



CALIFORNIA
HEALTH
POLICY
STRATEGIES, L.L.C.

December 20, 2018

Ms. Jennifer Kent
Director
Department of Health Care Services
P.O. Box 997413, MS 0000
Sacramento, CA 95899-7413

Re: Coordinated Care Assessment Project Comments: Prison and Jail Reentry

Dear Director Kent:

On behalf of California Health Policy Strategies (CalHPS), I am writing to offer our comments and recommendations to improve the coordination of health and behavioral care services provided to individuals who are transitioning from prison and jails to the community. We appreciated the inclusion of this issue in the Advisory Committee's discussions and hope to offer some additional recommendations for consideration.

CalHPS has managed the Reentry Health Project with support from the California Health Care Foundation. Our 2017 [report](#) focused on opportunities for improving care coordination and maximization of federal funds for medically fragile and seriously mentally ill reentry populations. Additional work and analysis have helped to further refine our recommendations.

Many of our recommendations are consistent with the department's care coordination agenda. Given this, we offer relevant recommendations in the following comments. They include the following issues:

1. Medi-Cal eligibility establishment
2. Suspension of Benefits
3. Retention of Managed Care Plan
4. Plan Selection Prior to Release
5. Use of CalHEERS
6. Warm Handoff for Medically Fragile from prison
7. 30-day Supply of Medication upon release
8. Access to County Mental Health for parolees

Background:

California's criminal justice system includes around 200,000 people who are incarcerated and more than 400,000 who are under community supervision. About 36,000 people were released from California prisons annually over the past decade, and over a million people were admitted and released from jails, with many cycling through the criminal justice system multiple times in a given year.

Criminal justice populations are generally characterized by elevated rates of chronic physical and mental health problems relative to the general population.¹ A 2011 RAND study of the health status of prison populations in California revealed that 18% reported having hypertension, 14% asthma, 13% hepatitis, and 9% a sexually transmitted disease. Behavioral health problems are also common among incarcerated people; the same California study found that 58% of inmates reported a problem with drug abuse or dependence, and many reported depression (19%), anxiety (8%), mania (10%), posttraumatic stress disorder (6%), and/or schizophrenia (6%).² These challenges are exacerbated in many systems by chronic overcrowding. The result is that health and medical costs now form a major part of most corrections budgets, totaling about a fifth of all corrections expenditures nationwide and 31% in California.³ In California, the challenge in meeting the physical and mental health needs of the people in prisons is a major part of the ongoing crisis in the state's corrections system and the impetus for reform.

The profile of the criminal justice populations is growing older. For example, the portion of people age 50 years or older in California state prisons grew from 4% to 21% between 1990 and 2013, while the percentage of people age 25 years or younger decreased from 20% to 13%.⁴ This reflects a national trend toward "greying" prison populations that is expected to continue, due in large part to the historically long "tough on crime" sentences that have been being imposed for most street crimes since the early 1990s.⁵ The aging trend among criminal justice populations is important for policymakers to consider because age is strongly associated with declining physical and mental health. This means

¹ See Massoglia, Michael and William Pridemore. 2015. "Incarceration and Health." *Annual Review of Sociology*, 41(4) [[Link](#)]; and Schnittker, Jason, Michael Massoglia, and Christopher Uggen. 2012. "Out and Down: Incarceration and Psychiatric Disorders." *Journal of Health and Social Behavior*, 53(4).

² RAND. 2012. "Understanding the Public Health Implications of Prisoner Reentry in California."

³ Pew Trust. 2014. "State Prison Healthcare Spending: An Examination."

⁴ Grattet, Ryken and Joseph Hayes. 2015. "California's Changing Prison Population." *PPIC*.

⁵ Carson and Sabol. 2016. "The Aging of the State Prison Population." *Bureau of Justice Statistics*. [[PDF](#)]

older adults are far costlier to incarcerate compared to younger cohorts,⁶ and prisons and jails are among the most expensive places to deliver care.

Communities across the US and California have already been facing the serious health challenges associated with individuals leaving prison. For example, a 2007 study of over 30,000 people released in Washington State found that the adjusted risk of death was 12.7 times higher for people in the two weeks following release compared to the general population. The leading causes of death were drug overdose, cardiovascular disease, homicide, and suicide.⁷ A similar study that looked at hospitalization rates of Medicare eligible formerly incarcerated persons found that about one in 70 are hospitalized for an acute condition within seven days of release, and one in 12 by 90 days, a rate much higher than in the general population.⁸

Providing adequate medical care to criminal justice populations is often particularly difficult and costly because many are experiencing complex health problems in equally complicated social conditions. Their illnesses and disabilities are often complicated by chronic poverty, long periods without health care, residence in a low-income community, and substance abuse. Correctional rehabilitative programs are increasingly designed to provide “wraparound” social services, but less attention has been paid to coordinating these services with healthcare for medically needy people.

Further, many incarcerated people have cycled through jails and prisons, homeless shelters, emergency rooms, drug treatment programs, psychiatric care, and other institutional settings for decades. They frequently lack the education, experience, and sometimes ability to maintain gainful employment. Chronic illness and disability limit other forms of independence. Consequently, many become high utilizers of multiple health, human service and criminal justice systems. Despite their relatively small numbers, these high utilizers are both vulnerable and costly. They consume disproportionately more resources in the criminal justice, health, and welfare systems than other groups, and their complex situations make full recovery difficult to achieve.

The serious health and behavioral health problems that these groups face when leaving jails and prisons should be an important consideration for policymakers in their work to

⁶ For example, research shows people age 50 years or older cost around three times as much to incarcerate compared to their younger peers, largely because of medical costs. See State of Florida Correctional Medical Authority. 2007. “Report on Older and Aging Inmates in the Florida Department of Corrections.”; Anno, Jaye et al. 2004. “Meeting the Health Needs of Elderly, Chronically Ill, and Terminally Ill Inmates.”

⁷ Binswanger, Ingrid et al. 2007. “Release from Prison — A High Risk of Death for Former Inmates.” *New England Journal of Medicine*, 356(2).

⁸ Wang, Emily et al., 2013. “A High Risk of Hospitalization Following Release From Correctional Facilities in Medicare Beneficiaries.” *JAMA Internal Medicine*, 173(17). Ahalt, Cyrus et al. “Paying the Price: The Pressing Need for Quality, Cost and Outcomes Data to Improve Correctional Healthcare for Older Prisoners.” *Journal of the American Geriatrics Society*, 61(11).

find ways to structure services to more effectively help individuals manage their health problems and experience better health outcomes.

Specific Issues and Recommendations:

The Reentry Health Project identified an extensive inventory of issues and recommendations related to eligibility establishment of benefits, care coordination, federal financial participation maximization, treatment integration for individuals with co-occurring disorders, release of information and housing. In the comments below, we are highlighting nine areas of concern for the Department to consider.

1) Medi-Cal Eligibility Establishment Issues: Suspension of Benefits – Time Limit

- a) **Issue:** Current law limits Medi-Cal benefit suspension for incarcerated individual for one year after which a new application is required to re-establish eligibility. While this policy of suspension in lieu of termination is an improvement in promoting continuity of coverage for released individuals compared to the prior policy of immediate termination of eligibility on entering jail or prison, the policy does not address the issue for those who are incarcerated in prison or jail for more than one year.

In 2017, Senator Hernandez introduced SB 222 that would have extended the suspension of benefits to the date the inmate is no longer incarcerated or otherwise not eligible. It also required DHCS to develop and implement a simplified annual renewal process for inmates with suspended Medi-Cal benefits. SB 222 was held in the Senate Appropriations Committee's suspense file based on the costs of which approximately \$4 million per year to perform additional annual redeterminations that would otherwise occur because eligibility would continue (although benefits would continue to be suspended) for individuals incarcerated for more than a year.

New York is one of the few states that suspends Medicaid benefits when someone is incarcerated, and it is the only state to suspend Medicaid indefinitely, rather than only until a new eligibility determination is required.⁹ New York's practice of suspending Medicaid benefits indefinitely when an individual is incarcerated has been in place since 2007. New York state law also provides that time incarcerated shall not count toward the required redetermination period. If California enacted a similar policy, the additional administrative costs for redeterminations associated with SB 222 would not be incurred.

⁹ Medicaid and Financing Health Care for Individuals Involved with the Criminal Justice System Justice Center, The Council of State Governments

Specifically, 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.”¹⁰

- b) **Recommendation:** Consider the New York model to suspend Medi-Cal benefits indefinitely while the enrollee is incarcerated and do not toll the eligibility clock while incarcerated so that a redetermination is not required until after the individual is released and benefits are reinstated. This would likely require a statutory change to remove the existing one-year limit on suspension and clarify that the time during which an individual is incarcerated shall not be included in the calculation for determining annual redeterminations. It is our understanding that this was done without a federal waiver. However, we are awaiting still confirmation on the extent to which New York is using this authority to “stop the clock.”

Another way to remove the high cost for the redeterminations due to extending eligibility that we are now exploring would use the current Information Technology system to automatically determine eligibility based on income information from the federal hub. This process would check with federal databases regarding changes in status or income of the incarcerated individual and only require review when a significant change is detected. This approach would result in minimal additional costs.

2) Retention of Managed Care Plan When Medi-Cal Benefit is Suspended

- a) **Issue:** Medi-Cal’s current plan selection process is separate from, and subsequent to, the eligibility process, and is accomplished by completion of plan selection packet that is mailed to newly eligible individuals. If the participant fails to return a completed response to the packet, they will be assigned to a plan by default. The time it takes to select a plan can be a barrier to an individual identifying a regular source of care or continuing the treatment programs that may have been underway while incarcerated.

This plan selection process happens both for the newly eligible as well as those who were on suspended status. For those in suspended benefit status, the inmates prior managed care relationship does not stay in place, requiring a new plan selection process that delays access to their managed health care plan network. Under the Los Angeles County Whole Person Care Pilot, if the individual was enrolled in a Medi-Cal managed care plan at the time of incarceration in jail, the managed care

¹⁰NY 366(1)(a)

plan enrollment is placed on a hold status for up to 90 days. If the individual is released within 90 days, the individual is re-enrolled into the same managed care plan. However, if the individual's eligibility is redetermined during the 90 -days or is incarcerated beyond 90 days, upon release, the individual would be placed in fee-for-service and receive a new choice packet upon release. We are trying to determine the basis for the 90-day length and whether it derives from a state requirement.

- b) **Recommendation:** Establish a plan choice process model for inmates that is based on the Low-Income Health Program (LIHP), often called the "Bridge to Reform" that facilitated the enrollment of newly eligible individuals into coverage under the Affordable Care Act. This process was established in Welfare and Institutions Code 14005.61(c). Conceptually, we suggest a process in which the incarcerated individual with a suspended benefit would be sent information regarding health plan selection 60 days prior to release and could make a plan choice based on that information. If no choice is made, a plan would be assigned based upon any prior health plan relationship and established primary care physician if available, and otherwise based on the usual default procedure.

3) Plan Selection Prior to Release.

- a) **Issue:** As incarcerated individuals who will be newly Medi-Cal eligible upon reentry into the community, enrollment is an essential first step in gaining access to care on a fee-for-service (FFS) basis. However, allowing individuals to select their Medi-Cal managed care plan also can facilitate continuity of care, maintenance of needed medication regimes, transfer of medical records, and the establishment of a medical home. This requires a process that enables an individual to begin the plan enrollment process prior to release from custody.

For CDCR inmates, pre-release planning is conducted by the Division of Parole Operations' Transitional Case Management Program (TCMP). The program begins about 90-120 days prior to release, and helps to determine eligibility and assists in enrollment for potential benefits including Medi-Cal. The California Rehabilitation Oversight Board (C-ROB) 2018 annual report found that almost 100% of statewide inmate releases were screened for benefit eligibility, and about 30,000 Medi-Cal applications were submitted in FY 2017-18.¹¹

The next step in the process is plan selection, and generally takes place following an inmate's release from custody. The process requires the completion of plan selection packet that is mailed to newly eligible individuals. If the participant fails to return a completed response to the packet, they will be assigned to a plan by default. The time it takes to select a plan can be a barrier to an individual identifying a

¹¹ https://www.oig.ca.gov/media/crob/reports/C-ROB_Annual_Report_September_14_2018.pdf

regular source of care or continuing the treatment programs that may have been underway while incarcerated. Until plan selection and plan enrollment are completed, Medi-Cal eligible services are reimbursed on a FFS basis for the first one or two months after the inmate is released to the community.

As part of its Whole Person Care Pilot, Los Angeles County is also moving forward on a process that will ensure that inmates select a Medi-Cal managed care health plan prior to release and to improve the seamless transition to a primary care provider. In this process, the Health Care Options (HCO) application for plan selection is completed *along with* the application for Medi-Cal eligibility. The HCO application is then retained until the inmate is released. Prior to release, a Community Health Worker (CHW) will inform the selected primary care provider (PCP) that a new patient will be seeking care; the PCP may receive initial payment for services through Fee-For-Service (FFS) Medi-Cal until the HCO application is fully processed, usually in thirty days or less. Los Angeles County plans this to expand services to all inmates.

As with all enrollees in Medi-Cal managed care plans, formerly incarcerated persons are able to change their plan at any time, although there is an administrative lag for the enrollment process. For those establishing new Medi-Cal eligibility, plan selection should be facilitated prior to release as part of the pre-release application process.

- b) **Recommendation:** Inmates who did not have Medi-Cal eligibility prior to their incarceration or who may require a new health plan (e.g. they are being released to a county that is different to where they were previously enrolled) should complete their HCO applications concurrently with their eligibility application. This Los Angeles County model should be considered as one alternative for accelerating the plan selection process. In cases where an inmate will return to a county with a County Organized Health System (COHS) plan, no plan selection process should be required, and instead consideration should be given to an auto-assignment process prior to release that could include a point of contact for primary care.

4) Use of Automated Online Systems for Applying for Medi-Cal

- a) **Issue:** Corrections personnel assist CDCR's Transitional Case Management Program (TCMP) now provides assistance to incarcerated individuals with their applications for Medi-Cal prior to their release from custody. The process is laid out in a DHCS All County Welfare Director Letter 14-24. The letter established procedures for effective communication between the CDCR and the county welfare office to ensure the individual's application is processed on a timely basis and that any changes in the status of the individual are communicated. Currently this process requires that applications be completed manually and faxed with an identifying coversheet to the county welfare office that handles application for incarcerated individuals.

Currently none of the current online application systems (CalHEERS, C4Yourself, yourbenefits.laclrs, or mybenefitscalwin) have a mechanism to flag applications from CDCR facilities or jails that will ensure timely processing of the applications.

- b) Recommendation:** Fix CalHEERS and/or the other systems so that applications can be submitted online by prisons and jails and appropriately tracked. The capability of online entry of application data would improve the efficiency and accuracy of the application process both for CDCR staff and the counties. It would also allow better tracking of the application processes by establishing local work queues that can be monitored for timeliness. The change to CalHEERS or other online applications would require the ability to flag the applications and indicate on each the CDCR source and point of contact.

5) Warm Hand-Off for Medically Fragile People from Prison and Jails

- a) **Issue.** Successful transition for medically fragile individuals as they transfer from prison and jail to the community requires effective coordination between the care providers in the penal institutions and in the community. The term “warm hand-off” is often used to describe a transition process in which the client never loses contact with the referring provider until contact with the new provider is established. This warm hand-off boils down to some simple systems. These include: establishing a medical home with a community provider; making initial appointments following release from custody; sharing medical records as necessary; providing needed prescription drugs and other treatment regimens continuously after release; and empowering the reentry population with assistance and information to help them to actively participate in managing their health problems.

Several other states have used their contracts with their Medicaid managed care health plans to provide specific assistance and support for inmates who are transitioning from custody to the community. Particularly for individuals with complex and potentially expensive health conditions, Medicaid health plans have fiscal incentives for assisting transitioning inmates and are well positioned to help these individuals access a medical home, pharmacy services, and care coordination. These incentives relate to the capitated payments managed care plans receive for providing health care services to their enrolled members. The health plans may be willing to cover support services if they are a cost-effective alternative to paying for more expensive hospital or other health services that could otherwise be avoided.

Other states have negotiated provisions in managed care contracts to require health plans to engage with eligible inmates 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. These states include: Arizona, Colorado, Connecticut, Florida, Ohio, Louisiana, Massachusetts, and Rhode Island. A detailed

discussion of these states and specific contract provisions is included in the appendix.

- b) **Recommendation.** DHCS should include a provision in Medi-Cal managed care contracts to (1) assist with the pre-release planning process for their plan members who are returning to the community; and (2) provide a warm hand-off to health care services in the community. Addressing the needs of medically fragile state prison and jail inmates would be an appropriate target population for a demonstration project.

6) 30-day Supply of Medication upon release

a) Issue:

To ensure continuity of drug therapy as prisoners with ongoing medical needs are released or discharged to the community, CDCR and jails have adopted two general approaches: (1) provide a 30-day supply of medication when the inmate is released; or (2) provide the inmate with a prescription and/or voucher to be filled at a community pharmacy. The latter option increases the risk that medically fragile or seriously mentally ill former inmates will go without needed medication during their critical post-release period. To the extent FFP can be used to offset at least half the cost of medication, the best practice of providing a transitional medication upon release should be encouraged.

The CDCR has a policy of providing a 30-day supply of medication as the individual leaves prison. The policy also includes the availability of a consultation by appropriate licensed staff. However, the CDCR is not currently claiming Federal Financial Participation (FFP) for these services when provided to those eligible for Medi-Cal upon release.

At the San Diego Central Jail, inmates are not handed a supply of medication when they are released. Instead, a prescription for a 10-day supply of medication is faxed to a pharmacy *only* for inmates receiving psychiatric or HIV medication. The cost of the drugs is paid by the jail. Prescriptions for other medications are not provided. Previously, the Sheriff's Department paid for a 30-day supply of medication, but many filled medications were unclaimed by former inmates. To reduce costs, a decision was made to reduce the supply to ten days. However, this is likely to be adjusted to 14 days.

Through its Whole Person Care pilot, Los Angeles County has taken a different approach. As noted earlier, the county's five-year, \$900 million pilot proposes to target, among other groups, about 1,000 soon-to-be released inmates each month and will use community health workers to help them get the care and social services they need. The county is also working to get inmates released with a 30-day supply of medications. LA County DHS is now exploring the potential of obtaining FFP to

offset much of the pharmacy cost for its Medi-Cal eligible inmates who are released from jail. The federal match could be at least 50%, and up to 93%¹² of these inmates are part of the new expansion population under the Affordable Care Act.

To obtain FFP, the inmate must have (1) applied for, and be determined eligible for Medi-Cal eligibility prior to release; (2) receive the medication from a pharmacy that is an approved Medi-Cal provider; and (3) receive the medication outside the walls of the jail or prison. Reimbursement for Medi-Cal services, including pharmacy, can be obtained retroactively back to the date of release so long as the application for eligibility is filed prior to release.

- b) Recommendation:** The CDCR should apply to enroll as a Medi-Cal pharmacy provider for the purpose of providing needed medications to Medi-Cal eligible individuals upon release.

7) Access to County Mental Health for Parolees

- a) **Issue:** Current practices for serving seriously mentally ill (SMI) parolees can be highly fragmented, inefficient, and ineffective. Federal funds are not being maximized and transitions between parole services and county specialty mental health programs are challenging. Most significantly, SMI parolees are not able to access a county's far more comprehensive continuum of services, providers, and residential programs.

The Division of Adult Parole Operations (DAPO) Mental Health Services Continuum Program (MHSCP) provides parolees with a continuum of mental health care services after release from prison. The state spends about \$31.5 million to support a variety of programs that provide services to SMI parolees. Although most of the parolees are Medi-Cal eligible, few of these programs are currently drawing down Federal Financial Participation (FFP). As SMI parolees complete their parole and are discharged, the responsibility for their mental health care shifts to county specialty mental health programs. This transition requires a change in providers, case management, and other services, and increases the likelihood of an individual falling through the cracks. County specialty mental health programs also have access to more comprehensive services, including full service partnerships, and a more extensive network for providers.

The DHCS draft information notice, issued on November 28, 2018, provides needed guidance and clarification to county Mental Health Plans (MHPs) regarding their responsibility for serving parolees and other justice-involved individuals being supervised in the community. It is noteworthy that the draft guidance requires a Medi-Cal beneficiary's entitlement to receive specialty mental health services—

¹² The rate in calendar year 2018 was 94%; it will be 93% in 2019 and 90% in 2020 and thereafter.

something that applies “regardless of whether the beneficiary is currently receiving mental health services through the state parole system.”

The state’s draft guidance addresses a policy in many counties that excludes parolees from receiving specialty mental health services to which they are eligible and entitled. These county mental health policies reflect their limited resources and have generally prioritized services to non-parolees. Parolees, it was suggested, should receive their treatment services through state supported programs. This is one reason why parole created its own network of Parole Outpatient Clinics (POCs), rather than using the county specialty mental health programs. There was also a fiscal and programmatic rationale. When a parolee violated parole conditions and returned to custody as a parole violator, the cost of that short-term incarceration was a state responsibility. This gave the state a financial incentive to invest in programs such as specialty mental health and drug treatment that would reduce recidivism.

The draft guidance provides a needed update to state and local policies to reflect changes in the state/local structural relationship related to parolee recidivism. Prior to the state’s 2011 Public Safety Realignment Act, parole violators served time in state prison. However, under the new law, parolees now serve time in county jails when their parole is revoked by a local court. Counties do not receive an additional marginal allocation to reimburse their jail for the costs of incarcerating parolees. For this reason, counties have an incentive to serve the SMI parolee population.

- b)* **Recommendation:** The draft DHCS guidance creates an opportunity for a new level of collaboration between CDCR and county mental health. We suggest the creation of a work group that brings together key state and local stakeholders to evaluate the effectiveness of current parole programs for SMI individuals, determine opportunities for maximizing FFP, improve the quality and effectiveness of care, and ensure a seamless transition process following discharge from parole. This work group should consider opportunities for collaboration and alternative program designs that allow for the alignment of county services now provided to other justice-involved SMI individuals who are on Post Release Community Supervision or probation.

We again wish to thank you for the Department’s efforts to improve care coordination, and for calling out the unique needs of the justice-involved population.

We also appreciate the opportunity to comment on these issues, and hope that our findings and recommendations are considered. Please let us know if there are questions or additional information that may be helpful as you consider next steps.

Sincerely,



David Panush
President

cc: Mari Cantwell, Chief Deputy Director
Jacey Cooper, Assistant Deputy Director for Health Care Services
Brenda Grealish, Deputy Director for Mental Health & Substance Use Disorder Services
Rene Mollow, Deputy Director for Health Eligibility and Benefits

Appendix

Medicaid Managed Care & Reentry: State Initiatives - Overview

Multiple states have leveraged Medicaid managed care plans and corrections facilities' medical vendors to connect people to medical care during incarceration and upon reentry. Most commonly, these efforts first targeted high-need individuals. Details of states' efforts are below.

State	Initiative
Arizona	Arizona's Medicaid implementor, managed care plans, and corrections facilities work together to help medically-vulnerable, incarcerated individuals (1) apply for Medicaid and (2) connect with medical care upon release. This work is in fulfillment of Arizona's contract with managed care plans, which stipulates that plans must "conduct reach-in care coordination for members who have been incarcerated in the adult correctional system for 30 days or longer and have an anticipated release date." Managed care plans reach-in efforts include helping incarcerated people apply for Medicaid and scheduling medical appointments to occur within seven days of release. To date, 8,977 "pre-release" Medicaid applications have been approved. (812 have been denied and 2,962 applications are still pending.)
Colorado	Colorado's contracts with county-level managed care plans require them to collaborate with jails and prisons to coordinate members' transitions from incarceration. Managed care plans provide case management for incarcerated people, including connecting them to Medicaid. Colorado uses Medicaid funding to pay for case management for incarcerated people with behavioral health needs. During incarceration, case management involves support from nursing staff, mental health staff, and pre-release specialists. After incarceration, case management includes support from parole officers, reentry specialists, and mental health clinicians. Managed care plans conduct proactive in-reach, including setting up medical appointments, building data systems with jails to facilitate care coordination, member engagement, and other forms of care transition support.
Connecticut	Connecticut Department of Corrections' contract with its medical care vendor requires the vendor to coordinate reentry care for incarcerated people with identified physical and mental health needs. The vendor provides "discharge planners" who work with

	<p>individuals beginning 60-90 days prior to their release to coordinate appointments, identify and connect individuals to community providers, and provide short-term prescriptions and prescription vouchers to be used upon release. Kaiser Family Foundation suggests that this work has been successful: “about 60% of the incarcerated population is enrolled in Medicaid upon release, either through reinstatement of suspended coverage or through the pre-release enrollment process.” This success is partially attributed to inter-agency coordination, including clear documentation of roles, responsibilities, and funding.</p>
Florida	<p>Florida’s 2017 Managed Care Plan Contract stipulates that Managed Care Plans must reach out to Medicaid enrollees who are involved in the justice system, with a focus on “preventative measures to assess behavioral health needs.” In their provider handbooks, Medicaid managed care plans discuss the services they offer to reentry populations. Better Health Florida’s 2016 provider handbook, for example, guarantees that “members can receive psychiatry services within 24 hours of release from jail, juvenile detention or other justice facility” by calling “PsychCare at 1-800-221-5487.” In addition, Better Health Florida and Molina Healthcare report that they offer preventative-oriented behavioral healthcare outreach to members at risk of justice system involvement</p>
Louisiana	<p>Louisiana requires Medicaid managed plans to conduct pre-release care planning to ensure that high-need, incarcerated individuals can access medication upon release. The State identifies these high-need, incarcerated individuals nine months prior to release, using data-sharing between the Department of Corrections and the Louisiana Medicaid implementor. In addition, Louisiana works to enroll incarcerated individuals in Medicaid prior to release, including connecting them to a health plan. This is facilitated, in part, by automation of the Medicaid application and plan selection process.</p>
Massachusetts	<p>Massachusetts’s Medicaid implementor works with the Massachusetts’s Department of Corrections to enroll prisoners into Medicaid prior to their release. Massachusetts Department of Corrections, for example, uses its medical vendor to offer incarcerated people patient education and continuity of care prior to their release. Massachusetts has been relatively successful in its efforts. According to the Kaiser Family Foundation, “over 70% of individuals released from prison in fiscal year 2015 had a MassHealth [Medicaid] application submitted, and over three-</p>

	<p>quarters of submitted applications were approved.” Moreover, most individuals who did not have an application submitted were already enrolled. Massachusetts’s success is in part due to extensive collaboration and the efforts of multiple task forces.</p>
Ohio	<p>Ohio includes language in its 2018 Medicaid managed care plan contracts requiring them to “participate in the development, implementation, and operation of initiatives for early managed care enrollment and care coordination for inmates to be released from state prisons or state psychiatric hospitals and youths in Department of Youth Services custody.” Ohio has a pre-release Medicaid enrollment program which involves peer Medicaid educators, selection of a managed care plan before release, and requirements for Medicaid managed care plans to provide medically-fragile people with transition plans, pre-release conferences, and follow-up after release to connect them to health care providers. A National Association of Medicaid Directors official suggested that managed care plans’ case management efforts have been effective. The Urban Institute confirms this; it reports that as of May 2016, Ohio’s pre-release enrollment program “included 21 prison facilities that had enrolled more than 4,100 people in Medicaid before they were released into the community.”</p>
Rhode Island	<p>The Medicaid Leadership Institute worked with the state Medicaid implementor, corrections officials, and advocacy organizations to determine how to facilitate Medicaid applications from corrections facilities. The state conducted a pilot program in Medically-Assisted Treatment (MAT), which required managed care providers to amend their contracts to allow pilot participants access to Vivitrol just prior to and shortly after release. US Department of Health and Human Services National Institutes of Health and the manufacturer of Vivitrol subsidized this pilot program. The results are not yet available.</p>