health professionals to help identify people who have substance use

disorders, mental illnesses, or co-occurring substance use and mental disorders who will need treatment and supports in the community. It is becoming common for trained personnel to use validated screening and assessment tools to determine these needs, as well as people's risk of reoffending.⁴⁰³ Collecting these data for the reentry population can help identify how many people with behavioral health needs are eligible for public health care coverage and other benefits that are critical to wellness, and even survival (e.g., benefits that can be used for food and rent), when returning to the community.

This section focuses on tracking correctional facilities' progress in screening people for Medicaid and SSI/SSDI eligibility in order to decide whether applications should be submitted,* and then following how many applications result in successful enrollment.⁴⁰⁴ Examples of various data-tracking efforts are provided in this section to illustrate how some states and counties have accomplished these first important steps toward determining whether people are appropriately connected to Medicaid-covered health care treatment and other supports in the community following incarceration.[†]

FEDERAL LAW AND GUIDANCE

No federal laws were found that require prisons and jails to track the number of people who are screened for eligibility or enrolled in Medicaid, nor require state Medicaid agencies to collect data on which enrollees' applications were completed while they were incarcerated. Specific federal grant programs, however, may require that particular grant recipients collect information on Medicaid enrollment for people leaving prisons and jails. For example, since July 2013, the U.S. Department of Justice's Bureau of Justice Assistance has required recipients of Justice and Mental Health Collaboration Program grants and Second Chance Act co-occurring disorder grants to report on how many people are enrolled, including newly enrolled, in Medicaid.⁴⁰⁵

STATE APPROACHES

The Arnold Foundation study of 64 prison, jail, and community supervision programs indicated that, as of January 2015, 42 of these programs were able to provide information on the total number of people they enrolled in Medicaid.^{406‡} Still, most state prisons and jails are not tracking and reporting how many people are eligible and, of those, how many are actually enrolled in Medicaid and SSI/SSDI as a result of the facilities' enrollment efforts.

There may be state legislation, state Medicaid regulations, and other administrative directives to collect data on enrollment efforts in correctional settings, but it is unclear how many states have these mandates and what the level of implementation may be, primarily because of data system challenges.

* This paper distinguishes between the decision made in prisons and jails on whether to submit an application based on eligibility screening and the official "eligibility determination" made by the Medicaid agency, or the Social Service Administration's "allowance," that confirms an individual formally meets the criteria for successful enrollment. As mentioned in Issue 1, there are technology-driven processes for helping correctional facilities identify veterans so that they can be referred to a network of VA specialists who can connect them to health care and other benefits when applicable. (See e.g., https://csgjusticecenter.org/wp-content/uploads/2013/06/SnapShot_Veterans.pdf and other Issue 1 resources.)

† This paper also focuses on connecting people with health care benefits as one strand of a comprehensive reentry strategy. Although beyond the scope of this paper, indicators of successful reentry efforts should be considered as longer-term outcomes that can build on the data collected on benefit enrollment measures. (See [page 91](#).)

‡ These were conducted at different times among the agencies surveyed, including booking, prerelease, and during community supervision.

Are There State Requirements and Guidance Issued for Collecting Data?

- As part of Massachusetts' 2014 Medicaid suspension law for people who are incarcerated, provisions were made for enrollment data collection and reporting to legislators. The law states that by March 1 of each year, up to and including 2017, the Medicaid agency shall provide a status report to the clerks of the House and Senate that identifies (1) the number of people enrolled in MassHealth (Massachusetts' Medicaid program) before their incarceration and the number of people enrolled in MassHealth while incarcerated (indicating whether in a state prison or a "house of corrections"); (2) the number of people who had their MassHealth benefits reactivated; (3) how long benefits were received after coverage was reactivated; and (4) the cost to MassHealth for those benefits and any federal financial participation received.⁴⁰⁷
- California is implementing a bill passed in July 2014 to provide \$12.5 million in funding for Medicaid outreach and enrollment. Over the grant period (extended through June 2018), selected counties are conducting these activities for underserved populations, including people in county jails, state prisons, and county probation or post-release community supervision.* The grant program includes tracking and reporting the number of applicants who are successfully enrolled in Medicaid.⁴⁰⁸ San Diego County uses this initiative to enroll jail inmates and probationers through a centralized processing system that allows the county to track applications, their outcomes, and the percentage of probationer applicants who use their benefits. Through this initiative, the county has seen an 83 percent approval rate of applications.⁴⁰⁹

SSI/SSDI Tracking

The SAMHSA SOAR Technical Assistance Center offers an Online Application Tracking (OAT) system free to all SOAR-trained users who complete SSI/SSDI applications for people who are experiencing or are at risk of homelessness, which includes many applicants involved in the criminal justice system. The OAT system tracks demographic information but does not capture identifying information about individual applicants. Each case is given an ID code so that users can track whether applications have been approved or denied, or appeals have been submitted. In addition, the OAT system summarizes outcomes in reports that can be used for sustaining their enrollment efforts. SOAR estimates it takes 5 minutes or less to enter data on each application.⁴¹⁰

KEY CONSIDERATIONS AND STATE EXAMPLES

Consideration 1

Does your state track how many eligible adults in prison or jail are successfully enrolled in Medicaid and SSI/SSDI benefits that they can access upon release?

Medicaid expansion states may have a greater incentive to establish tracking systems, as they will have larger pools of eligible applicants and, consequently, will experience a potentially greater impact from their efforts. Nonexpansion states may have a smaller population, but, as seen in agencies that are tracking progress, there have been important strides made in enrolling eligible people using traditional criteria for a

* Post-release community supervision refers to the population who, under California's "realignment" legislation, are being supervised in the community by the county authority instead of the state even when they are released from prison.

disability or other categorical determination paired with income qualifications when applicable. This is particularly important for people whose mental illnesses may be deemed a disability.

For both expansion and nonexpansion states, there is also value in determining how Medicaid's [inpatient exception](#) may result in cost savings and changes in enrollment rates.*

In Practice

- In North Carolina—a nonexpansion state—the Department of Public Safety submits Medicaid applications for all people in prison who receive inpatient medical services that last more than 23 hours. Data indicate that even with the state's traditional, categorical Medicaid eligibility criteria, this process has resulted in about half (51 percent) of all people in this category being deemed eligible for Medicaid enrollment in FY2012–2013.⁴¹¹ In the previous year alone, North Carolina saved more than \$10 million in corrections costs from using the inpatient exception.⁴¹²

To determine how many eligible people leaving prisons and jails are actually enrolled in Medicaid and other benefits, it is important to consider the questions that follow.

Do you track how many people in prisons and jails are screened for eligibility and assisted with applications for Medicaid and SSI/SSDI benefits (and, when applicable, referrals to VA specialists)?

As discussed in Issue 1, ideally, personnel in correctional facilities screen everyone for Medicaid and other benefit eligibility, but they also should use validated assessment tools to identify priority populations prior to release (such as people who are identified as having chronic or serious health conditions or behavioral health disorders).⁴¹³

Medicaid Eligibility Screening in Expansion and Nonexpansion States

In states that have decided not to expand Medicaid, adult correctional facilities often focus Medicaid screening on people with disabilities, including those who have qualifying serious mental illnesses, and who meet their stricter income criteria. This translates to a relatively small number of individuals in their prisons and jails that need to be tracked. In contrast, in states that have expanded Medicaid, the majority of people leaving prisons and jails will be eligible for Medicaid based on their low-income or disability status. Having been previously enrolled at the time of admission also often indicates that a person will likely still be eligible upon release.

Some agencies rely on self-reporting to determine whether someone is eligible for benefits, while others use data checks with Medicaid, other data systems, or some combination. In all cases, it is useful to capture the total number of people screened for health care coverage and benefit eligibility and, of those, how many applications were submitted.[†] This will help policymakers and practitioners understand the reach and

* For more on the inpatient exception and related savings in other states, see Issue 2, [page 27](#). As of 2014, there were at least 15 states that take advantage of the inpatient exception, which includes both expansion and nonexpansion states. (See <https://www.openminds.com/market-intelligence/executive-briefings/states-terminate-rather-suspend-inmate-medicaid-benefits.html>.)

† It is important to remember the distinction between personnel in prisons and jails deciding whether someone is likely eligible for the purposes of filing applications and the formal "determination" made by the Medicaid agency—or the disability "allowance" determination ("allowance") made by the Social Security Administration office that the applicant is officially deemed "eligible" and can be enrolled.

potential impact of enrollment and referral programs. It may also be useful to capture information on why applications were not filed for individuals who seem to meet Medicaid and other benefit eligibility criteria. For example, high rates of refusal to complete an application by people who are eligible may be due, in part, to a lack of information about how Medicaid can help connect them to treatment and other supports while they are living in the community or in other settings (e.g., qualifying halfway houses),* and how Social Security benefits can help pay for basic necessities such as food and housing.

☑ *Of the applications filed for people in prisons and jails, are you tracking how many result in successful enrollment in Medicaid and SSI/SSDI, and how many referrals are made to the VA for benefits and health care?*

Tracking how many applications result in successful enrollment can help identify how well screeners understand eligibility criteria and application processes, and what improvements can be made to those processes. It will also help provide an estimate of the number of people who can access critical benefits that can promote successful reentry and the number who are likely to need Medicaid-covered services. Some agencies also track the reason for denials (see the snapshot of Massachusetts that follows) that can identify barriers to enrollment.⁴¹⁴ As discussed in Issue 3, “Assisting with Applications,” the Social Security Administration and Department of Veterans Affairs may be best positioned to track the number of individuals ultimately enrolled in their respective benefits. Still, some correctional agencies are also tracking data to gauge the success of all their enrollment and referral efforts.

Collectively, these measures related to Medicaid, Social Security, and other benefits go to the heart of whether enrollment efforts are successful and should be sustained. This information is foundational to developing an understanding of whether connections to health care and other essential supports make a difference in lowering recidivism rates and health care costs while improving individuals’ recovery and wellness.

Longer-Term Performance and Outcome Measures

Increasing enrollment in Medicaid and other publicly funded benefits is not sufficient to achieve better public safety and health outcomes for people leaving prisons and jails. Rather, a range of reentry services and supports that are tailored to their needs is required. Although beyond the scope of this paper, the following outcome measures are examples of the types of results that can be tracked over the long term when enrollment is part of a greater reentry strategy:

- Length of waiting lists for behavioral health evaluations and treatment
- Number of ER visits
- Number of timely admissions to community treatment services (e.g., within two weeks of referral)
- Use of block grant and other gap-filling programs for non-Medicaid-covered services
- Number of people connected to evidence-based services to promote wellness and recovery
- Recidivism rate (including number of revocations for technical violations of

* For more information on when Medicaid can be used for halfway houses, see the letter from Vikki Wachino to State Health Officials, “To Facilitate Successful Re-entry for Individuals Transitioning from Incarceration to Their Communities,” (Baltimore, MD: U.S. Department of Health & Human Services, Centers for Medicare & Medicaid Services, April 28, 2016) at <https://www.medicaid.gov/federal-policy-guidance/downloads/sho16007.pdf>.

probation and parole for people with mental illnesses and substance use disorders)

- Amount of cost savings for corrections (e.g., use of Medicaid Administrative Claiming, inpatient exception, automated processes) and for states (e.g., avoidance of uncompensated care and more costly emergency services)

Tracking these outcomes may require intensive evaluations and partnerships.

A Snapshot of Massachusetts: An Expansion State

In collaboration with MassHealth—the Massachusetts Medicaid program—the Department of Corrections (DOC) has worked to enroll eligible people in Medicaid prior to their release. As of 2016, there are 16 DOC facilities participating in the prerelease program, which began in 2004. There are 58 certified application counselors (CACs) in DOC facilities throughout the state. These counselors (DOC staff) are certified by MassHealth but also have been trained by the DOC’s Reentry Services Division to ensure a standardized application process for all facilities.

Data Tracked

The DOC has been tracking the following measures in its facilities:

- Total number of people released
- Total applications submitted
- Total approved
- Total pending
- Number of individuals receiving a MassHealth card before release
- Total ineligible (and reasons why)

Drawing from the most recent data provided by the DOC for FY2016,^{*} more than 75 percent of all people released from prison had MassHealth applications submitted.[†] Of those, only 4 percent were deemed ineligible; the total number of applications pending approval was about 5 percent on release.[‡] More than 85 percent of people were successfully enrolled at the time of release, which is attributed to extensive staff training.⁴¹⁵ For those successfully enrolled, more than 40 percent were expected to receive MassHealth cards before release in FY2016.[§] This and more detailed information is made available to DOC personnel to track progress and identify the need for any process improvements.^{**}

From the Medicaid administrative side, MassHealth also tracks data on applications coming from corrections, including directly from 14 Houses of Corrections (county jails) for its report to legislators. It uses special fax cover sheets to help identify applications coming from corrections.⁴¹⁶ MassHealth tracks the number of applications processed for people receiving inpatient benefits and cases where MassHealth benefits are activated upon reentry to the community.⁴¹⁷

* DOC data examined were from FY2014, FY2015 and part of FY2016 (at this writing, data were available from July 2015 thru February 2016, which is 75 percent of the fiscal year).

† That number was even higher in FY2014, when an automated system was still in use. That system was taken offline to make changes that would bring it into full compliance with ACA mandates.

‡ About another 5 percent had information that could not be verified, including citizenship, Social Security number, or name. The DOC refers to this as a Health Safety Net category.

§ Based on extrapolated data from July 2015 to March 2016.

**As part of larger reentry efforts, the DOC tracks how many individuals (not just Medicaid enrollees) have an appointment for medical or mental health services at their time of release.

Data Input and Tracking Processes for Massachusetts DOC

- The facility manager has access to MassHealth’s Medicaid Management Information System (MMIS) to check the status of all applications prior to release to update in the DOC Information Management System (IMS).
- The Reentry Services Division (RSD) has access to audit these IMS Reentry fields prior to release to ensure data are entered in accordance with the operations manual and trainings.
- RSD Correction Program Officers review all releases on the Monday of the following week and re-verify the status of MassHealth reflected in MMIS on the day of release.
- This information in MMIS is compared with the information in IMS through a Performance Measures Report, and inconsistent information is relayed back to the facility for clarification and updated in IMS.
- These final data are disclosed monthly on a Reentry Performance Measures report.
- RSD tracks the monthly performance measures report information closely to identify best practices or system flaws, allowing for quality control and retraining of staff, if needed.

ENROLLMENT IN MEDICAID

In Practice

- In Washington State, the enrollment rate is tracked for people leaving state prisons who submitted applications for Medicaid, which rose from under 20 percent in 2006 to 63 percent in 2014.⁴¹⁸ In March 2016, the Washington State Department of Corrections (DOC) reported that nearly 80 percent of adults leaving state prisons were being successfully enrolled in Medicaid coverage. Because it is difficult to collect the information for dependents (due to Social Security numbers, birth certificates, and other documentation often being not readily on hand), people with dependents are referred to assisters in the community for completing applications.⁴¹⁹
- West Virginia is developing strategies to use Medicaid and other provisions of the ACA to stretch state dollars for health care coverage and increase access to services. The state began billing Medicaid for eligible inpatient hospital stays in June 2014. The DOC is keeping data on enrollments for inpatient care during incarceration, prerelease enrollments, as well as enrollments completed during post-release supervision. The DOC has been tracking the following measures since November 2015:⁴²⁰
 - Number of people who are enrolled after 24 hours for inpatient stays
 - Projected dollar amount saved by billing Medicaid for eligible inpatient stays
 - Number and percentage of eligible people enrolled in Medicaid prior to release
 - Number and percentage of Medicaid-eligible people released to parole who are then enrolled in Medicaid before completing their supervision
- At the Cook County Jail in Illinois, data collection and analysis have been an intensive undertaking. Because the facility sees a high turnover of people booked into the jail, collecting data has been an essential component to understanding how to best improve processes and to develop ongoing policy. Research regarding the utilization of health services by people who obtained coverage and the impact of access to care on future arrests is under development. In 2015, Cook County screened 68,268 people and found 39,842 to be previously enrolled in some type of insurance, an additional 20,648 likely to be eligible, and initiated applications for 10,374 of those likely eligible.⁴²¹

Snapshot of Cook County, Illinois, Jail

DATA ELEMENTS	HOW COLLECTED/ANALYZED?
Reach	
How many incoming detainees were screened for eligibility/invited to apply?	<ul style="list-style-type: none"> Jail provides number of incoming detainees each day to TASC* TASC tracks number of detainees screened
Screening/Engagement Results	
Does this person have Medicaid coverage now? If so, are they nearing their annual redetermination date?	<ul style="list-style-type: none"> TASC checks state Medicaid website; records information in a database created and managed by TASC†
Is this person likely eligible?	<ul style="list-style-type: none"> Questions asked by application assister working at jail intake Results collected online in a database created and managed by TASC Results analyzed weekly for quality improvement in staff performance (time per encounter, proportion of eligible individuals who agree to apply), workflow process, and technological challenges and potential solutions
If not likely eligible, why not? <ul style="list-style-type: none"> Not Illinois resident Not U.S. citizen or eligible non-citizen Income too high 	
If likely eligible, did they choose to apply?	
If not, why not? <ul style="list-style-type: none"> Multiple reasons, such as "already has insurance" 	
Eligibility Determination Results	
Was this application approved?	<ul style="list-style-type: none"> For a period of time, results of eligibility determinations came back to the Cook County Health & Hospitals System from the Illinois Department of Human Services eligibility determination team Trends in application approvals were monitored to watch for: <ul style="list-style-type: none"> Reasons why people are found to be ineligible to improve case processes as needed (e.g., if a lot of applicants are found ineligible due to high incomes, staff can improve screening questions and reduce ineligible applications) Unexpected denials that may show a change in the eligibility determination process. For example, unwarranted denials due to incarceration
If not, why not?	

* TASC Illinois is a community-based organization that connects individuals with health care services and, together with other state programs, works nationally to link justice systems to community-based drug treatment and mental health services. (See www.tasc.org.)

† TASC is a certified Medicaid provider in Illinois with staff trained on maintaining confidentiality regarding protected health information, which allows staff to access this information.

ENROLLMENT IN SSI/SSDI

In Practice

- Oklahoma tracks application activity and SSI/SSDI enrollment rates in its state prison facilities that contain mental health units. The state credits its facilities' collaboration with the Social Security Administration and Oklahoma Disability Determination Division with increasing successful SSI/SSDI applications (the "allowance rate")* for people leaving prisons from the national average of 36 percent to 90 percent over four years.⁴²² These results were driven by SOAR training, and the application activities have been integrated into the Oklahoma Collaborative Mental Health Reentry Program.⁴²³
- The Miami-Dade Criminal Mental Health Project (CMHP) Jail [Diversión](#) Program diverts defendants with serious mental illnesses (SMI) or co-occurring SMI and substance use disorders from the criminal justice system into community-based treatment and services when appropriate.⁴²⁴ It now also addresses people returning to the community from jails after completing their sentences.⁴²⁵ Miami SOAR is an integral part of this project because SSI provides income that can help people released from jails secure basic housing and other necessities. Staff screen all incoming misdemeanor or felony diversion candidates for federal benefit eligibility and actively use the OAT system for tracking SSI and SSDI applications.⁴²⁶ Miami SOAR reported in 2014 that it had a 94 percent approval rate in an average of 27 days.⁴²⁷

Veterans Identification for Referral

There are agencies that ask people in prisons and jails to self-identify if they are veterans and, of those, some track referrals to Department of Veterans Affairs (VA) specialists. Other agencies track the number of referrals with the help of the Veterans Reentry Search Service (VRSS) system, discussed on page 11. This information can be used to determine if progress is being made in increasing the proportion of identified veterans who are referred to VA specialists, who can in turn help determine eligibility for particular VA health services and benefits.

- The Massachusetts Department of Corrections (DOC) uses VRSS to identify veterans in its facilities and provided March 2016 data for this paper that indicated there were 665 matches at that time.⁴²⁸ Based on this list and any self-reports, the VA provides intensive and comprehensive in-reach services to evaluate the level of services and benefits each person needs. Additional developments being explored by the DOC and VA include a potential reentry mentorship program that can provide community support that starts in the institution and includes transportation on the day of a veteran's release.⁴²⁹

* An allowance rate is the rate at which disability applications are approved as a result of the eligibility determinations made by the SSI/SSDI. (See, e.g., <https://www.ssa.gov/policy/docs/ssb/v72n4/v72n4p11.html>.) In contrast, Medicaid uses the term "eligibility determination rate" to refer to the percentage of applicants who are found eligible.

☑ ***Do you track when people returning to the community from prisons or jails are able to use activated or reinstated benefits in your state?***

As discussed in previous sections, timely access to mental health or substance use treatment following release can have a significant impact on whether people succeed when they return to the community. Even when the Medicaid and benefit enrollment processes have been completed during incarceration, individual states use different activation cycles (for example, the first of the month following release) and many do not activate benefits immediately on release. The activation process can take weeks, and without continuous care during this pre-activation period, Medicaid providers may not accept appointments, supplies of medication may run out, and individuals can relapse or decompensate. Agencies facing this issue may want to collect information on how many people this affects (e.g., the number of individuals released who are benefits-eligible but have not been activated per month, or the average number of days post-release prior to benefits activation) in order to promote changes in policies and systems.*

The goal for most prisons and jails is to get people the documentation they need (benefit cards or ID numbers) to access their benefits before they are released so they can be quickly connected to treatment and begin receiving payments. To track progress, agencies need to collect information on how many people receive prerelease that documentation or the information needed to use benefits. Some agencies can also work with probation or parole agencies to help ensure that people who are under community supervision can complete the enrollment and documentation processes. Several of the correctional agencies consulted for this paper indicated that it is difficult to reach people by mail after release. Most of these agencies do not, therefore, track how many people receive their Medicaid or other benefits after release. They stressed that referrals and coordination with other agencies and community groups are vital to help ensure that people complete their enrollment and can access benefits post-release.⁴³⁰

☑ ***Which entities collect data now, and which ones might collect data in the future?***

Policymakers can use an existing task force or working group—or create a new group—to help determine whether information on benefit eligibility screening and enrollment is already collected and which agency holds those data. In order to track progress, it is important to collect baseline data and develop or refine a process for efficiently gathering and sharing the data going forward. Doing so will also help ensure that all privacy mandates are kept regarding protected health and substance use treatment information.

Data will likely be found in multiple places, which may require memoranda of understanding (MOU) or other information-sharing agreements in order to track progress on enrolling eligible individuals. For example:

- **Screening for Eligibility:** The state health services agency or state Medicaid office may have numbers on how many people were previously enrolled upon incarceration or are otherwise eligible (determined by using a list provided in batches by the state Department of Corrections or by individual correctional facilities of who is incarcerated and comparing it against databases used to track enrollment and to check eligibility criteria).

* To the extent possible, agencies should consider tracking how many released individuals eligible for benefits were able to successfully schedule and attend a subsequent appointment with a treatment or service provider.

- **Applications Submitted:** Correctional agencies and their contractors, as well as the administrative agency receiving applications, may track the total number of applications submitted.
 - Applications may be done for all who are likely to meet eligibility criteria without regard to previous enrollment (e.g., based on self-reports) and/or more formal screening for eligibility.
 - Post-release data on applications may be held by probation and parole agencies and assisters in the community, including county services offices and community-based nonprofit agencies.
- **Successful Enrollment:** There are several agencies that may compile the number of new or reinstated enrollees, including the following:
 - Department of Health Services/social services or state Medicaid agency
 - Social Security Administration
 - VA specialists’ reports on connections to benefits and health care
 - Managed Care Organizations
- **Connections to Services:** It is challenging to track connections to services and whether data reflect actual appointments kept (versus the number of referrals) or measures of repeat engagement in services. Among those who may be able to assist with tracking are:
 - Benefit agencies issuing insurance and benefit cards or ID numbers
 - Treatment providers (both correctional and community-based)
 - Claims personnel from the Medicaid agency and from other benefit administrators

Formal agreements may be needed to outline roles and responsibilities with regard to data collection and information sharing among agencies.

Examples of Additional State Data

West Virginia’s Department of Health & Human Resources (DHHR) is able to collect information from a variety of data sources, including the following, to provide additional information on continuity of care:⁴³¹

- **Care connection.** Information to establish the “medical necessity” for services is collected on forms that also include criminal and legal history data that can be used to help identify the criminal justice population.
- **Claims.** DHHR is able to convey information on the provided and billed services rendered for an individual.
- **Retrospective reviews.** Reviews in which providers are scored on services in relation to policy, clinical effectiveness, and “Utilization Management Guidelines” are completed on an 18-month cycle.
- **Demographic information.** This information is gathered through eligibility reviews.

IMPLEMENTATION ISSUES

There is tremendous variation among states and counties regarding how screening, enrollment, and benefit activation or reactivation are conducted for people in prisons and jails, so tracking must be tailored to those practices. Although efficient automated systems and data-sharing processes are ideal, deficiencies in technology should not stand in the way of data collection and tracking. As has been demonstrated across the country, there are creative and effective interim approaches that can be implemented even with largely paper-based systems.

Post-Release Tracking

Facilities routinely discussed the difficulty in tracking enrollment once people have passed through prison and jail doors into the community—particularly for those who are not released to community supervision. This is a significant concern, given that many people may be required to do a full application following release because of presumptive eligibility requirements or because the process was not completed before release (as is often the case for short jail stays). Partnerships with community supervision agencies and community groups to track these numbers and share that information with correctional agencies would help to ensure that people do not fall through the cracks as they face difficult transition issues. However, the better solution is to try to complete processes to the extent possible before someone's release from prison or jail.

Individual and System-Level Tracking

An increasing number of agencies are tracking whether people have the information (e.g., offering health literacy programs that can help attendees understand how to avoid nonessential emergency room visits and access Medicaid services) and documentation they need before they are released to access their benefits; tracking whether documentation or ID numbers are provided prerelease or quickly post-release; and tracking referrals for veterans to help ensure continuity and coordination of care for individuals engaged in several federal benefit programs.

In addition to tracking individual-level data, it is important to gauge progress on system-level responses and policy changes to realize efficiencies and reduce costs (e.g., improved data systems, better information sharing, consideration of expansion and suspension options, and the use of Medicaid Administrative Claiming or the inpatient exception). Enrollment goals are undermined when policies and systems cannot be aligned to provide quick access to benefits on release such as delays in activating benefits in the Medicaid data system even when enrollment determinations are completed prerelease.

Aggregating and Reporting Data Across Agencies

Partnerships and formal agreements that facilitate cooperation between the facility staff or other people assisting with the applications and the Medicaid and other benefit agencies reviewing or approving the applications are essential. Processes have to be developed to identify the applications that are coming from jails or prisons, and track those results with the state Medicaid agency. For example, Colorado's Department of Health Care Policy and Financing developed software specifically for the state Department of Corrections to enter data and track the status of applications, which has made the application process more efficient.⁴³² Federally supported upgrades to MMIS and other systems, discussed in other sections, will be critical to long-term success.

Any discussion about data collection and analysis should include a focus on the types of groups that will receive information, in what form, and for what purpose. For example, policymakers are often given reports that do not provide the context, detail, or explanation needed to guide policy decisions. Similarly, all criminal justice and behavioral health decision makers and service providers should receive the data and information they need in a format that facilitates their work in helping people leaving prisons and jails address their health care coverage and treatment needs.

Next Steps

As more people are enrolled over time and tracking systems improve, the focus of correctional agencies may expand to better systematically gauge whether people are actually engaged in treatment and services that have been accessed through Medicaid and other public benefits (and to the extent possible, the type of treatment they receive that has been informed by assessments). These inquiries, currently the focus of just a few isolated intensive studies, will ultimately contribute to the research on whether engagement in these services is contributing to lower recidivism rates, improvements in people's recovery, and fewer uncompensated health care costs for states.

Criminal justice and health care professionals agree: Making sure people with mental illnesses and substance use disorders released from prisons and jails with mental illnesses and substance use disorders are connected to community-based treatment and supports can increase public safety, improve public health, and save money. Providing this continuity of care frequently depends on ensuring that eligible people in correctional facilities are enrolled in Medicaid and other publicly funded benefits—which can be complex and even require some system-level changes.

State leaders have very different opinions about the scope of their Medicaid programs. But, as this paper makes clear, whatever their eligibility criteria, states can partner with local governments to increase the likelihood that eligible people leaving correctional facilities have access to health care insurance and benefits. State and local leaders should review their Medicaid plans and policies to ensure coverage of the services that are essential to putting people with behavioral health needs leaving prisons and jails on a path to recovery that also helps lead them away from further criminal justice involvement.

By using the questions in this document as a basis for discussion, policymakers (including legislators and governors, leaders in corrections and behavioral health, Medicaid and other benefit authorities, as well as other key state and local agencies) will trigger important analyses of existing policy and practice. The examples in this report can help demonstrate how states and counties have navigated the implementation of enrollment and sustainability requirements for incarcerated people within Medicaid (in both expansion and nonexpansion states), veterans, and SSI/SSDI programs.

With an ever-changing health care environment, it is easy to get overwhelmed. What is most important is just to take an honest assessment of where your jurisdiction stands using the discussion paper's questions and then work with Medicaid and health policy partners to create a realistic plan for moving forward. Even in the earliest stages, plans should require collaboration and should contemplate how to best track progress. The ongoing results of this tracking will be important for informing future decision making on mid-course corrections and policy development.

Criminal justice professionals do not need to be Medicaid or benefit experts, but they do need to engage them fully in these efforts. This is an important time for states and counties to be truly innovative in how they leverage Medicaid, SSI/SSDI, and veterans health care and benefits to better address the needs of the large number of people leaving prisons and jails with behavioral health disorders. The discussions encouraged by this paper are a starting point for advancing efforts; the potential for change is largely dependent on the collective will of policymakers and professionals in criminal justice, behavioral health, and public health care to shape how health policy is implemented.

Updates on the CSG Justice Center's health policy work will be provided through its reentry and behavioral health newsletters. To sign up, go to <https://csgjusticecenter.org/subscribe/>. Information is available on Medicaid.gov, including <https://www.medicaid.gov/state-resource-center/state-resource-center.html>. Additional resources and links to information clearinghouses will be featured at the CSG Justice Center website.

Endnotes

1. “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).
2. The Pew Charitable Trusts has attributed this, in part, to individuals in corrections 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).
3. Kamala Mallik-Kane and Christy A. Visher, *Health and Prisoner Reentry: How Physical, Mental, and Substance Abuse Conditions Shape the Process of Reintegration* (Washington, DC: Urban Institute, 2008).
4. See Kamala Mallik-Kane and Christy A. Visher, *Health and Prisoner Reentry: How Physical, Mental, and Substance Abuse Conditions Shape the Process of Reintegration* (Washington, DC: Urban Institute, 2008); Emily A. Wang et al., “Discharge Planning and Continuity of Health Care: Findings from the San Francisco County Jail,” *American Journal of Public Health* 98, no. 12 (2008): 2182-2184, doi: 10.2105/AJPH.2007.119669, quoted in Alexandra Gates, Samantha Artiga, and Robin Rudowitz, *Health Coverage and Care for the Adult Criminal Justice-Involved Population* (Menlo Park, CA: The Henry J. Kaiser Family Foundation, 2014).
5. Marcia Regenstein and Sara Rosenbaum, “What the Affordable Care Act Means for People with Jail Stays,” *Health Affairs* 33, no. 9 (March 2013): 448-454, doi: 10.1377/hlthaff.2013.1119; Carolyn L. Yocom to Fred Upton and Joseph Pitts, *Medicaid: Information on Inmate Eligibility and Federal Costs for Allowable Services* (Washington, DC: U.S. Government Accountability Office, September 5, 2014), <http://gao.gov/assets/670/665552.pdf>.
6. There is a lack of data on the number of people in jails post-ACA who are eligible for Medicaid upon release. For a pre-ACA estimate, see Stephen A. Somers et al., “Medicaid Expansion: Considerations for States Regarding Newly Eligible Jail-Involved Individuals,” *Health Affairs* 33, no. 3 (March 2014): 455, doi: 10.1377/hlthaff.2013.1132; Maeghan Gilmore, *The Affordable Care Act and County Jails* (Washington, DC: National Association of Counties, 2014); The 60 percent estimate is based on 2002 data from the Bureau of Justice Statistics, *Profile of Jail Inmates, 2002*, by Doris J. James, NCJ 201932 (Washington, DC: U.S. Department of Justice, 2004).
7. Maureen McDonnell, Director for Business and Health Care Strategy Development, TASC, interview with Alex Blandford, Council of State Governments Justice Center, March 2016.
8. A 2014 Government Accountability Office (GAO) report found that in North Carolina—a state that did not expand Medicaid—“about 2 percent of inmates in the state’s prisons are eligible for Medicaid at any given time.” For further information, see Carolyn L. Yocom to Fred Upton and Joseph Pitts, *Medicaid: Information on Inmate Eligibility and Federal Costs for Allowable Services* (Washington, DC: U.S. Government Accountability Office, September 5, 2014), <http://gao.gov/assets/670/665552.pdf>.
9. Marcus Berzofsky, Laura M. Maruschak, and Jennifer Unangst, *Medical Problems of State and Federal Prisoners and Jail Inmates, 2011–12*. (Washington, DC: Bureau of Justice Statistics, U.S. Department of Justice, 2015); 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>); Ingrid A. Binswanger, Patrick M. Krueger, and John F. Steiner, “Prevalence of Chronic Medical Conditions Among Jail and Prison Inmates in the USA Compared With the General Population,” *Journal of Epidemiology and Community Health* 63, no. 11 (2009): 912–19, www.ncbi.nlm.nih.gov/pubmed/19648129; The National Center on Addiction and Substance Abuse at Columbia University, *Behind Bars II: Substance Abuse and*

the Prison Population. New York: The National Center on Addiction and Substance Abuse at Columbia University, 2010; Henry J. Steadman et al., "Prevalence of Serious Mental Illness among Jail Inmates," *Psychiatric Services* 60 (2009): 761–765; National Black Caucus of State Legislators, *Addressing Mental Health in the Criminal Justice System to Reduce Recidivism Rates and Improve Prisoner Health and Transition Back to the Community*, Resolution HHS-16-03, December 2015, www.nbcsl.org; Justice and Health Connect, *Health Disparities in the Criminal Justice System: Quick Facts* (New York, NY: Justice and Health Connect, n.d.), <http://www.jhconnect.org/wp-content/uploads/2013/09/health-disparities-final.pdf>.

10. See, e.g., David Cloud, *On Life Support: Public Health in the Age of Mass Incarceration* (New York, NY: Vera Institute of Justice, 2014).
11. U.S. Department of Health & Human Services, Office of Disease Prevention and Health Promotion, *America's Health Literacy: Why We Need Accessible Health Information* (Washington, DC: U.S. Department of Health & Human Services, Office of Disease Prevention and Health Promotion, 2008), <https://health.gov/communication/literacy/issuebrief/>; Ian M. Bennett et al., "The Contribution of Health Literacy to Disparities in Self-Rated Health Status and Preventive Health Behaviors in Older Adults," *Annals of Family Medicine* 7, no. 3, (2009): 204-211, doi: 10.1370/afm.940.
12. Agency for Healthcare Research and Quality, *2015 National Healthcare Quality and Disparities Report and 5th Anniversary Update on the National Quality Strategy* (Rockville, MD: U.S. Department of Health & Human Services, April 2016); Lisa Clemans-Cope et al., "The Affordable Care Act's coverage expansions will reduce differences in uninsurance rates by race and ethnicity," *Health Affairs* 31, no. 5 (2012): 920-930. Also see, *Substance Abuse and Mental Health Services Administration. Behavioral Health Barometer: United States, 2014*. HHS Publication No. SMA–15–4895. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2015, (stating that uninsured adults with serious mental illnesses are less likely to receive treatment/counseling).
13. See, e.g., Agency for Healthcare Research and Quality, *2015 National Healthcare Quality and Disparities Report and 5th Anniversary Update on the National Quality Strategy* (Rockville, MD: U.S. Department of Health & Human Services, April 2016); Susan Hayes et al., *Closing the Gap: Past Performance of Health Insurance in Reducing Racial and Ethnic Disparities in Access to Care Could Be an Indication of Future Results*, The Commonwealth Fund, March 2015, at http://www.commonwealthfund.org/~media/files/publications/issue-brief/2015/mar/1805_hayes_closing_the_gap_reducing_access_disparities_ib_v2.pdf.
14. 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).
15. 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). For a chart comparing the proportions of people in prison and jail and under probation and/or parole with mental illnesses, substance use disorders, and co-occurring disorders to the general public, see Table 1 in Alex M. Blandford and Fred C. 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), 1.
16. Estimates of prevalence vary widely due to differences in definitions and methodologies. For more, see Question 2 in Council of State Governments Justice Center, "Frequently Asked Questions about New Study of Serious Mental Illness in Jails," (New York, NY: Council of State Governments Justice Center, 2009), accessed August 1, 2016, https://csgjusticecenter.org/wp-content/uploads/2012/12/Psy_S_FAQ.pdf; see also Seth J. Prins, "Prevalence of Mental Illnesses in US State Prisons: A Systematic Review," *Psychiatric Services* 65, no. 7 (March 2014), doi: 10.1176/appi.ps.201300166. Note that some states specify the diagnoses that they accept as qualifying for an SMI to prioritize treatment resources and for other purposes; Henry J. Steadman et al., "Prevalence of Serious Mental Illness Among Jail Inmates," *Psychiatric Services* 60, no. 6 (June 2009): 761-765, doi: 10.1176/appi.ps.60.6.761. These numbers refer to jail admissions. Serious mental illness was defined in this study as "the presence of one or more of the following diagnoses in the past month: major depressive disorder; major depressive disorder not otherwise specified; bipolar disorder I, II, and not otherwise specified; schizophrenia spectrum disorder; schizoaffective disorder; schizophreniform disorder; brief psychotic disorder; delusional disorder; and psychotic disorder not otherwise specified. Even greater numbers of individuals have mental illnesses that are not 'serious' mental illnesses, but still require resource-intensive responses."

17. Karen M. Abram and Linda A. Teplin, "Co-occurring Disorders Among Mentally Ill Jail Detainees," *American Psychologist* 46, no. 10 (October 1991): 1036–1045, doi: 10.1037/0003-066X.46.10.1036; Pamela M. Ditton, *Mental Health and Treatment of Inmates and Probationers* (Washington, DC: U.S. Department of Justice, Office of Justice Programs, 1999).
18. 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, doi: 10.1176/appi.ajp.2008.08030416.
19. 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 et al., *More Mentally Ill Persons Are in Jails and Prisons than Hospitals: A Survey of the States* (Arlington, VA: Treatment Advocacy Center, 2010).
20. 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).
21. See, e.g., 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).
22. Ingrid A. Binswanger et al., "Release from Prison – A High Risk of Death for Former Inmates," *The New England Journal of Medicine* 356 (January 2007): 157-165, doi: 10.1056/NEJMsa064115; The Urban Institute, *Life After Prison: Tracking the Experiences of Male Prisoners Returning to Chicago, Cleveland, and Houston*, by Christy Visher, Jennifer Yahner, and Nancy G. LaVigne (Washington, DC: The Urban Institute 2010); Amy Blank Wilson et al., "Examining the Impact of Mental Illness and Substance Use on Recidivism in a County Jail," *International Journal of Law and Psychiatry* 34, no. 4 (2011): 264-268, doi: 10.1016/ijlp.2011.07.004.
23. See, e.g., Joseph P. Morrissey et al., "The Role of Medicaid Enrollment and Outpatient Service Use in Jail Recidivism Among Persons with Severe Mental Illness," *Psychiatry Services* 58, no. 6 (June 2007): 794-801, doi: 10.1176/appi.ps.58.6.794; Faye S. Taxman, "Reducing Recidivism Through A Seamless System of Care: Components of Effective Treatment, Supervision, and Transition Services in the Community," (paper prepared for Office of National Drug Control Policy Treatment and Criminal Justice Conference, February 20, 1998); Kavita Patel et al., "Integrating Correctional and Community Health Care for Formerly Incarcerated People Who are Eligible for Medicaid," *Health Affairs* 33, no. 3 (March 2013): 468-473, doi: 10.1377/hlthaff.2013.1164; Paul A. Kirby, MA, Warren Ferguson, MD, and Anne Lawthers, ScD, *Post-Release MassHealth Utilization: An Evaluation of the MassHealth/DOC Prison Reintegration Pilot* (Boston, MA: University of Massachusetts Medical School Center for Health Policy and Research, August 21, 2012); "Michigan Pathways Project Links Ex-Prisoners to Medical Services, Contributing to a Decline in Recidivism," Agency for Healthcare Research and Quality, last modified August 27, 2014, accessed April 22, 2016, <https://innovations.ahrq.gov/profiles/michigan-pathways-project-links-ex-prisoners-medical-services-contributing-decline>.
24. Joseph P. Morrissey et al., "Medicaid Enrollment and Mental Health Services Use by Mentally Ill Persons Following Jail Release," *Psychiatric Services* 57, no. 6 (June 2006): 809-815; Joseph P. Morrissey et al., "The Role of Medicaid Enrollment and Outpatient Service Use in Jail Recidivism Among Persons with Severe Mental Illness," *Psychiatry Services* 58, no. 6 (June 2007): 794-801, doi: 10.1176/appi.ps.58.6.794.
25. 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).

26. 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 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*.
27. 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*.
28. The Pew Charitable Trusts and the John D. and Catherine T. MacArthur Foundation, *State Prison Health Care Spending* (Washington, DC: The Pew Charitable Trusts and the John D. and Catherine T. MacArthur Foundation, 2014).
29. "Financing," U.S. Department of Health & Human Services, Centers for Medicare & Medicaid, accessed July 26, 2016, <https://www.medicaid.gov/affordablecareact/provisions/financing.html>.
30. Debra Miller, "Looking Ahead to 2016: Making the Match for Medicaid Expansion," *Capitol Ideas* 59, no. 1 (Council of State Governments, January 2016): 16.
31. Some states are also concerned about the overall costs of expansion. See, e.g., Carrie Abner, "To Expand or Not to Expand: For Some States, Expanding Medicaid Remains a Question," *Capitol Ideas Magazine* 59, no. 4 (July/August 2016): 26-29, http://www.csg.org/pubs/capitolideas/2016_july_aug/graphics/CI_July_August_2016.pdf.
32. A recent report has found state Medicaid spending is expected to increase, although forecasts are still uncertain. See, e.g., U.S. Department of Health & Human Services, Centers for Medicare & Medicaid Services, Office of the Actuary, *2015 Actuarial Report on the Financial Outlook for Medicaid*, by Christopher J. Truffer, Christian J. Wolfe, and Kathryn E. Rennie (Baltimore, MD: 2015), <https://www.medicaid.gov/medicaid/financing-and-reimbursement/downloads/medicaid-actuarial-report-2015.pdf>. For more on state efforts to control Medicaid costs, see V. Smith et al., *Medicaid Reforms to Expand Coverage, Control Costs, and Improve Care: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2015-2016*, Kaiser Family Foundation, October 2015.
33. Vern K. Smith, Eileen Ellis, and Kathy D. Gifford, *Medicaid in a Historic Time of Transformation: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2013 and 2014* (Menlo Park, CA: The Kaiser Commission on Medicaid and the Uninsured, The Henry J. Kaiser Family Foundation, 2013); Carter C. Price and Christine Eibner, "For States That Opt Out Of Medicaid Expansion: 3.6 Million Fewer Insured And \$8.4 Billion Less In Federal Payments," *Health Affairs* 32, no. 6 (2013): 1030–1036, doi: 10.1377/hlthaff.2012.1019.
34. For more information on savings reported by expansion states, see Deborah Bachrach, Patricia Boozang, and Dori Glanz, *States Expanding Medicaid See Significant Budget Savings and Revenue Gains* (Princeton, NJ: State Health Reform Assistance Network, The Robert Wood Johnson Foundation, April 2015).
35. For more on how other criminal justice agencies and practitioners (e.g., law enforcement, courts, probation, parole) can take action, see Joan Shoemaker, *Health Care Reform, The Patient Protection and Affordable Care Act: A Practical Guide for Corrections and Criminal Justice Professionals* (Alexandria, VA: American Corrections Association, July 2016). And for a state system's mapping example for criminal justice opportunities to increase Medicaid enrollment, see Connecticut's efforts at "Connecticut and the National Institute of Corrections Identify Opportunities to Increase Medicaid Enrollment," National Institute of Corrections, last modified April 8, 2015, accessed July 26, 2016.

36. See, e.g., Centers for Medicare & Medicaid Services, Health Insurance Marketplace, *Ten Ways Jails Can Help Make Connections to New Health Insurance Opportunities* (Rockville, MD: U.S. Department of Health & Human Services, n.d.), <https://marketplace.cms.gov/outreach-and-education/ten-ways-jails.pdf>; and Centers for Medicare & Medicaid Services, Health Insurance Marketplace, *Ten Ways Corrections Systems Can Help Link Returning Offenders to Health Insurance*, Health Insurance Marketplace (Rockville, MD: U.S. Department of Health & Human Services, n.d.), <https://marketplace.cms.gov/outreach-and-education/corrections-systems.pdf>.
37. See, e.g., Mattie Quinn, "Anti-Obamacare South Warms to Medicaid Expansion," *Governing Magazine*, December 1, 2015, <http://www.governing.com/topics/health-human-services/gov-medicaid-expansion-republicans-alabama-louisiana.html>.
38. Wachino to State Health Officials, "To Facilitate Successful Re-entry for Individuals Transitioning from Incarceration to Their Communities."
39. U.S. Department of Health & Human Services, Centers for Medicare & Medicaid Services, "Medicaid and Children's Health Insurance Program (CHIP) Programs; Mental Health Parity and Addiction Equity Act of 2008; the Application of Mental Health Parity Requirements to Coverage Offered by Medicaid Managed Care Organizations, the Children's Health Insurance Program (CHIP), and Alternative Benefit Plans; Final Rule," *Federal Register* 81, no. 61 (March 30, 2016), 18389-18445; U.S. Department of Health & Human Services, Centers for Medicare & Medicaid Services, "Medicaid Fact Sheet: Mental Health Parity Proposed Rule for Medicaid and CHIP," (Baltimore, MD: 2015); The White House also created a task force to coordinate federal agencies' efforts to help develop tools and oversee implementation in 2016. See "Making Mental Health and Substance Use Disorder Parity Work," The White House, last modified May 7, 2016, accessed July 15, 2016, <https://www.whitehouse.gov/blog/2016/05/07/making-mental-health-and-substance-use-disorder-parity-work-0>.
40. "Implementation of the Mental Health Parity and Addiction Equity Act (MHPAEA)," U.S. Department of Health & Human Services, Substance Abuse and Mental Health Services Administration, last modified April 28, 2016, accessed May 9, 2016, <http://www.samhsa.gov/health-financing/implementation-mental-health-parity-addiction-equity-act>; "Behavioral Health Services," 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/mental-health-services.html>.
41. The guidance was issued April 25, 2016 and published in the *Federal Register* on May 2016. See "Federal Policy Guidance," U.S. Department of Health & Human Services, Centers for Medicare & Medicaid Services, accessed July 21, 2016, <https://www.medicaid.gov/federal-policy-guidance/federal-policy-guidance.html>; and U.S. Department of Health & Human Services, Centers for Medicare & Medicaid Services, "Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability," *Federal Register* 81, no. 88 (May 6, 2016): 27497. <https://www.gpo.gov/fdsys/pkg/FR-2016-05-06/pdf/2016-09581.pdf>. These rules are discussed further in *Issue 4, 73-74*.
42. Natalie Ortiz, "Addressing Mental Illness and Medical Conditions in County Jails," *NACo Why Counties Matter Series 3* (Washington, DC: National Association of Counties, September 2015); and Natalie Ortiz, National Association of Counties, response to request from Martha Plotkin, Council of State Governments Justice Center, April 21, 2016.
43. *Ibid.*
44. Beth Schwartzapfel and Jay Hancock, *Out of Prison, Uncovered*, (New York: The Marshall Project December 6, 2016) at https://www.themarshallproject.org/2016/12/06/out-of-prison-uncovered?utm_medium=email&utm_campaign=newsletter&utm_source=opening-statement&utm_term=newsletter-20161206-650#.ZR7SumGum;
45. For details, see "Veterans," U.S. Department of Veterans Affairs, accessed July 5, 2016, <http://www.benefits.va.gov/persona/veteran-incarcerated.asp>.
46. See "Medicaid Employment Initiatives," U.S. Department of Health Human Services, Centers for Medicare & Medicaid Services, accessed July 5, 2016, <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Grant-Programs/Employment-Initiatives.html>.

47. For more on Medicaid eligibility, see “Eligibility,” U.S. Department of Health & Human Services, Centers for Medicare & Medicaid Services, accessed July 5, 2016, <https://www.medicaid.gov/medicaid-chip-program-information/by-topics/eligibility/eligibility.html>. See also “State Medicaid & CHIP Profiles” on the same website for each state’s eligibility requirements and “State Medicaid and CHIP Income Eligibility Standards” for a table of income standards.
48. “Medicaid 101: Eligibility,” The Medicaid and CHIP Payment and Access Commission (MACPAC), accessed May 31, 2016, <https://www.macpac.gov/medicaid-101/eligibility/>.
49. The only exception is older adults or people who qualify for Medicaid based on a disability. See “MAGI: Medicaid and CHIP’s New Eligibility Standards,” U.S. Department of Health & Human Services, Centers for Medicare and CHIP Services, accessed July 15, 2016, <https://www.medicaid.gov/medicaid-chip-program-information/program-information/downloads/modified-adjusted-gross-income-and-medicaid-chip.pdf>.
50. Wachino to State Health Officials, “To Facilitate Successful Re-entry for Individuals Transitioning from Incarceration to Their Communities;” See also, Robert A. Streimer to All Associate Regional Administrators, “Clarification of Medicaid Coverage Policy for Inmates of a Public Institution,” (Baltimore, MD: U.S. Department of Health & Human Services, Center for Medicare and State Operations, Disabled and Elderly Health Programs Group, December 12, 1997); Glenn Stanton to State Medicaid Directors and CMS Associate Regional Administrators for Medicaid, “Ending Chronic Homelessness,” (Baltimore, MD: U.S. Department of Health & Human Services, Center for Medicare & Medicaid Services, Disabled and Elderly Health Programs Group, May 25, 2004).
51. 42 United States Code § 1396d(a)(29)(A); 42 Code of Federal Regulations § 435.1009.
52. 42 C.F.R. § 435.1010; 42 U.S.C. § 1396d(a)(29)(A); 42 C.F.R. § 435.1009.
53. Wachino to State Health Officials, “To Facilitate Successful Re-entry for Individuals Transitioning from Incarceration to Their Communities.”
54. For more information on eligibility for disabled widow(er)’s SSDI benefits, see U.S. Social Security Administration, “DI 10110.001 Requirements for Disabled Widow(er)’s Benefits (DWB),” *SSA’s Program Operations Manual System*, <https://secure.ssa.gov/poms.nsf/lnx/0410110001>. For more information on eligibility for childhood disability SSDI benefits, see U.S. Social Security Administration, “DI 10115.001 Requirements for Entitlement to Childhood Disability Benefit (CDB),” *SSA’s Program Operations Manual System*, <https://secure.ssa.gov/poms.nsf/lnx/0410115001>.
55. Office of Justice Programs, Bureau of Justice Statistics, *Veterans in Prison and Jail, 2011-2012*, by Jennifer Bronson et al., Special Report NCJ 249144 (Washington, DC: U.S. Department of Justice, 2015).
56. Office of Justice Programs, Bureau of Justice Statistics, *Veterans in Prison and Jail, 2011-2012*, by Jennifer Bronson et al., Special Report NCJ 249144 (Washington, DC: U.S. Department of Justice, 2015).
57. See, e.g., Colorado, Florida, Indiana, Nevada, New York, Ohio, Pennsylvania, and Virginia at the time of this writing. There are also jails with special dorms for veterans. Some examples are provided in “Programs Proliferate for Incarcerated Veterans,” *Prison Legal News* 25, no.1 (January 2014): 28, <https://www.prisonlegalnews.org/news/2014/jan/15/programs-proliferate-for-incarcerated-veterans/>.
58. “Prisons Experiment with Programs to Help Incarcerated Veterans,” narrated by Patricia Murphy, All Things Considered, *National Public Radio*, December 7, 2015, <http://www.npr.org/2015/12/07/458828465/prisons-experiment-with-programs-to-help-incarcerated-veterans>.
59. Lama Hasan, “Growing Number of Prisons Offer Special Dorms for Military Vets,” *ABC News*, April 26, 2012, accessed May 9, 2016, <http://abcnews.go.com/Health/Wellness/special-jail-housing-military-veterans/story?id=16222008>.
60. Andrea K. Finlay et al., “U.S. Department of Veterans Affairs, Veterans Justice Outreach Program: Connecting Justice-Involved Veterans with Mental Health and Substance Use Disorder Treatment,” *Criminal Justice Policy Review* (December 18, 2014): 1-20, doi: 10.1177/0887403414562601.

61. Andrea K. Finlay et al., "Use of Veterans Health Administration Mental Health and Substance Use Disorder Treatment After Exiting Prison: The Health Care for Reentry Veterans Program," *Administration and Policy in Mental Health* (2015): 1-11, doi: 10.1007/s10488-015-0708-z.
62. Sachini Bandara et al., "State and Local Initiatives to Enroll Individuals in Medicaid in Criminal Justice Settings," John Hopkins Bloomberg School of Public Health, Center for Mental Health and Addiction Policy Research, accessed May 9, 2016, <http://www.jhsph.edu/research/centers-and-institutes/center-for-mental-health-and-addiction-policy-research/research/economics-and-services-research/arnold-foundation-project-map/>.
63. Sarabeth Zemel, Anita Cardwell, and Chiara Corso, *Toolkit: State Strategies to Enroll Justice-Involved Individuals in Health Coverage* (Portland, ME: National Academy for State Health Policy, 2015) <http://www.nashp.org/toolkit-state-strategies-to-enroll-justice-involved-individuals-in-health-coverage/>.
64. Minn. Stat. § 641.15 Subd. 3 (2015). Accessed July 5, 2016, <https://www.revisor.mn.gov/statutes/?id=641.15&format=pdf>.
65. Zemel, Cardwell, and Corso, *Toolkit: State Strategies to Enroll Justice-Involved Individuals in Health Coverage*; WA SB 5593 (2015); WA SB 5593 RCW 267 § 8(4)(2015).
66. See, e.g., DMA Health Strategies, Advocates for Human Potential, Inc., and TASC, Inc., *A Culture of Coverage for Justice-Involved Adults in Illinois: A Resource Guide for Implementing the Affordable Care Act for Criminal Justice Personnel in Illinois*, by Lisa Braude, Maureen McDonnell, and Sue Pickett (Springfield, IL: State of Illinois, Illinois Healthcare Implementation Council, January 2014), http://www2.centerforhealthandjustice.org/sites/www2.centerforhealthandjustice.org/files/publications/justice_involved_adults_illinois.pdf.
67. See, e.g., Shoemaker, *Health Care Reform—The Patient Protection and Affordable Care Act: A Practical Guide for Corrections and Criminal Justice Professionals*: 32. See also the U.S. Department of Health & Human Services' Centers for Medicare & Medicaid Services (CMS) series on how criminal justice agencies can better connect individuals in jails, prisons, and on community supervision with healthcare coverage options: "Ten Ways Corrections Systems Can Help Link Returning Offenders to Health Insurance," Centers for Medicare & Medicaid Services (Washington, DC: U.S. Department of Health & Human Services, 2014); "Ten Ways Jails Can Help Make Connections to New Health Insurance Opportunities," Centers for Medicare & Medicaid Services (Washington, DC: U.S. Department of Health & Human Services, 2014); "Ten Ways Probation & Parole Officers Can Help Link People to New Health Insurance Opportunities," Centers for Medicare & Medicaid Services (Washington, DC: U.S. Department of Health & Human Services, 2014).
68. 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 (December 2015): 2044-2051, doi: 10.1377/hlthaff.2015.0668. (See <http://content.healthaffairs.org/content/34/12/2044.abstract>.)
69. *Ibid.*
70. Samantha Artiga, *Profiles of Medicaid Outreach and Enrollment Strategies: The Cook County Early Expansion Initiative*, Issue Brief (Menlo Park, CA: The Henry J. Kaiser Family Foundation, April 2014). TASC also works nationally in partnership with other state programs to link justice systems to community-based drug treatment and mental health services. (Visit tasc.org for more information and resources.)
71. The National Association of Pretrial Services Agencies, *The Patient Protection and Affordable Care Act and the Pretrial System: A "Front Door" To Health and Safety, Appendix A: Enrolling Offenders in Medicaid at Pretrial Jail Intake: A Case Study of Cook County, IL* (Washington, DC: The National Association of Pretrial Services Agencies, February 2014).
72. Zemel, Cardwell, and Corso, *Toolkit: State Strategies to Enroll Justice-Involved Individuals in Health Coverage*.
73. Maureen McDonnell, Director for Business and Health Care Strategy Development, TASC, relating interviews with MDC personnel, correspondence with Martha Plotkin, Council of State Governments Justice Center, February 25, 2016.

74. Chris Koyanagi and Katy Blasingame, *Best Practices: Access to Benefits for Prisoners with Mental Illnesses* (Washington, DC: The Bazelon Center for Mental Health Law, 2006), http://justicesolutionsgroup.com/resourcecenter/uploads/pdf/DOC_BestPractices.pdf; Lt. Wolak, Operations Lieutenant, Los Angeles County Sheriff's Department, correspondence with Nicola Smith-Kea, Council of State Governments Justice Center, June 30, 2016.
75. Donna Bond, Coordinator of Mental Health Reentry Services, Oklahoma Department of Corrections, correspondence with Alex Blandford, Council of State Governments Justice Center, April 2016; Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, *Establishing and Maintaining Medicaid Eligibility upon Release from Public Institutions*, SMA 10-4545 (Rockville, MD: U.S. Department of Health & Human Services, 2010).
76. Minnesota Department of Corrections (DOC) to All Minnesota DOC facilities, "Medical Release Planning," Division Directive 500.187 (St. Paul, MN: Minnesota Department of Corrections, November 2015), http://www.doc.state.mn.us/DocPolicy2/html/DPW_Display_TOC.asp?Opt=500.187.htm; Minnesota Department of Corrections to All Minnesota Department of Corrections (DOC) facilities, "Release Health Care Summary," Instruction 203.012FRB (St. Paul, MN: Minnesota Department of Corrections, November 2015), <http://www.doc.state.mn.us/DocPolicy2/FormsWorking/NSI/203.012FRB.htm>.
77. See Centers for Medicare & Medicaid Services, "Security of the Marketplace Data Services Hub," (Baltimore, MD: U.S. Department of Health & Human Services, September 11, 2013), <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2013-Fact-sheets-items/2013-09-11.html?DLPage=1&DLEntries=10&DLFilter=data&DLSort=0&DLSortDir=descending>; U.S. Department of Health & Human Services, Centers for Medicare & Medicaid Services, *Justification of Estimates for Appropriations Committees*, (Baltimore, MD: U.S. Department of Health & Human Services, n.d.), <https://www.cms.gov/About-CMS/Agency-Information/PerformanceBudget/Downloads/FY2016-CJ-Final.pdf>.
78. U.S. Government Accountability Office, *Patient Protection and Affordable Care Act: CMS Should Act to Strengthen Enrollment Controls and Manage Fraud Risk*, GAO-16-29, (Washington, DC: U.S. Government Accountability Office, February 2016): 25.
79. For more information on barriers associated with obtaining state identification upon release, see Council of State Governments Justice Center, *State Identification: Reentry Strategies for State and Local Leaders* (New York, NY: Council of State Governments Justice Center, April 2016), <https://csgjusticecenter.org/wp-content/uploads/2016/04/State-Identification.pdf>.
80. Oregon Department of Human Services, Oregon Health Authority, Division of Medical Assistance Programs, "Medicaid Eligibility for Inmates of Jails and Prisons," presentation, (Salem, OR: June 2014), <https://www.oregon.gov/oha/healthplan/tools/Training%20Slides%20-%20Medicaid%20Eligibility%20for%20Inmates%20of%20Jails%20and%20Prisons.pdf>; Oregon Department of Human Services, Oregon Health Authority, Division of Medical Assistance Programs, *Guide to Oregon Medicaid Eligibility Determinations for Inmates under Age 65* (Salem, OR: June 13, 2014).
81. "Medicaid Portal," InterChange Government Health Portfolio, accessed July 25, 2016, <https://www.oregonmedicaid.gov/ProdPortal/>.
82. For more detail, see Oregon Department of Human Services, Oregon Health Authority, Division of Medical Assistance Programs, "Guide to Oregon Medicaid Eligibility Determinations for Inmates under Age 65," (Salem, OR: June 13, 2014).
83. Sachini Bandara et al., *State and Local Initiatives to Enroll Individuals in Medicaid in Criminal Justice Settings* (Baltimore, MD: John Hopkins Bloomberg School of Public Health, Center for Mental Health and Addiction Policy Research, 2015), <http://www.jhsph.edu/research/centers-and-institutes/center-for-men-tal-health-and-addiction-policy-research/research/economics-and-services-research/arnold-foundation-project-map/>; North Carolina was a Medicaid nonexpansion state at this writing.
84. National Association of Medicaid Directors, "North Carolina's Medicaid Enrollment Program," (Washington, DC: National Association of Medicaid Directors), http://medicaiddirectors.org/wp-content/uploads/2015/07/nc_case_study.pdf.
85. Zemel, Cardwell, and Corso, *Toolkit: State Strategies to Enroll Justice-Involved Individuals in Health Coverage*.

86. Bandara et al., *State and Local Initiatives to Enroll Individuals in Medicaid in Criminal Justice Settings*.
87. Anita Cardwell and Maeghan Gilmore, *County Jails and the Affordable Care Act: Enrolling Eligible Individuals in Health Coverage* (Washington, DC: National Association of Counties, 2012).
88. City of New York, *Mayor's Task Force on Behavioral Health and Public Safety: First Status Report* (New York, NY, July 2015): 10, <http://www1.nyc.gov/assets/criminaljustice/downloads/pdfs/BHTF%20First%20Status%20Report%208.15.pdf>.
89. See, e.g., DMA Health Strategies, Advocates for Human Potential, Inc., and TASC, Inc., *A Culture of Coverage for Justice-Involved Adults in Illinois: A Resource Guide for Implementing the Affordable Care Act for Criminal Justice Personnel in Illinois*, by Lisa Braude, Maureen McDonnell, and Sue Pickett (Springfield, IL: State of Illinois, Illinois Healthcare Implementation Council, January 2014): 6, http://www2.centerforhealthandjustice.org/sites/www2.centerforhealthandjustice.org/files/publications/justice_involved_adults_illinois.pdf.
90. Bandara et al., *State and Local Initiatives to Enroll Individuals in Medicaid in Criminal Justice Settings*.
91. For more on length of stay, see, e.g., Anita Cardwell and Maeghan Gilmore, *County Jails and the Affordable Care Act: Enrolling Eligible Individuals in Health Coverage* (Washington, DC: National Association of Counties, 2012); Community-Oriented Correctional Health Services, *The Implications of Expanded Medicaid Eligibility for the Criminal Justice Population: Frequently Asked Questions* (Oakland, CA: Community-Oriented Correctional Health Services, May 2011); Marcia Regenstein and Jade Christie-Maples, *Medicaid Coverage for Individuals in Jail Pending Disposition: Opportunities for Improved Health and Health Care at Lower Costs* (Washington, DC: The George Washington University, School of Public Health and Health Services, November 2012).
92. Alison Cuellar and Jehanzeb Cheema, "As Roughly 700,000 Prisoners are Released Annually, About Half Will Gain Health Coverage and Care Under Federal Laws," *Health Affairs* 35, no. 5 (May 2012): 931-938, doi: 10.1377/hlthaff.2011.0501.
93. The Centers for Medicare & Medicaid Services has a list of local community agencies that are certified application counselors that provide assistance: "Find Someone Nearby to Help You Apply," localhelp.healthcare.gov. In addition, see Enroll America's searchable database that lists agencies and individuals who can provide assistance with applications: "Find Local Help," <https://www.getcoveredamerica.org/connector/>, accessed July 25, 2016. See also Families USA's Enrollment Assister Resource Center for information and resources for community-based assisters: "Enrollment Assister Resource Center," <http://familiesusa.org/initiatives/enrollment-assister-resource-center>. See also, Elizabeth Hagan and Jessica Kendall, *Health Insurance for People Involved in the Justice System: Outreach and Enrollment Strategies* (Washington, DC: Families USA, October 2015).
94. "San Diego and Imperial Counties Work to Enroll People Involved with the Justice System in Medicaid," Council of State Governments Justice Center, last modified July 19, 2016, accessed August 1, 2016, <https://csgjusticecenter.org/reentry/posts/san-diego-and-imperial-counties-work-to-extend-medicaid-coverage-to-people-involved-in-the-justice-system/>; U.S. Department of Health & Human Services, Centers for Medicare & Medicaid Services, *Ten Ways Probation & Parole Officers Can Help Link People to New Health Insurance Opportunities* (Baltimore, MD: n.d.), <https://marketplace.cms.gov/outreach-and-education/ten-ways-probation-and-parole.pdf>; Jennifer Ryan et al., *Connecting the Justice-Involved Population to Medicaid Coverage and Care: Findings from Three States* (Menlo Park, CA: The Kaiser Commission on Medicaid and the Uninsured, The Henry J. Kaiser Family Foundation, June 2016), <http://kff.org/report-section/connecting-the-justice-involved-population-to-medicaid-coverage-and-care-issue-brief/>; Bandara et al., *State and Local Initiatives to Enroll Individuals in Medicaid in Criminal Justice Settings*.
95. See, e.g., DMA Health Strategies, Advocates for Human Potential, Inc., and TASC, Inc., State of Illinois, Illinois Healthcare Implementation Council, *A Culture of Coverage for Justice-Involved Adults in Illinois: A Resource Guide for Implementing the Affordable Care Act for Criminal Justice Personnel in Illinois*, by Lisa Braude, Maureen McDonnell, and Sue Pickett (Springfield, IL: State of Illinois, Illinois Healthcare Implementation Council, January 2014), http://www2.centerforhealthandjustice.org/sites/www2.centerforhealthandjustice.org/files/publications/justice_involved_adults_illinois.pdf.

96. U.S. Department of Health & Human Services, Centers for Medicare & Medicaid Services, "Medicaid Program: Mechanized Claims Processing and Information Retrieval Systems, 45 CFR Part 95, 42 CFR Part 433," *Federal Register* 80, no. 233 (December 4, 2015): 75817, <https://www.gpo.gov/fdsys/pkg/FR-2015-12-04/pdf/2015-30591.pdf>.
97. Vikki Wachino to State Medicaid Directors, "Availability of HITECH Administrative Matching Funds to Help Professionals and Hospitals Eligible for Medicaid EHR Incentive Payments Connect to Other Medicaid Providers," SMD# 16-003, (Baltimore, MD: Centers for Medicare & Medicaid Services, U.S. Department of Health & Human Services, February 29, 2016), <https://www.medicaid.gov/federal-policy-guidance/downloads/SMD16003.pdf>.
98. Ben Butler, *New HIE Funding Opportunities for Corrections: Health Information Technology's Role in Reducing Mass Incarceration* (Oakland, CA: Community Oriented Correctional Health Services, March 2016), 8, <http://cochs.org/files/CMS/New-HIE-Funding-Opportunities.pdf>.
99. See Centers for Medicare & Medicaid Services, Center for Medicaid and CHIP Services, "Medicaid and CHIP FAQs: Enhanced Funding for Medicaid Eligibility Systems," (Baltimore, MD: U.S. Department of Health & Human Services, 2013), <https://www.medicaid.gov/State-Resource-Center/FAQ-Medicaid-and-CHIP-Affordable-Care-Act-Implementation/Downloads/FAQs-by-Topic-75-25-Eligibility-Systems.pdf>; Eligibility for the enhanced federal share is contingent on state systems complying with the "Seven Conditions and Standards" found at Centers for Medicare & Medicaid Services, *Enhanced Funding Requirements: Seven Conditions and Standards, MITS-11-01-v1.0*, (Baltimore, MD: U.S. Department of Health & Human Services, 2011), <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/Downloads/EFR-Seven-Conditions-and-Standards.pdf>.
100. For more information, see Carolyn L. Yocom to U.S. Representatives Fred Upton and Joseph Pitts, "Medicaid: Information on Inmate Eligibility and Federal Costs for Allowable Services," (Washington, DC: U.S. Government Accountability Office, September 2014), <http://gao.gov/assets/670/665552.pdf>; and Deborah Bachrach et al., "States Expanding Medicaid See Significant Budget Savings and Revenue Gains," (Princeton, NJ: The Robert Wood Johnson Foundation, April 2015), http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2015/rwjf419097.
101. For more information on different types and examples of diversion programs and initiatives, many of which are working to connect people to community behavioral health treatment and other services, see Center for Health & Justice, *No Entry: A National Survey of Criminal Justice Diversion Programs and Initiatives* (Chicago, IL: TASC, 2013). For more on mental health courts, see "Mental Health Courts," Council of State Governments Justice Center, accessed July 25, 2016, <https://csgjusticecenter.org/mental-health-court-project/>. For more on justice-involved veteran diversion, see "Justice-Involved Veterans," National Institute of Corrections, accessed July 25, <http://nicic.gov/veterans>.
102. See Jamie Markham, *Releasing Jail Inmates to Limit Medical Expenses* (Chapel Hill, NC: 2014), <http://nccriminallaw.sog.unc.edu/releasing-jail-inmates-to-limit-medical-expenses/>; For an example of medical probation law, see CA AB 82.4, § 26605.7, http://leginfo.ca.gov/faces/billNavClient.xhtml?bill_id=201320140AB82: "(a) The sheriff, or his or her designee, after conferring with the physician who has oversight for providing medical care, or the physician's designee, may request the court to grant medical probation or to resentence a prisoner to medical probation" as long as specified criteria are met and "(b) Before a prisoner's release to medical probation, the sheriff, or his or her designee, shall secure a placement option for the prisoner in the community and, in consultation with the county welfare department or another applicable county agency, examine the prisoner's eligibility for federal Medicaid benefits or other medical coverage that might assist in funding the prisoner's medical treatment while in the community."
103. See "Medicaid Changes and Implications for the Jail Population," webinar, (Ohio Department of Mental Health and Addiction Services & Ohio Department of Medicaid, November 30, 2016).
104. 45 C.F.R. § 155.305, "Eligibility Standards."
105. See, e.g., Connecticut General Assembly, Office of Legislative Research, *The Affordable Care Act and Prisoners*, by Robin K. Cohen, 2013-R-0288 (Hartford, CT: August 2013), <https://www.cga.ct.gov/2013/rpt/2013-R-0288.htm>.

106. "Incarcerated People," U.S. Department of Health & Human Services, Centers for Medicare & Medicaid Services website, accessed July 18, 2016, <https://www.healthcare.gov/incarcerated-people/>.
107. Wachino to State Health Officials, "To Facilitate Successful Re-entry for Individuals Transitioning from Incarceration to Their Communities."
108. Robert A. Streimer to All Associate Regional Administrators, Division for Medicaid and State Operations, "Clarification of Medicaid coverage Policy for Inmates of a Public Institution" (Baltimore, MD, U.S. Department of Health & Human Services, Health Care Financing Administration, U.S. Department of Health & Human Services, December 12, 1997).
109. Wachino to State Health Officials, "To Facilitate successful re-entry for individuals transitioning from incarceration to their communities;" citing Social Security Act § 1902(a)(34).
110. 42 C.F.R. 435.916; Federal rules state that for those who are eligible, based on Modified Adjusted Gross Income (MAGI) criteria, eligibility may not be redetermined more frequently than every 12 months. For non-MAGI eligible groups, eligibility must be redetermined at least once every 12 months for individuals who are eligible due to blindness or disability that do not often change.
111. See, e.g., Joseph D. Dunne for Judith D. Moore to State Medicaid Directors, letter regarding redetermination regulation (Baltimore, MD: U.S. Department of Health & Human Services, Center for Medicaid and State Operations, February 6, 1997), <https://www.medicaid.gov/Federal-Policy-Guidance/downloads/SMD020697.pdf>.
112. U.S. Department of Health & Human Services, Centers for Medicare & Medicaid Services, "Medicaid Program; Eligibility Changes Under the Affordable Care Act of 2010; Proposed Rule," *Federal Register* 76, no. 159 (August 17, 2011): <https://www.gpo.gov/fdsys/pkg/FR-2011-08-17/pdf/2011-20756.pdf>; For more information on the ex-parte process, see Centers for Medicare & Medicaid Services, *Medicaid/CHIP Renewals: State Practices, Lessons Learned & Opportunities*, part of the Coverage Expansion Learning Collaborative (Washington, DC: U.S. Department of Health & Human Services, August 13, 2015), <https://www.medicaid.gov/state-resource-center/mac-learning-collaboratives/downloads/coveragelc-medicaid-chip-renewals.pdf>.
113. 42 C.F.R. 435.916(3)(i)
114. See Social Security Act § 1611 (e)(1)(A). There are circumstances under which residents of public institutions other than prisons and jails (e.g., nursing homes) may receive SSI payments. "Spotlight on Continued SSI Benefits for Persons Who Are Temporarily Institutionalized," Social Security Administration, accessed July 25, 2016, <https://www.ssa.gov/ssi/spotlights/spot-temp-institution.htm>.
115. The Bazelon Center for Mental Health Law, *For People with Serious Mental Illnesses: Find the Key to Successful Transition from Jail or Prison to the Community* (Washington, DC: Bazelon Center for Mental Health Law, November, 2009).
116. Medicaid may remain in effect during any SSI redetermination or appeals. Although states should exhaust all options before terminating Medicaid, in practice, some states continue to terminate Medicaid if SSI is no longer being received. Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, *Establishing and Maintaining Medicaid Eligibility upon Release from Public Institutions*, SMA 10-4545 (Rockville, MD: U.S. Department of Health & Human Services, 2010); 16 <https://store.samhsa.gov/shin/content/SMA10-4545/SMA10-4545.pdf>; Letter from the Director, Center for Medicaid and State Operations, Centers for Medicare & Medicaid Services, U.S. Department of Health & Human Services, to John Brian Murtaugh, New York Office of Court Administration (May 4, 2000); "SI 01715.015 Special Groups of Former SSI Recipients," *SSA's Program Operations Manual System*, <https://secure.ssa.gov/poms.nsf/lnx/0501715015>.
117. Social Security Act § 1614 (a)(3)(A).
118. See U.S. Social Security Administration, *What Prisoners Need to Know*, SSA #05-10133 (Washington, DC, June 2015), <https://www.ssa.gov/pubs/EN-05-10133.pdf>.

119. See U.S. Social Security Administration, “GN 02607.160 Title II Prisoner Suspension Provision,” *SSA’s Program Operations Manual System*, <https://secure.ssa.gov/poms.nsf/lnx/0202607160>. Note that the suspension policies for inmates who are receiving SSDI are different for people who were incarcerated before April 1, 2000.
120. For more information on the nature of these agreements, see U.S. Social Security Administration, “GN 02607.400 Prisoner (Inmate) Reporting Agreements,” *SSA’s Program Operations Manual System*.
121. 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*.
122. The Bazelon Center for Mental Health Law, *The Effect of Incarceration on Medicaid Benefits for People with Mental Illnesses* (Washington, DC: Bazelon Center for Mental Health Law): 6, http://www.bazelon.org/LinkClick.aspx?fileticket=_Ns68MefCJY%3D&tabid=441.
123. For more information, see U.S. Social Security Administration, “SI 00520.910 Prerelease Agreements with Institutions,” *SSA’s Program Operations Manual System*.
124. See, e.g., Tara Naisbitt to All County Welfare Directors, County Administrative Officers, County Medi-Cal Program Specialists/Liaisons, County Health Executives, County Health Directors, “Implementation of Assembly Bill (AB) 720 – Suspension of Medi-Cal Benefits For All Inmates and Other Requirements,” Letter No. 14-26, (Sacramento, CA: State of California – Health and Human Services Agency, Department of Health Care Services, May 6, 2014), <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2014/14-26.pdf>.
125. Catherine McKee et al., *State Medicaid Eligibility Policies for Individuals Moving Into and Out of Incarceration* (Menlo Park, CA: Kaiser Commission on Medicaid and the Uninsured, Henry J. Kaiser Family Foundation, August 2015): 6, <http://files.kff.org/attachment/issue-brief-state-medicare-eligibility-policies-for-individuals-moving-into-and-out-of-incarceration>.
126. Anita Cardwell and Maeghan Gilmore, *County Jails and the Affordable Care Act: Enrolling Eligible Individuals in Health Coverage* (Washington, DC: National Association of Counties, 2012); Health Care Financing Administration [now called the Centers for Medicare & Medicaid Services], “Clarification of Medicaid Coverage Policy for Inmates of a Public Institution,” letter, (Washington, DC, Health Care Financing Administration, December 1997); appendix to 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), <http://csgjusticecenter.org/wp-content/uploads/2013/12/ACA-Medicaid-Expansion-Policy-Brief.pdf>.
127. See, e.g., Open Minds, *Why Do States Terminate Rather Than Suspend Inmate Medicaid Benefits?* (Gettysburg, PA: Open Minds, July 2014), accessed July 18, 2016, <https://www.openminds.com/market-intelligence/executive-briefings/states-terminate-rather-suspend-inmate-medicare-benefits/>.
128. McKee et al., *State Medicaid Eligibility Policies for Individuals Moving Into and Out of Incarceration* (August 2015): 6, accessed July 18, 2016, <http://files.kff.org/attachment/issue-brief-state-medicare-eligibility-policies-for-individuals-moving-into-and-out-of-incarceration>.
129. Wachino to State Health Officials, “To Facilitate Successful Re-entry for Individuals Transitioning from Incarceration to Their Communities;” Glenn Stanton to State Medicaid Directors, “Ending Chronic Homelessness,” (Baltimore, MD: U.S. Department of Health & Human Services, Center for Medicaid and State Operations, Disabled and Elderly Health Programs Group, May 25, 2004), <https://www.medicare.gov/medicaid/tss/downloads/community-living/ending-chronic-homelessness-smd-letter.pdf>; 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, December 2013); 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); Shoemaker, *Health Care Reform—The Patient Protection and Affordable Care Act: A Practical Guide for Corrections and Criminal Justice Professionals*; Kathy Rowings and Andrew Whitacre, *Questions & Answers: Health Coverage Enrollment for Justice-Involved Individuals* (Washington, DC: National Association of Counties, July 2016): 4, www.naco.org/health-coverage-justice-2016.

130. See Question 9 in Richard C. Allen to Joan Henneberry, "Suspension of Medicaid Eligibility for Incarcerated Parents," letter, (Denver, CO: U.S. Department of Health & Human Services, Centers for Medicare & Medicaid Services, December 2, 2008), <https://www.colorado.gov/pacific/sites/default/files/December%20202008%20%20CMS%20Letter%20Responding%20to%20the%20Department's%20Questions%20Regarding%20the%20Implementation%20of%20SB%20008-006.pdf>.
131. See CA SB 695 §14011.10; see also Tara Naisbitt to All County Welfare Directors, County Welfare Administrative Officers, County Medi-Cal Program Specialists/Liaisons, County Health Executives, County Health Directors, County Meds Liaisons, "State Inmate Pre-Release Medi-Cal Application Process," Letter No. 14-24, (Sacramento, CA: State of California – Health and Human Services Agency, Department of Health Care Services, May 6, 2014), <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2014/14-24.pdf>, and Naisbitt to All County Welfare Directors, County Administrative Officers, County Medi-Cal Program Specialists/Liaisons, County Health Executives, County Health Directors, "Implementation of Assembly Bill (AB) 720 – Suspension of Medi-Cal Benefits For All Inmates and Other Requirements," Letter No. 14-26. For additional examples of state statutes related to suspension, see McKee et al., *State Medicaid Eligibility Policies for Individuals Moving Into and Out of Incarceration (August 2015)*. Information about Connecticut and several other examples are also available from Ryan et al., *Connecting the Justice-Involved Population to Medicaid Coverage and Care: Findings from Three States*.
132. "Incarcerated," Health-e-Arizona Plus, last modified December 11, 2015, accessed July 18, 2016, https://www.healtharizonaplus.gov/PolicyManual/eligibilitypolicymanual/index.html#page/MA/MA1500/MA1502.V_Incarcerated.html.
133. Ryan et al., *Connecting the Justice-Involved Population to Medicaid Coverage and Care: Findings from Three States*.
134. North Carolina Department of Health and Human Services, Division of Medicaid Assistance, Family and Children's Medicaid Manual § 3360 (revised 2013): <https://www2.ncdhhs.gov/info/olm/manuals/dma/fcm/man/MA3360.htm#TopOfPage>. For additional examples of states' suspension policies see McKee et al., *State Medicaid Eligibility Policies for Individuals Moving Into and Out of Incarceration (August 2015)*.
135. Kathy Rowings and Andrew Whitacre, *Questions & Answers: Health Coverage Enrollment for Justice-Involved Individuals* (Washington, DC: National Association of Counties, July 2016): 4, www.naco.org/health-coverage-justice-2016.
136. David L. Rosen, Dora M. Dumont, Andrew M. Cislo, Bradley W. Borckmann, Amy Traver, and Josiah D. Rich, Medicaid Policies and Practices in US State Prison Systems. *American Journal of Public Health* 104, no. 3 (March 2014): 418-420, doi: #10.2105/AJPH.2013.301563; 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, December 2013).
137. Kathy Rowings and Andrew Whitacre, *Questions & Answers: Health Coverage Enrollment for Justice-Involved Individuals* (Washington, DC: National Association of Counties, July 2016): 4, www.naco.org/health-coverage-justice-2016. See examples from Indiana, Colorado, and Oregon.
138. Examples are provided in McKee et al., *State Medicaid Eligibility Policies for Individuals Moving Into and Out of Incarceration* (August 2015).
139. Examples from 2013 can be found in Carolyn L. Yocom to U.S. Representatives Fred Upton and Joseph Pitts, *Medicaid: Information on Inmate Eligibility and Federal Costs for Allowable Services* (Washington, DC: Government Accountability Office, September 5, 2014), <http://gao.gov/assets/670/665552.pdf>. For additional examples, see e.g., Deborah Bachrach, Patricia Boozang, and Dori Glanz, *States Expanding Medicaid See Significant Budget Savings and Revenue Gains*, (Princeton, NJ: State Health Reform Assistance Network, Robert Wood Johnson Foundation, April 2015); Zemel, Corso, and Cardwell, *Toolkit: State Strategies to Enroll Justice-Involved Individuals in Health Coverage; and Shoemaker, Health Care Reform—The Patient Protection and Affordable Care Act: A Practical Guide for Corrections and Criminal Justice Professionals*.
140. Steven Rosenberg, "Medicaid Coverage for Jail Inmate's Inpatient Hospitalizations," *Sheriff*, (March/April 2015): 38, http://www.cochs.org/files/medicaid/Rosenberg_Medicaid_Coverage_for_Jail_Inmates.pdf.

141. The Pew Charitable Trusts, *How Medicaid Enrollment of Inmates Facilitates Health Coverage After Release* (Washington, DC: The Pew Charitable Trusts, December 2015); The Robert Wood Johnson study can be found at Deborah Bachrach, Patricia Boozang, and Dori Glanz, *States Expanding Medicaid See Significant Budget Savings and Revenue Gains* (Princeton, NJ: State Health Reform Assistance Network, Robert Wood Johnson Foundation, April 2015).
142. Commonwealth of Massachusetts Office of the State Auditor, *An Examination of State Policies and Practices Regarding Medicaid Coverage for Inmate Inpatient Health Care Costs*, by Suzanne M. Bump, 2013-5155-3M (Boston, MA: 2015), <http://www.mass.gov/auditor/docs/audits/2015/201351553m1.pdf>.
143. Deloitte, commissioned by Commonwealth of Kentucky, *Report on Medicaid Expansion in 2014* (Frankfort, KY: 2015), http://jointhehealthjourney.com/images/uploads/channel-files/Kentucky_Medicaid_Expansion_One-Year_Study_FINAL.pdf.
144. 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, December 2013); Christine Vestal, "States Missing Out on Millions in Medicaid for Prisoners," *Stateline: The Daily News Service of the Pew Charitable Trusts*, June 25, 2013, pewstates.org/projects/stateline/headlines/states-missing-out-on-millions-in-medicaid-for-prisoners-85899485969; Alison Lawrence, *Managing Corrections Cost* (Denver, CO: National Conference of State Legislatures, 2014) at <http://www.ncsl.org/documents/cj/managingcorrectionscosts.pdf>.
145. Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, *Establishing and Maintaining Medicaid Eligibility upon Release from Public Institutions*, SMA 10-4545 (Rockville, MD: U.S. Department of Health & Human Services, 2010): 14 – 16 <https://store.samhsa.gov/shin/content/SMA10-4545/SMA10-4545.pdf>.
146. See "Medicaid Changes and Implications for the Jail Population," webinar, (Ohio Department of Mental Health and Addiction Services & Ohio Department of Medicaid, November 30, 2016).
147. "Reinstatement of Medicaid for Public Institution Recipients (RoMPIR) – Program to Improve Service Access for Medicaid Recipients Released from Institutions," State of Ohio, Mental Health & Addiction Services, accessed July 26, 2016, <http://mha.ohio.gov/Default.aspx?tabid=224>; Tracy J. Plouck to Interested Stakeholders, "Reinstatement of Medicaid for Public Institution Recipients (RoMPIR) Project," (Columbus, OH: Department of Job and Family Services, February 5, 2010), <http://mha.ohio.gov/Portals/0/assets/Supports/Benefit%20Planning/rompir-odjfs-memo-201002.pdf>.
148. State of Ohio, Department of Rehabilitation and Correction, "Reinstatement of Medicaid for Public Institution Recipients: Rule 5111.0119," 07-ORD-14 (Columbus, OH: 2009); Ohio Revised Code 5163.45, "Confinement of Medicaid Recipient in Correctional Facility, accessed January 4, 2017, <http://codes.ohio.gov/orc/5163.45>
149. Susan Shin, Maryland Department of Health and Mental Hygiene, correspondence with Mark Larson, Center for Health Care Strategies, November 17, 2016.
150. The Maryland Addictions Directors Council, *ACA and the Criminal Justice System – 2014* (Towson, MD: The Maryland Addictions Directors Council, 2014), http://madc.homestead.com/ACA_and_Criminal_justice_-_2014.pdf; Maryland Mental Health and Criminal Justice Partnership, "Meeting Minutes: December 19, 2013," Recorded by Dan Martin (Lutherville: MD, 2013), <https://www.mhamd.org/wp-content/uploads/2015/04/MHCJP-MIN-121913.pdf>.
151. For a review of the challenges Maryland has faced, due to limited resources, in enrolling more of its individuals in incarceration in Medicaid, see Jay Hancock, "Thousands Leave Maryland Prisons With Health Problems and No Coverage," *National Public Radio*, April 24, 2016, accessed July 18, 2016, <http://www.npr.org/sections/health-shots/2016/04/24/475271336/thousands-leave-maryland-prisons-with-health-problems-and-no-coverage>.

152. North Carolina Department of Health and Human Services, "Medicaid Suspension/Termination for Incarcerated Beneficiaries and Beneficiaries Who Enter an Institution for Mental Disease (IMD)," *Family and Children's Medicaid MA-3360 Living Arrangement DHHS Policy Manual* (North Carolina: August 1, 2013); William W. Lawrence, Jr., MD to County Directors of Social Services and All Medicaid Eligibility Staff, "Medicaid Suspension for Incarcerated Recipients and Recipients who enter an Institution for Mental Diseases," DMA Adult Medicaid Administrative Letter No.: 09-08, Medicaid Suspension (North Carolina Department of Health and Human Services, August 27, 2008).
153. North Carolina Department of Health and Human Services, "Medicaid Suspension/Termination for Incarcerated Beneficiaries and Beneficiaries Who Enter an Institution for Mental Disease (IMD)," *Family and Children's Medicaid MA-3360 Living Arrangement DHHS Policy Manual* (North Carolina: August 1, 2013).
154. Judith Cox and Jaime Shimkus, "Medicaid Expansion and Inmates: Three Jails Solve the Puzzle," *Correct Care: The magazine of the National Commission on Correctional Health Care* 30, no. 1 (Winter 2016): 16-19, <http://www.ncchc.org/filebin/CorrectCare/30-1.pdf>.
155. Ben Butler, *New HIE Funding Opportunities for Corrections: Health Information Technology's Role in Reducing Mass Incarceration* (Oakland, CA: Community Oriented Correctional Health Services, March 2016): 8, <http://cochs.org/files/CMS/New-HIE-Funding-Opportunities.pdf>.
156. Zemel, Cardwell, and Corso, *Toolkit: State Strategies to Enroll Justice-Involved Individuals in Health Coverage*. For more on how states have implemented various forms of telephonic signatures for enrollment, see Rachel Meeks Cahill, *Telephonic Signatures: An Essential Tool for Enrollment* (Washington, DC: Enroll America, February 2013), <https://www.enrollamerica.org/telephonic-signatures-an-essential-tool-for-enrollment/>.
157. Shawn Smith to Income Maintenance Supervisors, Income Maintenance Lead Workers, Income Maintenance Staff, W-2 Agencies, Workforce Development Boards, Job Center Leads and Managers, Training Staff, Child Care Coordinators, "Processing Telephonic Applications from Offenders," DHS 14-49, (Madison, WI: Wisconsin Department of Health Services, November 24, 2014), <http://www.nashp.org/wp-content/uploads/2015/11/WI%20-%201.pdf>.
158. Pennsylvania Department of Corrections Staff, interview with Alex Blandford, Council of State Governments Justice Center, February 2016. Note that in 2016, Pennsylvania took steps to allow for suspension; legislation was signed into law in July 2016 (House Bill 1062).
159. McKee et al., *State Medicaid Eligibility Policies for Inmates Moving Into and Out of Incarceration* (2015).
160. Families USA, "Presumptive Eligibility: A Step Toward Streamlined Enrollment in Medicaid and CHIP," (Washington, DC: September 2011), accessed August 1, 2016 http://familiesusa.org/sites/default/files/product_documents/Presumptive-Eligibility.pdf.
161. *Ibid.*
162. See the answer to Question 6 at Centers for Medicare & Medicaid Services, Center for Medicaid and CHIP Services, "Medicaid and CHIP FAQs: Implementing Hospital Presumptive Eligibility Programs," (Baltimore, MD: U.S. Department of Health & Human Services, 2014), <https://www.medicaid.gov/federal-policy-guidance/downloads/faq-01-24-14-hospital-pe.pdf>.
163. Valerie Harr to County Welfare Agency Directors, Statewide Eligibility Determining Agencies, "Inpatient Acute Care Hospitalization Coverage for Inmates," Medicaid Communication #14-13, (Trenton, NJ: New Jersey Department of Human Services, Division of Medical Assistance and Health Services, December 9, 2014), http://www.state.nj.us/humanservices/dmahs/info/resources/medicaid/2014/14-13_Inmate_Med_Comm.pdf.
164. CA SB 87 § 14005.31-14005.39; CA SB 87 § 14005.81; Tara Naisbitt to All County Welfare Directors, County Welfare Administrative Officers, County Medi-Cal Program Specialists/Liaisons, County Health Executives, County Health Directors, County Meds Liaisons, "Medi-Cal and Related Programs for State and County Inmates," Letter No. 13-18, (Sacramento, CA: State of California – Health and Human Services Agency, Department of Health Care Services, December 20, 2013), <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/13-18.pdf>.
165. For more information on Indiana's use of PE for inpatient hospitalizations, see Indiana Family & Social Services Administration, "Medicaid for Incarcerated Individuals" training presentation for correctional facilities,

- (August 2015), [http://provider.indianamedicaid.com/media/146484/medicaid%20for%20incarcerated%20individuals%20training%20presentation%20\(correctional%20facility\).pdf](http://provider.indianamedicaid.com/media/146484/medicaid%20for%20incarcerated%20individuals%20training%20presentation%20(correctional%20facility).pdf); “Presumptive Eligibility for Inmates,” Indiana Family & Social Services Administration, Indiana Medicaid for Providers, accessed July 19, 2016, <http://provider.indianamedicaid.com/about-indiana-medicaid/member-programs/special-programs/qualified-provider-presumptive-eligibility-%28pe%29/presumptive-eligibility-for-inmates.aspx>.
166. See COCHS’ analysis of the April 28, 2016 CMS guidance to state health officials on justice-involved individuals (cautioning that contracts should be examined to identify who the payer is for an eligible individual’s inpatient hospital stay) by Steven Rosen to Colleagues, “CMS Guidance,” letter, (Oakland, CA: Community Oriented Correctional Health Services, 2016), <http://cochs.org/files/CMS/Guidance-Justice-Involved-Individuals.html>.
167. Pennsylvania, for example, created a centralized, state-level program under the County Commissioners Association of Pennsylvania (CCAP) to oversee the implementation of legislation allowing the state to seek federal reimbursement for allowable inpatient services. The program’s representatives serve as liaisons between the counties, the state Medicaid agency, and the department of corrections. The program personnel coordinate the submission and payment of claims. (For a detailed overview of this process, see “PIMCC Act 22 Service – The Process At a Glance,” County Commissioners Association of Pennsylvania, accessed July 26, 2016, <http://www.pacounties.org/ProgramServices/Documents/PimccAct22Matrix.pdf>.)
168. Iowa Department of Human Services, “Suspending Medicaid to Limited Benefits for Incarcerated Individuals Procedure Guide,” RC-0128 (Bluffs, IA: 2013), <http://dhs.iowa.gov/sites/default/files/RC-0128.pdf>; Iowa Code Ann. § 249A.38; Iowa Admin. Code R. § 75.12(1); Indiana Health Coverage Program Policy Manual § 2237.05.00 (undated) available at http://in.gov/fssa/files/Medicaid_Combined_PM.pdf. See Oregon’s similar 12-month limit at Oregon Department of Human Services, “House Bill 3536 Procedures,” (Salem, OR: 2014), http://www.dhs.state.or.us/spd/tools/mh_inmate/; see also California’s approach at Naisbitt to All County Welfare Directors, County Administrative Officers, County Medi-Cal Program Specialists/Liaisons, County Health Executives, County Health Directors, “Implementation of Assembly Bill (AB) 720 – Suspension of Medi-Cal Benefits For All Inmates and Other Requirements,” Letter No. 14-26.
169. Katrina Carter, Offender Services, Iowa Department of Corrections, correspondence with Alex Blandford, Council of State Governments Justice Center, March 3, 2016.
170. NY 11 § 366(1)(a).
171. Office of the Inspector General, *Audit Report: The Social Security Administration’s Pre-release Procedures of Institutionalized Individuals*, A-02-14-24085 (Washington, DC: U.S. Social Security Administration, 2015), http://oig.ssa.gov/sites/default/files/audit/full/pdf/A-02-14-24085_0.pdf, (including a table of some of the states with prerelease agreements, 6).
172. U.S. Social Security Administration, “SI 00520.900 Prerelease Procedure – Institutionalization,” SSA’s *Program Operations Manual System*.
173. The table was adapted from the U.S. Social Security Administration, *Entering the Community After Incarceration: How We Can Help* (Washington, DC: November 2015), SSA 05-10504, <https://www.ssa.gov/pubs/EN-05-10504.pdf>.
174. Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, *Establishing and Maintaining Medicaid Eligibility upon Release from Public Institutions*, SMA 10-4545 (Rockville, MD: U.S. Department of Health & Human Services, 2010), <https://store.samhsa.gov/shin/content/SMA10-4545/SMA10-4545.pdf>; Donna Bond, Coordinator of Mental Health Reentry Services, Oklahoma Department of Corrections, interview with Alex Blandford, Council of State Governments Justice Center, April 2016.
175. Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, *Establishing and Maintaining Medicaid Eligibility upon Release from Public Institutions*, SMA 10-4545 (Rockville, MD: U.S. Department of Health & Human Services, 2010), <https://store.samhsa.gov/shin/content/SMA10-4545/SMA10-4545.pdf>.

176. Individuals who are eligible for Medicaid through SSI and whose SSI benefits are terminated must reapply for SSI as a new applicant, and Medicaid eligibility will not be restored until the Social Security Administration approves the application for SSI. For a detailed explanation of how SSI suspension and termination affects Medicaid eligibility for individuals in prisons and jails, please see The Bazelon Center for Mental Health Law, *The Effect of Incarceration on Medicaid Benefits for People with Mental Illnesses* (Washington, DC: Bazelon Center for Mental Health Law): 5-6, http://www.bazelon.org/LinkClick.aspx?fileticket=_Ns68MefCJY%3D&tabid=441.
177. 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, December 2013).
178. Deborah Bachrach to Commissioners of Social Services, "Maintaining Medicaid Eligibility for Incarcerated Individuals," (Albany, NY: New York Department of Health, April 21, 2008), http://www.health.ny.gov/health_care/medicaid/publications/docs/adm/08adm-3.pdf.
179. Zemel, Cardwell, and Corso, *Toolkit: State Strategies to Enroll Justice-Involved Individuals in Health Coverage*.
180. U.S. Social Security Administration, "SI 00520.910 Prerelease Agreements with Institutions," *SSA's Program Operations Manual System*, <https://secure.ssa.gov/poms.nsf/lnx/0500520910>.
181. For a model prerelease agreement from the SSA, see Exhibit 2 in U.S. Social Security Administration, "SI 00520.930 Exhibits of the Prerelease Procedure, Agreement, and Referral," *SSA's Program Operations Manual System*, <https://secure.ssa.gov/poms.nsf/lnx/0500520930>. A sample executed prerelease agreement between the Social Security Administration and the Oklahoma Department of Corrections is available at "Agreement Between The Social Security Administration and The Oklahoma Department of Corrections," <https://soarworks.prainc.com/sites/soarworks.prainc.com/files/SSA%20DOC%20agreement.pdf>.
182. A number of examples were drawn from recently published sources. For more, see these key resources 1) Zemel, Cardwell, and Corso, *Toolkit: State Strategies to Enroll Justice-Involved Individuals in Health Coverage*; 2) Bandara et al., *State and Local Initiatives to Enroll Individuals in Medicaid in Criminal Justice Settings*; 3) McKee et al., *State Medicaid Eligibility Policies for Inmates Moving Into and Out of Incarceration*, (2015); 4) Shoemaker, *Health Care Reform, The Patient Protection and Affordable Care Act: A Practical Guide for Corrections and Criminal Justice Professionals*.
183. 42 U.S.C. § 1396a(a)(8) requires states to allow anyone to apply for Medicaid at any time. CMS then clarified that this also applies to individuals who are incarcerated. See Robert A. Streimer to All Associate Regional Administrators, Division for Medicaid and State Operations, "Clarification of Medicaid coverage Policy for Inmates of a Public Institution" (Baltimore, MD: U.S. Department of Health & Human Services, Health Care Financing Administration, U.S. Department of Health & Human Services, December 12, 1997); Most recently, CMS guidance in April 2016 to state health officials reiterated that "The state Medicaid agency must accept applications from inmates to enroll in Medicaid or renew Medicaid enrollment during the time of their incarceration." If individuals meet all eligibility criteria, they must be enrolled or reenrolled at any time, although states can suspend coverage until release. See also Wachino to State Health Officials, "To Facilitate Successful Re-entry for Individuals Transitioning from Incarceration to Their Communities": 6.
184. 42 C.F.R. 435.907; Wachino to State Health Officials, "To Facilitate Successful Re-entry for Individuals Transitioning from Incarceration to Their Communities": 7.
185. U.S. Department of Health & Human Services, Centers for Medicare & Medicaid Services, "Medicaid Program: Eligibility Changes under the Affordable Care Act of 2010," *Federal Register* 57, no. 57 (March 23, 2012), <http://www.gpo.gov/fdsys/pkg/FR-2012-03-23/pdf/2012-6560.pdf>.
186. 42 C.F.R. § 435.908.
187. Maureen McDonnell, Director for Business and Health Care Strategy Development, TASC, interview with Alex Blandford, Council of State Governments Justice Center, March 13, 2016. See, e.g., the Texas (nonexpansion state) community partner sign up at "Community Partner Program," Texas Health and Human Services Commission, accessed July 22, 2016, <https://www.texascommunitypartnerprogram.com/Tx.CPP/UI/HomePage.aspx>. In Illinois (an expansion state), see "Guide to ABE for Community Partners," Illinois

- Department of Human Services, accessed July 22, 2016, <http://www.dhs.state.il.us/page.aspx?item=67369>.
188. 42 U.S.C. § 1903(a)(7); 42 C.F.R. § 433.15(b)(7).
189. See “Medicaid Administrative Claiming,” U.S. Department of Health & Human Services, Centers for Medicare & Medicaid Services, accessed July 19, 2016, <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Financing-and-Reimbursement/Medicaid-Administrative-Claiming.html>; See Centers for Medicare & Medicaid Services, “Medicaid and CHIP FAQs: Enhanced Funding for Medicaid Eligibility Systems,” (Baltimore, MD: U.S. Department of Health & Human Services, 2013), <https://www.medicaid.gov/State-Resource-Center/FAQ-Medicaid-and-CHIP-Affordable-Care-Act-Implementation/Downloads/FAQs-by-Topic-75-25-Eligibility-Systems.pdf>.
190. Legal Action Center, TASC, Advocates for Human Potential, and the Bureau of Justice Assistance, *Frequently Asked Questions (FAQs) on Health Coverage and the Criminal Justice Population—2014* (Washington, DC: Legal Action Center, 2015), http://www.rsat-tta.com/Files/BJA_LAC-FAQ9-25-14-2.pdf.
191. 42 U.S.C. § 1631(m); 42 U.S.C. § 1383; Office of the Inspector General, *Audit Report: The Social Security Administration’s Pre-release Procedures of Institutionalized Individuals, A-02-14-24085* (Washington, DC: U.S. Social Security Administration, 2015), http://oig.ssa.gov/sites/default/files/audit/full/pdf/A-02-14-24085_0.pdf.
192. U.S. Social Security Administration, “SI 00520.900 Prerelease Procedure – Institutionalization,” SSA’s Program Operations Manual System, <https://secure.ssa.gov/poms.nsf/lnx/0500520900>.
193. U.S. Social Security Administration, “SI 00520.930 Exhibits of the Prerelease Procedure, Agreement, and Referral,” SSA’s Program Operations Manual System, <https://secure.ssa.gov/poms.nsf/lnx/0500520930>; Prison Law Office, *Benefits Available to Paroling Discharging Inmates* (San Quentin, CA: 2011), <http://www.cpoc.org/assets/Realignment/benefitsletteraug2011.pdf>.
194. Maureen McDonnell, Director for Business and Health Care Strategy Development, TASC, on December 8, 2015, interview with Alex Blandford and Martha Plotkin, CSG Justice Center.
195. Californians for Safety and Justice, Local Safety Solutions Project, Health Coverage Enrollment of California’s Local Criminal Justice Population (Oakland, CA: Californians for Safety and Justice, 2014).
196. Elizabeth Siggins, CSG Justice Center consultant working with Californians for Safety and Justice, in communication with Deanna Adams, Senior Reentry Fellow, CSG Justice Center, April 5, 2016.
197. NM SB 42 § 2(C), <http://www.nmlegis.gov/Sessions/15%20Regular/final/SB0042.pdf>; New Mexico Statutes Chapter 27. Public Assistance § 27-2-12.22. Incarcerated individuals; medicaid eligibility.
198. IL HB 3270 <http://www.ilga.gov/legislation/publicacts/fulltext.asp?Name=099-0415>.
199. IN HB 1269, <https://iga.in.gov/static-documents/e/f/4/c/ef4c65a0/HB1269.05.ENRH.pdf>. For individuals held for less than 30 days, the law allows, but does not require, corrections and jails to assist those detained in applying and accessing care.
200. Connecticut General Assembly, Office of Legislative Research, *The Affordable Care Act and Prisoners*, by Robin K. Cohen, 2013-R-0288 (Hartford, CT: August 2013), <https://www.cga.ct.gov/2013/rpt/2013-R-0288.htm>; Center for Health Care Strategies, Inc., *Fact Sheet: Medicaid Expansion and Jail-Involved Individuals: Opportunities to Promote Coverage, Improve Health, and Reduce Recidivism* (Hamilton, NJ: Center for Health Care Strategies, Inc., March 2014), http://www.chcs.org/media/Medicaid_Expansion_and_Jails_Fact_Sheet_032714.pdf.
201. Ryan et al., *Connecting the Justice-Involved Population to Medicaid Coverage and Care: Findings from Three States*.
202. “Incarceration – Overview,” Washington State Health Care Authority, Apple Health (Medicaid), last modified November 10, 2014, accessed July 19, 2016, <http://www.hca.wa.gov/medicaid/manual/Pages/90-110.aspx>; McKee et al., *State Medicaid Eligibility Policies for Individuals Moving Into and Out of Incarceration (August 2015)*.

203. See “Take Care Health Matters,” Colorado Criminal Justice Reform Coalition, Take Care Health Matters, accessed July 19, 2016, <http://takecarehealthmatters.org>; Shoemaker, *Health Care Reform—The Patient Protection and Affordable Care Act: A Practical Guide for Corrections and Criminal Justice Professionals*: 37.
204. Anne Peak, Shawnee Health Care, correspondence with Alex Blandford, Council of State Governments Justice Center, May 17, 2016; Videos were created by the Kentuckiana Regional Planning and Development Agency; See “Welcome to the Kentuckiana Regional Planning & Development Agency (KIPDA),” last modified July 15, 2016, accessed July 22, 2016, <http://www.kipda.org>.
205. Although the videos portray outreach in the community, some approaches in using plain language can be useful within correctional facilities as well. See “Assisting with Medicaid and Marketplace Enrollment,” U.S. Department of Health & Human Services, Substance Abuse and Mental Health Services Administration, SSI/SSDI Outreach, Access and Recovery (SOAR) TA Center, accessed July 19, 2016, <https://soarworks.prainc.com/article/assisting-medicaid-and-marketplace-enrollment>.
206. Kathy Rowings, Andrew Whitacre, *Questions & Answers: Health Coverage Enrollment for Justice-Involved Individuals* (Washington, DC: National Association of Counties, July 2016): 4, www.naco.org/health-coverage-justice-2016.
207. See Indiana Family and Social Services Administration, *Medicaid for Inmate: Frequently Asked Questions* (Indianapolis, IN: 2015), <http://provider.indianamedicaid.com/media/146487/medicaid%20for%20inmates%20faqs.pdf>.
208. Kathy Rowings, Andrew Whitacre, and Maeghan Gilmore, *Questions & Answers: The Affordable Care Act and County Jails* (Washington, DC: National Association of Counties, 2014), <http://www.naco.org/sites/default/files/documents/QandA-ACA%20Inmate%20Healthcare-OCT2014%20%28%29.pdf>; Juliette Forstenzer Espinosa and Marsha Regenstein, “How the Affordable Care Act Affects Inmates,” *Public Health Rep.* 129, no. 4 (Jul-Aug): 369–373, <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4037469/>.
209. Families USA, *Health Insurance for People Involved in the Justice System: Outreach and Enrollment Strategies* (Washington, DC: Families USA, 2015).
210. Bandara et al., “Leveraging The Affordable Care Act To Enroll Justice-Involved Populations In Medicaid: State And Local Efforts.”
211. *Ibid.*
212. Bandara et al., *State and Local Initiatives to Enroll Individuals in Medicaid in Criminal Justice Settings*.
213. See, e.g., Kathy Rowings, Andrew Whitacre, *Questions & Answers: Health Coverage Enrollment for Justice-Involved Individuals* (Washington, DC: National Association of Counties, July 2016): 4, www.naco.org/health-coverage-justice-2016.
214. Zemel, Cardwell, and Corso, *Toolkit: State Strategies to Enroll Justice-Involved Individuals in Health Coverage*.
215. Bandara et al., *State and Local Initiatives to Enroll Individuals in Medicaid in Criminal Justice Settings*.
216. Judith Cox and Jaime Shimkus, “Medicaid Expansion and Inmates: Three Jails Solve the Puzzle,” *Correct Care: The magazine of the National Commission on Correctional Health Care* 30, no. 1 (Winter 2016): 16-19, <http://www.ncchc.org/filebin/CorrectCare/30-1.pdf>.
217. Zemel, Cardwell, and Corso, *Toolkit: State Strategies to Enroll Justice-Involved Individuals in Health Coverage*.
218. Bandara et al., *State and Local Initiatives to Enroll Individuals in Medicaid in Criminal Justice Settings*.
219. Jamie Clayton, Imperial County Jail Commander, and Jessica Yocupicio, Catholic Charities, interview with Deanna Adams, Council of State Governments Justice Center, April 6, 2016.
220. Denver Sheriff Department, *The Affordable Care Act and County Jails: A Practical Guide to Strategies and Steps for Implementation* (Denver, CO: Denver Sheriff Department, December 2013), https://www.denvergov.org/Portals/776/documents/ACA_Brief.pdf; Bandara et al., *State and Local Initiatives to Enroll Individuals in*

Medicaid in Criminal Justice Settings. Chris Underwood to County Departments of Human/Social Services, County Jails, and Medicaid providers, "Medicaid Policy for Billing for Inmates Hospitalized at Least 24 Hours," #14-011 (Denver, CO: Colorado Department of Health Care Policy and Financing, May 6, 2014), <https://www.colorado.gov/pacific/sites/default/files/2014%20Agency%20Letters%20Number%2014-011.pdf>.

221. Shoemaker, *Health Care Reform—The Patient Protection and Affordable Care Act: A Practical Guide for Corrections and Criminal Justice Professionals*: 36.
222. For more information, see "Enroll America, Get Covered America", *Working with the Criminal Justice System: Education and Enrollment Strategies for the Recently Incarcerated* (Washington, DC: Enroll America, 2015), https://s3.amazonaws.com/assets.enrollamerica.org/wp-content/uploads/2015/08/Justice_Enrollment.pdf.
223. Bandara et al., *State and Local Initiatives to Enroll Individuals in Medicaid in Criminal Justice Settings*.
224. *Ibid*; *Correct Care: The magazine of the National Commission on Correctional Health Care* 30, no. 1 (Winter 2016), <http://www.pacenterofexcellence.pitt.edu/documents/Medicaid%20Expansion%20and%20Inmates%20.pdf>.
225. Zemel, Cardwell, and Corso, *Toolkit: State Strategies to Enroll Justice-Involved Individuals in Health Coverage*. The MOU referenced by NASHP is at "Memorandum of Understanding Between the Health Care Authority and any/all correctional or jailing facilities and State Hospitals (IMDs) performing the work of enrolling individuals into the Washington Medicaid system of record using WA Healthplanfinder," <http://www.nashp.org/wp-content/uploads/2015/11/WA%20-%201.pdf>.
226. New Hampshire Department of Health and Human Services, "Medical Assistance Manual § 175.01: Inmates With an Approaching Release Date," http://www.dhhs.nh.gov/mam_htm/newmam.htm, quoted in McKee et al., *State Medicaid Eligibility Policies for Individuals Moving Into and Out of Incarceration* (August 2015).
227. Bandara et al., *State and Local Initiatives to Enroll Individuals in Medicaid in Criminal Justice Settings*.
228. See e.g., Community Oriented Correctional Health Services, *Frequently Asked Questions: The Medicaid Administrative Claiming (MAC) Program* (May 2015) at http://www.cochs.org/files/medicaid/cochs_medicaid_MAC.pdf; Steven Rosenberg, *Medicaid Claiming and Public Safety Agencies: Issue Paper, COCHS*: May 2015, at http://www.cochs.org/files/medicaid/cochs_medicaid_Public_Safety.pdf; and by Medicaid at <https://www.medicaid.gov/medicaid-chip-program-information/by-topics/financing-and-reimbursement/medicaid-administrative-claiming.html>.
229. See, e.g., Steven Rosenberg, *Medicaid Claiming and Public Safety Agencies: Issue Paper, COCHS*: May 2015, at http://www.cochs.org/files/medicaid/cochs_medicaid_Public_Safety.pdf.
230. Legal Action Center and Bureau of Justice Assistance *Frequently Asked Questions (FAQs) on Health Coverage and the Criminal Justice Population—2014* at http://www.rsat-tta.com/Files/BJA_LAC-FAQ9-25-14-2.pdf.
231. Information from Illinois, Indiana, and New Mexico from Maureen McDonnell, Director for Business and Health Care Strategy Development, TASC, interview with Alex Blandford and Martha Plotkin, Council of State Governments Justice Center, December 8, 2015; see also, National Academy for State Health Policy, *Ohio: State Strategies to Enroll Justice-Involved Individuals in Health Coverage* (Portland, ME: National Academy for State Health Policy, 2015), <http://www.nashp.org/ohio-state-strategies-to-enroll-justice-involved-individuals-in-health-coverage/>.
232. Gloria Nagle to Toby Douglas, "MAA/TCM Time Survey Methodology and MAA Program Operational Plan," letter, (San Francisco, CA: U.S. Department of Health & Human Services, Centers for Medicare & Medicaid Services, November 1, 2013), http://www.dhcs.ca.gov/provgovpart/Documents/ACLSS/CMAA/CMAA-TCM_Imp_Plan/CMAA-TCM-IP-CMS-Approval-Amendment-Letter-11-01-13.pdf.
233. Maureen McDonnell, Director for Business and Health Care Strategy Development, TASC, interview with Alex Blandford and Martha Plotkin, Council of State Governments Justice Center, December 8, 2015.

234. See <http://www.ramsellphs.com/alameda-county-sheriffs-office/>. A pilot was completed with the Alameda Sheriff's Office Youth and Family Services Bureau and a mobile application is being used to track time from both clinical and administrative staff. Corrections agencies can direct bill if they are using only one billing code for Medicaid eligibility intake. Conversation with Patrick Sutton, Ramsell Public Health and Safety, with Martha Plotkin, CSG Justice Center, June 30, 2016.
235. Remarks by Mack Jenkins, San Diego Chief Probation Officer, *Medicaid Administrative Claiming and Targeted Case Management: Opportunities for Public Safety*, part of the Health Reform and Public Safety Webinar Series: New Opportunities, Better Outcomes, May 28, 2015, at <http://info.nicic.gov/hrps/?q=node/25>.
236. Maureen McDonnell, Director for Business and Health Care Strategy Development, TASC, interview with Alex Blandford and Martha Plotkin, CSG Justice Center, December 8, 2015.
237. Zemel, Cardwell, and Corso, *Toolkit: State Strategies to Enroll Justice-Involved Individuals in Health Coverage*; Shoemaker, *Health Care Reform—The Patient Protection and Affordable Care Act: A Practical Guide for Corrections and Criminal Justice Professionals*.
238. Kathy Rowings, *Case Study: Addressing Mental Illness and Medical Conditions in County Jails: Cook County, Ill.* (Washington, DC: National Association of Counties, 2015), <http://www.naco.org/resources/addressing-mental-illness-and-medical-conditions-county-jails-cook-county-ill>.
239. Samantha Artiga, *Profiles of Medicaid Outreach and Enrollment Strategies: The Cook County Early Expansion Initiative*, Issue Brief (Menlo Park, CA: The Henry J. Kaiser Family Foundation, April 2014); The National Association of Pretrial Services Agencies, *The Patient Protection and Affordable Care Act and the Pretrial System: A "Front Door" to Health and Safety: Appendix A* (Washington, DC: The National Association of Pretrial Services Agencies, 2014), <http://www2.centerforhealthandjustice.org/sites/www2.centerforhealthandjustice.org/files/publications/ACA%20and%20the%20Pretrial%20System%20%28Appendix%20A-%20Cook%20County%29%20-%20NAPSA%202014%20%281%29.pdf>.
240. Maureen McDonnell, Director for Business and Health Care Strategy Development, TASC, correspondence with Martha Plotkin and Alex Blandford, Council of State Governments Justice Center, April 6, 2016.
241. Cindi B. Jones to Housing Appropriations, "Status of DMAS Projects on Veterans and Inmates," presentation, (Richmond, VA: Department of Medical Assistance Services, September 16, 2013), http://hac.state.va.us/Committee/files/2013/09-16-13/DMAS_Veterans_and_Inmates_Projects.pdf.
242. Bandara et al., *State and Local Initiatives to Enroll Individuals in Medicaid in Criminal Justice Settings*.
243. Ohio Department of Rehabilitation & Correction, *2015 Annual Report*, by Gary C. Mohr (Columbus, OH: 2015), <http://www.drc.ohio.gov/web/Reports/Annual/Annual%20Report%202015.pdf>; Bandara et al., *State and Local Initiatives to Enroll Individuals in Medicaid in Criminal Justice Settings*; Zemel, Cardwell, and Corso, *Toolkit: State Strategies to Enroll Justice-Involved Individuals in Health Coverage*.
244. Zemel, Cardwell, and Corso, *Toolkit: State Strategies to Enroll Justice-Involved Individuals in Health Coverage*.
245. *Ibid.*
246. Bandara et al., *State and Local Initiatives to Enroll Individuals in Medicaid in Criminal Justice Settings*.
247. Ryan et al., *Connecting the Justice-Involved Population to Medicaid Coverage and Care: Findings from Three States*; Connecticut General Assembly, Office of Legislative Research, *The Affordable Care Act and Prisoners*, by Richard K. Cohen, 2013-R-0288 (Hartford, CT: 2013), <https://www.cga.ct.gov/2013/rpt/2013-R-0288.htm>.
248. Center for Health Care Strategies, Inc., *Fact Sheet: Medicaid Expansion and Jail-Involved Individuals: Opportunities to Promote Coverage, Improve Health, and Reduce Recidivism* (Hamilton, NJ: Center for Health Care Strategies, Inc., March 2014), http://www.chcs.org/media/Medicaid_Expansion_and_Jails_Fact_Sheet_032714.pdf.

249. Colorado Office of the State Auditor, *Report of the State Auditor: Inmate Benefits Application Assistance, Department of Corrections, Performance Audit* (Denver, CO: 2007), [http://www.leg.state.co.us/osa/coauditor1.nsf/All/9C48035F457619698725726C0055D4E3/\\$FILE/1822%20Inmate%20Benefits%20Perf%20Jan%202007.pdf](http://www.leg.state.co.us/osa/coauditor1.nsf/All/9C48035F457619698725726C0055D4E3/$FILE/1822%20Inmate%20Benefits%20Perf%20Jan%202007.pdf).
250. Office of the Inspector General, California Rehabilitation Oversight Board (C-ROB), *C-ROB Report, September 15, 2015* (Sacramento, CA: 2015): 29, http://www.oig.ca.gov/media/crob/reports/C-ROB_Annual_Report_September_15_2015.pdf.
251. McKee et al., *State Medicaid Eligibility Policies for Individuals Moving Into and Out of Incarceration* (August 2015); Among the resources for additional examples of enrollment activities, see Bandara et al., *State and Local Initiatives to Enroll Individuals in Medicaid in Criminal Justice Settings*; and Zemel, Cardwell, and Corso, *Toolkit: State Strategies to Enroll Justice-Involved Individuals in Health Coverage*.
252. 42 CFR § 435.908.
253. 42 CFR § 435.923.
254. Naisbitt to All County Welfare Directors, County Administrative Officers, County Medi-Cal Program Specialists/Liaisons, County Health Executives, County Health Directors, "Implementation of Assembly Bill (AB) 720 – Suspension of Medi-Cal Benefits For All Inmates and Other Requirements," Letter No. 14-26.
255. CA Penal Code § 4011.11; Naisbitt to All County Welfare Directors, County Administrative Officers, County Medi-Cal Program Specialists/Liaisons, County Health Executives, County Health Directors, "Implementation of Assembly Bill (AB) 720 – Suspension of Medi-Cal Benefits For All Inmates and Other Requirements," Letter No. 14-26.
256. Zemel, Cardwell, and Corso, *Toolkit: State Strategies to Enroll Justice-Involved Individuals in Health Coverage*.
257. *Ibid.*
258. Carol Mici, Assistant Deputy Commissioner - Classification, Programs, & Reentry, Massachusetts Department of Corrections, correspondence with Martha Plotkin, Council of State Governments Justice Center on March 21, 2016.
259. *Ibid.*
260. Lynn Patrone, Mental Health Advocate, Pennsylvania Department of Corrections, interview with Alex Blandford, Council of State Governments Justice Center, February 2016; For more information about COMPASS, please see "COMPASS," Pennsylvania Department of Public Welfare, accessed July 19, 2016, <https://www.compass.state.pa.us/Compass.Web/public/cmphome>.
261. U.S. Social Security Administration, *Entering the Community After Incarceration: How We Can Help* (Washington, DC: November 2015), SSA 05-10504, <https://www.ssa.gov/pubs/EN-05-10504.pdf>.
262. U.S. Social Security Administration, "SI 00520.910 Prerelease Agreements with Institutions," SSA's *Program Operations Manual System*, <https://secure.ssa.gov/poms.nsf/lnx/0500520910>.
263. *Ibid.*
264. Office of the Inspector General, *Audit Report: The Social Security Administration's Pre-release Procedures of Institutionalized Individuals*, A-02-14-24085 (Washington, DC: 2015), http://oig.ssa.gov/sites/default/files/audit/full/pdf/A-02-14-24085_0.pdf.
265. Dazara Ware, Senior Policy Associate, Policy Research Associates, correspondence with Alex Blandford, Council of State Governments Justice Center, July 2016.
266. U.S. Department of Human Services, Substance Abuse and Mental Health Services Administration, SSI/SSDI Outreach, Access and Recovery for people who are homeless (SOAR), *Best Practices for Increasing Access to SSI/SSDI upon Exiting Criminal Justice Settings*, by Dazara Ware and Deborah Dennis (Washington, DC: January 2013): 5, <https://soarworks.prainc.com/sites/soarworks.prainc.com/files/bestpracticesCJ-508.pdf>.

267. *Ibid*; The Bazelon Center for Mental Health Law, *Best Practices: Access to Benefits for Prisoners with Mental Illnesses* (Washington, DC: Bazelon Center for Mental Health Law, 2006), http://justicesolutionsgroup.com/resourcecenter/uploads/pdf/DOC_BestPractices.pdf.
268. Tricia Brooks, "Health Policy Brief: Hospital Presumptive Eligibility," *Health Affairs*, (Princeton, NJ: Robert Wood Johnson Foundation, January 2014), http://healthaffairs.org/healthpolicybriefs/brief_pdfs/healthpolicybrief_106.pdf.
269. 42 CFR 435.1110.
270. See the answer to Question 5 at Centers for Medicare & Medicaid Services, Center for Medicaid and CHIP Services, "Medicaid and CHIP FAQs: Implementing Hospital Presumptive Eligibility Programs," (Baltimore, MD: U.S. Department of Health & Human Services, 2014), <https://www.medicaid.gov/federal-policy-guidance/downloads/faq-01-24-14-hospital-pe.pdf>.
271. Tricia Brooks, *Presumptive Eligibility: Providing Access to Health Care Without Delay and Connecting Children to Coverage* (Washington, DC: Georgetown University, Health Policy Institute, Center on Children and Families, May 2011), http://ccf.georgetown.edu/wp-content/uploads/2012/03/Presumptive_eligibility_20111.pdf.
272. "PE/MOSAA Determiners," New Mexico Human Services Department, accessed February 27, 2016, http://www.hsd.state.nm.us/providers/PE_MOSAA_Determiners.aspx; New Mexico Human Services Department, Medical Assistance Division, *Presumptive Eligibility (PE) and Presumptive Eligibility Plus (PE+) Training Manual* (Santa Fe, NM: 2014), <http://www.nashp.org/wp-content/uploads/2015/11/NM%20-%20202.pdf>.
273. Zemel, Cardwell, and Corso, *Toolkit: State Strategies to Enroll Justice-Involved Individuals in Health Coverage*.
274. Pamela Acosta, Bernalillo County Metropolitan Detention Center Social Service Supervisor, interview with Maureen McDonnell, Director for Business and Health Care Strategy Development, TASC, February 26, 2016.
275. New Mexico Human Services Department, Medical Assistance Division, *Presumptive Eligibility (PE) and Presumptive Eligibility Plus (PE+) Training Manual* (Santa Fe, NM: 2014), <http://www.nashp.org/wp-content/uploads/2015/11/NM%20-%20202.pdf>.
276. Pamela Acosta, Bernalillo County Metropolitan Detention Center Social Service Supervisor, interview with Maureen McDonnell, Director for Business and Health Care Strategy Development, TASC, February 26, 2016.
277. Pamela Acosta, Bernalillo County Metropolitan Detention Center Social Service Supervisor, interview with Maureen McDonnell, Director for Business and Health Care Strategy Development, TASC, February 26, 2016 and August 1, 2016.
278. 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>.
279. "Does Medicare or Medicaid Come With Social Security or SSI Disability Benefits?" Nolo, accessed July 19, 2016, <http://www.nolo.com/legal-encyclopedia/does-medicare-medicare-come-with-social-security-ssi-disability-benefits.html>.
280. U.S. Social Security Administration, "SI 01715.010 Medicaid and the Supplemental Security Income (SSI) Program," *SSA's Program Operations Manual System*, <https://secure.ssa.gov/poms.nsf/lnx/0501715010>.
281. *Ibid*.
282. For example, a driver's license or birth certificate, proof of income, or other documentation may be required to complete a Medicaid application. Nancy La Vigne et al., *Release planning for successful reentry: A guide for corrections, service providers, and community groups* (Washington, DC: The Urban Institute, 2008).

283. Maureen McDonnell, Director for Business and Health Care Strategy Development, TASC, interview with Alex Blandford and Martha Plotkin, Council of State Governments Justice Center, December 8, 2015.
284. Fred C. Osher, et al., *Adults with behavioral health needs under correctional supervision: A shared framework for reducing recidivism and promoting recovery* (New York, NY: Council of State Governments Justice Center, 2012).
285. Maureen McDonnell, Director for Business and Health Care Strategy Development, TASC, interview with Alex Blandford and Martha Plotkin, Council of State Governments Justice Center on December 8, 2015.
286. Steven Rosenberg, "Eligibility and Enrollment How Does this Actually Work," webinar, (National Institute of Corrections and Community Oriented Correctional Health Services, June 18, 2014, 2015), <http://info.nicic.gov/hrps/?q=node/27>.
287. Alex M. Blandford and Fred C. 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 and the Council of State Governments Justice Center, 2013), <http://www.prainc.com/wp-content/uploads/2015/10/guidelines-successful-transition-people-behavioral-health-disorders.pdf>.
288. For more information and a list of the 10 Essential Health Benefits, see Cindy Mann to State Medical Directors, "Essential Health Benefits in the Medicaid Program," SMDL # 12-003, ACA # 21 (Baltimore, MD: U.S. Department of Health & Human Services, Centers for Medicare & Medicaid Services, November 20, 2012): 2, <https://www.medicaid.gov/Federal-Policy-Guidance/downloads/SMD-12-003.pdf>.
289. U.S. Department of Health & Human Services, Centers for Medicare & Medicaid Services, *Alternative Benefit Plans (ABPs)*, by Kirsten Jensen (Baltimore, MD: 2013): 4, <https://www.medicaid.gov/medicaid-chip-program-information/by-topics/benefits/downloads/abp-state-training-presentation.pdf>.
290. U.S. Government Accountability Office, *Report to Congressional Requesters: Behavioral Health: Options for Low-Income Adults to Receive Treatment in Selected States*, GAO-15-449 (Washington, DC: June 2015): 26, <http://www.gao.gov/assets/680/670894.pdf>.
291. *Ibid.*
292. 42 U.S.C. §1905(a)(B); See also, Legal Action Center, *The Medicaid IMD Exclusion: An Overview and Opportunities for Reform* (New York, NY: Legal Action Center, n.d.), http://lac.org/wp-content/uploads/2014/07/IMD_exclusion_fact_sheet.pdf.
293. Vikki Wachino to State Medicaid Directors, "New Service Delivery Opportunities for Individuals with a Substance Use Disorder," SMD #15-003 (Baltimore, MD: U.S. Department of Health & Human Services, Centers for Medicare & Medicaid Services, July 27, 2015), <https://www.medicaid.gov/federal-policy-guidance/downloads/SMD15003.pdf>.
294. 42 C.F.R. § 431, § 433, § 438, § 440, § 457, and § 495, <https://s3.amazonaws.com/public-inspection.federalregister.gov/2016-09581.pdf>.
295. U.S. Department of Health & Human Services, Centers for Medicare & Medicaid Services, "Medicaid and Children's Health Insurance Program (CHIP) Programs; Mental Health Parity and Addiction Equity Act of 2008; the Application of Mental Health Parity Requirements to Coverage Offered by Medicaid Managed Care Organizations, the Children's Health Insurance Program (CHIP), and Alternative Benefit Plans; Final Rule," Federal Register 81, no. 61 (March 30, 2016): 18389, <https://federalregister.gov/a/2016-06876>.
296. States have 18 months from when the final rule was issued to comply with its provisions. For more information on parity and resources from CMS on the rule and its oversight, see "Behavioral Health Services," 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/mental-health-services.html>. This paper does not delve into issues of state implementation of the parity provisions; for more information, see Substance Abuse and Mental Health Services Administration. Approaches in Implementing the Mental Health Parity and Addiction Equity Act: Best Practices from the States. HHS Publication No. SMA-16-4983, Rockville, MD: Substance Abuse and Mental Health Services Administration; 2016.

297. Julia Paradise, *Medicaid Moving Forward* (Menlo Park, CA: The Henry J. Kaiser Family Foundation, 2015), <http://kff.org/health-reform/issue-brief/medicaid-moving-forward/>.
298. For more information on implementing a health home option, see “Health Home Information Resource Center,” U.S. Department of Health & Human Services, Centers for Medicare & Medicaid Services, accessed July 20, 2016, <https://www.medicaid.gov/state-resource-center/medicaid-state-technical-assistance/health-homes-technical-assistance/health-home-information-resource-center.html>; See also “SAMHSA-HRSA Center for Integrated Health Solutions,” U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Health Resources & Services Administration, accessed July 20, 2016, <http://www.integration.samhsa.gov>.
299. HR 3590 § 2703; “Health Homes,” 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/Long-Term-Services-and-Supports/Integrating-Care/Health-Homes/Health-Homes.html>.
300. *Ibid.*
301. An analysis was released by SAMHSA in 2005 (pre-ACA) and can be found at U.S. Department of Health & Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, *State Profiles of Mental Health and Substance Abuse Services in Medicaid*, by Gail Robinson, Neva Kaye, David Berman, Mirabelle Moreaux, and Caity Baxter (Washington, DC: 2005), <https://store.samhsa.gov/shin/content/NMH05-0202/NMH05-0202.pdf>.
302. Alex M. Blandford and Fred C. 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 and the Council of State Governments Justice Center, 2013), <http://www.prainc.com/wp-content/uploads/2015/10/guidelines-successful-transition-people-behavioral-health-disorders.pdf>; 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, 2013).
303. 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>.
304. 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>; See also U.S. Department of Health & Human Services, Centers for Medicare & Medicaid Services, *Pathways for Covering Mental Health and Substance Use Disorder Services* (Baltimore, MD: February 9, 2015), <https://www.medicaid.gov/medicaid-chip-program-information/by-topics/benefits/downloads/pathways-2-9-15.pdf>; TASC, Inc., *7 Ways to Maximize Federal Funding for Services Provided to Individuals with Mental Health, Substance Use, and Chronic Health Conditions Involved in the Justice System* (Chicago, IL: TASC, Inc., 2016).
305. See “Health Home State Plan Option,” The Henry J. Kaiser Family Foundation, last modified April 2016, accessed July 16, 2016, <http://kff.org/medicaid/state-indicator/health-home-state-plan-option/>, and “Health Home State Plan Option [Map],” The Henry J. Kaiser Family Foundation, last modified April 2016, accessed July 16, 2016, <http://kff.org/medicaid/state-indicator/health-home-state-plan-option/#map>, for which states have approved state plan amendments for health homes.
306. For a list of approved SPAs, see “Medicaid State Plan Amendments,” U.S. Department of Health & Human Services, Centers for Medicare & Medicaid Services, accessed July 20, 2016, <https://www.medicaid.gov/state-resource-center/medicaid-state-plan-amendments/medicaid-state-plan-amendments.html>.

307. U.S. Department of Health & Human Services, 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, Substance Abuse and Mental Health Services Administration, 2013), Module 9: 9-6.; <https://store.samhsa.gov/shin/content/SMA13-4773/SMA13-4773.pdf>.
308. A list of all waivers that have been approved by CMS can be found at “Demonstrations & Waivers,” 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/waivers/waivers_faceted.html.
309. For more on comparability, see Medicaid Statute, Title XIX of 42 U.S.C. § 1902(a)(10)(B); for more on freedom of choice, see Medicaid Statute, Title XIX of 42 U.S.C. § 1902(a)(23); and for more on “statewideness”, see “Waivers,” Medicaid and CHIP Payment and Access Commission, accessed July 20, 2016, <https://www.macpac.gov/subtopic/waivers/>; and Medicaid Statute, 42 U.S.C. § Social Security Act 1902(a)(1).
310. For more information on how Section 1115 waivers have been used by some states to expand Medicaid eligibility, see Robin Rodwitz and MaryBeth Musumeci, *The ACA and Medicaid Expansion Waivers* (Menlo Park, CA: The Henry J. Kaiser Family Foundation, 2015), <http://kff.org/report-section/the-aca-and-medicaid-expansion-waivers-issue-brief/>.
311. Those states are CO, IA, IL, ME, MN, OR, UT, and VT. See Center for Health Care Strategies, Inc. *Medicaid Accountable Care Organizations: State Update* (Trenton, NJ: Center for Health Care Strategies, March 2015), <http://www.chcs.org/media/ACO-Fact-Sheet-32515-ak.pdf>.
312. Gabrielle de la Guéronnière, Legal Action Center correspondence with Alex Blandford, Council of State Governments Justice Center, July 6, 2016.
313. 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>.
314. Ken Cannon and Jenna Burton, *Adult Behavioral Health Benefits in Medicaid and the Marketplace* (Menlo Park, CA: The Henry J. Kaiser Family Foundation, June 2015), <http://files.kff.org/attachment/report-adult-behavioral-health-benefits-in-medicaid-and-the-marketplace>.
315. Chris Heiss, Center for Health Care Strategies, interview with Alex Blandford and Martha Plotkin, Council of State Governments Justice Center; Kathy Rowings and Andrew Whitacre, *Questions & Answers: Health Coverage Enrollment for Justice-Involved Individuals* (Washington, DC: National Association of Counties, July 2016), www.naco.org/health-coverage-justice-2016.
316. For an example, see New York State’s managed care contracts on Medicaid coverage of court-ordered services at “Court Orders and Medicaid Managed Care and Family Health Plus Enrollees,” New York State Office of Alcoholism and Substance Abuse Services, accessed July 25, 2016, <https://www.oasas.ny.gov/admin/hcf/mancare/court.cfm>; and “Medicaid Managed Care/Family Health Plus/HIV Special Needs Plan Model Contract,” March 1, 2014-February 28, 2019: section 10.9, http://www.health.ny.gov/health_care/managed_care/docs/medicaid_managed_care_fhp_hiv-snp_model_contract.pdf.
317. Vikki Wachino, “Coverage of Housing-Related Activities and Services for Individuals with Disabilities,” (Baltimore, MD: Centers for Medicare & Medicaid Services, June 26, 2015).
318. TASC, Inc., *7 Ways to Maximize Federal Funding for Services Provided to Individuals with Mental Health, Substance Use, and Chronic Health Conditions Involved in the Justice System* (Chicago, IL: TASC, Inc, 2016); Daniel J. Mistak, *Addressing the Disparate Impact of the Federal Response to the Opioid Epidemic* (Oakland, CA: Community Oriented Correctional Health Services, December 2015), <http://www.cochs.org/files/IMD/disparate-impact-opioid-epidemic.pdf>.

319. For more information on substance use treatment for adults involved in the criminal justice system, see U.S. Department of Health & Human Services, Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment, *Substance Abuse Treatment for Adults in the Criminal Justice System: Treatment Improvement Protocol (TIP) Series 44*. SMA #13-4056 (Rockville, MD: 2014); See also U.S. Department of Health & Human Services, National Institute on Drug Abuse, *Principles of Drug Abuse Treatment for Criminal Justice Populations: A Research-Based Guide*, by Bennett W. Fletcher, Redonna K. Chandler, and the Office of Science Policy and Communications, NIH #11-5316 (Bethesda, MD: 2014).
320. See e.g., U.S. Department of Health & Human Services, Office of the Assistant Secretary for Planning and Evaluation, Office of Disability, Aging, and Long-Term Care Policy, *How the Affordable Care Act Can Support Employment for People with Mental Illness* (Washington, DC: May 2014), <https://aspe.hhs.gov/sites/default/files/pdf/77081/ACAmiesIB.pdf>.
321. For more information on in-reach models, see David S. Buck, Carlie A. Brown, and J. Scott Hickey, "The Jail Inreach Project: Linking Homeless Inmates Who Have Mental Illness With Community Health Services," *Psychiatric Services* 62, no. 2 (February 2011): 120-22, doi: 10.1176/ps.62.2.pss6202_0120; and see "Just in Reach: JIR 2.0," Corporation for Supportive Housing, accessed July 20, 2016, <http://www.csh.org/csh-solutions/serving-vulnerable-populations/re-entry-populations/local-criminal-justice-work/12740-2/>.
322. For additional examples of how states have approached benefits for individuals in the criminal justice system, see U.S. Department of Justice, Bureau of Justice Assistance, *The Affordable Care Act and Criminal Justice: Intersections and Implications*, by Andrea A. Bainbridge (Washington, DC: U.S. Department of Justice, Bureau of Justice Assistance, July 2012), https://www.bja.gov/Publications/ACA-CJ_WhitePaper.pdf.
323. The Council of State Governments Justice Center, "Opportunities for Health and Criminal Justice Stakeholders" meeting, sponsored by the Jacob and Valeria Langeloth Foundation (Washington, DC: December 10, 2013).
324. Mark Larson and Katherine Heflin, Center for Health Care Strategies, correspondence with Alex Blandford, Council of State Governments Justice Center, July 2016; The Council of State Governments Justice Center, "West Virginia Expands Access to Substance Use Treatment through Justice Reinvestment," November 12, 2015, accessed July 25, 2016, <https://csgjusticecenter.org/jr/west-virginia/posts/west-virginia-expands-access-to-substance-use-treatment-through-justice-reinvestment/>.
325. Pennsylvania Department of Corrections, "Access to Mental Health Care Policy," Policy 13.8.1, (March 2, 2015), <http://www.cor.pa.gov/About%20Us/Documents/DOC%20Policies/13.08.01%20Access%20to%20Mental%20Health%20Care.pdf>.
326. Lynn Patrone, Mental Health Advocate, Pennsylvania Department of Corrections, correspondence with Alex Blandford, Council of State Governments Justice Center, March 14, 2016; U.S. Department of Health & Human Services, Substance Abuse and Mental Health Services Administration, GAINS Center for Behavioral Health and Justice Transformation, "The Use of Peer Support in State Correctional Facilities: How to Build Peer Support for Incarcerated Persons with Mental Illness," webinar, (September 3, 2014), <http://www.asca.net/system/assets/attachments/7503/SAMHSA%20ASCA%20Webinar%2009-3-14%20FINAL.pdf?1409837308>.
327. Texas Department of Health Services, *Home and Community-Based Services – Adult Mental Health: Provider Manual*, (Austin, TX, n.d.): 20, <https://www.dshs.texas.gov/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=8590002428>.
328. The Meadows Mental Health Policy Institute worked with the University of Texas at Austin's Texas Institute for Excellence in Mental Health to connect community stakeholders with implementation teams and to provide criminal justice subject matter expertise. (B. J. Wagner, Meadows Mental Health Policy Institute, correspondence with Alex Blandford, Council of State Governments Justice Center, July 22, 2016.)
329. California Department of Health Care Services, *Fact Sheet: Drug Medi-Cal Organized Delivery System Waiver* (Sacramento, CA: n.d.), <http://www.dhcs.ca.gov/provgovpart/Documents/DMC%20ODS%20FACT%20SHEET.pdf>.

330. See Andrew M. Slavitt to Mari Cantwell, letter, (Washington, DC: U.S. Department of Health & Human Services, Centers for Medicare & Medicaid Services, December 30, 2015), <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ca/medi-cal-2020/ca-medi-cal-2020-ca.pdf>; Additional information is available at “Drug Medi-Cal Organized Delivery System,” California Department of Health Care Services, last modified April 18, 2016, accessed July 20, 2016, <http://www.dhcs.ca.gov/provgovpart/Pages/Drug-Medi-Cal-Organized-Delivery-System.aspx>; Karen Baylor, “Drug Medi-Cal Organized Delivery System Pilot Fiscal Provisions,” California Department of Health Care Services, MHSUDS #15-034 (Sacramento, CA: California Department of Health Care Services, August 20, 2015), http://www.dhcs.ca.gov/formsandpubs/Documents/MHSUDS_Information_Notice_15-034_DMC-ODS_Fiscal_Provisions.pdf; Vikki Wachino to Mari Cantwell, letter, (Baltimore, MD: U.S. Department of Health & Human Services, Centers for Medicare & Medicaid Services, August 13, 2015), http://www.dhcs.ca.gov/provgovpart/Documents/CA_SUD_Amendment_Approval%20Letter_08-13-15_Final.pdf; See also, Anna Gorman, “California revamps Medicaid addiction treatment,” *Kaiser Health News: Behavioral Healthcare Magazine*, (December 10, 2015), <http://www.behavioral.net/print/news-item/california-revamps-medicaid-addiction-treatment>.
331. “California Medi-Cal 2020 Demonstration,” December 30, 2015-December 31, 2020, http://www.dhcs.ca.gov/provgovpart/Documents/MC2020_FINAL_STC_12-30-15.pdf; The pilot provides more intensive services for the criminal justice population to address their complex needs. See California Department of Health Care Services, *Fact Sheet: Drug Medi-Cal Organized Delivery System Waiver* (Sacramento, CA: n.d.), <http://www.dhcs.ca.gov/provgovpart/Documents/DMC%20ODS%20FACT%20SHEET.pdf>.
332. Sita Diehl et al., *State Mental Health Legislation 2014: Trends, Themes & Effective Practices* (Arlington, VA: National Alliance on Mental Illness, December 2014), <https://www.nami.org/legreport2014>.
333. IL HB 0001, <http://www.ilga.gov/legislation/BillStatus.asp?DocTypeID=HB&DocNum=1&GAID=13&SessionID=88&LegID=83490>.
334. State Plan Amendment Approval can be found at Center for Health Care Strategies, “Health Home State Plan Amendment,” VT #13-001 (Montpelier, VT: March 4, 2014), http://www.chcs.org/media/VT_13-001_Approvalpackage.pdf; Cindy Mann et al., “Medication Assisted Treatment for Substance Use Disorders,” (Baltimore, MD: U.S. Department of Health & Human Services, Centers for Medicaid & CHIP Services, Substance Abuse and Mental Health Services Administration, Centers for Disease Control and Prevention, National Institute on Drug Abuse, National Institute on Alcohol Abuse and Alcoholism, National Institutes of Health, July 11, 2014), <https://www.medicaid.gov/federal-policy-guidance/downloads/cib-07-11-2014.pdf>.
335. State Plan Amendment Approval can be found at Center for Health Care Strategies, “Health Home State Plan Amendment,” RI #13-001 (Providence, RI: November 6, 2013), http://www.chcs.org/media/Rhode_Island_Health_Home_State_Plan_Amendment.pdf.
336. TX Title 25 § 448.902(g) (5), [https://texreg.sos.state.tx.us/public/readtac\\$ext.TacPage?sl=R&app=9&p_dir=&p_rloc=&p_tloc=&p_ploc=&pg=1&p_tac=&ti=25&pt=1&ch=448&rl=902](https://texreg.sos.state.tx.us/public/readtac$ext.TacPage?sl=R&app=9&p_dir=&p_rloc=&p_tloc=&p_ploc=&pg=1&p_tac=&ti=25&pt=1&ch=448&rl=902); Mann et al., “Medication Assisted Treatment for Substance Use Disorders.”
337. Ohio Department of Alcohol & Drug Addiction Services, *Medication-Assisted Treatment: Proposed Low Dose Protocol for the Use of Buprenorphine and Suboxone: Medication-Assisted Policy Statement* (Columbus, OH: 2010), <http://mha.ohio.gov/Portals/0/assets/Treatment/OpiatesMAT/Buprenorphine%20and%20Suboxone%20Low%20Dose%20Protocol%20for%20web.pdf>.
338. See memo from Ohio State Medicaid Director at John McCarthy to Providers of Alcohol and Other Drug (AoD) Treatment Services, County ADAMHS Boards, Ohio Medicaid Managed Care Plans, “Medicaid Coverage for ODADAS Certified Providers Rendering Medication Assisted Treatment,” (Columbus, OH: Ohio Department of Job and Family Services, June 27, 2012), http://mha.ohio.gov/Portals/0/assets/Planning/Medicaid/polcy-memo-on-changes-to-medication-assisted-treatment-6.28.12_2.pdf.
339. Mann et al., “Medication Assisted Treatment for Substance Use Disorders.”

340. Vikki Wachino, "Best Practices for Addressing Prescription Opioid Overdoses, Misuse and Addiction," (Baltimore, MD: U.S. Department of Health & Human Services, Centers for Medicare & Medicaid Services, January 28, 2016), <https://www.medicaid.gov/federal-policy-guidance/downloads/cib-02-02-16.pdf>; For more information on federal legislation, regulations, and guidelines related to MAT, as well as funding opportunities and resources for providers, see "Medication-Assisted Treatment (MAT)," U.S. Department of Health & Human Services, Substance Abuse and Mental Health Services Administration, accessed July 20, 2016, <http://www.samhsa.gov/medication-assisted-treatment>; Although not Medicaid specific, the Substance Abuse and Mental Health Services Administration (SAMHSA) announced in March 2016 that applications could be submitted for *Targeted Capacity Expansion: Medication Assisted Treatment-Prescription Drug Opioid Addiction grants* totaling up to \$33 million over three years. See U.S. Department of Health & Human Services, Substance Abuse and Mental Health Services Administration, "SAMHSA is accepting applications for up to \$33 million for SAMHSA Medication Assisted Treatment grants," (Washington, DC: 2016), <http://www.samhsa.gov/newsroom/press-announcements/201603290100-0>.
341. The Council of State Governments, "Opportunities for Health and Criminal Justice Stakeholders," meeting, sponsored by the Jacob and Valeria Langeloth Foundation (Washington, DC: December 10, 2013); U.S. Department of Health & Human Services, Centers for Medicare & Medicaid Services, "Exploring Medicaid Health Homes: Tailoring Health Homes to Individuals with Opioid Dependency: A Multi-State Discussion," webinar, (Baltimore, MD: January 15, 2015), <https://www.medicaid.gov/state-resource-center/medicaid-state-technical-assistance/health-homes-technical-assistance/downloads/hh-opioid-dependency-spas.pdf>.
342. For New York State's approved SPA authorizing the state's health home model, see Michael Melendez to Jason Helgeson, "NYS Health Home SPA for Individuals with Chronic Behavioral and Medical Health Conditions-SPA #12-11," (Baltimore, MD: U.S. Department of Health & Human Services, Centers for Medicare & Medicaid Services, December 4, 2012), https://www.health.ny.gov/regulations/state_plans/status/non-inst/approved/docs/app_2012-12-04_spa_12-11.pdf; New York State, Health Home Services, "NYS Health Home SPA for Individuals with Chronic Behavioral and Medical Health Conditions," SPA #12-11, (2012), <https://www.medicaid.gov/state-resource-center/medicaid-state-technical-assistance/health-homes-technical-assistance/downloads/new-york-spa-12-11.pdf>; Note that the SPA does not specifically reference criminal justice; this was a priority for implementation that was identified by state officials.
343. For more information on the Criminal Justice Pilot under New York's Health Home Program, see National Association of Medicaid Directors, *New York's Health Home Project Criminal Justice Pilot Program* (Washington, DC: National Association of Medicaid Directors, 2014), http://medicaiddirectors.org/wp-content/uploads/2015/07/ny_case_study.pdf; New York State Division of Criminal Justice Services/ Office of Mental Health Justice & Mental Health Collaboration Program, "Medicaid Health Homes and Criminal Justice," webinar, (Albany, NY: June 22, 2015), https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/6_22_2015_hh_cj.pdf; and Community Based Care, New York City Department of Probation, and The New York City Department of Health and Mental Hygiene, "Health Home Collaborative Pilot: Care Management/Coordination for Criminal Justice Involved Individuals," webinar, (New York, NY: May 2014), https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/nyc_prob_pilot.pdf.
344. The Council of State Governments, "Opportunities for Health and Criminal Justice Stakeholders," meeting, sponsored by the Jacob and Valeria Langeloth Foundation (Washington, DC: December 10, 2013); The Council of State Governments Justice Center, "Medicaid's Health Home Model – Can It Improve Public Health and Public Safety?" July 10, 2013, accessed July 25, 2016, <https://csgjusticecenter.org/mental-health/posts/medicaids-health-home-model-can-it-improve-public-health-and-public-safety/>.
345. 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: May 2014), <https://www.medicaid.gov/medicaid-chip-program-information/by-topics/benefits/downloads/cms-adult-substance-abuse-services-coverage.pdf>.
346. National Association of Medicaid Directors, *Ohio's Medicaid Managed Care Prison Transition Program* (Washington, DC: National Association of Medicaid Directors, 2014), http://medicaiddirectors.org/wp-content/uploads/2015/08/oh_case_study_1.pdf.
347. Shoemaker, *Health Care Reform, The Patient Protection and Affordable Care Act: A Practical Guide for Corrections and Criminal Justice Professionals*.

348. National Association of Medicaid Directors, *Ohio's Medicaid Managed Care Prison Transition Program*.
349. National Academy for State Health Policy, *Ohio: State Strategies to Enroll Justice-Involved Individuals in Health Coverage* (Portland, ME: National Academy for State Health Policy, 2015), <http://www.nashp.org/ohio-state-strategies-to-enroll-justice-involved-individuals-in-health-coverage/>.
350. National Academy for State Health Policy, *Rhode Island: State Strategies to Enroll Justice-Involved Individuals in Health Coverage* (Portland, ME: National Academy for State Health Policy, 2015), <http://www.nashp.org/rhode-island-state-strategies-to-enroll-justice-involved-individuals-in-health-coverage/>.
351. Florida Agency for Health Care Administration, "Medical Management Assistance (MMA) Program – Contract No. FP###, Attachment II, Exhibit II-A," http://www.fdhc.state.fl.us/medicaid/statewide_mc/pdf/Contracts/2015-11-01/Exhibit_II-A-Managed_Medical_Assistance_MMA_Program_2015-11-01.pdf, quoted in McKee et al., *State Medicaid Eligibility Policies for Inmates Moving Into and Out of Incarceration*, (2015).
352. *Ibid.*
353. Andrew M. Slavitt to Mari Cantwell, letter, (Washington, DC: U.S. Department of Health & Human Services, Centers for Medicare & Medicaid Services, December 30, 2015), http://www.dhcs.ca.gov/provgovpart/Documents/Letter_to_State-CA.PDF.
354. IA HF 2463, Chapter 1140, § 95, https://www.legis.iowa.gov/DOCS/IowaActs/85/2/pdf/Chapter_1140.pdf.
355. New Mexico Human Services Department, *Medical Assistance Division Managed Care Policy Manual* (Santa Fe, NM: 2015), [http://www.hsd.state.nm.us/uploads/files/Providers/Manuals%20and%20Guides/Managed%20Care%20Policy%20Manual/MCO%20Policy%20Manual%20Update%20effective%2003032015\(1\).pdf](http://www.hsd.state.nm.us/uploads/files/Providers/Manuals%20and%20Guides/Managed%20Care%20Policy%20Manual/MCO%20Policy%20Manual%20Update%20effective%2003032015(1).pdf).
356. See New Mexico Human Services Department, "Medicaid Managed Care Services Agreement Among New Mexico Services Department, New Mexico Behavioral Health Purchasing Collaborative and HCSC Insurance Services Company, operating as Blue Cross Blue Shield of New Mexico," <http://www.hsd.state.nm.us/uploads/files/About%20Us/MAD%20Contracts/MCOs/BCBSNM%20Contract.pdf>. The contract requires compliance with all HSD policies.
357. Paul Kirby, Warren Ferguson and Anne Lawthers, *Post-Release MassHealth Utilization: An Evaluation of the MassHealth/DOC Prison Reintegration Pilot* (Boston, MA: University of Massachusetts Medical School Center for Health Policy and Research, August 2012). Other examples include the Wisconsin Department of Corrections' distributing pamphlets to people within its facilities about health care coverage options and ways to access care in the community, see at Wisconsin Department of Corrections, *Health Insurance Options: A Guide for Offenders and Agents* (Madison, WI: Wisconsin Department of Corrections, 2015), <http://www.nashp.org/wp-content/uploads/2015/11/WI%20-%203.pdf>. The Washington State Department of Corrections gives individuals who did not enroll in Medicaid prior to their release relevant materials and information on how to access federal health care Navigators in their communities assist them in enrolling and accessing services. These and additional examples are available at Zemel, Cardwell, and Corso, [Toolkit: State Strategies to Enroll Justice-Involved Individuals in Health Coverage](#).
358. Zemel, Cardwell, and Corso, *Toolkit: State Strategies to Enroll Justice-Involved Individuals in Health Coverage*.
359. Robert L. Trestman and Rob H. Aseltine, "Justice Involved Health Information: Policy and Practice Advances in Connecticut," *Perspectives in Health Information Management* (Winter 2014): 1-11, http://perspectives.ahima.org/justice-involved-health-information-policy-and-practice-advances-in-connecticut/#.Vw_AzRMrJp8; As part of the Wisconsin DOC's (a nonexpansion state) release planning efforts, the DOC gives individuals a two-week supply of prescription medications on the day of their release and a written prescription for another two-week supply. See National Academy for State Health Policy, *Wisconsin: State Strategies to Enroll Justice-Involved Individuals in Health Coverage* (Portland, ME: National Academy for State Health Policy, 2015), <http://www.nashp.org/wisconsin-state-strategies-to-enroll-justice-involved-individuals-in-health-coverage/>.
360. Anita Cardwell and Maeghan Gilmore, *County Jails and the Affordable Care Act: Enrolling Eligible Individuals in Health Coverage* (Washington, DC: National Association of Counties, 2012).

361. The examples in the text box were drawn from Nastassia Walsh, *Reducing Mental Illness in County Jails* (Washington, DC: National Association of Counties, July 2016). Several of these rural counties have joined with hundreds of other counties in the national Stepping Up Initiative to reduce the number of people with mental illnesses in jails across the country. For more about the Stepping Up Initiative, see “The Stepping Up Initiative,” The Council of State Governments Justice Center, accessed July 26, 2016, stepuptogether.org.
362. Allison Hamblin, James Verdier, and Melanie Au, *State Options for Integrating Physical and Behavioral Health Care* (Hamilton, NJ: Center for Health Care Strategies, Inc., October 2011), <http://www.chcs.org/resource/state-options-for-integrating-physical-and-behavioral-health-care/>.
363. Allison Hamblin, Vice President for Strategic Planning, Center for Health Care Strategies, correspondence with Alex Blandford and Martha Plotkin, Council of State Governments Justice Center, April 28 2016.
364. 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.
365. A few advanced payment models are discussed at The Medicaid and CHIP Payment and Access Commission (MACPAC), *Paying for Value in Medicaid: A Synthesis of Advanced Payment Models in Four States: Final Report*, by Kristin Dybdal et al., (Washington, DC: February 2014), https://www.macpac.gov/wp-content/uploads/2015/01/MACPAC_Visits_Final-Report-Feb-2014.pdf.
366. MHBG program is authorized by Title XIX, Part B, Subpart I and III of 42 U.S.C. § 300w–10, <https://www.gpo.gov/fdsys/pkg/USCODE-2010-title42/pdf/USCODE-2010-title42-chap6A-subchapXVII-partB.pdf>.
367. Allison Hamblin et al., *Medicaid and Criminal Justice: The Need for Cross-System Collaboration Post Health Care Reform* (Oakland, CA: Community Oriented Correctional Health Services, January 2011): 13, http://www.chcs.org/media/CHCS_Final.pdf; U.S. Department of Health & Human Services, Office of the Assistant Secretary for Planning and Evaluation, *Using Medicaid to Support Working Age Adults with Serious Mental Illnesses in the Community: A Handbook*, by Gary Smith et al., (Washington, DC: 2006): 14.
368. The grants were authorized by the Excellence in Mental Health Act (S 264).
369. For more information, see “Section 223 Demonstration Program for Certified Community Behavioral Health Clinics,” U.S. Department of Health & Human Services, Substance Abuse and Mental Health Services Administration, at <http://www.samhsa.gov/section-223>. SAMHSA recently issued a press release to announce the 8 states selected to participate in the Certified Community Behavioral Health Clinics Demonstration Program (see: <https://www.hhs.gov/about/news/2016/12/21/hhs-selects-eight-states-new-demonstration-program-improve-access-high-quality-behavioral-health>). The states are Minnesota, Missouri, New York, New Jersey, Nevada, Oklahoma, Oregon, and Pennsylvania.
370. “What are Federally qualified health centers (FQHCs)?” U.S. Department of Health & Human Services, Health Resources & Services Administration, accessed July 20, 2016, <http://www.hrsa.gov/healthit/toolbox/RuralHealthITtoolbox/Introduction/qualified.html>.
371. 42 U.S.C. § 254b.
372. “What are Federally qualified health centers (FQHCs)?” U.S. Department of Health & Human Services, Health Resources & Services Administration, accessed July 20, 2016, <http://www.hrsa.gov/healthit/toolbox/RuralHealthITtoolbox/Introduction/qualified.html>.
373. Truven Health Analytics, *Financing of Behavioral Health Services within Federally Qualified Health Centers* (Washington, DC: Truven Health Analytics, July 2012), http://www.integration.samhsa.gov/Financing_BH_Services_at_FQHCs_Final_7_23-12.pdf; Sam Shekar to Consolidated Health Center Program Grantees, “Medicaid Reimbursement for Behavioral Health Services,” 2004-05 (Washington, DC: U.S. Department of Health & Human Services, October 31, 2003), <http://www.integration.samhsa.gov/images/res/HRSAItr,%20financing%20doc%202.pdf>.
374. There are also FQHC “look-alikes” that do not receive the grant funding but may receive the Medicaid reimbursement. For more information on FQHCs’ financing mechanisms for behavioral health care, see Mary Brolin et al., *Financing of Behavioral Health services within Federally Qualified Health Centers*

(Washington, DC: Truven Health Analytics, 2012), http://www.integration.samhsa.gov/Financing_BH_Services_at_FQHCs_Final_7_23-12.pdf.

375. For more information, including a Frequently Asked Questions document, see “What are Federally qualified health centers (FQHCs)?” U.S. Department of Health & Human Services, Health Resources & Services Administration, accessed July 20, 2016, <http://www.hrsa.gov/healthit/toolbox/RuralHealthITtoolbox/Introduction/qualified.html>.
376. Marc De Hert et al., “Physical illness in patients with severe mental disorders: Barriers to care, monitoring and treatment guidelines, plus recommendations at the system and individual level,” *World Psychiatry* 10, no. 2, (June 2011): 138-151, <http://www.ncbi.nlm.nih.gov/pubmed/21633691>.
377. Benjamin Druss and Berry Mauer, “Health care reform and care at the behavioral health-primary care interface. *Psychiatric Services* 61, no. 11: 1087-1092, doi: 10.1176/appi.ps.61.11.1087; Also, for information on the outcomes of the grant program, see, Deborah M. Scharf et al. , *Evaluation of the SAMHSA Primary and Behavioral Health Care Integration (PBHCI) Grant Program* (Santa Monica, CA: The RAND Corporation, 2014), http://www.rand.org/content/dam/rand/pubs/research_reports/RR500/RR546/RAND_RR546.pdf.
378. U.S. Department of Health & Human Services, Centers for Medicare & Medicaid Services, “Amended Announcement: Cooperative Agreement- State Innovation Models: Funding for Model Design and Testing Assistance,” (Baltimore, MD: Center for Medicare & Medicaid Innovation, 2012): 4, https://innovation.cms.gov/Files/x/StateInnovation_FOA.pdf.
379. The program is authorized by the Mentally Ill Offender Treatment and Crime Reduction Act (MIOTCRA; S 162, H.R. 401).
380. “Justice and Mental Health Collaboration Program (JMHCPC),” U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Assistance, accessed July 20, 2016, https://www.bja.gov/ProgramDetails.aspx?Program_ID=66.
381. “Mental Health Services Act (MHSA): Funding,” California Department of Health Care Services, accessed July 20, 2016, <http://www.dhcs.ca.gov/services/MH/Pages/MHSAFunding.aspx>.
382. “MHSA Innovation 2 Project – Health Neighborhoods,” County of Los Angeles, Department of Mental Health, accessed July 27, 2016, http://file.lacounty.gov/dmh/cms1_220189.pdf.
383. “Recovery Works,” Indiana Family and Social Services Administration, March 5, 2016, <http://www.in.gov/fssa/dmha/2929.htm>.
384. For more about justice reinvestment and states that are engaged in the process, see “Justice Reinvestment,” The Council of State Governments Justice Center, accessed July 20, 2016, <https://csgjusticecenter.org/jr/>.
385. The Council of State Governments Justice Center, “Alabama Lawmakers Dedicate \$26.6 million in FY2017 to Implement Justice Reinvestment Policies,” accessed July 25, 2016, <https://csgjusticecenter.org/jr/announcements/alabama-lawmakers-dedicate-26-6-million-in-fy2017-to-implement-justice-reinvestment-policies/>.
386. “Kansas,” The Council of State Governments Justice Center, accessed July 25, 2016, <https://csgjusticecenter.org/jr/ks/>; Kansas Department of Corrections, meetings with Justice Reinvestment Team, Council of State Governments Justice Center.
387. Idaho Department of Correction, *Justice Reinvestment in Idaho: Impact at 18 months*, Report to the Legislature (Indiana, IN: February 1, 2016), https://intranet.csgjusticecenter.org/wp-content/uploads/2016/04/ID_18-Month-Impact-Report.pdf.
388. Correspondence between West Virginia Department of Military Affairs and Public Safety and CSG Justice Center staff, July 2016.
389. The “Texas Correctional Office on Offenders with Medical or Mental Impairments” was established pursuant to state legislation (TX § 614.001 (2005)) to contract with and provide oversight of local mental health authorities; see TX § 614.001 for information on the specific duties of the office.

390. See “Pennsylvania Mental Health and Justice Center for Excellence,” Center for Research on Health Care (CRHC) Data Center, last modified March 31, 2016, accessed July 20, 2016, <http://www.pacenterofexcellence.pitt.edu>; “Illinois Center of Excellence for Behavioral Health and Justice,” Illinois Center of Excellence for Behavioral Health and Justice, accessed July 20, 2016, <http://www.illinoiscenterofexcellence.org>; “Ohio Criminal Justice Coordinating Center of Excellence,” Northeast Ohio Medical University, accessed July 20, 2016, <http://www.neomed.edu/academics/criminal-justice-coordinating-center-of-excellence>; and “the Mental Health and Substance Abuse Technical Assistance Center at the Louis de la Parte Florida Mental Health Institute (FMHI),” University of South Florida, accessed July 20, 2016, <http://www.floridatac.com>.
391. Washington State Department of Social and Health Services, The Washington Institute for Mental Health Research & Training, and Washington State University Spokane, *Use of Sales Tax to provide local funding for mental health and chemical dependency services expands across the State*, by Anne D. Strode, (April 2009), <https://www.dshs.wa.gov/sites/default/files/BHSIA/dbh/documents/5763factsheet.pdf>.
392. Washington State Department of Social and Health Services, The Washington Institute for Mental Health Research & Training, Washington State University Spokane, *Final Report: Implementing E2SSB-5763 in Washington State Counties*, by Anne D. Strode (Olympia, WA: March 2008), <https://www.dshs.wa.gov/sites/default/files/BHSIA/dbh/documents/ssb-5763report.pdf>. For a resource on how this is possible in other states and counties, see “How Communities Can Fund Mental Health Services,” Care for Your Mind, last modified May 10, 2016, accessed July 25, 2016, <http://careforyourmind.org/how-communities-can-fund-mental-health-services>.
393. California Government Code §30025 designates (for counties) the Local Revenue Fund 2011 for “Public Safety Services,” which includes (under (i)(4)) “Providing mental health services to [...] adults in order to reduce [...] harm to themselves and others, homelessness, and preventable incarceration or institutionalization.” California Department of Corrections and Rehabilitation, *2011 Public Safety Realignment* (Sacramento, CA: 2013), <http://www.cdcr.ca.gov/realignment/docs/realignment-fact-sheet.pdf>.
394. State of California Board of State and Community Corrections, *2011 Public Safety Realignment Act: Third Annual Report on the Implementation of Community Corrections Partnership Plans* (Sacramento, CA: July 2015), <http://www.bscc.ca.gov/downloads/2011%20Public%20Safety%20Realignment%20Act%20-%20Third%20Annual%20Report%20on%20the%20Implementation%20of%20Community%20Corrections%20Partnership%20Plans.pdf>.
395. See, e.g., Christina Abernathy, *Corrections and reentry: Protected health information privacy framework for information sharing*. (Lexington, KY: Council of State Governments, American Probation and Parole Association, 2014); John Petrila and Hallie Fader-Towe, *Information Sharing in Criminal Justice—Mental Health Collaborations: Working with HIPAA and Other Privacy Laws* (New York, NY: The Council of State Governments Justice Center, 2010).
396. Wachino to State Medicaid Directors, “Availability of HITECH Administrative Matching Funds to Help Professionals and Hospitals Eligible for Medicaid EHR Incentive Payments Connect to Other Medicaid Providers;” See also, Ben Butler, *New HIE Funding Opportunities for Corrections: Health Information Technology’s Role in Reducing Mass Incarceration* (Oakland, CA: Community Oriented Correctional Health Services, March 2016).
397. Wachino to State Medicaid Directors, “Availability of HITECH Administrative Matching Funds to Help Professionals and Hospitals Eligible for Medicaid EHR Incentive Payments Connect to Other Medicaid Providers;” See also, Ben Butler, *New HIE Funding Opportunities for Corrections: Health Information Technology’s Role in Reducing Mass Incarceration*; COCHS has also prepared a film that highlights the need for correctional facilities to be able to access HIEs, see *The Unseen Provider*, The Robert Wood Johnson Foundation, Community Oriented Correctional Health Services, accessed July 25, 2016, http://cochs.org/health_reform/hie_conf/unseen_provider.
398. See U.S. Department of Health & Human Services, Centers for Medicare & Medicaid Services, Center for Medicaid and CHIP Services, “Medicaid and CHIP FAQs: Enhanced Funding for Medicaid Eligibility Systems,” (Baltimore, MD: 2013), <https://www.medicare.gov/State-Resource-Center/FAQ-Medicaid-and-CHIP-Affordable-Care-Act-Implementation/Downloads/FAQs-by-Topic-75-25-Eligibility-Systems.pdf>; Ben Butler, *Meaningful Use and Corrections: Unknown Opportunities*, (Oakland, CA: Community Oriented Correctional

Health Services, 2014), http://www.cochs.org/files/MU/cochs_meaningful_use.pdf; Eligibility for the enhanced federal share is contingent on state systems' complying with the "Seven Conditions and Standards" found at U.S. Department of Health & Human Services, Centers for Medicare & Medicaid Services, *Enhanced Funding Requirements: Seven Conditions and Standards*, MITS-11-01-v1.0 (Baltimore, MD: 2011), http://www.medicaid.gov/Medicaid_CHIP_Program_Information/By_Topics/Data_and_Systems/Downloads/EFR_Seven_Conditions_and_Standards.pdf; For more information on CMS' Electronic Health Records Incentive Programs, see "Electronic Health Records (EHR) Incentive Program," U.S. Department of Health & Human Services, Centers for Medicare & Medicaid Services, last modified July 14, 2016, accessed July 20, 2016, <https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/>.

399. See CMS' guidance on how correctional agencies may receive financial incentives through the Electronic Health Record Incentive Program (HITECH Act). A requirement was removed in 2012 such that providers seeing Medicaid enrollees while incarcerated in prisons and jails can count these individuals toward their "patient volume" and may be eligible for incentive payments as a result. The payment is made to the direct health care provider, but the provider is also able to pass it forward to "his/her employer pursuant to any existing contractual arrangements" (e.g., a provision could be included in a contract between a corrections agency and a health care provider such that the payment is assigned to the corrections agency). U.S. Department of Health & Human Services, Centers for Medicare & Medicaid Services to Prison and Jail Administrators, "How Your Agency Can Receive Financial Incentives For Using Electronic Health Records," (Baltimore, MD: March 2013), <http://www.thenationalcouncil.org/capitol-connector/wp-content/blogs.dir/2/files/2013/10/Corrections-Health-IT-Financial-Incentives-for-Using-EHRs.pdf>; "Financial Incentives for Using Electronic Health Records in Corrections," Council of State Governments Justice Center, last modified May 22, 2013, accessed July 31, 2016, <https://csgjusticecenter.org/nrrc/posts/financial-incentives-for-using-electronic-health-records-in-corrections/>.
400. Families USA, *State Plan Amendments and Waivers: How States Can Change Their Medicaid Programs* (Washington, DC: Families USA, June 2012), http://familiesusa.org/sites/default/files/product_documents/State-Plan-Amendments-and-Waivers.pdf.
401. "Waivers," The Medicaid and CHIP Payment and Access Commission (MACPAC), accessed July 27, 2016, <https://www.macpac.gov/subtopic/waivers/>.
402. For more information on when to use SPAs and waivers to change state Medicaid plans, see Families USA, *State Plan Amendments and Waivers: How States Can Change Their Medicaid Programs* and U.S. Department of Health & Human Services, 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, Substance Abuse and Mental Health Services Administration, 2013), <https://store.samhsa.gov/shin/content/SMA13-4773/SMA13-4773.pdf>.
403. Taxman, Faye, et al., Screening, Assessment, and Referral Practices in Adult Correctional Settings: A National Perspective. *Criminal Justice and Behavior*. 2007;34 (9):1216–1234. doi:10.1177/0093854807304431.
404. For a presentation of various activities, outputs, outcomes, and impacts for other intercept points along the criminal justice continuum, see Attachment B of Shoemaker, *Health Care Reform, The Patient Protection and Affordable Care Act: A Practical Guide for Corrections and Criminal Justice Professionals*.
405. "Performance Measurement Tool," U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Assistance, accessed, July 21, 2016.
406. Bandara et al., "Leveraging The Affordable Care Act To Enroll Justice-Involved Populations In Medicaid: State And Local Efforts," 2044–2051.
407. MA § 165 (227)(c) (2014), <https://malegislature.gov/Laws/SessionLaws/Acts/2014/Chapter165>. The Department of Corrections also tracks more detailed information for internal use in tracking and improving processes.
408. CA AB 82 (2013-2014); "AB 82, Section 71 – Medi-Cal Outreach and Enrollment Grant Funding," California Department of Health Services, last modified December 4, 2015; accessed July 21, 2016, http://www.dhcs.ca.gov/services/medi-cal/eligibility/Pages/OE_AB_82_71.aspx.

409. Kim Forrester, Chief, Agency Operations East & North Central Regions, County of San Diego Health & Human Services Agency, “Medi-Cal Eligibility Services for the Justice-Involved Population,” presentation, (January 27, 2016); Clara Lapastora, Senior Deputy Probation Officer, San Diego County Probation, correspondence with Deanna Adams, Council of State Governments Justice Center, on March, 29, 2016.
410. “SOAR Online Application Tracking (OAT) Program and User Guide,” U.S. Department of Health & Human Services, Substance Abuse and Mental Health Services Administration, SSI/SSDI Outreach, Access and Recovery for people who are homeless (SOAR), accessed June 2, 2016, <https://soarworks.prainc.com/article/soar-online-application-tracking-oat-program-and-user-guide>.
411. Terri Catlett and Beth Osborne, “North Carolina Department of Public Services & Medicaid: A Collaboration with the North Carolina Department of Health and Human Services/Division of Medical Assistance,” presentation, (Washington, DC: Innovative Health Care Access and Financing Approaches: Opportunities for Health and Criminal Justice Stakeholders, December 10, 2013).
412. Fred Osher et al., “Maximizing Medicaid: An Innovative Approach to Finance Health Care for Criminal Justice Populations,” webinar, (New York, NY: The Council of State Governments Justice Center, Legal Action Center, North Carolina Department of Public Safety, North Carolina Department of Health and Human Services, June 24, 2014): slide 15, <https://csgjusticecenter.org/wp-content/uploads/2014/06/2014-JC-Inpatient-Billing-Webinar-Slides-FINAL.pdf>.
413. For more information on screening and assessment tools, see e.g., U.S. Department of Health & Human Services, Substance Abuse and Mental Health Services Administration, *Screening and Assessment of Co-Occurring Disorders in the Justice System* (Rockville, MD: 2015), <http://store.samhsa.gov/shin/content/SMA15-4930/SMA15-4930.pdf>; See also, The Council of State Governments Justice Center, *Risk Assessment Instruments Validated and Implemented in Correctional Settings in the United States: An Empirical Guide* (New York, NY: The Council of State Governments Justice Center, 2014), <https://csgjusticecenter.org/wp-content/uploads/2014/07/Risk-Instruments-Guide.pdf>; U.S. Department of Justice, Office of Justice Programs, National Institute of Justice, *Mental Health Screens for Corrections*, by, Alberto R. Gonzales, Regina B. Schofield, and David W. Hagy, NCJ 216152 (Washington, DC: 2007).
414. For example, some denials may be related to confusion about which state’s Medicaid program governs for individuals being released to another state or incarcerated in a state other than their home state. For more guidance, see Wachino to State Health Officials, “To Facilitate Successful Re-entry for Individuals Transitioning from Incarceration to Their Communities.”
415. Carol Mici, Massachusetts Department of Corrections, interview with Martha Plotkin, Council of State Governments Justice Center, March 21, 2016; Heather Rossi, Senior Policy Manager, MassHealth, interview with Martha Plotkin, Council of State Governments Justice Center, March 24, 2016. Data provided by Carol Mici, Massachusetts Department of Corrections, in an e-mail message to Martha Plotkin, Council of State Governments Justice Center, March 21, 2016.
416. Heather Rossi, Senior Policy Manager, MassHealth, interview with Martha Plotkin, Council of State Governments Justice Center, March 24, 2016.
417. Heather Rossi, Senior Policy Manager, MassHealth, correspondence with Martha Plotkin, Council of State Governments Justice Center, March 30, 2016.
418. See Jocelyn Guyer, Deborah Bachrach, and Naomi Shine, *Medicaid Expansion and Criminal Justice Costs: Pre-Expansion Studies and Emerging Practices Point Toward Opportunities for States* (Princeton, NJ: Robert Wood Johnson Foundation, State Health Reform Assistance Network, November 2015), <http://statenetwork.org/wp-content/uploads/2015/11/State-Network-Manatt-Medicaid-Expansion-and-Criminal-Justice-Costs-November-2015.pdf>.
419. Ronna Cole, Washington State Department of Corrections, telephone call with Alex Blandford, Council of State Governments Justice Center, February 2016.
420. Charity Sayre, West Virginia Department of Military Affairs and Public Safety, correspondence with Sarina Rosenberg Asher and Alex Blandford, Council of State Governments Justice Center, January 26, 2016.
421. Program data were collected by TASC, Inc.

422. Donna Bond, Coordinator of Mental Health Reentry Services, Oklahoma Department of Corrections, correspondence with Alex Blandford, Council of State Governments Justice Center, April 4, 2016; see also, David Marimon et al., "Addressing the Intersection Between Behavioral Health and Criminal Justice Systems," webinar, (Washington, DC: National Criminal Justice Association, n.d.) <http://www.ncja.org/sites/default/files/documents/Addressing-the-Intersection-Between-Behavioral-Health-and-Criminal.pdf>.
423. For more about the Oklahoma reentry project and the measures tracked, see also U.S. Department of Health & Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, *Establishing and Maintaining Medicaid Eligibility upon Release from Public Institutions, SMA 10-4545* (Rockville, MD: 2010).
424. See "Criminal Mental Health Project," Eleventh Judicial Court of Florida, accessed May 16, 2016, <http://www.jud11.flcourts.org/scsingle.aspx?pid=285>.
425. Cindy Schwartz, Eleventh Judicial Circuit of Florida, correspondence with Dazara Ware, Policy Research Associates, July 2016.
426. Dazara Ware, Policy Research Associates, correspondence with Alex Blandford, Council of State Governments Justice Center, April 26, 2016.
427. Aaron Levin, "Defendants With Mental Illness Diverted to Security System," *Psychiatric News*, April 14, 2014, accessed July 25, 2016, <http://psychnews.psychiatryonline.org/doi/full/10.1176%2Fappi.pn.2014.4b30>.
428. Carol Mici, Massachusetts Department of Corrections, correspondence with Martha Plotkin, Council of State Governments Justice Center, March 21, 2016.
429. *Ibid.*
430. A list of local community agencies that are certified application counselors that provide assistance can be found at "Local Help," U.S. Department of Health & Human Services, Centers for Medicare & Medicaid Services, accessed July 21, 2016, localhelp.healthcare.gov. In addition, see Enroll America's searchable database that lists agencies and individuals who can provide assistance with applications: "Find Local Help," Get Covered America, accessed July 21, 2016, getcoveredamerica.org/connector/. See also, Families USA's Enrollment Assister Resource Center for information and resources for community-based assisters, including an October 2015 brief, Families USA, *Health Insurance for People Involved in the Justice System: Outreach and Enrollment Strategies* (Washington, DC: Families USA, 2015), with guidance for assisters on enrolling people who are involved in the criminal justice system.
431. Cynthia A. Parsons, West Virginia Department of Health and Human Resources, Behavioral Health and School Based Health Services, correspondence with Charity Sayre, West Virginia Department of Military Affairs and Public Safety, February 3, 2016, in response to request from Martha Plotkin, Council of State Governments Justice Center.
432. Zemel, Cardwell, and Corso, *Toolkit: State Strategies to Enroll Justice-Involved Individuals in Health Coverage*.

State and Local Examples/Mentions	Pages
ALABAMA	36 (footnote: variations in state suspension policies); 53 (text box: Medicaid eligibility for SSI recipients); 81 (text box: state-level funding, justice reinvestment)
ALASKA	8 (footnote: federal health program for Alaska Natives); 53 (text box: Medicaid eligibility for SSI recipients)
ARIZONA	25 (example: state suspension policies); 48 (mention: prerelease enrollment); 53 (text box: Medicaid eligibility for SSI recipients)
Cochise	25 (example: state suspension policies)
Coconino	25 (example: example: state suspension policies)
Maricopa County	25 (example: state suspension policies); 43 (example: partnering with Enroll America)
Mohave	25 (example: state suspension policies)
Navajo	25 (example: state suspension policies)
Pima County	25 (example: state suspension policies)
Yavapai	25 (example: state suspension policies)
Yuma	25 (example: state suspension policies)
ARKANSAS	27 (example, text box: savings through inpatient exception); 53 (text box: Medicaid eligibility for SSI recipients)
CALIFORNIA	11 (mention: veterans reentry); 25 (example: state suspension policies); 27 (example, text box: savings through inpatient exception); 31 (example: presumptive eligibility); 39 (mention: county survey on enrollment assistance); 45 (mention, text box: MAC); 48 (example: timing of applications); 48 (example: processing applications); 53 (text box: Medicaid eligibility for SSI recipients); 68 (example: Medicaid-covered services for people on parole); 70 (example: waiver to improve substance use treatment systems); 74 (example: waiver to improve service delivery and coordination); 81 (text box: state-level funding, innovation grants); 82 (text box: county-level funding); 89 (example: data collection requirements)
Alameda County	45 (mention, text box: MAC); 49 (footnote: application processing)
Butte County	43 (example: application assistance personnel)
Imperial County	16 (example: screening personnel); 43 (example: application assistance personnel)
Inyo County	17 (example: when to screen)
Los Angeles County	14 (text box: Veterans screening); 81 (example: state-level funding, innovation grants)

Napa County	43 (mention: application assistance personnel)
San Diego County	43 (example: application assistance personnel); 89 (example: data collection requirements)
Santa Barbara County	43 (example: application assistance personnel)
Santa Clara County	44 (example: application assistance personnel)
Santa Cruz	16 (example: screening personnel); 43 (mention: application assistance personnel)
Sutter County	43 (example: application assistance personnel)
COLORADO	25 (footnote: suspension policy); 27 (example: savings through inpatient exception); 41 (example: health insurance information and resources); 43 (example: application assistance personnel); 47 (example: timing of applications); 48 (example: processing applications); 53 (text box: Medicaid eligibility for SSI recipients); 75 (text box, example: benefit documentation); 98 (mention: data sharing)
Denver	16 (example: screening personnel); 43 (example: application assistance personnel); 49 (footnote: processing applications)
El Paso County	43 (example: application assistance personnel)
CONNECTICUT	40 (example: state guidance on application assistance); 47 (example: timing of applications); 53 (text box: Medicaid eligibility for SSI recipients); 76 (example, text box: benefit documentation); 59 (footnote: Medicaid Emergency Psychiatric Demonstration); 64 (footnote: ASOs)
DELAWARE	53 (text box: Medicaid eligibility for SSI recipients)
DISTRICT OF COLUMBIA	53 (text box: Medicaid eligibility for SSI recipients); 59 (footnote: Medicaid Emergency Psychiatric Demonstration)
FLORIDA	53 (text box: Medicaid eligibility for SSI recipients); 74 (example: managed care contracts); 82 (example: state-level funding, centers of excellence)
Miami-Dade County	95 (example: tracking SSI/SSDI applications)
GEORGIA	50 (example: completing SSI/SSDI applications using SOAR); 53 (text box: Medicaid eligibility for SSI recipients)
Fulton County	50 (example: completing SSI/SSDI applications using SOAR)
HAWAII	53 (text box: Medicaid eligibility for SSI recipients);
IDAHO	53 (text box: Medicaid eligibility for SSI recipients); 82 (text box: state-level funding, justice reinvestment)

ILLINOIS	12 (example: state guidance on eligibility screening); 17 (timing of applications); 40 (state guidance on application assistance); 45 (text box, mention: MAC); 53 (Medicaid eligibility for SSI recipients); 59 (footnote: Medicaid Emergency Psychiatric Demonstration); 71 (text box, example: MAT)
Cook County	14 (example: who is screened); 46 (example: timing of applications); 93 (example: tracking enrollment); 94 (snapshot: data collection)
INDIANA	31 (example: presumptive eligibility); 40 (example: state laws for application assistance); 40 (mention: universal enrollment); 42 (mention: state guidance on staffing for enrollment); 45 (text box, mention: MAC); 53 (text box: Medicaid eligibility for SSI recipients); 81 (example: state-level funding, innovation grants)
IOWA	32 (example: suspension/termination); 53 (text box: Medicaid eligibility for SSI recipients); 75 (example: cross-sector coordination of care)
KANSAS	53 (text box: Medicaid eligibility for SSI recipients); 81 (text box: state-level funding, justice reinvestment)
KENTUCKY	27 (two examples: savings through inpatient exception); 41 (example: health insurance information and resources); 43 (example: application assistance personnel); 53 (text box: Medicaid eligibility for SSI recipients); 58 (mention: Alternative Benefit Plans)
Fayette County	29 (example: suspension)
Louisville	43 (example: application assistance personnel)
LOUISIANA	53 (text box: Medicaid eligibility for SSI recipients)
MAINE	53 (text box: Medicaid eligibility for SSI recipients); 59 (footnote: Medicaid Emergency Psychiatric Demonstration)
MARYLAND	29 (example: suspension); 53 (text box: Medicaid eligibility for SSI recipients); 59 (footnote: Medicaid Emergency Psychiatric Demonstration)
MASSACHUSETTS	26 (footnote: fee-for-service limited inpatient benefit); 27 (example: savings through inpatient exception); 43 (mention: application assistance personnel); 49 (example: processing applications); 53 (text box: Medicaid eligibility for SSI recipients); 75 (example, text box: benefit documentation); 89 (example: state requirements for data collection); 92 (snapshot: data tracking); 95 (example, text box: Veterans benefits)

MICHIGAN	27 (example: savings through inpatient exception); 48 (mention: timing of applications); 53 (text box: Medicaid eligibility for SSI recipients); 58 (mention: ABPs); 78 (mention, text box: leveraging federal block grants)
MINNESOTA	12 (example: state guidance for screening); 15 (example: screening specific populations); 53 (text box: Medicaid eligibility for SSI recipients); 76 (example, text box: rural counties)
MISSISSIPPI	53 (text box: Medicaid eligibility for SSI recipients);
MISSOURI	53 (text box: Medicaid eligibility for SSI recipients); 59 (footnote: Medicaid Emergency Psychiatric Demonstration)
MONTANA	53 (text box: Medicaid eligibility for SSI recipients)
NEBRASKA	53 (text box: Medicaid eligibility for SSI recipients)
NEVADA	53 (text box: Medicaid eligibility for SSI recipients)
NEW HAMPSHIRE	44 (example: application assistance personnel); 53 (text box: Medicaid eligibility for SSI recipients)
Merrimack County	76 (example, text box: rural areas)
NEW JERSEY	31 (example: presumptive eligibility); 53 (text box: Medicaid eligibility for SSI recipients)
NEW MEXICO	40 (example: state guidance for applications); 40 (mention: universal enrollment); 45 (mention, text box: MAC); 51 (example: presumptive eligibility); 53 (text box: Medicaid eligibility for SSI recipients); 75 (example: policies for MCOs to improve service quality and delivery)
Bernalillo County	14 (example: who is screened); 45 (mention, text box: MAC); 51 (example: presumptive eligibility)
NEW YORK	20 (footnote: Medicaid redetermination); 32 (example: Medicaid redetermination); 35 (mention: suspension/termination data systems); 50 (example: completing SSI/SSDI applications); 53 (text box: Medicaid eligibility for SSI recipients); 72 (health home model); 96 (footnote: substance use funding)
New York City	16 (example: screening personnel); 43 (example: application assistance personnel); 76 (example, text box: benefits documentation)
Monroe County	29 (example: facilitating Medicaid reactivation); 43 (mention: application assistance personnel)

NORTH CAROLINA	16 (example: screening process); 25 (example: state suspension policies); 27 (example: savings through inpatient exception); 29 (example: suspension/termination); 46 (example: when to screen); 53 (text box: Medicaid eligibility for SSI recipients); 59 (footnote: Medicaid Emergency Psychiatric Demonstration); 90 (example: inpatient exception)
NORTH DAKOTA	53 (text box: Medicaid eligibility for SSI recipients)
OHIO	14 (who is screened); 27 (example: savings through inpatient exception); 28 (example: suspension and data-matching); 45 (mention: MAC); 47 (example: peers and enrollment); 53 (text box: Medicaid eligibility for SSI recipients); 70 (mention: state policies to enhance services, telehealth); 71 (example, text box: MAT); 73 (example: managed care)
OKLAHOMA	15 (example: screening specific populations); 33 (example: prerelease agreements); 53 (text box: Medicaid eligibility for SSI recipients); 95 (example: enrollment in SSI/SSDI)
OREGON	16 (example: screening process); 53 (text box: Medicaid eligibility for SSI recipients)
Multnomah	43 (mention: application assistance personnel)
PENNSYLVANIA	26 (footnote: limited Medicaid benefit); 30 (example: suspension/termination); 35 (mention: suspension/termination data systems); 49 (example: processing Medicaid applications); 53 (text box: Medicaid eligibility for SSI recipients); 69 (example: SPAs)
RHODE ISLAND	16 (example: screening process); 35 (mention: suspension/termination data systems); 43 (example: application assistance personnel); 53 (text box: Medicaid eligibility for SSI recipients); 59 (footnote: Medicaid Emergency Psychiatric Demonstration); 71 (example: MAT); 72 (example: home health model); 74 (example: managed care contracts)
SOUTH CAROLINA	53 (text box: Medicaid eligibility for SSI recipients)
SOUTH DAKOTA	53 (text box: Medicaid eligibility for SSI recipients)
TENNESSEE	53 (text box: Medicaid eligibility for SSI recipients)
TEXAS	53 (text box: Medicaid eligibility for SSI recipients); 69 (example: SPAs); 71 (example, text box: MAT)
UTAH	53 (text box: Medicaid eligibility for SSI recipients)

VERMONT	53 (text box: Medicaid eligibility for SSI recipients); 71 (example, text box: MAT)
VIRGINIA	46 (example: when applications are completed); 53 (text box: Medicaid eligibility for SSI recipients)
New River Valley (region)	76 (example, text box: rural areas)
WASHINGTON	12 (example: state guidance for eligibility screening); 40 (example: state guidance for application assistance); 44 (example: application assistance personnel); 48 (mention: timing of applications); 53 (text box: Medicaid eligibility for SSI recipients); 59 (footnote: Medicaid Emergency Psychiatric Demonstration); 82 (example, text box: county-level funding); 93 (tracking enrollment)
Thurston County	43 (mention: application assistance personnel)
WEST VIRGINIA	53 (text box: Medicaid eligibility for SSI recipients); 59 (footnote: Medicaid Emergency Psychiatric Demonstration); 68 (example: Medicaid-covered services); 82 (text box: state-level funding, justice reinvestment); 93 (example: tracking enrollment); 97 (example, text box: data collection)
WISCONSIN	29 (example: reenrollment after termination); 47 (example: timing of applications); 53 (text box: Medicaid eligibility for SSI recipients)
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