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Supporting Incarcerated Individuals Transitioning to the Community: State and Health Plan Approaches and Lessons

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Background

Approximately 11 million people cycle through the United States' justice system each year.[i] Of these individuals, a disproportionately large number are young, nonwhite, low-income males. They are seven times more likely to suffer from mental illness, substance abuse, infectious disease, and chronic conditions than the rest of the population.[ii] Individuals often enter the justice system with exacerbated chronic conditions, as studies have found that 80 percent do not receive treatment in the year prior to arrest.[iii] In the first two weeks after release, these individuals have a mortality rate that is 12 times higher than the general public's.[iv] On top of these health issues, an estimated 60 percent of incarcerated individuals have incomes below 133 percent of the federal poverty level before arrest.[v]

Several states have implemented pre-release programs, which connect care coordinators with soon-to-be-released individuals and enroll or re-enroll them into Medicaid coverage and health plans. By ensuring immediate health care coverage, pre-release programs aim to increase access to services, build a continuum of care upon release, improve health outcomes, and foster successful re-entry into the community.

Individuals serving time in local jails are usually incarcerated for one-year or less or while they await trial or bond funding. The unpredictability of a release date makes it especially difficult to connect or reconnect individuals with coverage or a managed care organization (MCO), since the average jail releases more than 75 percent of incarcerated individuals within 72 hours.[vi] Since individuals sentenced for a year or longer are typically moved to state or federal prisons, connecting these individuals to health coverage prior to a release date is not quite as great a challenge.

Molina Healthcare, Inc. contracted with NORC at the University of Chicago to profile and study pre-release programs. This report highlights **Maryland's Presumptive Eligibility for Correctional Facilities** program, **New Mexico's Supporting Incarcerated Individuals Transitioning to the Community** program, and **Ohio's Medicaid Pre-Release Program**. The NORC team conducted an extensive review of relevant literature about pre-release care coordination programs, and held key stakeholder interviews. In the spring of 2017, eight interviews were conducted with key program and policy experts working for MCOs, state Medicaid agencies, a detention center, and other organizations. Although NORC did not obtain or analyze quantitative data, this issue brief includes limited quantitative information provided by Molina Healthcare of New Mexico.

Policy Levers that Support Pre-release Programs

Historically, Medicaid has played a very limited role in covering incarcerated individuals' healthcare costs. Federal Medicaid law prohibits the use of federal matching funds to pay for services provided to an inmate of a public institution except when the individual is a patient in a medical institution.[vii] However, multiple states have taken steps to help justice-involved individuals enroll in Medicaid immediately upon release thanks to new and strengthened federal policies that have removed barriers and provided a path to the establishment of pre-release care coordination programs across the U.S. The Affordable Care Act (ACA), passed in 2010, provides significant opportunities for states to address the healthcare needs of justice-involved individuals transitioning back to the community. In addition, states have the option to suspend, instead of terminate, an individual's coverage during their prison or jail term. Inmates' Medicaid eligibility is maintained, but the state Medicaid agency limits reimbursement to covered inpatient services in a medical institution.

The Affordable Care Act

- **Medicaid Expansion.** The ACA gives states the option of expanding Medicaid to non-disabled adults less than 65 years of age without dependent children with incomes below 133 percent of the federal poverty level. As of February 2018, 33 states and the District of Columbia have implemented an expansion[viii] and as a result many justice-involved individuals living in expansion states are now eligible for Medicaid coverage.[ix,1]
- **Presumptive Eligibility.** Presumptive eligibility is a Medicaid policy option that permits states to authorize qualified entities, such as federally qualified health centers, hospitals, and schools, to screen for Medicaid eligibility and temporarily enroll eligible individuals into Medicaid. The ACA expanded presumptive eligibility to include the Medicaid expansion population where most incarcerated adults fall, thus triggering state conversations on how presumptive eligibility can be leveraged to increase access to care. Most states have leveraged presumptive eligibility for inmates receiving in-patient services and/or are including presumptive eligibility as an option for inmates post-release. Other states are considering correctional facilities as a qualified entity to conduct presumptive eligibility determinations. For example, Maryland pursued a state plan amendment to allow the State to include correctional facilities as a qualified entity.

Suspension of Medicaid upon Incarceration. Benefits of suspension include greater ease to "re-activate" coverage than initiate a new application and to ensure timely coverage upon release.[x] Given the ACA expansions to presumptive eligibility and enrollment, many states are now exercising this option. As of July 2016, 16 states and the District of Columbia suspend coverage for the duration of an individual's incarceration. Fifteen states suspend Medicaid eligibility for a specific period of time (typically 30 days to one year) and the remaining states terminate Medicaid eligibility altogether.[xi] Not having to go through the eligibility and enrollment process anew when an individual is transitioned out of jail or prison reduces administrative burden on states and makes it easier to provide incarcerated individuals with post-release Medicaid-covered services.

Program Overviews

While the use of one or more of the three federal Medicaid policy levers discussed above are viewed as prerequisites to developing pre-release programs, our study found that strong state and community leadership and robust state and local interagency partnerships are essential to the success of the program. Buy-in from key stakeholders, such as detention center and prison staff, MCOs, and local health departments, is also critical. Each program we studied relies on (or is developing the framework for) care coordinators to work with incarcerated individuals. The key goals for both pre- and post-release are to better coordinate behavioral and physical health services, enhance medication adherence, decrease inappropriate emergency department utilization, and lower recidivism. In addition, each program coordinates (or plans to coordinate) connections for individuals to a broad spectrum of social services and resources, such as housing and employment support programs. Across the board, the programs studied are taking a holistic approach to addressing the needs of this population, focusing on individuals' medical, behavioral health, and social needs post-release.

Maryland

Maryland's expansion of Medicaid eligibility to low-income adults set the stage for the state to pursue a state plan amendment to designate correctional facilities as "qualified entities" for the purpose of determining presumptive eligibility for individuals who were unable to enroll in full Medicaid. Along with the goal to improve health coverage access for the justice-involved populations, these initiatives closely align with the state's efforts to boost access to opioid and other substance use disorder treatment. The Maryland Department of Health, where Medicaid is administratively housed, supports local health departments to conduct full Medicaid eligibility determinations in detention centers.

Set to launch in 2017 but pushed to 2018, the **Presumptive Eligibility for Correctional Facilities** program seeks to use presumptive eligibility as a secondary option for individuals who have challenges completing the full Medicaid application while incarcerated. Individuals who attempt, but do not complete, the full application are directed to the nearest local health department to complete the full application and enroll into an MCO upon release. In 2016, Maryland was selected to participate in the national **Connecting Criminal Justice to Health Care Initiative**, funded by the

[1] It should be noted, however, that while most incarcerated individuals in expansion states qualify for coverage, some states enroll only select groups of individuals, such as those with disabilities, while seven states (Minnesota, Alaska, Hawaii, Arizona, Montana, Louisiana, and Illinois) expanded Medicaid but did not implement large-scale enrollment programs. Signed Out Of Prison But Not Signed Up For Health Insurance. (2016, December 06). Retrieved from http://www.npr.org/sections/health-shots/2016/12/06/504443879/signed-out-of-prison-but-not-signed-up-for-health-insurance

U.S. Department of Justice Bureau of Justice Assistance.[xii] The initiative aims to increase coordination across all relevant health and criminal justice entities; improve data collection and exchange; leverage the available workforce; and ensure availability of appropriate resources. Through this initiative, the state Department of Health partnered with the Maryland Department of Public Safety and Correctional Services as well as health and detention centers within Baltimore, Harford, and Washington counties to explore the various models to develop the program currently being implemented statewide.

The Medicaid agency has allocated $3M to boost the enrollment workforce and resources across the 24 jurisdictions for pre-release enrollment activities. For phase two, the state is working towards introducing a care coordination connection into its justice-involved efforts.

New Mexico

Supporting Incarcerated Individuals Transitioning to the Community is the result of collaboration among the New Mexico Human Services Department (Medicaid agency), Molina Healthcare of New Mexico and the Metropolitan Detention Center in Bernalillo County, which is in Albuquerque. The goal of New Mexico's program is to address the healthcare and social needs of incarcerated individuals upon their release from the Metropolitan Detention Center. The program connects Molina care coordinators with soon-to-be-released individuals to educate them about Medicaid benefits, assess their healthcare and social needs, and develop an individualized post-release care plan.

In April 2015, the New Mexico legislature passed legislation to initiate the **Medicaid for Incarcerated Individuals Program,** which authorized the Medicaid agency to suspend, rather than terminate, Medicaid coverage for incarcerated individuals. Legislation also passed designating correctional facilities as qualified entities, which allows them to determine presumptive eligibility for incarcerated individuals.

This legislation set the stage for leadership within New Mexico's Medicaid agency, the Metropolitan Detention Center, and Molina Healthcare of New Mexico to work together to establish the pre-release care coordination program. More recently, in July 2017, the Human Services Department issued a Letter of Direction, indicating all Medicaid MCOs will be required to engage with the 27 participating statewide detention centers and provide care coordination before and/or after release, as appropriate.

Ohio

Ohio state legislature expanded its Medicaid managed care program in 2014. Beginning that year, the Department of Rehabilitation and Corrections, Department of Medicaid, the Mental Health and Addiction Services Department, and all contracted MCOs began developing the **Medicaid Pre-Release Enrollment Program.** Unlike the Maryland and New Mexico programs, the state opted to implement the program in prisons, due to the challenges inherent in implementing such a program with the jail population, as discussed earlier. Ohio is also the only state of the three interviewed that requires all MCOs serving the Medicaid population to participate in its pre-release care coordination program.

Exhibit 1 provides a summary of the Maryland, New Mexico and Ohio programs. As of December 2017, Maryland's transition services are enrollment only; some counties are doing more but these efforts are not tied directly to a state initiative. The state has another program that works with detention centers to provide mental health service and care coordination, but this does not fall under the Medicaid Agency and is separate from presumptive eligibility initiative. While each of these three state programs are evolving, they are all designing and implementing models that best fit the needs of their specific state, localities and populations.

EXHIBIT 1. PRE-RELEASE PROGRAM CHARACTERISTICS IN MARYLAND, NEW MEXICO, AND OHIO

State Program	Program Location	Implementation Date	Justice Facility	MCOs Involved	Enrolled Members
Maryland: Presumptive Eligibility for Correctional Facilities	Statewide	July 2017	Jails Prisons in development	No	N/A
New Mexico: Care Coordination Program for Jail-Involved Members	Bernalillo County	June 2016	Jail	1 MCO (August 2017)	366 (January 2018)
Ohio: Medicaid Pre-Release Program	Statewide	Sep 2014	Prisons	All (5 total)	~19,000 (December 2017)

Importance of Leadership Support from All Key Partners, Communication among Partners and Adequate Timing for Program Design, and Implementation

Importance of Support from All Partners. The importance of strong advocates and program champions across all partners to ensure adequate funding and program support was a key theme of every person interviewed. Champions educate others about program benefits and highlight the potential return on investment to the state, local communities, health plans and their members and other stakeholders. Additionally, strong program leaders identify creative ways to link and utilize existing structures to build economies in the programs, such as using existing portals for program training or streamlining processes.

Securing MCO buy-in is critical, but can be a challenge, since MCOs are not directly compensated for pre-release activities when individuals are incarcerated, because Medicaid coverage is suspended.[2] To address this challenge, Ohio mandates MCO participation. In New Mexico, all MCOs expressed interest, though Molina was first to partner with the Metropolitan Detention Center as a pilot program. At the time of our interview with Maryland Medicaid officials, a formal conversation with MCOs about their involvement was being planned as part of its phase two approach.

Strong stakeholder partnerships must start at the earliest stages of planning and development. This was an important theme expressed by those we interviewed. In New Mexico, project pre-planning involved staff from all parties – the state Medicaid Agency, the Metropolitan Detention Center, and Molina Healthcare of New Mexico. Molina staff noted the invaluable and critical support received from Medicaid agency partners in cutting through red tape that might have otherwise prevented care coordinators from gaining necessary access to the Metropolitan Detention Center to do their work.

Communication among Partners. One common challenge across programs is the different vocabulary used among the various partners involved in developing the program; understanding each partners' language to facilitate inter-agency communication is particularly important during start-up (e.g., member or enrollee, retroactive eligibility, eligibility suspension, protected filing dates on the healthcare side versus inmates, lockdowns, charge sheets, and detention versus arrest on the justice side).

Timing of Program Implementation. New Mexico's planning took a full year before the "soft" start of the pilot program in June 2016. For one month before implementation, Metropolitan Detention Center staff worked with Molina members to educate them on the program and reported back to Molina and the state about the interest of individuals in participating. The "soft" start gave Molina and the Metropolitan Detention Center the time needed to work out design and technical issues prior to the "hard" start. The program was fully implemented on July 1, 2016, when Molina care coordinators began meeting in the jail with enrollees. Ohio also used a phased-in approach and first launched its program statewide in women's prisons, with all 27 state prisons and populations added by the end of 2016.

Partnerships with State and Local Agencies, and Community Organizations

Creating partnerships among state and local agencies, community organizations, correctional facilities, and MCOs, if applicable, is a necessary ingredient to successful pre-release programs. Common partnerships include those with housing and employment support services, healthcare providers, peer recovery and substance use organizations, pharmacies, and pre-trial services and custody programs.

Each program utilizes resources and partnerships with different state agencies for needed services. For example, in New Mexico, members are assigned to social service coordinators at the Metropolitan Detention Center, who are the initial referral source to other agencies, including Molina. Molina also partners with the Albuquerque Center for Hope and Recovery to provide its jail-involved members with peer support, behavioral health services, job development, computer labs, and support groups. Members are also connected with transition services provided by the University of New Mexico Hospital to address psychiatric, forensic, behavioral, and social needs. A Community Custody Program with a triage room where Molina care coordinators can meet with members and work with them to address their needs is projected to open in May 2018. The Molina offices are located one block from the anticipated location of this triage space; Molina staff work with members who stop by the Molina offices any time during business hours.

[2] Suspension occurs when a member has been incarcerated for greater than 30 consecutive days.

In Ohio, partnerships between MCO care coordinators and parole officers help to coordinate successful transitions back into the community. In Maryland, the Medicaid Agency works with local health departments because of their strong connections with location detention centers, their role in Medicaid enrollment, and the on-site behavioral health and social services most provide.

Program Operations

Building Program Staff Capacity and Ensuring Safety. Employing the right staff to work on pre-release programs is another key component for program success. Molina Healthcare of New Mexico identified two male care coordinators with relevant experience, who were interested in working on the program. They work with both the male and female populations at the detention center. One of these care coordinators is bilingual and serves the detention center's large Spanish-speaking population. Molina Healthcare of New Mexico also chose its care coordinators based on their job knowledge, approachability and ability to build rapport with incarcerated individuals. As of August 2017, the detention center had 12 social service coordinators, who coordinate care and provide case management for all individuals during their incarceration. A program manager and a social service supervisor, who serve as points of contact for the MCOs, oversee these coordinators. After referral, one social service coordinator is dedicated to assisting those who have selected Molina Healthcare of New Mexico as their health plan, introducing the individual to a Molina care coordinator and helping with program-related case management activities.

As in other states, Ohio MCOs carefully choose the care managers assigned to the program. For example, Molina Healthcare of Ohio assigned 12 case managers, primarily nurses and social workers, to the program. Staff were selected based on their previous experience or interest in the population and program. In Ohio, the prisons leverage Peer-to-Peer Medicaid Guides to educate their peers about the availability of the pre-release program and the benefits of care coordination. Incarcerated individuals are selected to participate as Guides as a reward for good behavior and are then given training to help them support and educate their peers.

In Maryland, local health department staff have presence in more than 80 percent of jails to conduct Medicaid determinations and are in the final stages of identifying staff in the remaining 20 percent. Maryland hopes to leverage these trained and screened health department staff, who are permitted to enter the county jails to assist with care coordination services as well.

Addressing the safety of care coordinators working within justice facilities is also critical. The Metropolitan Detention Center provides private, supervised rooms within the units where care coordinators meet with incarcerated individuals. Other safety concerns are addressed by not allowing incarcerated individuals to have any physical contact during meetings with care coordinators. The care coordinators notify the social services staff and guard for each unit prior to meeting with a member to ensure they are aware in case of a lockdown or other security issue. In Maryland, detention centers provide health suites in secured areas to address safety concerns and ensure health department staff entering the facilities are properly trained and oriented by detention center staff prior to starting their work. Ohio leverages existing video-conference capabilities, allowing care managers to meet remotely with incarcerated individuals throughout its 27 state prisons.

Training MCO Staff. Both state and MCO leadership highlighted the importance of thorough training for care coordination or care management staff regarding jail or prison policies, processes, safeguards and operations, as well as Medicaid program policies. In New Mexico and Ohio, MCO staff training occurs both inside and outside of the justice facilities. Molina care coordinators in New Mexico undergo the same training as correctional officers; the Metropolitan Detention Center provides jail orientation and tours of the facility, as well as safety courses prior to engagement with the facility, e.g. Defensive Tactics, Inmate Con Games, and Prison Rape Elimination Act training. Tours of the detention center allow care coordinators to observe procedures and increase their familiarity with the jail environment. Molina care coordinators in New Mexico have badges that allow them access to all Metropolitan Detention Center units and meeting rooms to meet with members. In Ohio, training for MCO care managers includes facility tours and meetings with Peer-to-Peer Guides.

Information Technology (IT) Infrastructure and Data Sharing. Leveraging existing technology is one of the biggest challenges noted by program leadership. Modifying existing IT systems to interface and communicate with each other is listed as key to optimizing resources and time and for smooth program operation and cost-effectiveness.

Initially, Ohio manually shared data among all involved parties (Department of Medicaid, Ohio Department of Rehabilitation and Correction, prisons, and MCOs). Different parties used email, calls, or a portal to securely share files. Ohio has since moved to sharing most data on a centralized secure site, significantly improving cross-agency sharing. For example, re-enrollment forms are completed by incarcerated individuals and stored on the site. In New Mexico, the Human Services Department and the Metropolitan Detention Center complete an automated daily data exchange of incarcerated or released members, which is shared with all MCOs. Similar to New Mexico, the Maryland Department of Health and the Maryland Department of Public Safety and Correctional Services exchange incarceration data daily. This information is used to suspend Medicaid enrollees who become institutionalized in prisons only. Maryland is in the process of making similar arrangements with local detention centers.

Eligibility and Enrollment Processes

State eligibility and enrollment processes require strong coordination and data sharing across agencies and involved entities. These processes include a multi-stepped approach that leads up to release and post-release care coordination. Exhibits 2 and 3 provide an overview and comparison of the data sharing, eligibility and enrollment processes and steps for New Mexico and Ohio, which are currently in operation.

EXHIBIT 2. NEW MEXICO AND OHIO ELIGIBILITY AND ENROLLMENT STEPS

New Mexico	Ohio
New Mexico Eligibility Determination ▪ The state Human Services Department (Medicaid Agency) sends an automated and updated eligibility roster, which includes Medicaid status and detention location to Molina every day. Once a member has been incarcerated for 30 days, their status changes to "incarcerated" and their Medicaid status changes to "suspended." ▪ The Metropolitan Detention Center identifies the members who are eligible for care coordination. Social service coordinators at the detention center, trained as presumptive eligibility determiners, have access to the state's eligibility portal and pre-screen Molina members to ensure eligibility for the pilot program. ▪ The Metropolitan Detention Center sends voluntary program participant referrals to Molina. Molina also provides MDC with a list of "high utilizers", or those who have incurred greater than $5,000 in claims. ▪ In addition to data exchanged between Molina and the state, the detention center sends the state its in-custody and releasing lists daily; the state sends back the benefit status of incarcerated individuals daily.	**Ohio Eligibility Determination** ▪ The Ohio Department of Rehabilitation and Corrections screens individuals and identifies those with Critical Risk Indicators who are also eligible for pre-release care management.[3] ▪ The Department of Rehabilitation and Corrections then sends MCOs a list of incarcerated individuals who have enrolled in their plan and includes information on who meets particular Critical Risk Indicators. ▪ All three entities (MCOs, the Department of Rehabilitation and Corrections, and the Ohio Department of Medicaid) have access to the secure site and use it to share and obtain information. Documents are stored on the site and users can work from forms already online.
New Mexico Enrollment in the Pre-release Program ▪ Detention center staff educates eligible incarcerated individuals on the program. If interested, the member signs consent and release of information forms. ▪ Detention center staff completes a pre-screen form with the member to collect initial demographic, contact information, criminal history including repeat offender status, type of charges, parole officer, bond information, anticipated court date, and current legal status and sends this to Molina. The following week, participants meet with a Molina care coordinator in the jail. This is followed by the completion of both a Health Risk Assessment[4] and an initial face-to-face Comprehensive Needs Assessment (as needed).[5] This assessment is completed within 60 days prior to release with all individuals referred by MDC. ▪ Post-release touch points are required in the home and electronically per Medicaid contractual requirements.	**Ohio Enrollment in the Pre-release Program** ▪ Incarcerated individuals participate in a pre-enrollment class approximately 90 to 120 days before release.[6] ▪ Interested individuals fill out the necessary paperwork and select an MCO. ▪ Medicaid eligibility is determined and, if eligible, the individual is enrolled in the selected MCO. ▪ The MCO care manager conducts a video conference with the individuals identified as having Critical Risk Indicators to discuss and revise, if necessary, the draft transition plan. ▪ For those who meet Critical Risk Indicator's criteria, upon release, individuals receive a Medicaid health plan ID card. Within five days of release, the member and MCO care manager meet about the transition process.

[3] Critical Risk Indicators include infectious disease or having at least two out of the three: serious mental illness, chronic condition, or recovery services level of care.

[4] Collects contact information as well as physical, mental, and long-term health care needs.

[5] Required by HSD, the FCNA identifies the last time the participant met with a PCP or behavioral health provider and any needs related to activities of daily living, housing, or employment.

[6] For additional information on pre-enrollment and enrollment classes, see 'Care Management, Coordination, and Engagement' below.

EXHIBIT 3. SUMMARY OF SIMILARITIES BETWEEN NEW MEXICO AND OHIO ENROLLMENT AND DATA SHARING PROCESSES FOR PROGRAM PARTICIPANTS

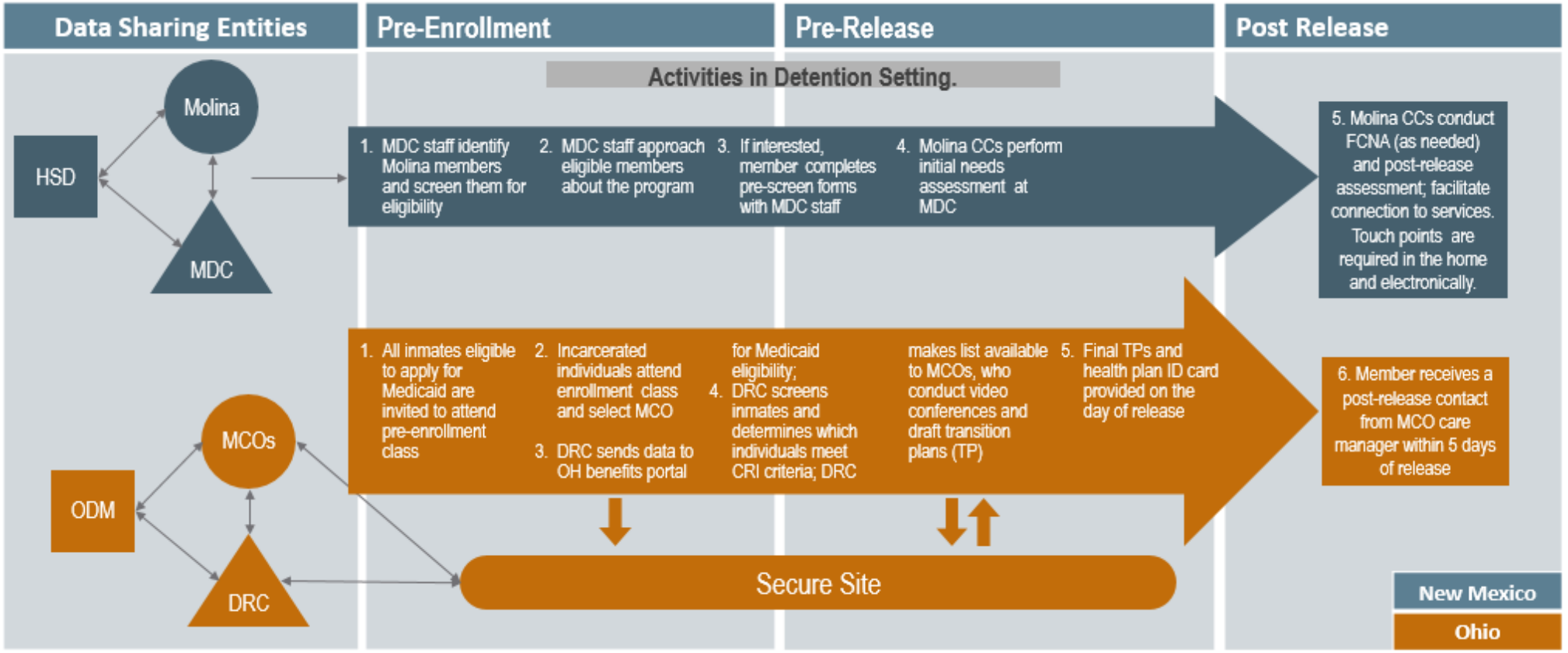


*Table acronyms: HSD – Human Services Department (New Mexico); MDC – Metropolitan Detention Center; FCNA – Face to Face Comprehensive Needs Assessment; DRC – Department of Rehabilitation and Corrections; ODM – Ohio Department of Medicaid; CRI – Critical Risk Indicators; CC – Care Coordinators; CM – Care Manager, TP – Transition Plan.

Engagement, Care Management, and Coordination

Timely care management is critically important for a released individual's successful transition to the community. This includes connecting newly released individuals to health and behavioral health services, community agencies, and identifying and addressing other barriers to a successful transition.

Engagement. In New Mexico, the Metropolitan Detention Center noticed that as more incarcerated individuals are participating in the pre-release care coordination program, other individuals have become more interested in it, most likely due to the positive feedback they hear from past participants. The Metropolitan Detention Center is also working to better identify individuals who are in jail for short periods and who may slip through the cracks; for example, an individual may post bond and be released before meeting with a care coordinator. Metropolitan Detention Center is in the process of making changes to the jail management system to create and test an alerting system that notifies MCOs when a member is released.

Education. As noted above, Ohio's prisons offer incarcerated individuals pre-enrollment and enrollment classes during which designated Peer-to-Peer Guides educate individuals about the benefits of applying for Medicaid prior to release, and of Medicaid managed care. Peer-to-Peer Guides do not assist with MCO selection, but provide information and the tools needed for an individual to make an educated choice. For individuals identified as having a Critical Risk, the Guides provide additional information on the transition plan and the benefits of care management. In New Mexico, Metropolitan Detention Center staff educate individuals about Medicaid and give them the option of enrolling. Center social service coordinators do not assist with MCO selection, but inform individuals about the benefits of managed care and provide information on value-added services provided by MCOs. Additionally, for those who enroll in Molina Healthcare and qualify for the care coordination program, detention center social service coordinators educate Molina members about the pre-release program prior to a Molina care coordinator visiting the member in the facility.

Transition Planning. In Ohio, the first step in the transition planning process is to identify which individuals have Critical Risk Indicators. The Department of Rehabilitation and Corrections then sends MCOs a list of those who have a Critical Risk and are enrolled in their MCO.[7] After attending pre-enrollment classes, qualifying and interested individuals complete the necessary care coordination program paperwork. Incarcerated individuals complete their enrollment paperwork on an electronic form that is saved on a secure site. MCO care managers access this information on the secure site to develop a draft transition plan, which is presented to the individual for discussion via videoconference. The videoconference, which typically lasts about 20 minutes, provides MCO staff the opportunity to confirm contact information, identify the participant's needs, and modify the draft transition plan, as needed. The assessment helps maintain member engagement, particularly for those who were initially hesitant about participating. Following the videoconference, the health plan care manager finalizes the transition plan, which is presented along with a Medicaid health plan ID card to the individual upon release from prison.

In New Mexico, Metropolitan Detention Center's social service coordinators work with incarcerated individuals to identify resources that will help them transition into the community. While their efforts are focused on high and moderate need individuals, they also engage in planning with individuals who only need to be connected to specific resources. Molina care coordinators complete the state-mandated health-risk assessment, a 12-question survey that addresses physical, mental, and long-term health needs. If the assessment determines that an individual requires a higher level of care coordination post-release, Molina care coordinators then complete the 30-page face-to-face Comprehensive Needs Assessment, which covers daily living activities and identifies necessary post-release services. If there is not enough time to complete the comprehensive assessment prior to release, Molina care coordinators meet and conduct the assessment post-release.

Post-Release. In New Mexico, upon release, the Molina care coordinator performs another in-person assessment to evaluate the individual's new living situation and needs, notes any changes, and works with the prospective member to establish connections with appropriate services and supports post release. Molina has established relationships with a variety of services in the community to provide members with contacts outside of the healthcare system. For example, Molina partners with pharmacies so that individuals can leave the detention center with prescriptions issued during incarceration (excluding controlled substances) that they may require and assists them in obtaining 90-day supply prescriptions via mail order, if getting 30-day prescriptions filled at a local pharmacy is not feasible. Prior to, or in

[7] See Enrollment section above.

conjunction with Molina's involvement, Metropolitan Detention Center staff provide incarcerated individuals with many intervention options.

In Ohio, for those at Critical Risk prior to release, the MCO care manager will have already scheduled any appointments needed by a member immediately following release. Once a member is released from prison, MCO care managers reach out to the member within five days. Care managers will confirm that a member received the final transition plan, identify any barriers the member may have encountered in making scheduled appointments, and discuss any concerns or needs the member has as they re-engage with the community. While the program is designed to be transitional and help members through the prison-release process, care managers will work with a member as long as he or she chooses to engage with the program.

As noted above, Maryland plans to develop a program to connect released individuals with a short-term care coordinator employed by the local county health department who will connect members to an MCO and will help members to transition back into the community.

Molina Health Care of New Mexico: Metropolitan Detention Center Care Coordination in Action

Molina Healthcare of New Mexico's first engagement with this member was during a visit to the Metropolitan Detention Center During the Health Risk Assessment and Comprehensive Needs Assessment, the individual indicated that he had been using illegal drugs for the past 20 years and had contracted HIV and Hepatitis C. Prior to this engagement, the member had received sporadic medical care. Upon his release, a Molina care coordinator reconnected with the member and assisted him in establishing contact with an Intensive Outpatient Program for substance abuse. The care coordinator also assisted the member in re-establishing a relationship with a physical health provider to receive treatment for HIV and Hepatitis C. The member has continued to engage with his Molina care coordinator for health-related questions, as well as questions regarding community resources. As of March 2017, the member stated that he had completed his outpatient program and intends on continuing to attend behavioral health appointments with his providers.

Molina Health Care of Ohio: Pre-Release Program In Action

A 53-year-old Molina member, diagnosed with a variety of chronic illnesses, mental health disorders, and substance use issues, was released in September of 2016. Through a teleconference prior to his release, a Molina case manager worked closely with the member to develop his transition plan. Post-release, the member was very overwhelmed with managing his illnesses but found support in his frequent contact with his case manager. The member sought treatment and reported that his case manager helped him to receive his final transition plan and attend his scheduled appointments. The member also reported that he was able to consistently obtain and fill his prescriptions to manage successfully his health conditions. The member has not visited the emergency room since his release. The member continues to maintain an open relationship with his case manager and stated during his most recent contact, "Thank you, you have helped me every time I've called."

Program Impact and Quantitative Findings

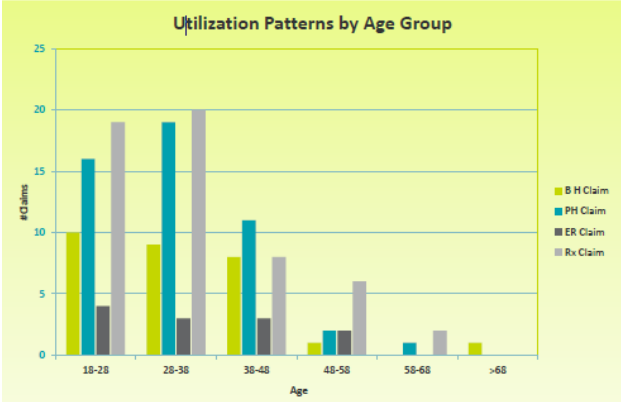
The pre-release programs highlighted in this issue brief are at different stages of implementation and, as such, the data available regarding program outcomes varies. Since Maryland has yet to launch its program and Ohio has not made its program data public at the time of this report, this brief only includes a summary of preliminary quantitative information supplied by Molina Healthcare of New Mexico. As noted earlier, NORC did not conduct a quantitative analysis for this study and therefore is unable to assess whether differences are statistically significant.

Demographics. Molina Healthcare of New Mexico reports that 63 percent of its pre-release program population identifies as Hispanic, compared to approximately 49 percent of the residents in Bernalillo County.[xiii] The second largest population of pre-release program participants is white (24 percent), followed by smaller populations of Black (7 percent) and Native American (5 percent) members. Seventy-two percent of Molina's members participating in the pre-release program are ages 38 or younger.

Program and Utilization Outcomes: As of December 31, 2017, the Metropolitan Detention Center had engaged 366 incarcerated individuals who agreed to participate; 21 declined to participate.

Molina reported that among program participants, those ages 18-28 and 28-38 showed higher patterns of health service utilization compared to other age groups (Exhibit 4).

EXHIBIT 4. MOLINA HEALTHCARE OF NEW MEXICO SERVICE UTILIZATION IN APRIL 2017, BY AGE GROUP



Information provided shows a decrease in emergency department claims, inpatient utilization, and behavioral health and physical health services for Molina pre-release program participants compared to Molina members who were or had been previously incarcerated and had not enrolled in the pre-release program.[8] From October 2017 data, pharmacy claims among the Molina population decreased after participation in care coordination. Molina anticipated these claims would increase as individuals became more engaged with health services; further data are needed to understand this finding. The cost of those participating in the program was $3,941 per month versus $11,795 per month for those not receiving Molina care coordination. Lastly, Molina's calculations as of November 2017 found that the recidivism rate of participants was 15 percent compared with 25 percent for those who did not engage with the program compared to 57 percent nationally, suggesting the program might be helping members effectively engage and live within their communities.

Lessons

This review highlights key themes across programs that may be helpful to other states, localities, and MCOs considering pre-release or justice-involved programs for the Medicaid population.

Garnering Buy-in from All Partnering Entities is Key. Organizational leadership from multiple entities - State Medicaid Agencies, Departments of Corrections, justice facilities, MCOs, and community organizations – all play vital roles to the success of a program.

Gaining MCO Involvement is Critical. While Ohio required MCOs to participate in pre-release programs, at the time of our interviews, Maryland and New Mexico had not. Since the interviews, New Mexico has issued guidance requiring all MCOs and all detention centers to participate. Since MCOs are not directly compensated for pre-release activities, some MCOs have questioned the benefits that can be realized from investing in these activities. Alternatively, in Ohio, care management costs are accounted for in the capitation payment for the member that is paid to the MCOs during the month of release. However, as Molina Healthcare of New Mexico's initial program data shows, better pre- and post-release engagement may improve health outcomes and lower recidivism rates for participants. As a result, the MCOs responsible for a member's care may be more likely to develop and participate in pre-release programs, even if they are not paid directly for engaging members.

Communication is Vital. Clear, frequent communication among partners at every stage in the process is essential, especially during the eligibility and enrollment phase. Strong cross-agency partnerships have played a large role in program success. Effective strategies include developing an alert system for when an individual is, or about to be, released, and flagging individuals who are likely to exit the criminal-justice system quickly.

Having the Right Staff to Educate, Engage and Gain the Trust of Incarcerated Individuals is Essential. For a variety of reasons, incarcerated individuals are often reluctant to trust staff. Gaining the trust of incarcerated individuals and their families requires time, positive word-of-mouth support from peers and program staff, and staff who can quickly engage and develop rapport with individuals.

Programs should be Thoughtfully Tailored. The most effective programs consider every step in an area's criminal justice system cycle, from prevention to re-integration to possible recidivism. Interventions will likely be different for every

[8] There are potential challenges with making this comparison though there are opportunities to mitigate these challenges. However this work is outside of the scope of the current project.

locality and its political, healthcare and social services environment. Care or transition plans should correspond to a person's specific needs and priorities and be aligned with resources and supports available in the community.

Data Sharing is Difficult and Takes Time, but is Necessary. In both New Mexico and Ohio, the programs started with manual processes and became more automated over time, which greatly improved data sharing capabilities and efficiency. Stakeholders should be flexible and anticipate that systems will evolve over time.

Sustainability and Funding Support Rely on Data that Highlights a Program's Impact. Receiving continued support for these programs from state legislators, local officials, MCOs, and other stakeholders is more likely when there is evidence of improved health outcomes, reduced recidivism, and increased state and local savings. Tangible indicators of success include reductions in uncompensated care, appropriate use of health services, avoidance of emergency room and inpatient stays, and reduced recidivism. Evidence of positive results in utilization and outcomes also will help encourage MCOs to participate.

Medicaid Coverage plus Care Coordination Assists Transitions Back into the Community. Enrolling eligible individuals into Medicaid and arranging post-release health services fosters an individual's successful reentry into the community. This is achieved by conducting a health risk assessment, developing a transition plan, addressing a member's most pressing concerns, connecting them with required services, and closely monitoring outcomes. It is also crucial that the care plan is shared among partnering agencies, for example, detention center social service coordinators, to reduce duplication of efforts, maximize services, and provide consistency in the coordination of care.

Conclusion

The programs addressed in this brief are still in their early stages; with time, their long-term impact will become clearer. Any changes to the ACA that may lead to the loss or reduction of federal matching funds for the Medicaid expansion population could create uncertainty for the future of pre-release programs. Despite this, states will likely continue to consider and implement these types of programs, if there is evidence that pre- and post-release care coordination positively impacts justice-involved individuals and improves their health, their transition to the community, and their likelihood of remaining outside of the justice system. In New Mexico, preliminary information provided by Molina Healthcare of New Mexico shows reduced emergency department visits, increased use of health services, and lower recidivism rates compared with the Metropolitan Detention Center population not choosing to participate in the program.[9] In time, programs may continue to expand to new MCOs, detention centers, and states. New Mexico, for example, is now requiring all MCOs to work with 27 detention centers statewide, engaging with members while they are incarcerated and connecting with them after release. For example, New Mexico is initiating this expansion by establishing similar projects with the Santa Fe Jail, the Dona Ana, Roswell Detention Center, and McKinley County correctional facilities. These types of pre-release programs demonstrate how cross-agency partnerships and effective care coordination can increase access to coverage for hard to reach and vulnerable populations.

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NORC at the University of Chicago is an independent research organization headquartered in downtown Chicago with additional offices on the University of Chicago's campus, the DC Metro area, Atlanta, Boston, and San Francisco. NORC also supports a nationwide field staff as well as international research operations. With clients throughout the world, NORC collaborates with government agencies, foundations, educational institutions, nonprofit organizations, and businesses to provide data and analysis that support informed decision-making in key areas, including health care, education, economics, crime, justice, and energy. NORC's decades of leadership and experience in data collection, analysis, and dissemination—coupled with deep subject matter expertise—provide the foundation for effective solutions.

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