Medicaid 1115 Justice Waiver Opportunities:

Connecting Community Partners to Improve Care Transitions

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MEDICAID & JUSTICE INVOLVED POPULATIONS

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This five-part series, 1115 Medicaid Justice Demonstration Waivers: Bridging Healthcare, will focus on helping stakeholders optimize the continuity of care for persons in carceral settings and during their transition back to the community.

Date	Topic
APR 5	• Medicaid Authority and Opportunity to Build New Programs for Justice-Involved Individuals (replay link HERE)
MAY 18	• 1115 Waivers to Improve Carceral Healthcare Delivery Information
JUNE 15	• 1115 Waivers & Transitions of Care
JULY 13	• Medication Assisted Treatment for SUD in Carceral Populations
AUG 17	• Healthcare Considerations for Incarcerated Youth

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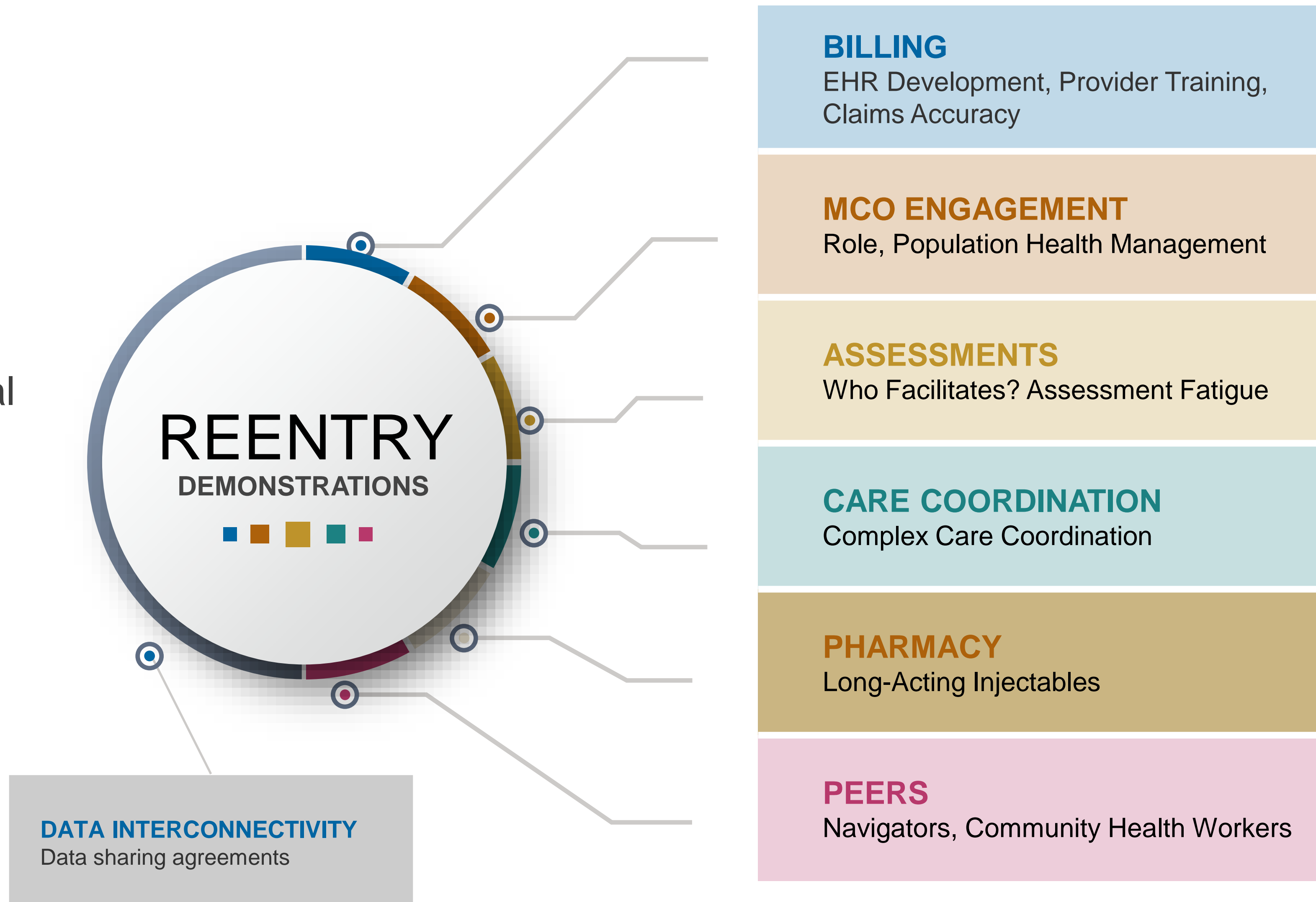
THE OPPORTUNITY: SECTION 1115 WAIVERS FOR REENTRY INITIATIVES

CMS designed the Reentry Section 1115 Demonstration Opportunity to improve access to community resources that address the health care and health-related social needs of the carceral population, with the aims of improving health outcomes, reducing emergency department visits, and inpatient hospital admissions for both physical and behavioral health issues once they are released and return to the community.

The purpose of this demonstration opportunity is to provide short-term Medicaid enrollment assistance and pre-release coverage for certain services to facilitate successful care transitions.



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TODAY'S PRESENTERS:

Rich VandenHeuvel, MSW

Principal, HMA

Lansing, MI

- 25+ years of experience in community based behavioral health as a clinician, supervisor and CEO
- Former CEO for a public behavioral health managed care organization
- Former executive director of a multi-county community mental health organization
- SME in in evidence-based treatment for justice involved individuals including medically assisted treatment, behavioral health and integrated care with multiple state departments of corrections and over 40 local jurisdictions nationally

Michael DuBose, MSW

Principal, HMA

Washington, DC

- CEO Community Oriented Correctional Health Services
- Former Corrections Administrator of DC DOC
- Former Healthcare Administrator of DC DOC
- Performed audits and inspections of jails and prisons for Homeland Security, Immigrations, Customs and Enforcement, US Marshals Service and select states throughout the US and the US Virgin Islands
- SME in the areas of healthcare, food services, environmental services, programs and services, including mental health and substance abuse

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TODAY'S AGENDA

- ❑ Health Assessments and Transition Planning
- ❑ Collaboration with Community Providers
- ❑ Insurance Enrollment Strategies
- ❑ Q&A

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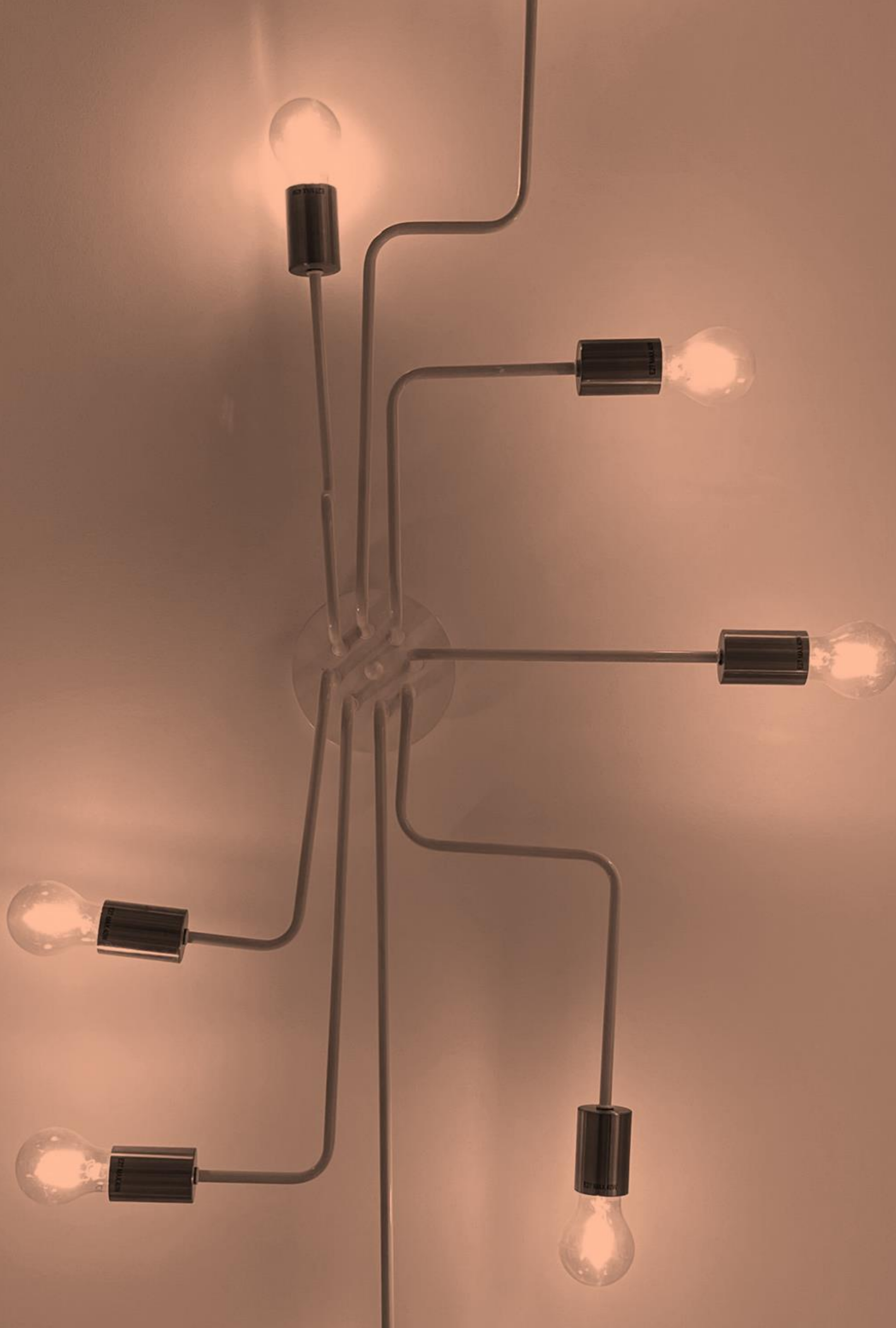

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HEALTH ASSESSMENTS AND TRANSITION PLANNING

HEALTH NEEDS OF THE JUSTICE INVOLVED POPULATION

Justice-involved individuals have higher rates of **physical and behavioral health diagnoses**

- Specifically, higher rates of high blood pressure/hypertension, asthma, diabetes

There are a disproportionate number of incarcerated people with **mental health disorders**

- 37% of people in prison have been diagnosed with a mental illness
- 44% of people in jails have been diagnosed with a mental illness
- 27% of people who have been jailed three or more times in the past year have a moderate to severe mental illness

Some research shows that an estimated 65% percent of the United States prison population has an active **SUD**

- Other studies show more than half (58%) of state prisoners and two-thirds (63%) of sentenced jail inmates met the criteria for drug dependence or abuse

Sources: Waddell et al (2020); Howell et al (2020; Hawks et al (2021); Springer, (2019); Bronson (2017); Sawyer (2019) Prison Policy Initiative, (2019); USDOJ, Bronson et al (2020)

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UNTREATED MENTAL HEALTH DIAGNOSES AND SUBSTANCE USE DISORDER

- The mortality rate post-release is 12.7 times the mortality rate for all citizens, driven mainly by opioid related deaths

- **Comprehensive substance use treatment, both in custody and at reentry, reduces recidivism, overdoses, and death.**

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Source: NIDA (2020) Criminal Justice Drug Facts

Reentry Population:

OVERDOSE MORTALITY

Table 2. **Deaths After Release From Prison by Leading Causes, Overall and by Sex**

Variable	Overall (*n* = 76 208)		Men (*n* = 63 979)		Women (*n* = 12 229)	
	Deaths, *n*	Deaths per 100 000 Person-Years (95% CI)	Deaths, *n*	Deaths per 100 000 Person-Years (95% CI)	Deaths, *n*	Deaths per 100 000 Person-Years (95% CI)
All-cause death	2462	737 (708–766)	2124	752 (720–784)	338	653 (583–722)
Unintentional injuries	828	248 (231–265)	683	242 (224–260)	145	280 (234–326)
Overdose	558	167 (153–181)	436	154 (140–169)	122	236 (194–277)
Motor vehicle accidents	183	55 (47–63)	168	60 (50–68)	15	29 (14–44)
Drowning	23	7 (4–10)	22	8 (5–11)	1	2 (0–11)
Cardiovascular diseases	319	95 (85–106)	290	103 (91–114)	29	56 (36–76)
Ischemic heart	170	51 (43–59)	159	56 (48–65)	11	21 (9–34)
Cerebrovascular	39	12 (8–15)	30	11 (7–14)	9	17 (8–33)
Hypertensive heart	36	11 (7–14)	33	12 (8–16)	3	6 (1–17)
Cancer	238	71 (62–80)	205	73 (63–83)	33	64 (42–85)
Lung	86	26 (20–31)	72	25 (20–31)	14	27 (13–41)
Liver	32	10 (6–13)	29	10 (7–14)	3	6 (1–17)
Blood/lymph	21	6 (4–9)	19	7 (4–10)	2	4 (0–14)
Esophagus/stomach	18	5 (3–8)	17	6 (3–9)	1	2 (0–11)
Pancreas	10	3 (1–5)	8	3 (1–6)	2	4 (0–14)
Homicide	219	66 (57–74)	213	75 (65–86)	6	12 (4–25)
By firearm	163	49 (41–56)	159	56 (48–65)	4	8 (2–20)
Suicide	212	63 (55–72)	191	68 (58–77)	21	41 (23–58)
By firearm	43	13 (9–17)	41	15 (10–19)	2	4 (0–14)
Infectious disease	158	47 (40–55)	136	48 (40–56)	22	42 (25–60)
Viral hepatitis	69	21 (16–26)	59	21 (16–26)	10	19 (7–31)
HIV	37	11 (8–15)	31	11 (7–15)	6	12 (4–25)
Septicemia	21	6 (4–9)	17	6 (3–9)	4	8 (2–20)
Pneumonia	19	6 (3–8)	17	6 (3–9)	2	4 (0–14)
Liver disease	73	22 (17–27)	66	23 (18–29)	7	14 (5–28)
Alcoholic	58	17 (13–22)	53	19 (14–24)	5	10 (3–23)
Respiratory disease	67	20 (15–25)	52	18 (13–23)	15	29 (14–44)
Lower respiratory disease	42	13 (9–16)	35	12 (8–16)	7	14 (5–28)
Diabetes mellitus	49	15 (11–19)	46	16 (12–21)	3	6 (1–17)
Kidney disease	12	4 (2–6)	12	4 (2–7)	0	0 (0–7)
Other	287	86 (76–96)	230	81 (71–92)	57	110 (82–130)

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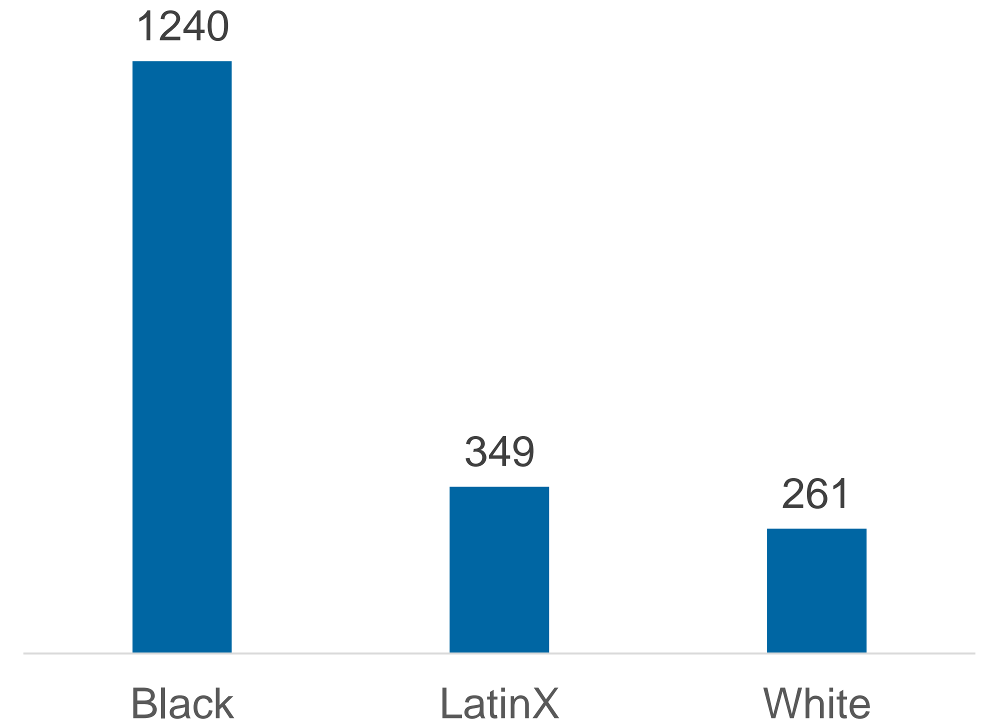
Source: Binswanger et al (2013)

PEOPLE OF COLOR ARE FAR MORE LIKELY TO ENTER THE NATION'S JUSTICE SYSTEM THAN THE GENERAL POPULATION

- Black Americans are incarcerated at nearly five times the rate of whites, and Latinx people are 1.3 times as likely to be incarcerated than non-Latinx whites
- Racial and ethnic minorities in the U.S. also experience health disparities, including higher rates of chronic disease and premature death compared to whites
- **Hypothesis:** Improving transitions of care for the justice involved population improves health equity



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 Source: The Sentencing Project (2021) The Color of Justice Racial and Ethnic Disparities in State Prisons

THE IMPORTANCE OF TRANSITION PLANNING: SAMHSA

Transition planning by the jail and community providers improves reentry outcomes

- Planning for reentry should begin at intake and continue throughout incarceration
- It is important for incarcerated people to have enough medications and prescriptions to allow them to follow treatment plans and avoid relapse until they see their providers.
- People who are picked up upon release from jail and provided transportation directly to services have better outcomes than people who do not
  - Literal, not figurative, "warm handoff"
- Ideally the community worker providing transportation will have already done some in-reach work with these clients.

Successful transitions require collaboration between the carceral setting and the community

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Source: SAMHSA (2022) Intercept 4: Reentry

CMS MEDICAID DIRECTOR LETTER: IMPROVING CARE TRANSITIONS

Minimum Benefits for the Reentry Section 1115 Demonstration Opportunity:

- **Case management** to assess and address physical and behavioral health needs and HRSN
- **MAT services** for all types of SUD as clinically appropriate, with accompanying counseling; and
- **A 30-day supply of all prescription medications** that have been prescribed for the beneficiary at the time of release, provided to the beneficiary immediately upon release from the correctional facility

SMD# 23-003

RE: Opportunities to Test Transition-Related Strategies to Support Community Reentry and Improve Care Transitions for Individuals Who Are Incarcerated

April 17, 2023

Dear State Medicaid Director:

The Centers for Medicare & Medicaid Services (CMS) is issuing the following guidance for designing demonstration projects under section 1115 of the Social Security Act (the Act) (42 U.S.C. § 1315) to improve care transitions for certain individuals who are soon-to-be former inmates of a public institution (hereinafter referred to as incarcerated individuals, except when quoting from statute) and who are otherwise eligible for Medicaid. This letter also provides guidance to interested states about development and submission of the associated section 1115 demonstration application.

NOTE: these are the minimum… states are encouraged to explore additional services, including pre-release services and services "provided by peer supporters / community health workers with lived experience," supplies, equipment, and appliances

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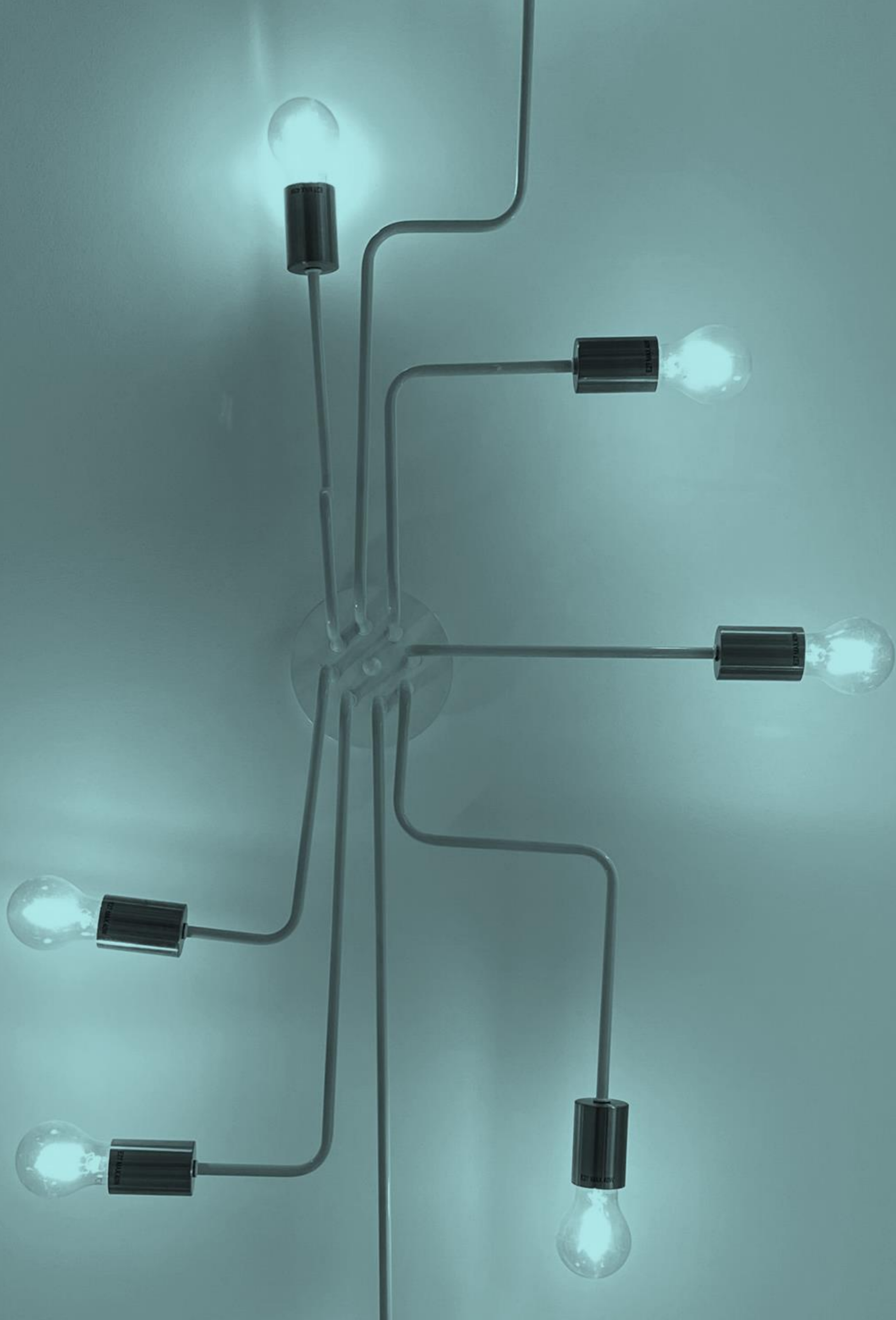
Source: CMS (2023) SMD# 23-003



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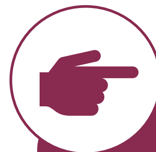
COLLABORATION WITH COMMUNITY PROVIDERS

THE HANDOFF: TRANSITIONING FROM JAILS AND PRISONS

Most incarcerated people are in custody for a short period of time.

- 2018: the average length of stay in prisons was **2.7 years**
- 2017: the average length of stay in jail nationally was **26 days**
- Majority of jail inmates are **"unsentenced" - 71% at midyear** of 2021

"Warm" Handoffs imply time to plan and predictable release dates
- ➢ **More common in prison sentences**



"Hot" Handoffs occur when there is minimal time to plan for transitions, sometimes hours or less
- ➢ **More common with jails**

Successful transition planning requires strategies for both "warm" and "hot" handoffs – requiring community collaboration

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Sources: NCSL (n.d.); NGA (2021) Expanding Access to Medications for Opioid Use Disorder in Corrections and Community Settings; USDOJ, Zeng (2022) Jail Inmates in 2021

STAKEHOLDERS TO ENGAGE UPON REENTRY: AN INSTRUCTIVE LIST FOR JI WAIVERS

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Stakeholder	Roles
Community Corrections and Reentry	Corrections reentry specialists, case managers, and persons coordinating wrap-around services.
Public Health and Healthcare Systems	Clinical Coordinator and clinicians, care coordinator, social workers, peers, counselors, and other direct care staff. Community-based providers, such as health, behavioral health, social support, and peer recovery services. Infectious disease specialist and department of public health lead.
Corrections	Health Care Administrator; Correctional health service provider; Corrections administrators, wardens, and officers.
Public Safety	Parole board and parole supervising authority; State and local reentry councils
Medicaid and Managed Care	Medicaid agency and Managed Care Organizations (MCOs), entities involved with eligibility and enrollment and data sharing. Local agencies responsible for block grants for uninsured and safety net providers, including entities involved in eligibility, coverage, continuity of care and connection to community providers.
Behavioral Health	Behavioral health agency, mental health agency

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Source: NGA (2021) Expanding Access to Medications for Opioid Use Disorder in Corrections and Community Settings

BEST PRACTICES FOR REENTRY TO ENSURE CONTINUITY OF CARE

General

- **Establish a relationship** (ideally face to face) with community treatment providers prior to release
- **Use peer supports**/navigators/persons with lived expertise to facilitate pre and post release linkages
- **Establish formal agreements** between providers, payors and correctional environments
- **Monitor data** RE: successful (and unsuccessful linkages) regularly between facilities and community providers/referral sources as part of formalized practices/agreements
- **Initiate quality** improvement activities where needed based upon this data
- **Establish processes** for both “warm” and “hot” handoffs w/ “go to” providers

SUD

- **Work collaboratively** to share relevant information with each other through uniform release of information practices.
- **Screen and assess** for opioid addiction at all intercept points - establish a process to refer individuals for a full clinical substance addiction assessment when indicated.
- **Deliver medication assisted treatment** in the correctional facility and upon release in the community.
- **Integrate cognitive behavioral interventions** in the correctional facility and in the community to address criminogenic risk and need factors.
- **Facilitate in-reach** by community-based behavioral health treatment providers and probation staff into correctional facilities.
- **Create a relapse prevention plan**, distribute materials on overdose prevention and provide naloxone upon release when possible.

Opioid-Use Disorder

- **Train probation and parole officers** on how to work with people who have opioid addictions.
- **Specialize caseloads** for those individuals who have co-occurring substance addictions and mental illnesses.
- **Provide MAT access** to all three FDA approved medication options
- **Continue MAT services** throughout all intercept points, including reentry.
- **Dispel stigmas** - the length of time a person is on MAT should not be associated with success or failure
- **Support patients’ decisions** to start or stop MAT in conjunction with a licensed medical practitioner.

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Source: National Reentry Resource Center; Justice Center for the Council of State Governments

JAIL, PRISON AS PART OF THE SAFETY NET HEALTHCARE ECOSYSTEM

The jail is a health care site in the *community's* health care safety net

- A county resident receives the same care for acute and chronic conditions wherever they seek care in the county, including the jail, and transitions are managed and supported

The prisons are health care sites in the *state's* health care safety net

- A state resident receives the same care for acute and chronic conditions wherever they seek care in the state, including the prison, and transitions are managed and supported

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COORDINATING CARE TRANSITIONS FROM JAILS AND PRISONS

In general, all correctional facilities are unique.

- State prisons are typically run by the same state department
- Jails are commonly county run, most often the responsibility of an elected local official (sheriff or warden)
  - Note, there are "unified" states where the state runs both jails and prisons
- While healthcare services, facility census and staffing vary by facility, this variance is typically much greater across county jails

Strategies to support justice involved individuals with Medicaid waiver/1115 demonstration authority must understand, plan for and engage with both prison and jail systems to address this variance.

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A NOTE RE: TRANSITIONS AND MAT

The State Medicaid Director Letter put special emphasis on continuity of medication assisted treatment for those managing substance abuse disorder.

- Two of the three services noted in the letter (SMD # 23-003) are (1) access to all forms of MAT and (2) A 30-day supply of all medications
- To ensure continuity of care, and manage risk to individuals this means that a person reentering from incarceration must have access to medication w/in 30 days of release
  - Not access to an appointment, or an intake, or an assessment, but access to medication to ensure continuity of care
- Community systems of care often struggle mightily with timely access to the standard of care for OUD, which is MAT (with related counseling)

Timely access to care needs to be understood, and planned for, in this context

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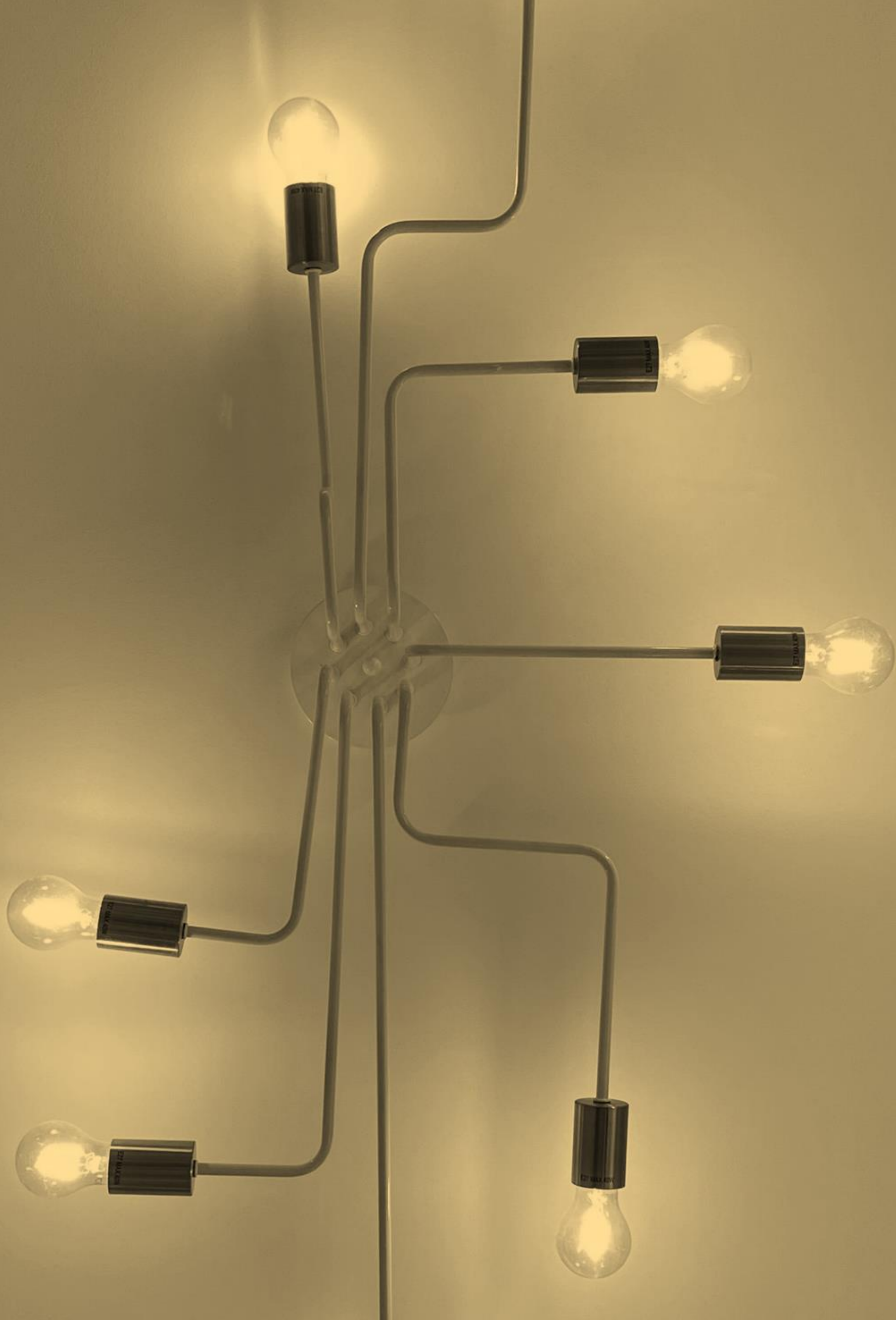

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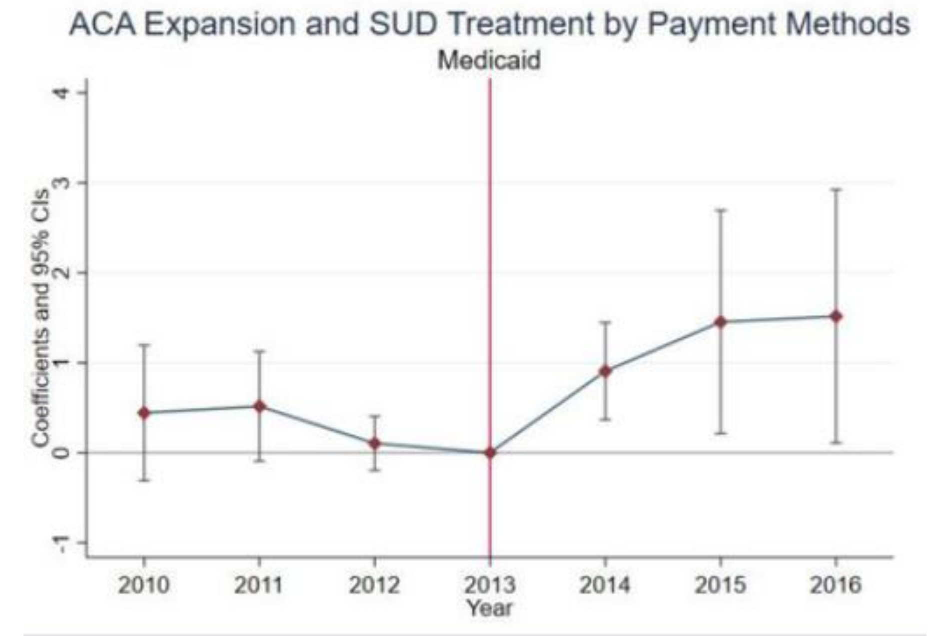
INSURANCE ENROLLMENT STRATEGIES

MEDICAID ENROLLMENT AT RELEASE: NATIONAL DATA

Given the higher rate of many health conditions, including Behavioral Health, it is imperative that incarcerated people have active health insurance at the time of release

- The expansion of Medicaid under the Affordable Care Act led to a decrease in both violent and public order crimes
- There is some evidence of higher treatment rates among previously incarcerated people when they have Medicaid coverage >>



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Sources: Aslim et al (2022) The Effect of Public Health Insurance on Criminal Recidivism; Bird et al (2015) The Effect of Health Insurance Enrollment on Recidivism in the Criminal Justice Population

MEDICAID TERMINATION VS SUSPENSION POLICIES

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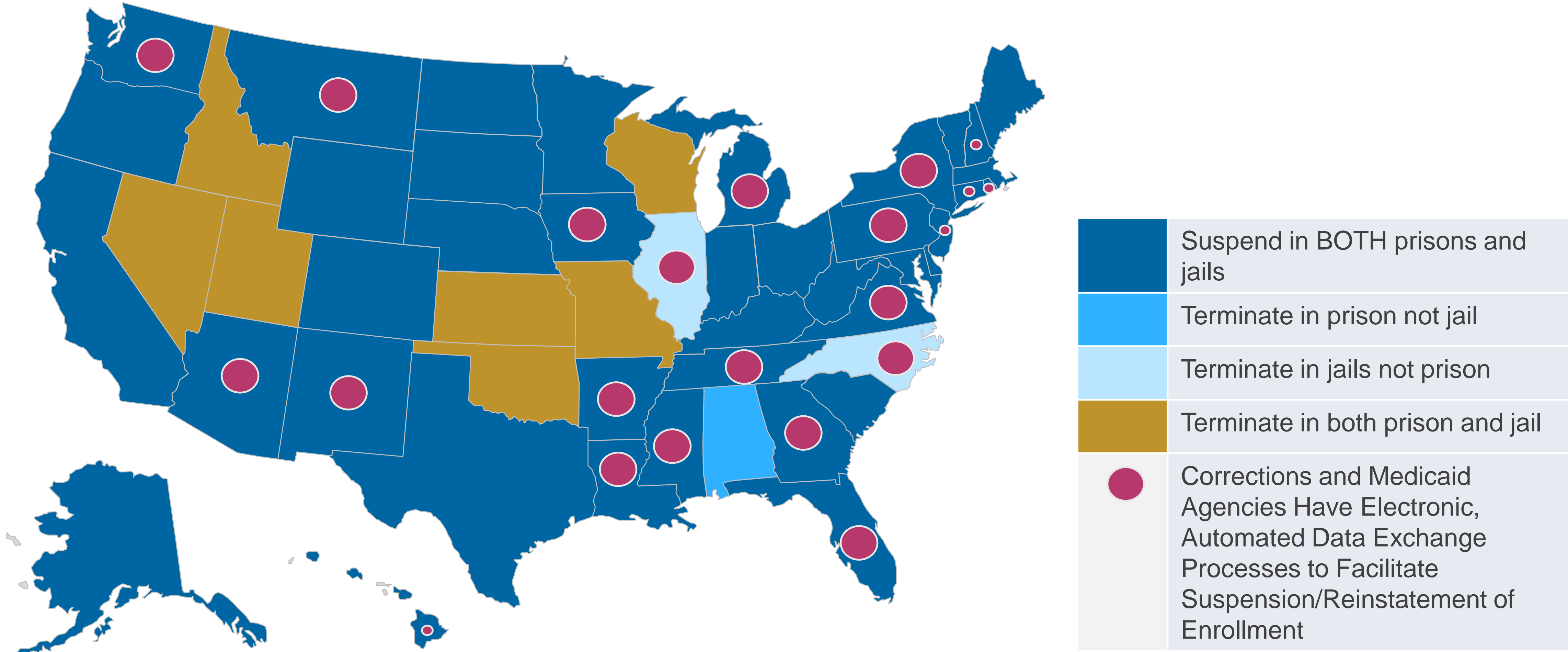
Medicaid Eligibility Suspended Rather Than Terminated for Enrollees Who Become Incarcerated



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Source: KFF (2019) States Reporting Corrections-Related Medicaid Enrollment Policies in Place for Prisons or Jails

EXAMPLES OF INSURANCE ENROLLMENT STRATEGIES

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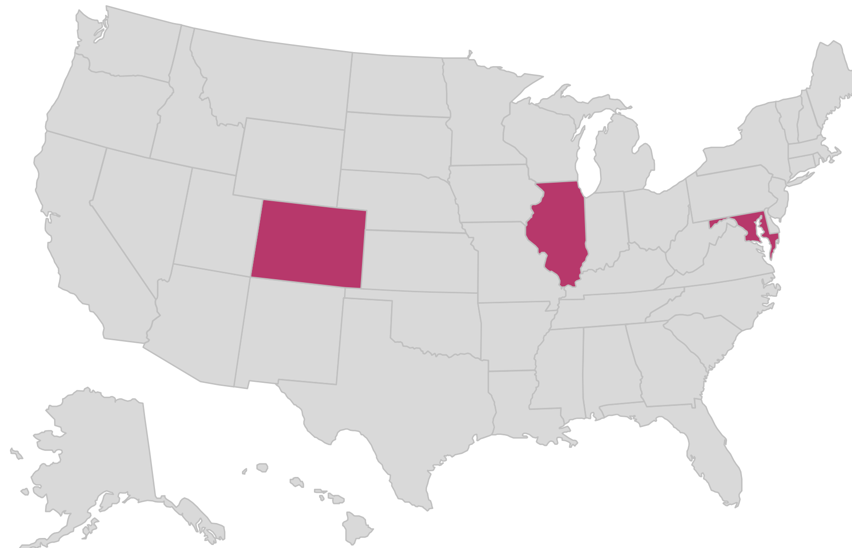
Illinois

Used a local CBO, “Get Covered Illinois” to perform enrollment functions for justice involved populations.

Colorado

Use two nurse case managers to remotely complete applications for individuals nearing release and for those that decline at release, they can reconnect with the nurse after release and receive post release application assistance through their probation/parole officers.



Maryland

Baltimore County: four chief enrollers and one supervisor - facilitated provision of internet-connected laptops and established a schedule for routine enrollment sessions covering the male, female, and work release populations in the jails.

Harford County: health department staff assisting with enrollment; moved enrollment activity to jail intake instead of discharge so inmates in case of earlier-than expected release into the community.

Washington County: two case workers from the local health department as volunteers to do enrollment five days a week

Recognize the challenges associated with working inside a jail/prison setting and carefully identify those best suited for work in this type of environment.

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STRATEGIES FOR MORE SUCCESSFUL ENROLLMENT AND REENTRY OUTCOMES

- Establish electronic interface between jail and Medicaid to suspend and enroll at intake or reactivate at discharge/release
- Medicaid monitors jail intake in order to suspend ….challenging with reinstatement
- Use facility CM/DP/Navigators/Peer Counselors to facilitate enrollment
- Establish remote capabilities to perform enrollment functions, including video conferencing, tele-services or by telephone
- Leverage community-based enrollment resources (CM/DP/Navigators/Peer Counselors, Assisters) for in-reach and presence in settings such as probation and parole, specialty court, half-way houses, day reporting centers, etc.
- Justice partners should be open to allowing CM/DP/Navigators/Peer Counselors/Assisters into their space to perform these important functions
- Allow and encourage in-reach of Medicaid Enrollment Specialists inside the facility prior to release
- Establish "Direct-Cross System Collaboration and Communication" between Medicaid/DOH/CJ/Courts
- Enrollment occurs after 24 hour hospitalization
- Enrollment occurs at some health encounters within the facility

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MEDICAID FINANCING STRATEGIES

While states have advanced coordination across Medicaid and justice agencies have begun to prioritize efforts to enroll the CJ population in Medicaid and facilitate better linkage to essential care, most states have not yet sought to leverage this available federal funding for these efforts.

Funding Enrollment Assistance

- Use Medicaid administrative claiming for public employees’ prerelease enrollment efforts
- Partner with managed care organizations or leverage their capitation rates to fund reenrollment
- Use the Federal Medical Assistance Percentage for carved-out behavioral health plans or systems to enroll incarcerated people with mental health or substance use disorders
- Leverage funding sources for community-based organizations

Funding IT Development

- Leverage Medicaid funding to help build integrated IT interfaces

Funding Transition Services

- Secure funding for Medicine provided at release from incarceration
- Pursue administrative claiming for case management activities

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CALIFORNIA Cal-AIM ELIGIBILITY AND ENROLLMENT: STATUTORY MANDATE

California statute mandates all counties implement pre-release application processes in county jails and youth correctional facilities by January 1, 2023.

- 2021 Amendment to the California Penal Code Section 4011.11 Pre-Release Medi-Cal Application Process: By January 1, 2023, the board of supervisors in each county, in consultation with the county sheriff, shall designate an entity or entities to assist both county jail inmates and juvenile inmates with the Medi-Cal application process

- **Rationale:** The pre-release application process will help ensure justice-involved individuals have Medicaid (Medi-Cal) coverage upon reentry into the community in order to facilitate access to needed services
    - "Establishing a prerelease application process is foundational to providing Medi-Cal services in the 90 days pre-release"

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CALIFORNIA Cal-AIM EXAMPLE

California Department of Health Care Services (DHCS):

- "DHCS recommends that each county social service department (SSD), county sheriff, and county probation office collaborate with their county board of supervisors to identify the best way to implement a pre-release Medi-Cal application process in compliance with the state's mandate"
  - Counties may leverage and build upon existing pre-release application processes
- DHCS recommends that SSDs and county correctional facilities (CCFs) establish:
  - Dedicated points of contact to support initial planning and ongoing collaboration
  - Establish a secure form of communication to transmit and receive information between organizations
- DHCS is working to automate processes w/in Statewide Automated Welfare System (SAWS)

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CALIFORNIA Cal-AIM EXAMPLE

Providing Access and Transforming Health Initiative = PATH

- PATH supports California's efforts to build, maintain, and scale the capacity necessary to implement CalAIM
- There is a particular focus on historically under-resourced organizations, which helps advance health equity and address social drivers of health
- It is a five-year, $1.85B initiative to help fund:
  - Community-based organizations (CBOs)
  - Public hospitals,
  - County agencies
  - Tribal and Designees of Indian Health Programs

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QUESTIONS & DISCUSSION

Our subject matter experts are currently partnering with state, county, and city governments, healthcare systems and service providers to address the many challenges faced in providing care to persons who are justice involved:

- 1115 Waivers
- Reentry/Transitions in Care
- SUD/MAT
- Workforce and staffing
- Crisis/988
- Quality and patient safety
- COVID pandemic response
- Infection control
- Urgent, emergent, and chronic disease management
- Healthcare screening and assessment
- Risk mitigation
- Interface/collaboration between custody and clinical teams
- Integration of behavioral health, dental, and primary care
- Telehealth and innovations in care delivery
- Data-driven operations and quality/patient safety solutions

Questions?

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