BY MICHAEL GROHS, CONTRIBUTING EDITOR

'Medicaiding' Ex-offenders

How states are providing post-incarceration continuity of care.

WHEN the Affordable Care Act (ACA) became the law of the land, a situation arose in the correctional arena. The ACA requires almost everyone to have health insurance. That includes inmates who have been released, sometimes after years of incarceration. Inmates already tend to be less healthy than the general population and often lose access to medical services once they are released from custody. They now need to be aligned with health care, and often that alignment is enrollment with Medicaid.

While the process may be complicated, the success of doing so has been experienced in the 31 states (and Washington, DC) that expanded access to Medicaid under the ACA. Nick Little, vice president of Strategic Contracting & Compliance at Wexford Health Sources, a Pittsburgh, Pa.-based provider of correctional health care, notes that with the passing of the ACA, most inmates qualify for Medicaid benefits "as long as their state approves the expansion of its Medicaid-eligible population."

Inmates often enter a facility with a substance abuse disorder or a mental illness, and the demographic tends to have high rates of chronic conditions such as diabetes, hypertension, and infectious diseases such as hepatitis and HIV. Continuity of care has long been an issue with the inmate population, but the ACA and Medicaid enrollment has had a significant impact on that. For example, says Little, "ACA Medicaid coverage reduces the duplication of medical services for chronically ill inmates" and "increased Medicaid coverage reduces the number of emergency room visits for general and/or specialty care."

Martha Harbin, director of External Relations at Corizon Health, says "There is increasing awareness of the importance of a successful re-entry program to reducing recidivism, and many clients are including more discharge-planning positions in

Where is the justice in overpaying for correctional health care?

If you think health care costs are excessive, come talk to us. We provide you with discounts through our national provider networks. Our state-of-the-art telehealth capabilities can save you hundreds of thousands of dollars in transportation, security, and meal costs. We also have programs that can save you millions by protecting you against fraud, overpayment, and unnecessary services. To learn more about a company that treats you fairly, visit wexfordhealth.com.

Wexford Health
SOURCES INCORPORATED

QUALITY CARE | PROVEN STAFFING EXPERTISE | EXPERIENCED MANAGEMENT TEAM | TECHNOLOGICALLY ADVANCED SERVICES | COST CONTROL

their health services contracts."

The funding, says Little, is arranged so the states that did expand Medicaid eligibility will receive a 100% federal funds match through 2017. (In 2020, that rate will diminish to 90%.) This match "is a significantly greater percentage than anything that has been provided in the past. State correctional agencies are saving millions of dollars through matching federal funds on inpatient hospitalization of inmates alone."

In May 2016, the Indiana Department of Corrections (IDOC) released a press release stating that the agency had reached a milestone by registering more than 12,000 released inmates with HIP 2.0/Medicaid. (HIP [Healthy Indiana Plan] 2.0 is essentially Indiana's Medicaid). Qualification is based on income and not disability. As a 2015 *Pew Report* pointed out, correctional expenses and health care are "two fiscal pressure points," especially when they intersect. The report furthered that in 2011, states alone spent more than $7.7 billion on inmate health care.

Indiana state law required that the DOC begin applying for HIP 2.0/Medicaid for "all offenders released from their custody." In order to accomplish this, IDOC moved quickly in order to utilize Presumptive Eligibility (HPE) to enroll offenders. This allows offenders to be covered under Medicaid while hospitalized, thus allowing the hospital to bill Medicaid rather than IDOC. By doing so, IDOC's health care provider realized significant cost savings and then reimbursed IDOC. According to an April 2016 report, since July 2015, the sum of claims paid by Medicaid for offenders with HPE has been more than $3.8 million.

Other states have reported similar savings. According to a 2015 study conducted by the Robert Wood Johnson Foundation, in combined fiscal years 2015 and 2016, states have reported significant savings: Arkansas ($2.8 million), Colorado ($10 million), Kentucky ($16.4 million), and Michigan ($19.2 million). Gov. Bill Walker of Alaska advocated expanding the state's Medicaid program anticipating that in 2016, $4.1 million in federal reimbursements would be realized from inmate inpatient health costs alone. According to the study, the state auditor in Massachusetts reviewed correctional health costs from 2011 and 2012. She found that over that period, the state had failed to submit claims for roughly $11.6 million in eligible services. These lost reimbursements were divided between county jails ($7.6 million) and state facilities ($4.1 million).

State-to-state Differences

The enrollment process is not universal. Corizon's Harbin says, "There is no standard process for aligning inmates with Medicaid services. Medicaid coverage eligibility varies from state to state as do the services that prisons and jails have the staffing and funding to provide. For example, after passage of the Affordable Care Act, some of our clients invited Navigators into their facilities to enroll patients while other communities did not have Navigators available."

Inmates who are in custody are not eligible for Medicaid coverage (unless they are hospitalized), and if they are on Medicaid upon arrival, that coverage is suspended until the time at which they are released. IDOC screens each offender who enters the Department using a daily report and master tracking database. Those tools are used by the facility's Medicaid Processing Unit to fulfill one of HIP 2.0's requirements, which involves reporting offenders who have active coverage to the Indiana Family and Social Services Administration (FSSA) for suspension. Upon notification, FSSA completes a status change, and the offender's coverage is suspended throughout incarceration. (Coverage can be easily reactivated upon the inmate's release.) In an effort to facilitate the on-boarding process, IDOC implemented the Medicaid Processing Unit, which completes Medicaid applications on behalf of all offenders 60 days before release. As part of the re-entry process, the unit's staff encourages offenders who are about to be released to use their coverage for mental health and substance abuse treatments in addition to their medical needs.

Transitional Case Management Program

Krissi Khokhobashvili, Public Information Officer at the California Department of Corrections and Rehabilitation (CDCR) explains that their facilities' reentry plan begins about 120 days prior to release when the Division of Adult Parole Operations (DAPO) uses contracted social workers to provide Transitional Case Management Program (TCMP) for inmates transitioning back into the community. TCMP provides services in two components: institutional based and community based. There are 68 case workers statewide who help inmates with the applications for Medi-Cal and get the applications to the counties where the inmate will be going 60 to 90 days prior to release. The county then sends back a benefit card. Before release, there is an exit interview in which the benefit worker and inmate discuss the benefit status, which is available upon release. On the institutional based component, TCMP provides counseling, guidance and parole plan services for those with HIV and/or AIDS. This is voluntary on the inmate's part. According the CDCR's website, TCMP also provides "pre-release assessments on a prioritized workload for inmates identified as part of the prison's Mental Health Services Delivery System, by way of information

gathering, and referral to the DAPO Parole Outpatient Clinics (POC)." In this case, as a condition of parole, inmate participation is mandatory. TCMP also serves as a liaison between prison staff and DAPO's Nursing Consultant, Program Review (Medical Placement Coordinator) to identify and refer inmates who will require continuity of care upon release. TCMP also participates in the completion of inmate service plans and documents the details in the database.

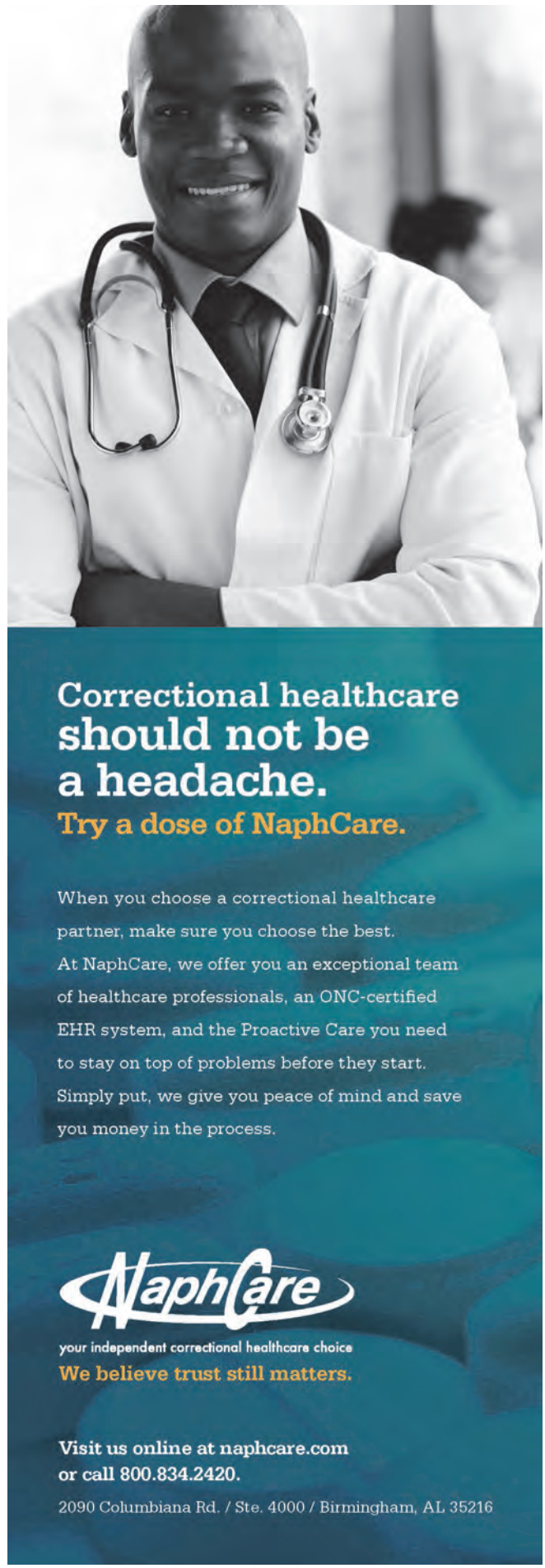
As for community-based components, TCMP develops parole service plans prior to release and, within the first 90 days of release, offers guidance counseling to parolees who have been diagnosed with HIV and/or AIDS. Similar services will be provided for high risk inmates who have been identified as having needs for services based on the assessment tool the Correctional Offender Management Profiling for Alternative Sanctions, as well as serving as a resource person to DAPO staff, referring parolees requiring medical placement to the DAPO Medical Placement Coordinator, and documenting the service plan components in the appropriate database.

The Minnesota DOC, says Nanette Larson, director of Health Services at the Minnesota Department of Corrections, "Employs dedicated release planners to assist the inmate with the application process. We have worked directly with the Department of Human Services, the state's Medicaid agency, to develop an enrollment process for those who receive release planning services."

At Wexford, says Little, there are two steps to ensuring an inmate has access to Medicaid benefits upon his or her release. The first is that inmate must go through a process to be enrolled. Corrections agencies coordinate with their state's Medicaid agency to develop policies and procedures to efficiently register inmates in Medicaid and align them with services. "Wexford Health currently works with multiple states with effective Re-Entry Programs that have policies and procedures in place to ensure as many inmates are enrolled as possible."

The second step is that the inmate being released will need to be connected to a medical provider working in the community. "Our correctional discharge planners are crucial in identifying medical providers in the inmate's community that see Medicaid patients and can provide the care that is specifically needed for that inmate." Discharge planners are the ones who often make the initial doctor's appointment for the soon-to-be released inmate as well as facilitate the release of medical records from the corrections agency to the medical provider in the community to ensure accuracy and consistency of care.

Harbin notes that in facilities that work with Corizon, Medicaid alignment "ideally begins about three months before release and includes educating patients about the options available to them and helping them with their applications. In the Arizona



Released inmates can be covered under Medicaid in 31 states and the District of Columbia that expanded access to heath care under the Affordable Care Act.

DOC, where we recently launched a re-entry program, our staff works with about 10 to 12 inmates per week, and we are actively working with our client to greatly increase the number being served."

Qualification does not seem to pose a challenge for those in the 31 states or Washington, D.C., that opted to expand Medicaid. Most inmates qualify because so few earn more than $15,000 per year while incarcerated. (The ACA expanded Medicaid eligibility to those who had an income of less than 133% of the federal poverty level.) Says Little, "The 19 states that have chosen not to expand their Medicaid eligible population in accordance with the ACA are not able to receive federal matching funds for inmates that are admitted to a community hospital." They are also not eligible to receive federal funding for additional community programs such as mental health, substance abuse treatment, etc.

'Unique Challenges'

The process is not simple. "Enrolling inmates in Medicaid presents a number of unique challenges," says Little. For one, Medicaid requires having a mailing address and very often an inmate's address changes from institution to institution, or they do not have a permanent address when they are released into the community. Larson agrees. A serious challenge is "finding housing for persons with felony histories and mental health and medical challenges."

There is also the matter of follow-through on the inmate's part to keep the appointment and see the community physician, which is necessary for success "but not always a guarantee." In addition, there is the concern of finding specialty providers that meets the specific needs of the inmate in their community. Harbin points out that the ACA has provided a bridge to released inmates and health care; however, "Even in those states, instituting changes in both the correction and Medicaid agencies is challenging. Some states, such as Arizona, Colorado and Oregon have made significant efforts to align processes." She furthers that the goal is for those who are now eligible for Medicaid or other insurance to have better access to primary care services upon release so they will be better able to manage chronic conditions. "Continuity of care is particularly important for those with mental illnesses. Without access to regular health care and necessary medications, they often decompensate and wind up back in the criminal justice system."

A critical aspect for success, stresses Little, is coordination between the various state agencies. "At a minimum, the correction agency and Medicaid agency need to agree on policies. In many states the human services agency does the Medicaid enrollment, so they need to be involved." Harbin furthers, "An important role for the correctional health care provider is to help ensure that individuals leaving the criminal justice system have their personal medical histories. Often, the correctional health care provider has been the patient's only consistent primary care provider and may possess the most complete history. Successful application for coverage often requires documentation of conditions." ✪


UNION SUPPLY™
Group
GREAT SERVICE
SMALL COMPANY VALUES
INNOVATIVE PRODUCTS
CELEBRATING 25 YEARS
UNION SUPPLY COMPANY
Providing Clothing, Shoes & Electronic Commissary Products
FOOD EXPRESS USA
Providing Food & Personal Care Commissary Products
UNION SUPPLY DIRECT
Providing Full Service Family Inmate Package Programs
UNION SUPPLY MEDIA
Providing Music, Books And Movies Via Tablet PC Technology
US COMMISSARY SOLUTIONS
Providing Full Service, Automated, End-To-End Integrated Commissary Solutions
UNION SUPPLY Company
FOOD EXPRESS USA
UNION SUPPLY Direct
UNION SUPPLY Media
US COMMISSARY Solutions
UnionSupplyGroup.com