Information Sharing between Medicaid and Corrections Systems to Enroll the Justice-Involved Population: Arizona and Washington

Medicaid Areas of Flexibility to Provide Coverage and Care to Justice-Involved Populations

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January 2017

Medicaid and the Justice-Involved Population

States have flexibility in deciding who will be covered under their Medicaid program within established federal guidelines. Many states have increased the number of justice-involved individuals covered by Medicaid by expanding eligibility to low-income adults. Medicaid cannot pay for medical services provided to persons while they are incarcerated, except when in-patient services are provided in a community based hospital setting. However, many other people involved in the justice system—from arrest through community-based supervision—are eligible to receive Medicaid benefits when they are not incarcerated, if they are income eligible and meet certain other criteria. Providing health care services to people involved with the justice system could improve public health and public safety, given their high prevalence of mental health issues, substance abuse, and chronic health conditions including HIV and hepatitis. This series of briefs highlights areas of flexibility within Medicaid that can facilitate enrollment in health coverage and access to necessary care in the community for justice-involved people.

Many states have launched prerelease enrollment initiatives to ensure that Medicaid benefits are available to eligible individuals upon reentry into the community.[1] But integration of correctional and Medicaid data and communication between agencies with different data systems remain a significant challenge. Historically, many states terminated Medicaid eligibility when someone was incarcerated to help ensure compliance with federal requirements that Medicaid not be used to pay for inmate health care, except for inpatient care when provided in a community medical institution. Although the Centers for Medicare and Medicaid Services (CMS) have encouraged states to suspend (rather than terminate) benefits for incarcerated people,[2] and reentry best practice guidelines suggest that health care services should be lined up before release,[3] many states deny people who would otherwise qualify for Medicaid

if their applications are processed while they are "inmates of a public institution" (Mallik-Kane et al. 2014). This makes reentry planning and Medicaid application assistance challenging for prisons and jails. Although incarcerated people generally are eligible for Medicaid while incarcerated (if otherwise eligible under the state's Medicaid program) and may apply or reapply for Medicaid before release, states often lack the technological infrastructure to coordinate the Medicaid eligibility determination process with prisons and jails. States also lack the infrastructure needed to ensure that appropriate medical information can be easily transferred between jails and prisons and community health providers to ensure appropriate continuity of care.

This issue brief examines two initiatives—one in Pima County, Arizona, and the other in Washington State—where state and local Medicaid and correctional agencies have developed systems to coordinate enrollment and communicate regularly on the status of individuals within the correctional system. Although each faced unique issues relating to its own information technology systems and databases in Medicaid and correctional facilities, both experiences may provide useful lessons for other states and counties. The brief is based on interviews with key individuals involved in the information sharing programs in Pima County and Washington State, publicly available resources, and documents provided by the interviewees. It provides background on the data integration challenges, explains how Pima County and Arizona's Medicaid program and Washington State have addressed them, and highlights key lessons learned. The brief also describes some other information exchange initiatives Pima County has implemented to share medical records and related information with behavioral health and other providers after individuals return to the community.

Overview: Pima County's Information Sharing Systems for Medicaid Enrollment and Continuity of Care at Jail Transitions

Arizona has several initiatives designed to connect the justice-involved population to Medicaid coverage and services.[4] Pima County was the first in Arizona to enroll adults returning to the community from jail and piloted Arizona's initial Medicaid suspension project. The county also partners with area nonprofits to provide enrollment assistance for those who were not previously enrolled in Arizona Health Care Cost Containment System (AHCCCS), the state's Medicaid program, and are about to be released or awaiting trial. Finally, Pima County has initiated health information exchange projects designed to promote continuity of care and a more seamless transition between health care services provided in the jails and in the community. All these systems involve collaboration between multiple agencies and ongoing communication of information and records to facilitate both enrollment and care.

The Suspension System: Information Exchanges between Medicaid and the Jail and between Medicaid and Health Care Providers

Interviewees reported that in addition to continuity of care, one reason the state was initially interested in the suspension program was to ensure that it did not pay Medicaid managed care organizations (MCOs) to care for people who had been incarcerated. Pima County first recognized the need for a Medicaid suspension policy when it encountered obstacles obtaining coverage for incarcerated people nearing their release from jail. In 2006–07 the county began helping incarcerated adults apply for Medicaid at the time they were released from jail, building on earlier successful efforts to enroll uninsured minors in the juvenile justice system in health coverage. The county was particularly concerned about meeting the immediate behavioral health and chronic health needs of adults returning to the community. But it took several weeks to process a Medicaid application, make the eligibility determination, and enroll someone in a managed care plan; problems occurred when people could not receive care—particularly medications—immediately upon release. As a result, the county decided to work with Medicaid (through AHCCCS) on a program to suspend rather than terminate, enrollment. Although the county initially focused on people returning to the community from jail, it later expanded its efforts by working with the Pima County Superior Court to enroll people awaiting trial on bail release.

We started this initiative in 2007 because when we were doing applications [for Medicaid] *on release,* [individuals being released] *would time out or get terminated and it would take another 45 days to get a person active who needed meds immediately.*

—Pima County official

Pima County's suspension and reinstatement processes rely on frequent electronic data transfers from the local jail to the Medicaid agency about recent admissions and releases. The Pima County Sheriff's Department (PCSD) operates the jail in Tucson. It has a daily population of approximately 1,850, 80 percent of whom are detained before trial. The population is highly transient; the jail releases 60 percent of people within 12 hours. PCSD sends data to Medicaid three to four times a day; different datasets reflect bookings (i.e., admissions) and releases. The personal identifiers exchanged are booking number, name, date of birth, and sex. Additionally, the data files indicate movement in and out of the facility, so records are flagged as bookings or releases with the associated dates. Release records additionally include information on whether the individual was released to the community or to another institution (e.g., transferred to another jurisdiction or to state prison).

If someone has been incarcerated more than 24 hours, the state suspends enrollment. The state previously suspended enrollment for anyone booked into jail, but the county worked with Medicaid to

delay suspension because most people are released within 12 hours. As a result, PCSD restricts its data feed to those individuals who remained in the facility for at least 24 hours. This also limits the number of data matches needed between the jail's file and AHCCCS's Medical Management Information System.

A county official explained that frequent data transfers are necessary because the population turns over so quickly, and it is essential to provide information promptly when someone is released. While each state's confidentiality rules may differ, in Arizona a correctional facility may not release historical information about its population but may release information about someone currently incarcerated. Data become "historical" 24 hours after someone is released, so the jail has to make sure it is providing "live information" to Medicaid.

Upon receipt of booking dates from the jail, AHCCCS performs an automated data match to suspend benefits. After the suspension, AHCCCS informs the reporting jail that the enrollee has been suspended. AHCCCS also sends a daily file that identifies the individuals who have been incarcerated to both the MCOs and the regional behavioral health authorities (RBHAs), which coordinate behavioral health in Arizona. AHCCCS keeps the person enrolled but on a "no pay" status. Beneficiaries can be suspended for up to 12 consecutive months, usually the maximum time someone would spend in the county jail. (For those in the prison system, AHCCCS suspends enrollment for detainees sentenced to less than 12 months; enrollment is terminated if detainees receive a sentence of more than 12 months.) There are no confidentiality requirements that prevent AHCCCS from informing an MCO or RBHA that an enrollee has been suspended because he or she is incarcerated.

The reinstatement process works similarly, only using information provided by PCSD on release date and release type to determine that an individual has been released to the community (as opposed to being transferred to another jail or prison). Neither AHCCCS nor the MCOs are informed in advance of an individual's anticipated release date. But in most cases the enrollment is automatically reinstated when PCSD sends the release data. The two systems have been integrated so the data are communicated via a secure file transfer protocol server and the suspension is lifted automatically. In most cases, individuals are re-enrolled with the same MCO they had been in before they were incarcerated. Returning enrollees can obtain services without a new Medicaid card. They can rely on their old cards, seek a new one, or the provider can look them up based on other identification.

County and state officials stated that they have heard of only a few incidents where reinstatement of coverage was problematic for people who were suspended after being jailed for over 24 hours and subsequently released a day or two later. If there are problems, it is usually because of the data exchange and it can be addressed quickly because the agencies work closely together. AHCCCS also has a system for informing MCOs and providers that someone's enrollment has been suspended and that if they have to come into an office to seek services, they should provide the services and contact AHCCCS to get the suspension lifted. A state Medicaid official describes the process this way:

> We have over 50,000 Medicaid providers, and we include information on the file they see. If they see a suspension hasn't been lifted, we have a clear message that tells them this person's enrollment will be reinstated and to provide services while they await confirmation; they are also encouraged to contact AHCCCS if they continue to have questions. . . . We have some providers

who are hesitant to provide services without an active payer; if they see that message they are reassured that they will get reimbursed.

Together, Arizona's Medicaid expansion and policy of suspension upon incarceration have led to an increase in coverage among justice-involved people when they are residing in the community. Interviewees reported that the share of people entering jail with Medicaid rose from 19 percent to just over 50 percent since Medicaid expansion—a majority of the jail population in Pima County. Given this volume, the suspension and automatic reinstatement program is important to both controlling Medicaid MCO payments and facilitating continuity of care for incarcerated people. These efforts also have moved beyond Pima County. Eight additional Arizona counties (out of a total of 15) have established a "suspense agreement" with the state Medicaid agency to suspend rather than terminate Medicaid enrollment of adults when they are incarcerated. According to an AHCCCS official, the state is suspending—and reinstating upon release—approximately 90 percent of all individuals enrolled in Medicaid at the time they are incarcerated. Interviewees also reported that the state was initially interested in the suspension program to ensure that it did not pay MCOs to care for people who had been incarcerated. Today, AHCCCS emphasizes suspension as a mechanism to ensure continuity of care, and it has launched initiatives to connect those reentering the community to health care services, including through information exchanges.

Enrolling Justice-Involved People in Medicaid: Information Exchange between the Pima County Superior Court, the Jails, and AHCCCS

Pima County also provides enrollment assistance—both before trial and in anticipation of a completed sentence—to help justice-involved individuals enroll in Medicaid for the first time or after they were previously terminated from the program.[5] The county partners with the Pima Community Access Program (PCAP), a nonprofit with many years of experience connecting low-income residents to health coverage, to provide enrollment assistance for the justice-involved population. PCAP, the local RBHA,[6] and other local agencies help incarcerated people apply for coverage 30–45 days before release.

Although other counties submit paper applications to Medicaid, Pima County uses a more automated system: its staff complete an application through AHCCCS's online web tool (HEAplus) and send a list of people they completed applications for; AHCCCS then processes the applications and automatically approves those who are eligible upon confirmation of release. The county has tried to prioritize applications for people with the most complex or chronic needs because they do not have the resources to assist everyone who is being released apply for Medicaid.

Don't forget your community partner organizations …. There are a lot of pieces to the criminal system, and sometimes people forget to include little 501(c)(3)s that could help. There is strength in numbers.

—Pima County nonprofit representative

AHCCCS also maintains records on people whose Medicaid enrollment was terminated, and that information can simplify a new application. Applicants who are entirely new to Medicaid sometimes experience delays of up to 45 days to obtain coverage, and knowing about prior enrollment would reduce that wait. Sometimes, community partners help people complete their applications after they are released and try to connect people with necessary services pending their enrollment in AHCCCS.

We've seen that people decompensate very quickly without medical care. Once they come into the jail and we get them on their meds and stabilized, we get them to stabilization in health and mental health. If they get out and their enrollment wasn't activated, they couldn't get services. [Getting them enrolled] *will go a long way to improve continuity of care from jail to providers on the outside.*

—Pima County official

Connecting Justice-Involved People to Health Services: Arizona's Statewide Health Information Exchange and the Pima County Justice Information Exchange

Two other information exchange efforts in Arizona and Pima County facilitate better care coordination as people transition both in and out of correctional facilities.[7] Both systems are bidirectional so people entering or exiting a correctional facility can have records transferred to their new providers. For example, information from a community-based provider automatically updates the correctional electronic medical record to foster treatment continuity when people are admitted. Similarly, correctional records are accessible to community providers on release.

Arizona uses a statewide health information exchange that enables health care providers to share medical records and promote continuity of care.[8] Interviewees reported that Pima County's correctional provider was an early adopter of that system. Except for prescriptions, the statewide exchange does not include behavioral health information, which is subject to more stringent confidentiality requirements. Pima County participates in a second justice–health data exchange that connects the Regional Behavioral Health Authority (RBHA) with the jail and its correctional health care provider to share mental health treatment records and facilitate a coordinated handoff between correctional and community providers.

The Justice Information Exchange is based on open-source technology, which interviewees told us is easily replicable. This exchange is expanding to include the Pima County Superior Court, which oversees pretrial services, so eligible individuals can be connected to a community-based provider pending trial. To date, Pima County has not had a formal evaluation of the impact of its Justice Information Exchange. We also have a justice health data exchange where jail booking information is sent to the regional behavioral health authority, which takes the information and bumps it against their

enrollment database and shares information back to the correctional care provider at the jail and it populates the electronic medical record.
—Pima County official

What began as a manual sharing of jail records with AHCCCS has developed into an extensive information exchange systems connecting correctional facilities to Medicaid agencies and providers. AHCCCS designed its program to take the jail's data and work with it. One county official emphasized the importance of state Medicaid agencies being able to accommodate different data systems in correctional facilities around the state for information sharing to work. The information exchange programs also built on earlier collaborations and partnerships among agencies and between individuals working for those agencies. Interviewees emphasized the importance of these personal relationships; one described it as having "champions" for these initiatives in the agencies who work together.

On the county side, the jail is an essential partner, but not the only one. The county health department and county court also work collaboratively with the jail. Public defenders, nonprofit agencies, the local RBHA, MCOs, and physical and behavioral health providers work together to improve systems and address individual cases. The county relies greatly on PCAP and other community agencies to provide enrollment assistance to people who are about to be released. Thus, while the county has had to invest resources into these efforts, it has also leveraged the work of local nonprofits and outside grants to support some of these initiatives.

We're all committed to doing it. And we don't think there needs to be a fancy solution. Our exchanges are really simple and rely on technology that's available to a lot of people. It's affordable, it's simple, and as a government agency we've tried to make sure that's true.

—Pima County official

Overview: Washington's Information Exchange between Medicaid and the Department of Corrections

Information exchange between Washington's Medicaid agency, the Health Care Authority (HCA), and the Department of Corrections (DOC) has been operational since 2012, when it was established to ensure that the DOC was billed at Medicaid rates for inpatient services. In anticipation of expanding Medicaid coverage to low-income adults, the state developed a more robust system in 2013 to ensure that Medicaid, rather than the DOC, would be billed when eligible incarcerated people received inpatient care outside a state correctional institution. Interviewee called this a "pseudo suspense" model, as it allows for billing of inpatient services during incarceration but terminates all other Medicaid

benefits. In March 2016, the Washington legislature passed SB 6430, which enables people "to apply or retain their enrollment in medical assistance during periods of incarceration" and directs the state's Medicaid agency "to suspend, rather than terminate" Medicaid benefits for incarcerated people.[9] Washington officials are working to implement this new requirement by July 2017, building on the pseudo suspense model that operates in 15 facilities statewide. This brief documents the earlier efforts that form the framework for SB 6430 implementation.

Washington's "Pseudo Suspense" Model

In Washington, the DOC initially provided Medicaid with a baseline census file of the correctional population. Under the pseudo suspense model now in effect, DOC sends HCA a daily electronic file that lists people admitted or released the previous day. The information provided to HCA includes name, birth date, gender, Social Security number, and, if the person has been in DOC's system previously, his or her Medicaid identifier number. HCA then matches this file to its Medicaid Management Information System (MMIS). Washington assigns a unique Medicaid identifier number that stays with someone even if he or she terminates coverage. According to one Interviewee, "That Medicaid number, if you're assigned as a child, it stays with you for life." If a newly admitted person does not already have a Medicaid number, HCA attempts to match the individual's demographics with current records. DOC reviews each possible match to either confirm it or tell HCA that the individual needs a number assigned. Because of aliases and "bad data," some individuals do not match immediately to the MMIS, so staff at both DOC and HCA manually go into the databases to work through these issues, including clearing up partial matches. HCA assigns a new Medicaid number to anyone not already in its system and DOC adds that Medicaid identifier number to its own data systems.

Once an incarcerated person is matched to the MMIS system, HCA sets up an inpatient hospitalization-only benefit for them and then terminates all other Medicaid benefits. The MMIS shares this information with the "field" within HCA, which runs a centralized system for enrollees who are determined eligible as one of the modified adjusted gross income (MAGI) groups (including adults without children), and the Department of Social and Health Services, which serves traditional non-MAGI populations through local field offices.

For the DOC lists, we set up a parallel coverage group in our MMIS. When they become incarcerated we turn off Medicaid and only allow inpatient hospitalizations. We overlay a different service package that only pays inpatient claims.

—Washington Medicaid official

This daily information exchange between DOC and HCA began in 2012 when the state legislature passed a law requiring DOC to use HCA's provider payment system to pay hospitals for services provided to inmates and to reimburse hospitals for those services at Medicaid rates.[10] According to state Medicaid officials, Washington implemented its current pseudo suspension mechanism in 2014 when the state expanded Medicaid. Before expansion, most prisoners were not eligible for Medicaid coverage of inpatient hospitalization.

Medicaid officials reported that the increased volume of prisoners who became Medicaid-eligible made the transition to a system that facilitated billing Medicaid for allowable inpatient services worthwhile. Now, upon admission to the DOC, people with Medicaid coverage are identified through the data transfer from DOC to HCA and placed in pseudo-suspense mode so that inpatient hospitalization services will be covered by Medicaid. If Medicaid-eligible people in prison are hospitalized but did not have Medicaid when they entered prison, the DOC attempts to enroll them in Medicaid.

Medicaid coverage and billing rates for inpatient hospitalization are also important to community corrections in Washington because DOC is responsible for people on community supervision if they become incarcerated in local jails. Under state law, if an offender under DOC supervision in the community violates a condition of release and is incarcerated for less than 30 days in a jail, DOC is responsible for covering the cost of that person's medical care there. If such an individual has a qualifying inpatient event, DOC staff—not jail staff—help that person apply for Medicaid so the inpatient stay is covered by Medicaid.

The DOC-HCA data match currently manages inpatient Medicaid benefits during incarceration, but it does not reinstate full Medicaid benefits at release. Although Medicaid officials report that the system for providing inpatient hospitalization coverage and terminating other Medicaid benefits when someone is incarcerated at a DOC facility has been working reasonably smoothly, reinstatement of full Medicaid benefits upon release is not automatic. People must reapply for Medicaid after they have been incarcerated. As HCA moves to a full suspension system under the new state law, it plans to continue its daily match with the DOC-provided file of admissions and release data, but it will make the inpatient hospitalization coverage the only benefit *without* terminating enrollment, and then turn the full benefits back on when someone is released. Medicaid officials reported that they are exploring the DOC data to determine when someone is released from incarceration. The issue is that release from one institution or agency does not necessarily mean a release from incarceration. Individuals may be transferred to another jurisdiction where they remain incarcerated (e.g., from a state prison to local jail). As one Medicaid official explained; "DOC tells us when they are released. If someone is released from prison, we don't know if they are now in jail."

HCA also plans to expand and adapt this state DOC data-matching process to the approximately 65 city- and county-operated jails throughout Washington in order to implement the new state suspension requirement. But Medicaid officials report that expanding statewide will require coordination across local jurisdictions and an investment of funds: "We don't own the data; the cities and counties have contractors that control their jail booking and reporting data. There will be a cost but now we don't

know what it is or where it will come from." Medicaid officials believe that jails will need to coordinate with VINELink, a nationwide vendor that maintains booking and reporting information and contracts with nearly all Washington jails. Medicaid officials indicated that using a common vendor as an intermediary would streamline the information exchange between HCA and the local jails.

Helping Incarcerated People Apply for Medicaid before Release

HCA works with both DOC and county and city jails to facilitate prerelease enrollment in Medicaid so coverage is available the day someone is released. At present, this process is paper intensive, with staff entering data from paper applications into the Washington Healthplanfinder, the state's integrated eligibility determination and enrollment platform.[11] DOC worked with HCA to create a simplified two-page version of the Medicaid application, which captures the basic financial information regarding eligibility and includes the incarcerated person's signature. This two-page document is forwarded to DOC's headquarters staff, who collect the demographic information from DOC systems to complete the online application questions. Officials hope to integrate the current application process with implementation of Medicaid suspension under SB 6430. State officials are working on developing system functionality so users can report someone as incarcerated in Healthplanfinder and the system will allow the inpatient hospital coverage only. They also are working on a mechanism in the Medicaid eligibility system that would enable people to apply for coverage while incarcerated (opened in suspense) so it will be easier to move them out of suspense when they are released.

DOC uses dedicated staff to submit applications through the Healthplanfinder on behalf of incarcerated people within 30 days of expected release. The group helped includes individuals who had been in pseudo suspense and had their Medicaid enrollment terminated, as well as those who were not previously enrolled in Medicaid. DOC staff submit the applications because people in custody do not have access to the Internet, and DOC staff have permission to bypass the incarceration screening questions on the application portal.

DOC staff begin working with people 45–90 days ahead of their anticipated release to inform them about Medicaid and the opportunity to apply for coverage before they are released. HCA requires DOC to obtain a signature on a hard-copy form before DOC staff can submit an application for that person to Healthplanfinder. Paper applications are filled out and signed at the facilities, then scanned and e-mailed to DOC headquarters. A supervisor oversees three staff at DOC headquarters who enter information from the paper applications into Healthplanfinder approximately 15 days before the scheduled release date. Because Healthplanfinder asks whether someone is incarcerated (as a screening tool to determine eligibility), DOC, HCA and Healthplanfinder developed a workaround (documented in a memorandum of understanding) that allows that box to be checked "no" for individuals who had a release date within 30 days from submission of the application; otherwise the system would have determined them ineligible for Medicaid. Eligibility determinations are made within 24 hours through Healthplanfinder. According to a DOC official, 70–80 percent of people leaving incarceration have had their Medicaid applications screened before release, and "most have benefits active the day they walk out."

DOC staff have shared information and protocols with other states and are planning to work with HCA to facilitate an automatic reinstatement of benefits when people are released after the new suspension system is implemented.

We release nearly 7,000 people every year and you're looking at 5,000 walking out with Medicaid, which is incredibly important when you think about the number of mentally and chronically ill offenders, being able to keep their prescriptions and coordinate doctors' appointments. It's critical to the success of offenders in reentry to the community.

—Washington Department of Corrections official

HCA also has a memorandum of understanding (MOU) for city and county jails to enroll incarcerated people in Medicaid, to ensure coverage for inpatient hospitalization services and in anticipation of release. The system is modeled on the DOC application system. Under the MOU, applications can be submitted through Healthplanfinder within 30 days of the person's anticipated release. Facilities operating under the MOU have the same workaround as DOC, allowing them to bypass the question on current incarceration. Under the MOU, HCA provides training and materials on Medicaid eligibility and use of Healthplanfinder and links facilities with local in-person assister organizations. The facilities are required to obtain written verification that the person knowingly applied for Medicaid. According to one official, only a minority of jails currently participate in this prerelease application program because of a lack of staff time to assume this responsibility.

Data integration is going to be huge. If people can identify systems that would help them get that data, that's the biggest piece. What comes along with that is trying to figure out with the least amount of money how you can make it happen.

—Washington Medicaid official

Lessons Learned

Although the initiatives in Arizona and Washington differ, they have common themes.

Strong collaborations among committed partners from multiple agencies were critical. Without the strong commitment of correctional officials, the state Medicaid agencies could not have implemented an effective suspension program. Without a strong partner in the Medicaid agency, correctional facilities could not have obtained coverage for incarcerated people.

A key success has been "working really closely with our partners, state partners, exchange partners, cities, counties, keeping the communications open. It won't happen unless everyone wants it to."

—Washington Medicaid official

Statewide policies laid the groundwork for success. In Arizona, the state is committed to a robust health information exchange that facilitated successful integration of correctional facilities' data. In Washington, the legislature's 2012 cost-saving initiative that required hospitals to bill DOC for inpatient stays through the Medicaid agency's electronic billing system and accept Medicaid rates for those services and its 2016 suspension legislation were the catalysts for increased collaboration and problem-solving.

Information exchanges became more efficient over time. The Pima County jail initially shared manual records with AHCCCS, but today the system is automated. In Washington, tying DOC into the Medicaid bill payer system facilitated a more robust pseudo suspension system when more people became eligible for Medicaid in 2014.

Because of our linkage with the state's Medicaid bill payer system, I think we had a leg up on a lot of other states. . . . The ease of the system, connectivity, and relationship between our two state agencies, they no longer talk about health care in Washington without considering offenders, and that's the biggest lesson learned.

—Washington Department of Corrections official

It was easier for larger correctional systems to participate in a suspension/reinstatement and application program than smaller systems and facilities. In Arizona, the state has successfully

implemented the enrollment suspense system with prisons and most counties, but some smaller counties have had a more difficult time identifying a staff person with the time and capacity to gather the necessary data and send it to Medicaid regularly. In Washington, the state will have to coordinate with over 65 jails to implement the new suspension system. To streamline the process, Washington's Medicaid agency is investigating exchanging data with a private vendor that manages jail booking data; or the agency may need to develop the capacity to work with different data systems and receive files in different formats.

For reinstating benefits, particularly among people incarcerated in local jails, correctional files with admission and release dates may be preferable to census or "stock" files. The daily census or stock population of a correctional facility shows everyone who is in custody—useful information for establishing who is incarcerated at a particular moment in time. A person's absence from the daily census, however, does not necessarily mean he or she has been released from custody; individuals may have been transferred to another institution or jurisdiction (e.g. from a local jail to state prison or vice versa). Files with admission dates, release dates, and release type provide more information about an individual's length of stay and final destination, information that would help Medicaid agencies determine their eligibility for renewed coverage.

Very few misdemeanors stay in longer than seven days. If they are suspended they will get out, become very unhealthy, and just cost the system more. We share the data to make sure people can continue to get services, so they don't come back to the jail, so that the jail isn't the only place they receive services. That's normally who we're dealing with, the real high users of service. If the only care they're getting is the jail, they won't be healthy individuals. We are happy our state recognizes that and works with us in that regard.

—Pima County jail official

It may be easier to use information exchanges to turn off benefits than to reinstate them upon release from incarceration. Medicaid agencies have a strong financial incentive to turn benefits off when a person is incarcerated, and the data needed to establish incarceration is relatively simple. It is more complicated to track releases because people leaving a correctional facility may not have a definite release date or may be transferred to another institution. Further, any cost savings from reinstating benefits are likely to be longer term, so the financial incentive is smaller.

Confidentiality issues are unique to each state and must be addressed. Confidentiality issues arise in different contexts and the rules vary in different states and localities; take, for example, Arizona's prohibition on sharing historical, but not current, criminal justice date. Information about behavioral health—particularly substance abuse—is subject to particularly strong protections that may apply even

if a medical release form has been signed. Smaller agencies may have less secure information technology systems, making information sharing more challenging. While not insurmountable, these issues need to be addressed up front and continually assessed as systems are designed and implemented.

Funding issues are a challenge on the corrections side. State Medicaid agencies receive federal matching funds for enrollment and eligibility systems, including modernization of information technology.[12] Correctional systems have had to find funding for their enrollment and eligibility costs from non-Medicaid sources which often has left them reliant on more resource intensive paper processes.

Developing systems to ensure that Medicaid paid for inpatient hospitalization services enabled corrections and Medicaid agencies to design and develop information exchanges that also facilitated enrollment upon release. Although many state and county corrections officials are committed to ensuring continuity of care after people are released from incarceration, correctional facilities also have a strong financial incentive to have Medicaid cover the high costs of inpatient hospitalizations. Hospitalizations can be an important starting point for information exchanges with the state Medicaid agency.

Evaluating success needs to be a joint effort. Correctional facilities alone cannot monitor what happens to enrollees after they are released: Interviewees reported that correctional facilities are unable to track Medicaid coverage and health care access after people are released into the community. Over time, developing the capacity to monitor whether previously incarcerated people obtain and maintain Medicaid coverage and receive services will enable state and local officials to evaluate the impact of these efforts. The continued collaboration between all involved is providing increased opportunities to close the gaps in care for these members and to ultimately improve health outcomes and reduce recidivism.

Conclusion

State and county correctional facilities can set up information exchanges with state Medicaid agencies to share data on people who have been admitted to and released from prisons and jails; such exchanges can facilitate suspension of benefits during incarceration and reinstatement of benefits upon release. Strong collaborations, open communication, and the commitment of staff who can work through data-matching and other implementation challenges are important elements of a successful partnership. Although jails present unique challenges because of the high and rapid turnover in their populations, Arizona's experience demonstrates that these challenges can be overcome.

Notes

1. See Sachini Bandara, Lauren Riedel, Beth McGinty, Colleen Barry, and Haiden Huskamp, "State and Local Initiatives to Enroll Individuals in Medicaid in Criminal Justice Settings," Johns Hopkins Bloomberg School of Public Health, accessed September 26, 2016, http://www.jhsph.edu/research/centers-and-institutes/center-for-mental-health-and-addiction-policy-research/research/economics-and-services-research/arnold-

foundation-project-map/; and Pew Charitable Trusts (2015). Researchers documented 64 initiatives as of January 2015, including 8 states and 32 counties that had suspended Medicaid benefits instead of terminating enrollment (Bandara et al. 2015).

2. Centers for Medicare and Medicaid Services, Center for Medicaid and State Operations, letter to state Medicaid directors, "Ending Chronic Homelessness," May 25, 2004, https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Supports/Community-Living/Downloads/Ending-Chronic-Homelessness-SMD-Letter.pdf; Centers for Medicare and Medicaid Services, letter to state health officials, "To Facilitate Successful Reentry for Individuals Transitioning from Incarceration to Their Communities," SHO # 16-007, April 28, 2016, https://www.medicaid.gov/federal-policy-guidance/downloads/sho16007.pdf.
3. See, for example, the Transition from Jail to Community Online Learning Toolkit, http://tjctoolkit.urban.org/.
4. The state has described some of these initiatives in Betlach (2016). See also Ryan et al. (2016).
5. For more information on Arizona's prerelease application efforts and those of Connecticut and Massachusetts, see Ryan et al. (2016).
6. At the time of our interviews, Arizona's behavioral health system was administered by the Division of Behavioral Health Services within the Department of Health Services. The RBHAs were integrated into AHCCCS on July 1, 2016. Interviewees explained that the RBHAs would continue to contract with providers following this administrative change.
7. This issue brief focuses on enrollment-related data exchanges, but exchanges of health records is a critical element of what Interviewees repeatedly described as the need for a "warm handoff" as individuals with significant health care needs transition in and out of incarceration—even temporarily—to ensure that they receive necessary and appropriate care. AHCCCS received a State Innovation Model planning grant to, among other things, focus on complex members transitioning from the justice system (see Betlach 2016). Arizona and Pima County have both led initiatives to promote information sharing between correctional facilities and community providers to improve continuity of care. See Davis and Cloud (2015); "Helping Pima County Exchange Justice-Health Information: SEARCH Shares Detail of Project Success at NIEM in November," blog post, SEARCH, November 04, 2014, http://www.search.org/helping-pima-county-exchange-justice-health-information-search-shares-details-of-project-success-at-niem-in-november/; and Butler (2014, 2016).
8. "Health Information Exchange (HIE)," ADOA-ASET, accessed September 27, 2016, https://hie.az.gov/.
9. Substitute S. 6430, State of Washington, 64th Leg., 2016 Reg. Sess. (Wash. 2016), Sections 1 and 2. http://lawfilesext.leg.wa.gov/biennium/2015-16/Pdf/Bills/Session%20Laws/Senate/6430-S.SL.pdf.
10. Rev. Code Wash. § 72.10.030.
11. Operated by the Washington Health Benefits Exchange (Washington's state-based marketplace), the Healthplanfinder is an integrated eligibility determination and enrollment platform for both Medicaid and qualified health plans, the private insurance plans created under the Affordable Care Act. The Healthplanfinder works with both HCA and the state's Department of Social and Health Services, which HCA has designated to run certain traditional Medicaid programs, including those for people with disabilities and people needing long-term services and supports. Once a person is found eligible for Medicaid, the information is sent to the state's Medicaid Management Information System, which is operated by the HCA.
12. Centers for Medicare and Medicaid Services, "Final Rule, Medicaid Program; Mechanized Claims Processing and Information Retrieval Systems (90/10)," CMS-2392-F, RIN 0938-AS53, 80 FR 75817 (December 4, 2015), https://www.gpo.gov/fdsys/pkg/FR-2015-12-04/pdf/2015-30591.pdf

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Acknowledgments

This brief was prepared with funding from the Office of the Assistant Secretary for Planning and Evaluation, United States Department of Health and Human Services, under Contract Number HHSP233201500064I, awarded September 2015. The views, opinions, and findings expressed in this brief are those of the authors and do not necessarily represent the official positions and policies of the United States Department of Health and Human Services or its agencies. We are grateful to the Office of the Assistant Secretary for Planning and Evaluation and to all our funders, who make it possible for Urban to advance its mission.

The views expressed are those of the authors and should not be attributed to the Urban Institute, its trustees, or its funders. Funders do not determine research findings or the insights and recommendations of Urban experts. Further information on the Urban Institute's funding principles is available at www.urban.org/support.

The authors wish to thank the national and state experts who contributed their knowledge and perspectives to the development of this brief. We also wish to thank Catherine McKee of the National Health Law Program, Richard Cho of the Council of State Governments Justice Center, and the Centers for Medicare & Medicaid Services for their insightful review. We also appreciate the contributions of Jesse Jannetta, Rebecca Peters, Jeremy Marks, and Emily Hayes to the project as a whole.

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