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Policy Brief

Toward a Comprehensive Model of Integration for Justice-Involved Individuals Using Medi-Cal Managed Care Organizations (MCOs)

February 2019

Executive Summary

There is growing recognition of the unique health and behavioral health needs of justice-involved individuals and the urgency of creating a more effective delivery system to provide those services. This policy brief describes a comprehensive model for integrating care for the justice-involved population. The model recognizes the central role of Medi-Cal Managed Organizations (MCOs) to coordinate health care services for its members – including the justice-involved population. But these plans can't do the job on their own. The model also relies on a collaboration with community health centers, state and local justice system agencies, and counties.

The core elements of the model include:

- **Expanded Role of Medi-Cal MCOs.** These health plans have responsibility and fiscal incentives for managing and coordinating the care of complex, high utilizing and costly Medi-Cal beneficiaries. Other states are already contracting with their Medicaid plans to undertake in-reach for prison and jail inmates who are medically fragile or SMI. The health plan could also coordinate the transfer of health records from prison and jail to the community provider and clinician.
- **Seamless Transition from Prison/Jail.** The process of transitioning health and behavioral health care for inmates should begin while they are still incarcerated. Pre-release planning should assist inmates in obtaining eligibility for health and social service entitlement programs, help obtain valid identification, assist Medi-Cal eligible individuals with health plan selection, set up appointments with community providers, coordinate transfer of medical records, obtain appropriate release of information authorization, and facilitate communication between institution and community clinicians. A proposal to create a transitions hub for medically fragile CDCR inmates is discussed.
- **Specialized Provider Network.** A health plan could establish a provider network that offered a medical home option for prepared to serve justice involved

individuals. These providers would have more familiarity with the criminal justice system and could be better equipped to either provide mental health and SUD services themselves or coordinate treatment with the county behavioral health departments.

- **Community Health Workers (CHWs).** Providing justice-involved individuals the help of a person with an understanding of the criminal justice system and the local health and behavioral health systems can increase the chances that transition to the community with be successful. CHWs who themselves have a history of incarceration will have shared life experiences that can build rapport and trust with the recently released individual. Ideally, these CHWs would support the transition process by that beginning while the inmate is still incarcerated. In the community, the CHWs would also be embedded with the clinical team.

- **Probation/Parole Engagement.** Probation officers and parole agents have a compelling interest in being part of the team that is coordinating treatment and care of the justice-involved individuals whom they are supervising. Both clinicians and public safety staff need to understand each other's roles and find a balance of appropriate information sharing about their common client.

- **Supplemental County Incentive Funding.** Counties have strong incentives to support effective programs that improve public safety, reduce recidivism and homelessness, and reduce jail costs associated with the care and treatment of seriously mentally ill and medically fragile inmates. A county might be willing to invest in a program that can reduce health and behavioral health jail costs.

- **Data Sharing and Performance Metrics.** The model also requires a robust data sharing system to allow for the health plan to facilitate a continuity of care when inmates leave the prison or jail by allowing the sharing of health records between the prison or jail and the community provider. The data system should also allow for the collection of performance measures that can provide evaluation and the feedback that can lead to improvements.

As part of the state's Medi-Cal 2020 waiver, nine counties have targeted formerly incarcerated individuals for their Whole Person Care (WPC) pilots. These pilots now operate under the auspices of the state's five-year waiver and are designed to coordinate health, behavioral health and social services to improve health outcomes of Medi-Cal beneficiaries who are high utilizers of the health care system. As the waiver's 2020 expiration date approaches, policy-makers are considering how to institutionalize the best practices that are emerging from Whole Person Care pilots and other innovative efforts to coordinate care for complex need individuals. The approach described in this policy brief suggests a potentially sustainable pathway to address this need.

Overview:

As state and county governments embrace greater efforts to improve the transition of individuals from incarceration to the community, and coordinate care for justice-involved individuals, there is need for exploring new models that are sustainable and can be integrated into the current health care delivery system's structure and culture of coverage. The challenge ahead is how to develop a comprehensive system of care that facilitates a collaboration with state and local criminal justice agencies, MCOs, county behavioral health agencies, community health workers, community health centers, and, importantly, the formerly incarcerated individuals themselves.

Many counties included the justice-involved population in their Whole Person Care (WPC) pilot proposals as part of the state's 1115 Medicaid Waiver process. Counties recognized the reentry population's exceptionally high rates of medical and behavioral health problems, and the need for improving this population's connections with medical, behavioral health, and other services upon discharge from jail and prison

There are currently nine approved WPC pilots (Contra Costa, Kern, Los Angeles, Mendocino, Placer, Riverside, San Mateo, Santa Cruz, and Small County Collaborative) that have specifically targeted the formerly incarcerated individuals. There are four counties that have program designs which directly engage local jails and/or probation departments in their collaborative efforts to serve the reentry population. (A detailed discussion of these pilots can be found in our June 2018 Policy Brief, Overview of Reentry Focused Whole Person Care Pilots.[1])

The state's 1115 Medi-Cal Waiver Whole Person Care (WPC) pilots are scheduled to end in 2020. Citing new CMS rules for future waivers relating to fiscal neutrality, DHCS staff are pessimistic that the state's current waiver would be extended. For counties with WPC pilots that target the justice-involved population, the challenge ahead is to sustain initiatives that are deemed to be successful. The policy framework, infrastructure and relationship building that has occurred in these WPC pilots should not be lost. Moreover, the lessons from WPC counties should be disseminated throughout the state so that other counties can benefit from what has been learned.

The model outlined in this policy brief suggests a comprehensive approach for meeting the unique needs of the justice-involved population. As more attention is focused on finding better ways to reduce recidivism and improve health and behavioral health outcomes, the core elements of this model are emerging and evolving. Progress is being made.

[1] http://calhps.com/reports/WPCBrief-6102018.pdf

Core Elements of a Comprehensive Model of Care for Justice-involved Individuals

- **Expanded Role of Medi-Cal MCOs.** Prior to the passage of the Affordable Care Act, most justice-involved individuals were either ineligible for Medi-Cal upon release or could not afford private health insurance. A 2008 survey of San Francisco county jails found that 90% of the people entering county jail had no health insurance.[2] The Affordable Care Act's Medicaid expansion to low-income, nondisabled adults under age 65 with incomes below 138% of the federal poverty level opened the door to health coverage for millions of Americans – including the previously uninsured who are involved with the criminal justice system. The federal government initially provided 100% of the cost of coverage for the newly eligible individuals, stepping down to a 90% match during 2020 and beyond.

  Over 80% of the Medi-Cal population is now served by managed care plans that receive a capitated payment for organizing and providing care. Particularly for medically fragile inmates with costly and complex medical needs, the capitated payment provides a fiscal incentive for plans to adopt strategies that keep former inmates out of emergency rooms and hospitals. This could include assistance in finding a medical home, scheduling initial appointments, pharmacy services and care coordination.

  California could institutionalize the relationship between MCOs and the reentry population through its contracts with the plans. Other states are already contracting with their Medicaid plans to undertake in-reach for prison and jail inmates who are plan members and are medically fragile or SMI. The health plan could coordinate the transfer of health records from prison and jail to the community provider. Appendix 1 summarizes the efforts in other states. (A full discussion and analysis is contained in our policy brief on Medicaid Managed Care Organization and Reentry.[3])

- **Seamless Transition from Prison/Jail.** The process of transitioning health and behavioral health care for inmates should begin while they are still incarcerated. In our model, pre-release planning should assist inmates in obtaining eligibility for health and social service entitlement programs, help obtain valid identification, assist Medi-Cal eligible individuals with health plan selection, set up appointments with community providers, coordinate transfer of medical records, obtain appropriate release of information authorization, and facilitate communication between institution and community clinicians.

  In most cases, California Department of Corrections and Rehabilitation (CDCR) does not have a protocol or procedures to ensure continuity of care and an effective

[2] Wang, Emily et al. 2008 "Discharge Planning and Continuity of Health Care: Findings from the San Francisco Jail." *American Journal Public Health*, 98 (12).

[3] http://calhps.com/wp-content/uploads/2019/01/Policy-Brief-MC-Managed-Care-model-Final.pdf

transition to community-based health care services. About 3,000 inmates or 6.5% of all releases are classified by CDCR as "high risk" because of their serious medical needs. This population is characterized by complex, costly health conditions that require extensive care coordination and care continuity following release into the community. The vast majority are eligible for Medi-Cal and will become Medi-Cal managed care plan enrollees.

To address the need, the CalHPS Reentry Health Project facilitated a series of discussions that included CDCR's Health Care Services, L.A. Care and Partnership Health Plan, the Transitions Clinic Network, and several community health centers. A proposal to establish a CDCR Transition Hub emerged from these discussions. (See Appendix 2)

The Transitions Hub proposal addresses the need for a process for coordination and pre-release planning of complex, chronically ill state prison inmates who are returning to their communities from state prison. It proposes the establishment of a five-year demonstration project to determine the effectiveness of a care coordinator model that would provide pre-release planning and coordination to facilitate the transition of medically fragile inmates to the community. Administered through a hub that would serve multiple prisons, the model would rely on specially trained community health workers with histories of incarceration as well as clinical staff to engage inmates prior to their release. The hub staff would assist CDCR's Transitional Case Management Program (TCMP) in Medi-Cal eligibility where needed, help inmates with health plan selection, set up appointments with community providers, coordinate transfer of medical records, and serve as a liaison between CDCR Health Care Services and community based clinical services. The project would include an evaluation component to determine effectiveness and potential savings. The cost of the five-year project, including evaluation, is estimated at $5 million.

Los Angeles County's Whole Person Care (WPC) pilot is undertaking a similar effort for inmates who are transitioning from jail. The program aims to enroll roughly 1,000 LA County jail inmates per month who are eligible for Medi-Cal, are high utilizers of health or behavioral health services, and are at high risk due to chronic medical conditions, mental illness, substance use disorders, homelessness, or pregnancy. An additional 400 individuals per month recently released from custody will be enrolled from the community, via referrals from Probation, CDCR, and community-based reentry services agencies. The pilot provides both pre- and post-release services. The following services are provided pre-release (in jail):

- In-person meetings within the first 3 days of custody, to conduct a comprehensive psychosocial assessment and develop a re-entry care plan;
- Increased Medi-Cal enrollment efforts (enrollment starting at jail intake for activation after release);
- Referrals to local Homeless Initiative programs (e.g., SSI advocacy program);

- Provision of a discharge medical or behavioral health visit;
- Provision of a 30-day supply of prescription medication at release for participants with chronic health or mental health conditions;
- Generation of a "Continuity of Care Document" for transmittal to the participant's health care provider in the community;
- Establishment of a Whole Person Care release desk to arrange transportation, shelter or other services for those being released with little notice; and
- An in-person or video-conference visit with the Community Health Worker (CHW) to be assigned to the participant in the community, to establish a point of contact upon release.

The WPC Reentry post-release program connects participants to CHWs with a prior personal history of incarceration. CHWs assist participants to effectively engage with community-based health, behavioral health, and social service providers as they return to the community. The following services are provided post-release:

- Mentorship and social support;
- Health and social service navigation;
- Linkage to housing, employment, education, legal assistance and social supports;
- Accompaniment to key health and behavioral health appointments
- Assistance with adherence to treatment and medication regiments; and
- Connection to transportation.

- **Specialized Provider Network.** A health plan should establish a provider network to specifically provide a medical home option for justice involved individuals. These providers would have more familiarity with the criminal justice system and could be better equipped to either provide or coordinate treatment with the county behavioral health department for mental health and SUD services. Ideally, FQHCs or other community clinics that both provide comprehensive health services and behavioral health care could offer a trusted, one-stop shop for the justice-involved population. Clinical and administrative staff at these health centers could be receive training to better understand the unique needs of the justice-involved population, reduce stigma, address trauma, and establish protocols for coordinating with criminal justice agencies. Providers in the specialized network would provide patient center services (i.e., access to primary care services within two-weeks of release from custody; behavioral health; medication assisted treatment for SUDs; and access to housing, social services, education & employment support and other community programs for the reentry population).

  The concept of a specialized provider network is not unique. For example, the Inland Empire Health Plan in Riverside and San Bernardino counties has a specialized network of providers to serve its beneficiaries in the foster care system. However, until recently, there have been a limited number of providers that

now provide specialized health care services to meet the unique needs of the justice-involved population.

A new initiative to create a specialized provider network is being led by the Transition Clinic Network (TCN). TCN has developed a model of care that is specifically tailored to meet the needs of the justice-involved population transitioning from custody. Starting in 2006 with a pilot project in a San Francisco community health center, the model has spread and now links together 29 clinics in twelve states, including eight in California. The use of community health workers with a history of incarceration is a component of the model. An evaluation published in Health Affairs found that the TCN model reduced emergency room visits and hospitalizations in half.[4]

The California Health Care Foundation (CHCF) is now supporting the expansion of the TCN model to up to twenty-five new sites in California. The initial cohort of clinics includes thirteen sites. Each site was responsible for funding the CHWs that will be embedded in the clinic team that serves the justice-involved population. A policy brief published by CHCF identifies funding strategies to pay for CHWs in these clinics. [5]

- **Community Health Workers (CHWs).** Providing justice-involved individuals the help of a person with an understanding of the criminal justice system and the local health and behavioral health systems can increase the chances that transition to the community with be successful. CHWs who themselves have a history of incarceration will have shared life experiences that can build rapport and trust with the recently released individual. Ideally, these CHWs would be embedded in the clinical team. They may be the "secret sauce" for effective engagement with the justice-involved population and if engaged with the individual before release they can provide a "warm hand-off" from jail or prison and help navigate the complex, and at times confusing local health care delivery system.

  CHWs play a central role in the Los Angeles WPC pilot program. These workers are stationed in county jail facilities and the community. To date, the Los Angeles WPC has hired about 50 CHWs. Five CHWs are full county employees and have passed LA Sheriff background checks. These workers are situated inside three of the Los Angeles county jails. Five other CHWs have passed their LA Sheriff background checks and are in the process of onboarding and training. There are approximately 35-40 CHWs that are deployed in community contracted sites. A total of 19 agencies have contracted with the Los Angeles WPC pilot program.

[4] Shira Shavit, et al. "Transitions Clinic Network: Challenges and Lessons in Primary Care for People Released from Prison," Health Affairs, June 2017. https://www.healthaffairs.org/doi/10.1377/hlthaff.2017.0089

5 "How To Pay for It - Financing Community Health Care Workers, CHCF, November 2018. https://www.chcf.org/wp-content/uploads/2018/11/HowToPayForCommunityHealthWorker.pdf

Both the jail and community-based CHWs are integral to Los Angeles county's WPC pilot success. The workers stationed in the jails are especially useful for improving the average rate of program follow-through among reentry participants. Additionally, ongoing training is a necessary component of the CHW program to provide institutional support and reduce burn-out.

- **Probation/Parole Engagement.** Probation officers and parole agents have a compelling interest in being part of the team that is coordinating treatment and care of the justice-involved individuals whom they are supervising. Both clinicians and public safety staff need to understand each other's roles and find a balance of appropriate information sharing about their common client.

  Placer and Riverside county have developed WPC pilots that directly engage their probation departments to meet the behavioral and physical health needs of high-risk individuals reentering the community.

  The Placer County Probation Department has dedicated probation officers to work closely with the Placer WPC team. These dedicated officers identify individuals who are within 90 days of scheduled release from jail and who also meet one or more of the WPC target population criteria. The Probation Officer also identify those individuals who are interested in working with the WPC Team to receive the support needed to transition back to the community. These officers connect the Placer WPC team with the individual and facilitate contact at the time of release from jail.

  The Riverside County WPC has embedded specialized nurses at each probation reporting center. New probationers and individuals on Post-Release Community Release (PRCS) must report to their local Probation Department Office within 48 hours. A nurse is housed at each Probation Department Office. The nurse enrolls the probationer into the screening part of the WPC pilot and evaluates the individual for pilot eligibility. The probationer is screened for the following: length of time on probation (minimum 12 months), at-risk of or experiencing homelessness, social needs, Medi-Cal eligibility, behavioral health needs, and physical health needs. The nurse then acts as a direct liaison to facilitate the connection of that individual with the primary care resources they require. Based on screening results, the nurse will coordinate follow-up appointments.

- **Supplemental County Incentive Funding.** Counties have strong incentives to support effective programs that improve public safety, reduce recidivism and homelessness, and control jail costs associated with the care and treatment of seriously mentally ill and medically fragile inmates. As jails face increasing scrutiny for health and behavioral health care provided to incarcerated inmates, these costs are rapidly escalating. Further, up to 90% of the treatment and medication costs could be reimbursed by the federal government, if the services are provided in the

community. A county might be willing to invest in a specialized network of providers for the justice-involved population if true, off-setting savings could be demonstrated through lower jail costs. Additional local funding could be used to provide incentive payments to providers in the specialized network to pay for the extra costs of the population and for services that are not otherwise matchable for federal financial participation (FFP).

- **Data Sharing and Performance Metrics.** The model also requires a robust data sharing system to allow for the health plan to facilitate the transfer of medical records when inmates leave the prison or jail. The data system should also allow for the collection of performance measures that are tied to evaluate the approach and provide feedback that can lead to improvement.

Appendix

1. 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 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 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. Massachusetts's success is in part due to extensive collaboration and the efforts of multiple task forces.
Ohio	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."
Rhode Island	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.

Appendix 2. CDCR Health Transition Hub Proposal

CDCR Health Transitions Hub
Facilitating Community Health Care of Complex, Chronically Ill Prison Inmates

I. Executive Summary:

This proposal addresses the need for a process for coordination and pre-release planning of complex, chronically ill state prison inmates who are returning to their communities from state prison. In most cases, the California Department of Corrections and Rehabilitation (CDCR) does not have a protocol or procedures to ensure continuity of care and a effective transition to community-based health care services. About 3,000 inmates or 6.5% of all releases are classified by CDCR as "high risk" because of their serious medical needs. This population is characterized by complex, costly health conditions that require extensive care coordination and care continuity following release into the community. The vast majority are eligible for Medi-Cal and will become Medi-Cal managed care plan enrollees.

This proposal recommends the establishment of a five-year demonstration project to determine the effectiveness of a care coordinator model that would provide pre-release planning and coordination to facilitate the transition of medically fragile inmates to the community. Administered through a hub that would serve multiple prisons, the model would rely on specially trained community health workers with histories of incarceration as well as clinical staff to engage inmates prior to their release. The hub staff would assist Transitional Case Management Program (TCMP) in Medi-Cal eligibility where needed, help inmates with health plan selection, set up appointments with community providers, coordinate transfer of medical records, and serve as a liaison between CDCR Health Care Services and community based clinical services. The project would include an evaluation component to determine effectiveness and potential savings. The cost of the five-year project, including evaluation, is estimated at $5 million.

This proposal includes the following:

- Background
- Proposed Target Population
- Description of the Clearinghouse Model
- Budget
- Evaluation and Potential for Sustainability.

II. Background

The California Department of Corrections and Rehabilitation (CDCR) spends over $3 billion to provide health and mental health services for its 120,000 inmates. This represents about 25% of CDCR's 2018-19 budget. Criminal justice populations have disproportionate rates of chronic physical and mental health problems relative to the general population.[6] As the state's prison inmate population continues to age, these costs are likely to increase. 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%.[7]

As the quality of institutionalized care has improved along with higher costs, greater attention is being focused on the needs of inmates who are returning from prison to their communities. 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 was drug overdose, cardiovascular disease, homicide, and suicide.[8] Another 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 twelve by 90 days, a rate much higher than in the general population.[9]

Prior to the passage of the Affordable Care Act, most individuals returning from incarceration were uninsured and mainly relied on community safety net clinics and hospitals for their care. The expansion of Medi-Cal eligibility to include low income childless adults has dramatically increased the percentage of formerly incarcerated individuals who can access Medi-Cal services, which are provided in most cases through managed care plans.

As part of CDCR's pre-release planning process, inmates receive assistance for accessing health coverage, SSI and other benefits upon release from prison. This process generally begins approximately 90-120 days prior to release. According to the latest California Rehabilitation Oversight Board (C-ROB) report, as of 2017, 100% of statewide inmate releases are screened for benefit eligibility.[10] However, inmates are generally unable to pick their Medi-Cal managed care plan until they return to the community.

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[6] 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). [Link]

[7] Grattet, Ryken and Joseph Hayes. 2015. "California's Changing Prison Population." *PPIC*. [PDF]

[8] Binswanger, Ingrid et al. 2007. "Release from Prison — A High Risk of Death for Former Inmates." *New England Journal of Medicine*, 356(2). [PDF]

[9] Wang, Emily et al., 2013. "A High Risk of Hospitalization Following Release From Correctional Facilities in Medicare Beneficiaries." *JAMA Internal Medicine*, 173(17). [Link]

[10] California Rehabilitation Oversight Board. 2017. "Annual Report."

With the exception of counties that are served by a County Organized Health System (COHS), Medi-Cal beneficiaries have a choice of health plan offered in their county. In COHS counties there is only one plan.[11] Enrollment is a Medi-Cal plan is mandatory for most Medi-Cal beneficiaries and if no plan is chosen, there is a default process that places the beneficiary in a plan based on an algorithmic formula.

For individuals returning to the community, it may take 30-60 days following release before they are enrolled in a plan. The Medi-Cal beneficiary receives fee-for-service Medi-Cal during this interim period but does not have access to the benefits of being in managed care such as access to a medical home, and specialists. This delay can be highly problematic for individuals with serious or chronic medical conditions.

In most cases, CDCR does not have a protocol or procedures to ensure continuity of care and an effective transition to community-based health care services. This lack of coordinated care impacts patients' health outcomes and utilization in the community. Direct referral to primary care-based health services is associated with lower emergency department and hospitalization rates in chronically ill patients post release from incarceration.[12] Successful transitional pre-release planning requires a a clear idea of where to direct the individual to ensure continuity of care. But at present, there is no one to refer the inmate to until the inmate knows where he or she selects a health plan and identifies a primary care provider.

At the provider level, a variety of approaches are being utilized to address the unique needs of justice-involved individuals who are transitioning from prison and jails. Key elements include establishing a medical home that provides patient-centered care and uses Community Health Workers (CHWs) who help facilitate a continuity of care as the individual leaves custody. CHWs also help formerly incarcerated individuals navigate the complex health and social service delivery systems in the community.

The Transitions Clinic Network (TCN) works with health systems to implement the Transitions Clinic (TC) model of care, a cost-savings, evidence-based program that improves health and reentry outcomes among chronically ill individuals returning from incarceration. First started in San Francisco, TCN, an affiliate of University of California, San Francisco, supports health systems in caring for chronically ill individuals returning from incarceration. The TCN model of care has been successfully implemented in community-based clinics in 11 states and Puerto Rico. All TCN programs employ CHWs, who have a personal history of incarceration. The CHWs play an integral role as part of their clinical team that provides health and behavioral health care services. They also address the social determinants of health (housing, employment, food security, etc.). In this model, the CHWs connect with inmates while still incarcerated and help with

[6] There are six COHS operating in twenty-two counties. https://healthconsumer.org/wp/wp-content/uploads/2016/10/County-Organized-Health-System-Medi-Cal-Plans.pdf

[12] Shavit S, Aminawung JA, Birnbaum N, et al. Transitions Clinic Network: Challenges And Lessons In Primary Care For People Released From Prison. Health Aff (Millwood) 2017;36:1006–15

enrollment in Medi-Cal and care coordination when the inmate is released. In California, in reach to incarcerated patients via CHWs is occurring in San Quentin State Prison, Solano and Santa Clara County jails, and in the Los Angeles jail as part of the county's Whole Person Care pilot. When Santa Clara County jail began allowing CHWs to connect to patients prior to release show rates for post release primary care appointments increased from 30% to 70%.[13]

In addition to improving patient engagement, there is compelling evidence that improved coordination and the use of CHWs can improve care and reduce costs by keeping patients out of emergency rooms and hospitals. A randomized controlled trial conducted at the Southeast Health Center, a Transitions Clinic in San Francisco, demonstrated a 51% reduction in emergency department visits over 12 months, an average cost savings of $912 per patient.[14]

Medi-Cal managed care plans also have an incentive to engage medically complex and potentially costly inmates as early as possible. Several other states, including Arizona, Colorado, Florida, and Ohio, have negotiated provisions in managed care contracts to require their Medicaid health plans to engage with eligible individuals while they are still incarcerated and connect them to a managed care plan and to conduct outreach and coordination upon their release.

Arizona, for example, included a specific provision in its Medicaid managed care plan contracts requiring the plans to provide in-reach to individuals in jail and prison with complex medical needs. Staff with Arizona's Medicaid agency advised that health plans were persuaded that the intervention would be cost effective and would save money. No additional funding was provided. The contracts require plans to do the following:

- Implement 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.
- Collaborate with criminal justice partners 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 the member's release.
- Collaborate with the member's behavioral health contractor if the plan is not the behavioral health provider.

[13] Administrative data as reported by Dr. Ari Kriegsman, Santa Clara Valley Medical Center

[14] Wang, Emily et al. 2012. "Engaging Individuals Recently Released from Prison Into Primary Care." *American Journal of Public Health*, 109(2). [Link]. There is also preliminary data (Not published yet under peer review) showing that TCN programs reduce ambulatory care sensitive hospitalizations and shorten the length of stay of hospitalizations.

III. Initial Target Population: Complex, Chronically Ill Prison Inmates

For the purposes of the demonstration project, the medically fragile population within CDCR is suggested as an initial target population. This population is characterized by complex, costly health conditions that require extensive care coordination and continuity following release into the community.

CDCR's Correctional Health Care Services Division classifies this medically fragile population as being "High Risk 1s and 2s." In 2016-17 fiscal year, CDCR released 822 High Risk Priority 1s (1.9% of total releases), and 2,006 High Risk Priority 2s (4.6% of total releases). To be classified as "High Risk," an inmate must have one or more risk factors as described in the table 1.

For the initial phase of the Health Transitions Hub project, we recommend prioritizing coordination efforts on the ambulatory population of high risk, complex and chronically ill inmates. There is a critical need for coordination in the transition of inmates requiring skilled nursing home (SNF) level care, but most Medi-Cal managed care plans do not include long term care services in their benefit structure. As a carved-out Fee-For-Service benefit, there are additional challenges in finding an appropriate placement for these inmates. However, in some cases, the hub staff may be able to assist.

If the demonstration project is successful, the target population could be expanded to includes inmates with less intensive medical conditions (e.g., 12,400 inmates classified as "medium" health care risk or 29% of releases in 2016-17).

Table 1. CDCR Definition of High Risk (Priority 1 and Priority 2)

Flag	Description
High Risk Diagnosis/Condition	Patients identified as having a diagnosis classified as High Risk. These diagnoses or combination of conditions are deemed high risk due to current or future adverse health events. (Each condition "high Risk criteria is considered one risk factor. There are 31 conditions that are identified, e.g., HIV, Cardiomyopathy & Congestive Heart Failure, Cancer, Asthma, COPD, Diabetes, Seizures, Chronic Pain, etc.)
Multiple Higher Level of Care Events – Medical	Patients with two or more community hospital inpatient admissions (excluding admissions for acute/trauma related issues).
Prolonged Medical Bed Stay	Patients in Correctional Treatment Center (CTC), Outpatient Housing Unit (OHU) or Skilled Nursing Facility (SNF) for more than 80 days of the last 180 days in prison.
Multiple Higher Level of Care Events – Mental Health	Patients with three or more Mental Health Higher Level of Care Admissions.
Polypharmacy	Patients prescribed 13 or more medications.
High Risk Specialty Consultations	Patients with three or more appointments with a "high risk" specialist(s) (e.g., oncologists, vascular surgeon).
Advanced Age	Patients who are sixty-five years of age or older.
Multiple Medium Risk Diagnoses/Conditions	Four or more Medium Risk chronic conditions.

Source: CDCR – Correctional Health Care Services

IV. Description of Health Transitions Hub Model

The demonstration project proposes to establish a "Health Transitions Hub" staffed by community health workers and health care clinicians who would provide an interface between the medically high-risk inmates, CDCR medical staff and community providers and health plans.

The Health Transitions Hub would be responsible for pre-release health care coordination and planning for about three thousand high risk, medically high-risk inmates released annually – about 250 per month. Approximately 80% of CDCR's high risk, medically high-risk inmates are housed in four prisons: the California Medical Facility (CMF) at Vacaville, the California Health Care Facility (CHCF) at Stockton, R.J. Donovan in San Diego, and the California Institution for Men at Chino.

The Hub's administration would operate inside one of these institutions, which has the greatest volume of medically high-risk inmates. The Hub would initially focus on inmates being released from CMF and CHCF but would have the potential for expansion to serve medically high-risk inmates being released from any state prison.

The Hub's proposed staff would include: a supervising RN; a consulting physician; five CHW's who have lived experiences and have a personal understanding of the incarcerated population; and an administrative position to provide support for the team. The CHWs employed by the Hub would have shared life experiences and a history of incarceration.

To function effectively, the Hub would benefit by having a designated CDCR utilization management nurse position to help facilitate coordination with the correctional health services staff.

The Hub would develop a protocol in collaboration with the CDCR Health Care Services staff. A suggested timeline could begin 120 days prior to an inmate's release or sooner. The CHW assigned to that prison by the Hub would receive a patient summary indicating the patient's health care issues.

The CHWs, with supervision from the clinical staff, would do the following:

- Meet with the inmate in person or via a teleconference;
- Assist in health plan selection;
- Facilitate release of information;
- Provide patient education; (i.e. overdose prevention education, chronic disease self-management)
- Facilitate medical record transfer (with assistance of a CDCR Utilization Management Nurse);
- Assist in coordinating communication with prison-based clinicians and community providers.
- Patient activation and engagement
- Health utilization counseling (health system navigation, education about maximizing interactions with providers)
- Collaborate with other contracted providers to for SSI evaluation
- Collaborate with CDCR staff, parole and probation to address housing, other provided services related to behavioral health and social determinants of health.

- Referrals to relevant community-based services related to social determinants of health when available.

V. Proposed Budget

The demonstration project would require a total expenditure of $5 million over five years. This would include staffing for the clearinghouse and an evaluation of the projection. The CDCR would be authorized to enter into an Interagency Agreement with UCSF to contract with the Transitions Clinic Network (TCN), which would be responsible for implementing and managing the Hub. TCN is a nationally recognized leader in transforming the health care system to better serve formerly incarcerated individuals. TCN has run a medical discharge clinic out of San Quentin for the past decade.

VI. Evaluation and Potential for Sustainability

The demonstration project would include an evaluation to determine cost effectiveness and improved health care outcomes for the program participants. Specifically, the evaluation would provide information on ER visits, hospitalizations, and overall costs to Medi-Cal. The evaluation could also consider the impact on recidivism.

As noted earlier, other states have directed their Medicaid managed care plans to engage inmates who are former members of their respective plans and are returning to their communities. In these states, the Medicaid plans have recognized the potential for maintaining continuity of care for the high risk, medically fragile population as well as potential savings. The Hub demonstration project would help document the value of this approach.

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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.