



Policy Brief

Medicaid Managed Care Organizations and Reentry

January 2019

Executive Summary

When transitioning out of incarceration, some individuals face a “gap” in access to healthcare. Correctional facilities provide healthcare to incarcerated people, but there are serious challenges in providing care continuity as they return from custody into the community. Logistical complications, compounded by other challenges of reentry, can delay and/or prevent individuals from connecting to health care providers. This is a problem with significant health, fiscal, and societal ramifications.

This policy brief discusses how many states are addressing the need for transitional support for incarcerated individuals through their Medicaid managed care organization (MCOs) and contracts with that mandate assistance and support for reentry. Requiring MCOs to do in-reach, i.e. contact the individual before leaving prison or jail, is possible and can work well. It is also helpful to note that often state-level initiatives have begun at a county level and/or initially focused on high-need individuals.

This brief discusses state initiatives, including information on their origins, stakeholders, and efficacy. The following states are discussed:

- **Arizona’s** Medicaid agency, MCOs, and corrections facilities work together to help medically-vulnerable, incarcerated individuals apply for Medicaid and connect with medical care upon release. (See section III for an in-depth discussion of Arizona’s work.)
- **Colorado’s** contracts with county-level MCOs require them to collaborate with jails and prisons to coordinate transitions from incarceration. MCOs provide case management for incarcerated people, including connecting them to Medicaid. (See section III for an in-depth discussion of Colorado’s work.)

- **Connecticut** requires its MCOs to coordinate reentry care for individuals with specific medical needs. The vendor provides “discharge planners” for individuals prior to release, and roughly 60% of the incarcerated population is enrolled in Medicaid upon release.
- **Florida’s** 2017 contract with MCOs stipulates that MCOs must reach out to Medicaid enrollees in the justice system, with a focus on “preventative measures to assess behavioral health needs.” (See section III for an in-depth discussion of Florida’s work.)
- **Louisiana** [requires](#) MCOs to conduct pre-release care planning to ensure that high-need, incarcerated individuals can access medication upon release. Louisiana has also automated its Medicaid application and plan selection process to facilitate this.
- **Massachusetts’s** Medicaid agency has successfully collaborated with the Massachusetts Department of Corrections to enroll prisoners into Medicaid prior to their release. Most of these Medicaid applications are approved.
- **Ohio** has a [pre-release Medicaid enrollment program](#), linked to MCO contract language, which includes peer educators and the selection of a managed care plan before release. The state also requires MCOs to provide medically-fragile people with transition plans, pre-release conferences, and post-release follow-up to connect them to health care providers.
- **Rhode Island** conducted a [pilot program](#) in Medically-Assisted Treatment (MAT), funded by a public-private partnership, which required managed care providers to amend their contracts to allow pilot participants access to Vivitrol just prior to and shortly after release.

As California and other states consider statewide initiatives to connect reentry populations to Medicaid, they may benefit from considering other states’ experiences. Based on the evidence reviewed in this brief, states that require MCOs to help reentry populations connect to Medicaid are most successful when they:

- Build upon existing systems, when possible;
- Devote attention to data and information-exchanges;
- Cultivate buy-in from stakeholders, including identifying “champions” in different agencies and organizations; and
- Consider rolling out a reach-in initiative or care coordination in stages, beginning with the most vulnerable populations.

I. Introduction

Reentry into society is riddled with challenges for formerly-incarcerated people. One such challenge is connecting with a health care provider. To minimize gaps in care during the reentry process, a best practice is to offer a system that allows the inmate to experience a “warm hand off,” i.e. continuous contact with care providers as the individual transitions from the prison or jail health care providers to a medical home in the community. This requires: establishing a medical home with a community provider prior to release; making initial appointments that occur 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 actively participate in managing their health problems. When these systems are not in place, however, individuals transitioning into society may face gaps in healthcare provision.

Interviewees in multiple states reported that delays in connecting to health providers can have negative health consequences for individuals, can cost society more money, and can increase recidivism. Individuals with complex health needs—including the medically-fragile and seriously mentally ill—are especially vulnerable to gaps in healthcare provision. In addition, when a patient’s health conditions are costly, interrupted medical care can increase the likelihood of unnecessary emergency room visits and hospital stays. Consequently, MCOs recognize the fiscal incentives and health care advantages of providing assistance to people transitioning out of prison and jails. MCOs are also well-positioned to help reentry populations access a medical home, pharmacy services, and care coordination.

Experts agree that states should work with MCOs to ensure a “warm hand off” and continuity of care. According to the [Kaiser Family Foundation](#), engaging managed care plans in the work to improve continuity of care for reentry populations “is important to ensure that individuals with complex or chronic health conditions, including behavioral health needs, have an effective transition to treatment in the community.” Similarly, an [Urban Institute](#) study recommends that states adopt policies to “engage MCOs in care coordination” and “require MCOs [to] provide Medicaid-allowable services for reentry population[s].”

Over the past two decades, states have worked with managed care plans to connect incarcerated individuals to healthcare in time for their reentry into society. In many states—and especially states which have expanded Medicaid—most incarcerated people now meet the categorical and income requirements to be Medicaid-eligible. Consequently, [most of these states](#) pursue two strategies to connect their reentry populations to healthcare: (1) states suspend (rather than terminate) Medicaid enrollment for Medicaid enrollees who become incarcerated, and (2) conduct outreach to incarcerated people to facilitate enrollment in Medicaid prior to release. A subset of these states also requires Medicaid managed care plans to help reentry populations connect to health services. Arizona, Colorado, Florida, and Ohio, for example, have negotiated provisions in Medicaid managed care contracts that require health

plans to engage with eligible inmates during incarceration to connect them to a managed care plan, and to conduct outreach and coordination upon their release.

The next sections of this brief review state-level efforts to connect reentry populations to Medicaid while engaging managed care plans.

II. Summary of State-Level Initiatives

Multiple states have leveraged MCOs and corrections facilities’ medical providers to connect people to medical care during incarceration and upon reentry. Most commonly, these efforts first targeted high-need individuals. Below, please find summaries detailing different state efforts.

State	Initiative
Arizona	Arizona’s Medicaid agency, 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 described in Arizona’s contract with MCOs, 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.” MCOs 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. MCOs 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. MCOs 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 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.
Florida	Florida’s 2017 Managed Care Plan Contract stipulates that MCOs 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.
Louisiana	Louisiana requires MCOs 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 agency. 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.
Massachusetts	Massachusetts’s Medicaid agency 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

	<p>MassHealth [Medicaid] application submitted, and over three-quarters of submitted applications were approved.” Moreover, most individuals who did not have an application submitted were already enrolled.</p> <p>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 MCO 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 MCOs 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 agency, 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>

III. Discussions of Ongoing Work in Arizona, Florida, and Colorado

Arizona

Overview

Arizona’s Medicaid agency—Arizona Health Care Cost Containment System (AHCCCS)—works with corrections facilities to ensure timely re-instatement of Medicaid for reentry populations. The AHCCS also works with managed care plans and corrections facilities to help medically-vulnerable, incarcerated individuals (1) apply for Medicaid and (2) connect with medical care upon release.

Contract Language

Arizona’s contract with its MCOs 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.” This involves collaborating with criminal justice partners to identify incarcerated people with “physical and/or behavioral health chronic and/or complex care needs prior to member’s release.” In addition, plans must ensure that their members are able to have an appointment with “appropriate provider(s).... within 7 days of member release.” Lastly, the contract outlines the responsibilities of a “Justice System Liaison,” designated by the plan, who is responsible for communicating with the justice system.

Implementation

Timeline. AHCCCS added new responsibilities to managed care plans’ contracts in 2016. The updated contracts stipulate that plans must “implement reach-in care coordination” for medically-vulnerable people who have been incarcerated for 30 days and who have a release date. (Previously, county health departments, regional behavioral health authorities, and nonprofits had worked together to help incarcerated people apply for Medicaid.) AHCCCS officials report that managed care plans have been successfully implementing reach-in and that plans’ justice system liaisons have been very active and engaged. Reach-in has involved 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.) California Health Policy Strategies has reached out to AHCCCS officials to request additional performance metrics related to care coordination.

Although Arizona’s initial efforts to connect reentry populations to Medicaid focused on the vulnerable, the state has expanded its efforts over the past few years. This is in part due to continued enthusiasm among many stakeholders. In 2016, for example, Arizona Governor Doug Ducey identified reducing recidivism as a key goal during his State of the State address. This helped motivate efforts to ensure healthcare access for reentry population. In addition, 2016 legislation required the Department of Corrections (DOC) to increase Medicaid enrollment and care coordination for reentry populations. Today, AHCCCS and counties successfully share data to facilitate Medicaid suspension and enrollment, the AHCCCS has specialized staff to process pre-release Medicaid applications, and in-reach efforts promote coordinated care and continuity of care. Again, California Health Policy Strategies has reached out to AHCCCS officials to request additional performance metrics.

Implementation notes. The [Kaiser Family Foundation](#), the [Urban Institute](#), and AHCCCS officials attribute Arizona’s success to buy-in from multiple stakeholders. The AHCCCS and the DOC cooperate well, and many jails have also joined the work. The Urban Institute reports that “champions” of this work in different agencies have built strong relationships across agencies, helping promote the information-sharing necessary to connect reentry populations to Medicaid.

Current Challenges. Some counties are not participating in Medicaid suspension programs, likely because it is difficult for smaller counties to implement Medicaid suspension, due to limited staff time and capacity to regularly share information with AHCCCS. The incomplete uptake of suspension negatively affects continuity of care for reentry populations.

Lessons Learned

AHCCCS built its information system around existing correctional facility information systems, which made inter-agency data exchange easier. Obtaining timely, accurate information from correctional facilities has been a challenge for other states’ Medicaid implementors. Arizona seems to have addressed this relatively well. In addition, widespread buy-in from stakeholders (AHCCCS, DOC, jails, legislature, governor) allowed for strong collaboration, which was necessary for Arizona’s programs to succeed.

Colorado

Overview

In Colorado, Medicaid is administered at the [county level](#). Health First Colorado—Colorado’s Medicaid agency—contracts with three types of Medicaid managed providers: Behavioral Health Organizations (BHOs), Managed Care Organizations (MCOs), and Regional Care Collaborative Organizations (RCCOs). The following discussion focuses on BHOs and RCCOs, which Health First Colorado assigns to patients based upon their county of residence.

Colorado’s BHOs and RCCOs administer case management for incarcerated people, including preparing for healthcare access upon reentry. Medicaid funding is used to pay for case management for incarcerated people with behavioral health needs. Both Medicaid and jails are administered at the county-level—Colorado has 64 counties—which multiplies coordination and data-sharing challenges. As a result, Colorado’s efforts to connect reentry populations to Medicaid are inconsistent across the state. Nonetheless, the state is proceeding with considerable momentum; in 2017, for example, Governor John Hickenlooper convened a Behavioral Health and Criminal Justice Task force to identify how to improve outcomes for criminal justice-involved Coloradans.

Contract Language

Colorado’s contracts with Behavioral Health Organizations contains a special section dedicated to members involved with the correctional system. Specifically, the contracts call for Behavioral Health organizations to “collaborate with agencies responsible for the administration of jails, prisons and juvenile detention facilities to coordinate the discharge and transition of incarcerated adult and child/youth Members.” This involves collaborating with and sharing information with corrections facilities. In addition, plans “shall ensure Members receive medically necessary initial services after release from correctional facilities and shall ensure ongoing services thereafter” including “medication management and other behavioral health care services.” Lastly, the contracts call for plans to “propose innovative strategies” to address member needs and to report on the efficacy of their work.

Colorado’s contracts with Regional Care Coordination Organizations stipulate that they must report on care coordination provided to criminal justice-involved members.

Implementation

Timeline. Over the past decade, Colorado has introduced in-reach efforts to help mentally ill incarcerated people connect with health services upon release. In 2007, the Colorado General Assembly passed [legislation](#) initiating and funding an [in-reach initiative](#) for incarcerated individuals with mental illnesses. [In 2011](#), the General Assembly funded [jail based behavioral](#)

[health services](#), which included case management dedicated to transitional care and reentry for incarcerated people with “substance use disorders and co-occurring substance use and mental health disorders.” This funding was extended in 2012.

In 2014, Colorado expanded Medicaid under the Affordable Care Act, which meant that about 75% of incarcerated people were now Medicaid-eligible upon release. To address this new, Medicaid-eligible population, the Department of Health Care Policy and Financing and the Department of Corrections (DOC) worked together to develop case management processes allowing incarcerated people to apply for Medicaid 40 days ahead of their release. Most recently, the Department of Health Care Policy and Financing has been working with corrections facilities to automatically screen people for Medicaid eligibility upon their incarceration. Inmates who meet Medicaid requirements are placed in a “limited benefits package” version of Medicaid (Colorado’s form of Medicaid suspension) and can switch to full Medicaid 24 hours after their release.

Implementation Notes. Colorado has made significant progress in connecting vulnerable reentry-populations to Medicaid, although this process is ongoing. [The Urban Institute](#) and others note that Colorado’s decentralized Medicaid administration and incarceration system prove challenging for reentry policies. Because individuals released in any one of the 64 counties could be planning to reside in a different county, it requires coordination across any pair of individual counties. The number of agencies and organizations involved necessitates considerable coordination and persistence. The Department of Health Care Policy and Financing has championed these efforts, [reaching out](#) to county sheriffs and jail staff to initiate and facilitate coordination.

In addition, Governor John Hickenlooper has pushed this work forward. In 2017, the Governor directed a Behavioral Health and Criminal Justice Task force to identify how to improve outcomes for criminal justice-involved Coloradans. The task force included state, county, and city-level officials from healthcare, justice, and academic organizations. The task force produced [a report](#) outlining recommendations within a year of the governor’s request.

Colorado’s RCCOs and BHOs provide case management for incarcerated people, including connecting them to Medicaid. Colorado uses Medicaid funding to pay for case management for people reentering society who have behavioral health needs. (Case management costs incurred during custody, however, are financed by the Colorado DOC.) 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. A Department of Health Care Policy and Financing official confirmed that RCCOs and BHOs are doing 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. California Health Policy Strategies has reached out to Health First Colorado officials to request additional performance metrics.

Current challenges. Information sharing between health officials and corrections officials has been difficult. There is considerable lag time in transferring patient info from prisons and jails to BHOs, due to privacy restrictions and internal regulations. The Department of Health Care Policy and Financing, the DOC, and BHOs are working together to resolve these issues. In addition, corrections facilities cannot share incarcerated peoples' health histories and housing circumstances with BHOs and RCCOs due to privacy regulations. This partially addressed by efforts to flag enrollment data sent to RCCOs to indicate that some enrollees are applying from jail or prison, prompting further follow-up from RCCOs.

Another challenge has been cultivating buy-in from all relevant parties, including ensuring awareness of new developments and opportunities. Given the large number of groups involved, progress can be piecemeal. The Department of Health Care Policy and Financing, for example, is currently working with sheriffs to encourage information-sharing. This has entailed identifying early adopters and presenting convincing evidence and best practices to other sheriffs.

A final challenge is that the needs of justice-involved people are greater than the current system can address. To address this, the Department of Health Care Policy and Financing may consider requiring (and paying) RCCOs to provide more intensive care coordination.

Lessons Learned

Colorado's experience has demonstrated the importance of effective inter-agency data - sharing, the benefits of using existing structures (rather than building new ones), and the importance of coordination and cultivating buy-in when operating in an environment with jurisdictional complexity.

Florida

Overview

Florida has facilitated its reentry populations' access to Medicaid, though there is sometimes a gap between a person's release and a person's ability to access care. Florida's Medicaid administrator—the Agency for Health Care Administration (AHCA)—requires MCOs to conduct in-reach to prisons/jails, but it is unclear to what extent this is taking place. It is important to note that Florida has not opted to expand Medicaid eligibility allowed under the Affordable Care Act. This significantly reduces the potential justice-involved population that could benefit from in-reach.

Contract Language

[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 and provide services that can potentially prevent the need for future inpatient services or possible deeper involvement in the forensic or justice system.” In addition, this contract requires plans to “ensure a linkage to pre-booking site for assessment, screening or diversion related to behavioral health services for enrollees who have justice system involvement.” The 2017 Managed Care Plan Contract differs somewhat from its [2012 predecessor](#), which contained more specific language about the maximum number of hours and days permitted between a patient's release and his/her connection to care.

Implementation

Timeline. In 2005, a joint Florida Department of Corrections-Florida Department of Children and Families working group discussed Medicaid for reentry populations and offered recommendations to facilitate Medicaid enrollment for reentry populations. In 2008, the Florida state legislature passed a bill, signed by the governor, stipulating that [Medicaid should be suspended](#) (rather than terminated) for inmates and that these people should be Medicaid-eligible upon release, until the person is deemed no longer eligible. Multiple actors voiced support for improving care coordination for reentry populations. In 2008, the [Council for State Governments](#) advocated for “establishing transition teams and community collaboration” for reentry populations. In 2010, Governor Rick Scott's [Law and Order Transition Team](#) recommended that the Department of Corrections engage in pre-release planning with disabled inmates, in order to ensure that they may receive Medicaid benefits after release. The team also recommended that the legislature “expand programs that help reentering inmates apply for government benefits for which they are qualified.” California Health Policy Strategies has reached out to Florida's Department of Corrections to request information on the status of these recommendations.

Implementation notes. An AHCA representative mentioned that Florida’s jails and prisons work with incarcerated people to help them secure access to health care upon their release. A [2018 Kaiser Family Foundation Medicaid budget survey](#), however, reports that Florida does not implement Medicaid outreach or assistance strategies to facilitate enrollment prior to release.

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. California Health Policy Strategies has reached out to additional AHCA officials and Florida’s Department of Corrections to request additional performance metrics.

Current challenges. At present, Florida does not connect incarcerated people with Medicaid immediately upon their departure from jail or prison. There are two reasons for this. First, the AHCA does not always have accurate information about when people are released from jail/prison. The AHCA obtains accurate information about when people enter jail/prison and actionable information on how long people will stay in jail/prison. The Department of Corrections does not, however, contact the AHCA when it releases people. Moreover, release dates can change—sometimes people are released early due to good behavior.

A second reason that Florida does not connect incarcerated people with Medicaid immediately upon their departure is that MCOs become active on the first of the month. When people are released from jail/prison earlier than the first of the month, they may have to wait until the first of the next month for their “span” to be lifted. According to the AHCA, when patients visit a healthcare provider after they have been released but before their Medicaid “span” has ended, the healthcare provider contacts the AHCA, and the AHCA can make a manual adjustment to the system.

Lessons learned

Connecting incarcerated people to Medicaid requires considerable inter-departmental coordination and data-sharing. The state cannot predict when someone will be released with precision, which can hamper coordination between the Department of Corrections and the AHCA. Sometimes, existing technical systems are inadequate to actualize new laws and objectives.

IV. Conclusion and Key Take-Aways

States, MCOs, and justice-involved individuals can all benefit from systems to ensure continuity of care for reentry populations. From a health standpoint, ensuring a “warm hand off” is beneficial for the patient. From a fiscal and societal standpoint, continuity of care can reduce health costs, and access to behavioral health services can help address criminogenic risks.

Multiple states have negotiated contracts mandating that MCOs assist and support incarcerated people in their transition from custody to community. This has proven successful in a number of states. As California and other states consider statewide initiatives to connect reentry populations to Medicaid, they may benefit from the following take-aways:

- **Build upon existing systems.** Connecting reentry populations to Medicaid requires considerable coordination and the introduction of new systems that impose implementation burdens for key stakeholders. Instead, consider options to use existing systems rather than creating new ones. Arizona had success building upon its existing data infrastructure; Colorado used its existing network of BHOs and RCCOs rather than bringing in new providers.
- **Devote attention to data and information-exchanges.** Information-sharing is one of the most common challenges for states working on healthcare for reentry populations. Like Colorado, California’s county-based Medicaid system faces more complex communications challenges that states with more centralized administration. This effort requires timely and accurate information, such as the dates that people are leaving prison. Rules and privacy concerns often hinder data-sharing, so states might consider involving data privacy experts when developing processes. In addition, different state agencies often use different (or even incompatible) data systems, which can limit communication between agencies. Lastly, states should consider the time and effort required to share data—this is sometimes an impediment for smaller counties who would otherwise participate in reentry programs.
- **Cultivate buy-in from stakeholders, including identifying “champions” in different agencies and organizations.** Collaboration among MCOs, corrections facilities, Medicaid agencies, and others is critical to success. Bringing together different agencies and organizations can be challenging, especially in states with decentralized administration of Medicaid and/or corrections facilities. Agencies spearheading new initiatives should conduct outreach and build relationships with other agencies and organizations. States noted that having “champions” in different sectors was especially useful—a “champion” is able to communicate the importance of the initiative to his/her organization and is motivated to connect with other organizations to realize the goal.

- **Consider rolling out a reach-in initiative or care coordination in stages, beginning with the most vulnerable populations.** When it is not possible to implement an initiative all at once, it may make sense to first target medically fragile and seriously mentally ill individuals who are involved with the justice system. These populations are the most vulnerable, from a health standpoint, and ensuring a “warm hand off” may reduce treatment costs more substantially than it would for those with less expensive medical conditions.

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About the Reentry Health Policy Project

- This brief is part of the Reentry Health Policy Project, which seeks to identify state and county level policies and practices that impede the delivery of effective health and behavioral health care services for formerly incarcerated individuals who are medically fragile (MF) and living with serious mental illness (SMI), as they return to the community. The report also offers specific recommendations and best practices for addressing these barriers. The Reentry Health Policy Project was managed by California Health Policy Strategies LLC with support provided by the California Health Care Foundation.

About California Health Policy Strategies (CalHPS), LLC.

- CalHPS is a mission-driven health policy consulting group based in Sacramento. For more information, visit www.calhps.com.

Appendix A: Arizona MCO Contract Excerpts

The [January 1st 2018 amended contract](#) includes the following:

Criminal Justice System Reach-in Care Coordination: To facilitate the transition of members transitioning out of jails and prisons into communities, AHCCCS is engaged in a data exchange process that allows AHCCCS to suspend eligibility upon incarceration, rather than terminate coverage. Upon the member's release, the member's AHCCCS eligibility is un-suspended allowing for immediate care coordination activities. To support this initiative the Contractor is required to participate in criminal justice system "reach-in" care coordination efforts.

The Contractor shall 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. Reach-in care coordination activities shall begin upon knowledge of a member's anticipated release date. The Contractor shall collaborate with criminal justice partners (e.g. Jails, Sherriff's Office, Correctional Health Services, Arizona Department of Corrections, including Community Supervision, Probation, Courts), to identify justice-involved members in the adult criminal justice system with physical and/or behavioral health chronic and/or complex care needs prior to member's release. When behavioral health needs are identified, the Contractor shall also collaborate with the member's behavioral health Contractor (if the member's care is not integrated).

The Contractor shall report the Reach-In Plan to AHCCCS, as described below, in the annual Medical Management Plan and report outcome summaries in the Medical Management Evaluation, as specified in Section F, Attachment F3, Contractor Chart of Deliverables. The Contractor shall monitor progress throughout the year and submit quarterly reporting to AHCCCS, as specified in Section F, Attachment F3, Contractor Chart of Deliverables, of the number of members involved in reach-in activities. In addition, AHCCCS may run performance metrics such as emergency room utilization, inpatient utilization, reduction in recidivism and other access to care measures for the population to monitor care coordination activities and effectiveness.

Reach-in Plan Administrative Requirements: 1. Designation of a Justice System Liaison who will be responsible for the reach-in initiative and who: a. Resides in Arizona, b. Is the single point of contact to communicate with justice systems and c. Is the interagency liaison with the Arizona Department of Corrections (ADOC), County Jails, Sherriff's Office, Correctional Health Services, Arizona Office of the Courts (AOC) and Probation Departments 2. Identification of the name(s) and contact information for all criminal justice system partner(s) 3. Description of the process for coordination with Maricopa County jail, if appropriate, for identification of those members in probation status 4. Designation of parameters for identification of members requiring reach-in care coordination (e.g. definition of chronic and/or complex care needs) through agreement with reach-in partners 5. Description of the process and timeframes for communicating with reach-in partners 6. Description of the process and timeframes for initiating communication

with reach-in members 7. Description of methodology for assessment of anticipated cost savings to include analysis of medical expense for these identified members prior to incarceration and subsequent to reach in activities and release.

Reach-in Plan Care Coordination Requirements: 1. Develop process for identification of members meeting the established parameters for reach-in care coordination (chronic and/or complex care needs). The Contractor must utilize the 834 file data provided to the Contractor by AHCCCS to assist with identification of members. The Contractor may also use additional data if available for this purpose. 2. Strategies for providing member education regarding care, services, resources, appointment information and health plan case management contact information 3. Requirements for scheduling of initial appointments with appropriate provider(s) based on member needs; appointment to occur within 7 days of member release. Strategies regarding ongoing follow up with the member after release from incarceration to assist with accessing and scheduling necessary services as identified in the member's care plan 5. Should re-incarceration occur, strategies to reengage member and maintain care coordination 6. Strategies to improve appropriate utilization of services 7. Strategies to reduce recidivism within the member population 8. Strategies to address social determinants of health
The Contractor must notify AHCCCS upon becoming aware that a member may be an inmate of a public institution when the member's enrollment has not been suspended, and will receive a file from AHCCCS as specified in Section D, Paragraph 54, Capitation Adjustment.

Appendix B: Colorado MCO Contract Excerpts

Behavioral Healthcare Base Contract:

2.4.2.4.2.5. Members involved with the correctional system

2.4.2.4.2.5.1. The Contractor shall collaborate with agencies responsible for the administration of jails, prisons and juvenile detention facilities to coordinate the discharge and transition of incarcerated adult and child/youth Members. Exhibit A Page 19 of 86

2.4.2.4.2.5.2. The Contractor shall ensure Members receive medically necessary initial services after release from correctional facilities and shall ensure ongoing services thereafter. The Contractor shall provide the continuation of medication management and other behavioral health care services prior to community reentry and continually thereafter. The Contractor shall have a plan in place for monitoring and reporting results semi-annually to the Department. Contractor shall include historical results, analysis, and trends in subsequent semi-annual submissions to the Department.

2.4.2.4.2.5.2.1. DELIVERABLE: Post-Correctional System Member Service Results.

2.4.2.4.2.5.2.2. DUE: Semi-annually, by August 31st and February 28th of each year.

2.4.2.4.2.5.3. The Contractor shall designate a staff person as the single point of contact for working with correctional facilities (e.g., jails, prisons, and juvenile detention facilities, etc.) that may release incarcerated or detained Members into the Contractor's Service Area.

2.4.2.4.2.5.4. The Contractor shall collaborate with correctional facilities to obtain medical records or information for Members who are released into the Region, as necessary for treatment of behavioral health conditions.

2.4.2.4.2.5.5. The Contractor shall work with the Department on any other initiatives including but not limited to Medicaid eligibility issues related to Members involved or previously involved with the state correctional system.

2.4.2.4.2.5.6. The Contractor shall propose innovative strategies, the use of new or existing technology, communication protocols/strategies and coordination techniques with the courts, parole officers, police officers, correctional facilities and their staff, and other individuals needed to meet the requirements of Members involved with the correctional system. This information shall be provided on a template provided by the Department or Contractor. The template is subject to approval by the Department.

2.4.2.4.2.5.6.1. DELIVERABLE: Correctional System Strategies and Techniques.

2.4.2.4.2.5.6.2. DUE: Within sixty (60) days after the Operational Start Date or later if agreed upon by the Department and the Contractor.

Regional Care Coordination Organization Contract:

6.4.14. The Contractor shall provide the Department with a report outlining its care coordination activities. The Contractor shall submit the report using a template that has been mutually agreed upon by the Contractor and the Department. The report shall describe the Contractor's approach to care coordination and stratification of Members within their region and shall contain, at a minimum, narrative and statistics that address the following:

6.4.14.1. Direct care coordination activities of the contractor:

6.4.14.1.1. The number of unique Members for whom care coordination services were provided by the Contractor during the reporting period.

6.4.14.1.2. The number of FTE, including level of licensure, the Contractor has dedicated and applied to care coordination.

6.4.14.1.3. The number of new care coordination cases initiated by the Contractor within the reporting period, reported separately for each of the following groups to the extent that each group is identifiable via claims history:

6.4.14.1.3.1. Adult members.

6.4.14.1.3.2. Children.

6.4.14.1.3.3. Foster children.

6.4.14.1.3.4. Criminal justice involved (CJI) members.

6.4.14.1.4. The number of established and on-going care coordination

6.4.14.2. Delegated care coordination activities:

6.4.14.2.1. The number of entities to whom the Contractor has delegated care coordination responsibilities, including the number of FTE and level of licensure the delegated care coordination entity has dedicated and applied to care coordination. Exhibit B, Statement of Work Page 33 of 57

6.4.14.2.2. The number of unique Members for whom care coordination services were provided by a delegated entity during the reporting period.

6.4.14.2.3. The number of FTE, including level of licensure, the delegated entities have dedicated and applied to care coordination.

6.4.14.2.4. The number of new care coordination cases initiated by delegated entities within the reporting period, reported separately for each of the following groups to the extent that each group is identifiable via claims history:

6.4.14.2.4.1. Adult members.

6.4.14.2.4.2. Children.

6.4.14.2.4.3. Foster children.

6.4.14.2.4.4. Criminal justice involved (CJI) members.

6.4.14.2.5. The number of established and on-going care coordination cases that were on file with delegated entities during the reporting period.

Appendix C: Florida MCO Contract Excerpts

Florida's 2012 contract with Managed Care Plans:

"9. Community Services for Medicaid Recipients Involved with the Justice System

The Health Plan shall make every effort as follows to provide medically necessary community-based services for Health Plan enrollees who have justice system involvement:

- a. Ensure a linkage to pre-booking sites for assessment, screening or diversion related to behavioral health services;
- b. Provide psychiatric services within twenty-four (24) hours of release from jail, juvenile detention facility, or other justice facility to assure that prescribed medications are available for all enrollees;
- c. Ensure a linkage to post-booking sites for discharge planning and assuring that prior Health Plan enrollees receive necessary services upon release from the facility. Health Plan enrollees shall be linked to services and receive routine care within seven (7) calendar days from the date they are released;
- d. Provide outreach to homeless and other populations of Health Plan enrollees at risk of justice system involvement, as well as those Health Plan enrollees currently involved in this system, to assure that services are accessible and provided when necessary. This activity shall be oriented toward preventive measures to assess behavioral health needs and provide services that can potentially prevent the need for future inpatient services or possible deeper involvement in the forensic or justice system; and
- e. The Health Plan or its designee shall document efforts to develop a cooperative agreement with justice facilities to enable the Health Plan to anticipate enrollees who were Health Plan enrollees prior to incarceration who will be released from these institutions. The cooperative agreement must address arrangement for persons who are to be released, but for whom re-enrollment may not take effect immediately. All enrollees who were Health Plan enrollees prior to incarceration and Medicaid recipients who are likely to enroll in the Health Plan upon return to the community"

Florida's 2017 contract with Managed Care Plans:

"The Managed Care Plan shall maintain written procedures for identifying, assessing, and implementing interventions for enrollees with complex medical issues, high service utilization, intensive health care needs, or who consistently access services at the highest level of care. This shall include, at a minimum, the following:Ensure a linkage to pre-booking sites for assessment, screening or diversion related to behavioral health services for enrollees who have justice system involvement."

"Behavioral Health Problems. The Managed Care Plan shall provide outreach to homeless and other populations of enrollees at risk of justice system involvement, as well as those enrollees currently involved in this system, to assure that services are accessible and provided when necessary. This activity shall be oriented toward preventative measures to assess behavioral

health needs and provide services that can potentially prevent the need for future inpatient services or possible deeper involvement in the forensic or justice system.”