



**Medicaid Beyond the Silos Series
Health Care Out from Behind Bars: Meeting
Reentering Prisoners' Efficiently
Centene Corporation
Alliance for Health Reform
Friday, December 11, 2015**

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ED HOWARD: Good afternoon, my name is Ed Howard and I want to welcome you on behalf of Senator Blunt, Senator Cardin and the Board of the Directors of the Alliance for Health Reform to today's program on Health and Reemerging Prisoners. And we actually are concluding with this program, a three part series, exploring the intersection between healthcare and social policy. Back in August we looked at the connection between health and housing, in October it was the coordination of health services and non-medical home and community based services and today, the subject is how we get needed healthcare to those re-entering society from correctional settings. It may come as a surprise to some of you that there are so many people who are classified in that category. There are, I think it's, 700,000 people who are released from prisons every year and another nine or ten million are released from local jails. Just so we are all starting from the same page, this population has real health problems and let me take mental health problems as an example. Fifty-six percent of state prisoners, 45% of federal prisoners and almost two-thirds of jail inmates have some sort of mental health problem.

By the way, I should mention here that mental health issues are particularly important to both of the Alliance Honorary Co-Chairs, Senator's Blunt and Cardin and Senator Blunt is the sponsor of bipartisan legislation to expand the demonstration program of certified community behavioral health centers from eight states, which is in the current law, to as many as 24 states. Now, the Alliance does not endorse legislation, but it does take note of relevant policy choices and this is one. And we also take note of the opportunities to coordinate Medicaid and other coverage and the justice system and that's going to be the central theme of today's conversation. We are going to look at what the most promising approaches are that seem to be in the universe, why they are being pursued and why they are worth pursuing and the barriers that exist to their wider adoption.

We are pleased to acknowledge support for today's program by the Centene Corporation, which is one of America's largest private insurers, operating Medicaid plans and others in what are now two dozen states. So we are very happy about that.

And one item of housekeeping, you can see the hashtag if you want to tweet about this subject of re-entry and the credentials for the WiFi are on your table and I just want to do one item: There is a single sheet of logistics tips that is in your packets and on the screen right now and I want to call attention to our plea that you do fill out the blue evaluation form that is in your packet. If enough of you do, as you see on the screen, we will make a modest donation to the DC Central Kitchen, which actually serves 5,000 meals a day to some of the District's most vulnerable residents and they run a culinary training program that builds skills and helps find jobs for a lot of unemployed DC residents, including a number of them involved in the justice system. In fact, we would encourage you to make your own tax deductible donation at DCcentralkitchen.org.

The commercials are over and we should get to the program. We have a wonderful panel and to introduce that panel and co-moderate today's discussion, I want to introduce my Alliance colleague, health policy associate, Beeta Rasouli.

BEETA RASOULI: Thanks, Ed. We do have a great lineup of panelists today and you can also refer to your packets for more biographical information. We are going to start with Matt McKillop who is a research officer at the PEW Charitable Trusts, where he leads PEW's research on state and local correctional healthcare. Matt will tell us what we need to know about state prison healthcare's funding and also highlight some policies that may contain costs and improve health. Then we will turn to Kara Miller, who is the Chief of Care Management and Performance Improvement at the Ohio Department of Medicaid, Bureau of Health Research and Quality Improvement. She will discuss Ohio's Medicaid pre-release enrollment initiative and touch on some of the program's successes and challenges. And then finally we will hear from Saroya Friedman-Gonzalez, who is Vice President of Workforce Development at the National Urban League. She will discuss the National Urban League's integrated case management approach and describe lessons learned from their programs being implemented across the country. We are really glad to have you all here today and I think we are going to hear some great perspectives on the issue. With that being said, I'm going to turn it over to Matt to kick us off.

MATT MCKILLOP: Thank you Beeta and Ed and thank you to the Alliance for inviting PEW to participate in this very important discussion. I will just start off quickly, for anyone who is not terribly familiar with the PEW Charitable Trust. We are a non-profit, non-partisan organization here in town that works to help improve public policy throughout the country and in particular, our correctional healthcare policy work sort of has three overarching objectives: First is to help provide a long term look at state correctional healthcare spending, second to help policy makers understand and preserve the value of that spending at the state and local spending as inmates are in prison or jails and when they return to the community. Then third, to help highlight policies and practices that can contain costs while maintaining or improving health outcomes.

So, we have a somewhat extensive line of research on this, but I will just highlight a couple pieces in particular that I think have been made available in your packets. First, on the left of the slide there is a 50 state study we did last year or published last year, looking at state prison healthcare spending from 2007 through 2011 and looking at trends and cost drivers of some of that spending and promising cost containment strategies that states were employing. And the second is a newer brief on the opportunities for states and localities to facilitate health coverage for inmates of jails and prisons when they return to the community through Medicaid enrollment. So obviously, very relevant for today's discussion and I will be talking a bit about what's in there.

So, I wanted to start off just by thinking a little bit about how health and healthcare fits into the larger discussion that is being had here in town and throughout the country on criminal justice reform and why it's an important element. And to kind of oversimplify, I think there are sort of two key reasons. One is that if you look at over the last decade or two, healthcare and corrections independently have each been fiscal pressure points for states and localities. So when we really began to dive into this work, a part of our interest was, what is happening from a fiscal point of view at the intersection of those two cost drivers? And that being correctional healthcare. So what we found was a similar trend and some of the evidence of that is that in 2001, healthcare being delivered inside prisons

represented 10% of all dollars that states were spending on operating prisons, but by 2011, that had actually doubled to 20%. So as healthcare spending begins to consume a larger and larger portion of the prison spending pie, it is really gaining increased attention from corrections officials as well as other officials in states.

The second reason I would point to is really, I think, increased recognition among a lot of stakeholders about the intersection between public health and public safety and the health profile of a lot of inmates in prisons and jails. Ed touched on this, but inmates tend to enter and continue to have high rates of substance use disorder, high rates of mental illness, chronic conditions like diabetes, hypertension and asthma as well as infectious diseases such as HIV/AIDS and hepatitis C. And so more and more we are understanding that the nature and quality of treatment that is provided to people with these conditions while they are incarcerated and then whether and how that treatment is continued when they are released into the community, really does impact not just them of course, but the wider community in terms of public safety and in terms of public health.

So I want to transition here, for the rest of the presentation, to talk about how Medicaid fits into this and provides an opportunity for states and localities to address some of these issues. So a little bit of background -- states and localities have never been precluded from enrolling inmates into Medicaid solely because of their incarceration status. As this guidance from CMS says, "Individuals who meet state's Medicaid eligibility criteria, maybe be enrolled in the program before, during and after the time in which they are held in jail and prison." And that is from 2004, very clearly prior to ACA. I think the key clause in that guidance though was, "who meet state's Medicaid eligibility criteria". Traditionally the barrier over time was that many, many states did not offer Medicaid to non-disabled adults without dependent children. And so that was a category that most inmates fell into and so due to that, they were not eligible for Medicaid either while they were incarcerated or in the community and so while it wasn't the fact that they were incarcerated that prevented them from being able to enroll, it was the fact that they didn't fit other criteria.

So the Affordable Care Act offered an opportunity to change this. As everybody here knows, I'm sure, the ACA contained an expansion of state Medicaid criteria and the Supreme Court has held that that expansion is optional, but for states that elect to participate in expansion, what it did is transform the program from being governed by a categorical eligibility systems where you had to fit one of these four categories: Children, pregnant women, parents of dependent children and elderly and disabled adults, to a wider basket in which the key criterion is whether or not your income falls below a certain threshold and that threshold is 138% of the federal poverty level and for everyone who newly falls into that category, of course the federal government is providing enhanced Medicaid match rates of 100% initially in the first year, scaling down to 90% in 2020, going forward. So this is true statewide, but its especially relevant in this case because the switch to an income governed criteria solely, removed the barrier of non-disabled childless adults that I mentioned before and made many, many more inmates eligible to be enrolled.

A number of states have taken action in this regard and I will touch on just a few of these really quick. So, Massachusetts actually presents an interesting example, because this was prior to the Affordable Care Act, because of course Massachusetts had reformed its healthcare system and served as a model to some extent for the Affordable Care Act. So in 2008, it began enrolling inmates six months prior to release and has in fact over time reached virtual 100% enrollment of eligible inmates when they leave a prison and to some extent, localities as well. Ohio, which you will hear more about here in a moment, is another example. Last fall, the Corrections Department and the Medicaid Office began a joint initiative to enroll inmates beginning three months prior to release and that enrollment takes place over the phone and in some cases, with the support of peers in the prisons and as of July, they had enrolled over 700 inmates in Medicaid. New Mexico passed a law last spring that reiterated that people are not precluded for being enrolled solely due to their incarceration status and changed their system of suspending coverage, rather than terminating, which I will touch on a little bit more here in a moment. In Bernalillo County, which is the largest county in New Mexico, has begun a pilot program.

Then the last example I point to though, is Wisconsin, which is interesting because Wisconsin has not participated in the Affordable Care Act's Medicaid expansion, but it did receive an 1115 waiver for the federal government to begin covering non-disabled childless adults up to 100% of the federal poverty level, not 138%. So this allowed it take similar advantage of the opportunities that the other states are. The key difference is that they are not receiving the enhanced federal support, because their expansion does not -- is not entirely in accordance with the Affordable Care Act. But I think the key thing to see here is that states need not expand Medicaid in accordance with the Affordable Care Act in order to take advantage of these opportunities.

Real quick, I just want to touch on a strategy in addition to preserving care continuity, that Medicaid enrollment offers. In general, states and localities are prevented from receiving any federal Medicaid reimbursement for care provided to inmates, with one exception and that is, in patient care delivered to inmates outside of correctional facilities. This has been true, as you can see here, this guidance is from 1997. This again, predates the Affordable Care Act, but has become increasingly relevant as more and more inmates are enrolled. Because in order to receive this reimbursement, it of course is only applicable for people who are enrolled in the Medicaid program. So, again, it was always an opportunity, the fact that very few inmates were enrolled while they were incarcerated, meant that in practice, there were not very many inmates for whom states or localities could receive reimbursement. As they enroll more, they can take greater advantage of this and one kind of policy option in particular is converting from a system in which Medicaid eligibility or coverage is terminated as people enter a jail or prison, which means those people have to reapply later on. That coverage can be suspended so that Medicaid is not billed for the care provided inside a correctional facility, but it can be temporarily reactivated when somebody is in a hospital and the state can receive federal reimbursement for that and then it can be re-suspended as soon as that care ends. So, this provides an important cost saving strategy for states and localities.

Just a couple quick examples here, these are all states that have reported savings or estimated savings from fiscal year 2014 and '15. And with that, I will hand it over to my colleague.

KARA MILLER: So good afternoon and I also wanted to thank the Alliance for inviting Ohio Medicaid to come here and to share a lot of the exciting work that we are doing with our corrections partners.

Just a little bit about Ohio Medicaid, we are the largest payer in the State of Ohio. There are about three million covered lives in Ohio Medicaid and about 80% of them are covered or enrolled in Medicare Managed Care plans, which is one of our key partners in this effort. We are also an expansion state and have been so since the beginning of 2014.

So just to look at the inmate population at a glance in Ohio. There are 27 state prisons in the State of Ohio, 24 of them are male, and three of them are female. There are currently over 50,000 inmates who are residing in a state prison. The majority is male, average age is mid 30s. The average stay in prison is a little over two years and there is an age population about 16% is over the age of 50. Ohio does have a rather low recidivism rate, 27.5, but the state leaders are looking to even further lower that recidivism rate, which is one of the main reasons why we have this partnership. It's well below the national average of 50%. As no surprise, there is a high prevalence of chronic care mental health issues and individuals who have prior drug and alcohol addiction issues. Approximately 20% in 2014 had a mental health issue, 80% had a history of drug or alcohol addiction, 40% have a chronic condition, about 12% have hepatitis C and less than 1% of our population has HIV. Upon admission, it was determined that about one third of the individuals who are admitted to a state prison had Medicaid and less than 1% had some sort of private insurance. So I just wanted to give a feel for the health needs that our inmate population is facing. With expansion, we realize that many of the individuals who were incarcerated would be eligible for Medicaid upon their release to the community because they are childless adults with zero income. So with expansion, Medicaid realized that we could play a positive role in helping these individuals seek that needed treatment once they were in the community and to improve their health outcomes.

So how did we get started in Ohio? We had a very strong partnership with our Department of Rehabilitation and Corrections. This started about two years ago when we worked with corrections to have Medicaid be the payer of inpatient hospitalizations. So we had that partnership where we actually had to apply for Medicaid on behalf of incarcerated individuals so that Medicaid could be the payer of that. As I mentioned, because we are an expansion state, we realized we already had the strong partnership formed, why not take it a step further and extend the opportunity to bring the community Medicaid eligibility and enrollment process into the walls of the facility, so that on their day of their release, they would have a health insurance card that they could start accessing services. So we started to meet weekly at the beginning of 2014 and still continue to meet at this time to work through our implementation processes. So there was a lot of planning upfront that went into working with our systems and putting some structures and processes in place so that we would be able to accomplish this. In

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September, 2014, we launched the program at our first facility, it was a female facility and at the time because we recognized the health needs that the populations faced, we expanded our partnership beyond corrections and we also included the mental health and addiction services agency, our Department of Health and then as I mentioned, the Medicaid Managed Care plans that the Department of Medicaid contracts with, since many of these individuals would be receiving their healthcare through a Medicaid plan.

We do have a deliberate slow phase in of our process, because we don't have all the kinks worked out. We do plan to expand this to all 27 facilities by the end of December 2016. Our program goals are to provide continuity and healthcare treatment, reduce recidivism and improve health outcomes.

So at a very high level, this is what Ohio's program looks like. What we do is, about three months prior to a release month, we begin this process. So, in the month of December, we are beginning to work on March, 2016 releases. We backed up, like I said, the community Medicaid eligibility and enrollment process into the facility so that on the day of the release, they would have access to benefits. What is unique to Ohio is that we actually are using selected inmates and we train them and they actually serve as the Medicaid navigators or the Medicaid guides, where as individuals are ready to be released and go through this process, they actually hold an enrollment class. So their peers are actually the ones who are educating them about Medicaid, educating them about the different health plans that they can select from and they also have them complete all the necessary forms. There is an authorization form so that the Corrections Department can apply for Medicaid on their behalf. We also have them sign a consent to release information so that clinical information can be shared between the Corrections Agency and the selected Managed Care plan, so they can provide that care management. And then there is a few other forms. This is a voluntary program, but we -- I mean, why not? Why not take care of this and apply for this before they are released? It removes one less -- it takes away one stressor.

So, what happens then is, once the inmates go through this enrollment class, we get them on the phone with our state enrollment broker who collects a few demographic pieces of information, asks them what health plan they want to select and they capture all that information. The phone calls take less than three minutes, I think we are down to right now, and the Corrections Department then sends a big batch enrollment file over to our online benefit system and it goes through what we call a "no touch" process, because what we are doing is that we are making some assumptions about this population. So in essence what we have done, we have set up a special process for these individuals where we have taken what could be a lengthy application process and we boiled it down to about 13 questions and a three minute phone call. It goes through a no-touch process and when eligibility is determined and enrollments are confirmed, there is another file that gets sent to our Corrections Department, where they actually do a screening and they look to see, of the individuals who applied for Medicaid, were approved for Medicaid, how many of them have what we call a chronic risk indicator? And so if a person is flagged as having a chronic risk indicator, what that means is, they have Hepatitis C or they have HIV or they meet two or more of the following criteria: They have a chronic

condition, a mental health issue or they have a history of drug or alcohol addiction. If they meet any of those criteria, they are flagged by the corrections department and there is some clinical information that is pulled from their system. That indicator and that clinical information then gets transferred to the managed care plan that the individual has selected and then as the state, we require that those health plans provide prerelease care management to those individuals. And what that means is, about seven to 14 days prior to their release, the health plan care manager develops a transition plan. So just like when you are in the hospital or you are in a nursing facility, you get sent home with your discharge instructions or your transition plan. So, the plan care manager, to the best of their ability develops this transition plan and then in a video conference between the plan care manager and the inmate, they review this transition plan as an opportunity for them to start forming that relationship. The inmate is able to provide any input to the transition plan, know that doctor is not going to work for me, I would rather go to this pharmacy to get my medications, things like that. And then at the conclusion of that video conference, it's lasts about 15 minutes, the care manager will go back, update the transition plans so that on the day of their release, the person walks out of the facility with a Medicaid card and with a transition plan if they have been identified as that high risk individual. So, on the day of release, like I said, they have those two things in hand and then we want the plan to follow-up with these individuals within five days of release. We know that housing or post release living arrangements can be in question, I mean, up until the day of release. So we are hoping that if that is in play, that during this video conference and having that health insurance ID card with the plan member services line, that they will be able to take advantage of some of those resources.

So the health plans are not just helping these individuals with their healthcare, care management is meant to bring the healthcare piece together with the non-medical piece such as the social services. So many of our care managers are helping individuals with housing, with transportation if they need it, to get medical appointments. I have heard stories about them helping individuals fill out financial aid applications, college applications, but most important, its to try to get them in a stable environment and help their re-entry to the community be a success, especially for those individuals who need to continue their mental health treatment in the community and making sure that they -- because they are giving a limited supply of meds when they are released and to make sure that they are able to continue to have those meds.

So where are we at today? Inclusive of enrollments for January 1, 2016, there are about 1,900 individuals who will be enrolled in a managed care plan. Ohio does have 20,000 releases per year. So when this is fully up and running, we will probably be close to having about 1,000 individuals come through this process, because even though there are 20,000 releases, there are certain individuals who do not participate in this program and that is if there is -- it's based on immigrant status, if they are released to post transitional control, they are still considered incarcerated, so they are not able to apply. If their sentence is less than 90 days -- and there is a couple other reasons why they may not be able to apply for this program. But regardless, the mission is to use these Medicaid guides to be able to educate everyone about the benefits of having health insurance, even if they are not able to apply or don't want to take advantage of it. We have eleven facilities that

are active right now with enrollment, two more will come on in December and then like I said, the rest will be in 2016. We have had many successes, but we have also had our share of challenges. Our goal is to fully automate this process and drop in some of those human elements such as using the Medicaid guides. Those inmates that do serve as the Medicaid guides really are passionate about this. They want their sisters and -- they are their sisters and their brother's keepers and they want to do whatever they can to help encourage this so that they don't come back and they take the job very seriously. I'm always very surprised when I go into the facilities to do the trainings, just the -- how savvy they are with their questions. They really are thinking about this the right way. So I would say that is an attribute unique to Ohio that as other states bring this up, that it's a model that they consider, especially for sustainability and to take it to scale.

So our goal is automation. We do have a lot of behind the scenes manual processes, which does introduce some risk for maybe error and we want to try to eliminate that as we move towards a more automated process. Our success is also attributed to the very strong partnership that we have with Corrections and we still meet weekly and we will be revisiting and constantly refining our processes, so we are very open about what is working and what is not working and correcting them. And then just one other thing that I would say is, a critical aspect of this project is the ability to share information to be able to coordinate care and oftentimes when the community behavior health providers often will -- or may throw up some barriers or concerns around sharing information as it relates to confidentiality requirements. So one thing that we built into our process, as I mentioned, is upfront making sure that we get that consent to be able to share information so that it's not a barrier that is hidden behind any more. And I think that has really helped Ohio be successful.

And so with that, I will hand it over. Thank you.

ED HOWARD: Thanks very much, Kara. I should point out, what you were describing sounded very much like kind of the epitome of the theme of our three briefing series, which is trying to get Medicaid out of the siloes that it finds itself in, in many instances. So, I'm really glad to hear that. We will turn to Saroya.

SAROYA FRIEDMAN-GONZALEZ: Thank you. I also want to thank the Alliance for allowing National Urban League to present some of our work. So, I think we are a little bit of a different -- or, I'm a little bit of a different panelist, because I'm going to sort of share some of the work that we are doing on the ground. But before I do, I just want to give you guys a brief overview of what the National Urban League is, in case anyone doesn't know. We are a national organization; we have been around since 1910. Our mission to enable African-Americans and other underserved urban residents to have self-sufficiency, parity, power and civil rights and we do this through program areas of focus. We have a focus on health and quality of life, a focus on workforce or employment in training programs, focus on youth and education work, focus on entrepreneurship and we also have a Washington bureau here in DC that focuses a lot on advocacy and policy issues. Our work is made possible through 94 Urban League affiliates, boots on the ground around the country. That means that we have community based organizations that

are multi-service community based organizations, their own 501C3's in 94 different cities around the country. So, I am going to give you a quick overview of our workforce programs, you know, our portfolio; we have about eight different programs that we operate. We have an urban seniors jobs program targeting seniors 55 years and older. We have an urban youth empowerment program that targets youth 14 to 24. We have an urban reentry jobs program that focuses on the reentry population, specifically adults. We have an urban supply chain jobs program focused on finding long term unemployed jobs in the supply chain sector. We have an urban construction jobs, that focused on construction. A tech jobs program focusing on tech jobs. We have a project, Empower You, which is a capacity building effort to really work with the affiliates to make sure they are providing best in class services in their communities. Then we have an Americore Healthy Living peer educator program. That is sort of the breadth of our programs and all of our programs have an integrated model.

For the purposes of today, because it's a focus on health, I'm going to really talk about four of our programs where there is a very concrete health related program as part of the model. One of the things that I wanted to just quickly share about our programs and workforce, is that our programs are designed, meaning the pieces that we offer the participants that walk through, based on our experiences in the field and what we think the need is. So we try to put together programs that are targeting the needs of the participant. And so the four programs that have a well defined health program within it is, our Urban Youth Empowerment Program, our Americore Healthy Living peer educators program, our urban reentry jobs program and our seniors program.

I want to talk a little bit about how we -- all of our programs, as I said, have an integrated case management approach and so what that means is that our community based organizations are Urban League affiliates, often partner with other local community based organizations to provide certain services that they know their clients need. And they do that through MOU's. And they also focus on sectors when they are trying to find them jobs and they tailor services to address the needs -- but all of the programs are focused towards finding them a job. So everything that we are looking at through our programs, the end goal is to make them economically self-sufficient. So in our Urban Youth Empowerment Program, we are targeting a population as young as 14, as old as 24, that have been involved in the juvenile justice system. So many have not been tried as an adult, although we have operated some programs where actually the youth have been tried as an adult. The program has various components aimed at trying to get these youth on to careers and part of the approach may be keeping them in school and so they each have a mentor that they are connected with. There is career readiness around exposing them to the various high demand sectors. But then an important piece of the case management is making sure that they have the appropriate health related services. So either the affiliate themselves may offer services related to health and mental health or they will partner with an agency that does and they will be the main point of contact and follow that youth through. There is also a volunteer or community based or sort of justice, whatever you want to call it, there is that component as well, which is really around promoting volunteerism with a goal around developing self esteem for the youth, which is connected with the mental health and sort of giving them a sense of confidence.

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Then the goal, as I said, is either to have them stay in high school, get a GED or enter post secondary education or get a job. That is really what we are aiming for in this program. The program, we operate it at its height in 21 cities, but a lot of it is contingent on funding, so there are cycles and we competitively award affiliates as we sub grant out. I think one of the important pieces to note within our Urban Youth Empowerment program is sort of where we have done well. We have done an incredible job in terms of, we are held up to federal standards, benchmarks that we need to meet and we have been refunded based on our strong performance. So the areas where we have done particularly well are around connecting youth to jobs, having them stay in school as well as keeping them from returning to prison. So, what this slide doesn't show, but I want to point out, is that really the goal is making sure that fewer than 20% of the youth return to the criminal justice system or the juvenile justice system and consistently we have been below 10% and most of the time, anywhere between four and seven percent for this population, depending on when you are measuring it. And that is an important metric that I think is worth noting on, because obviously it's the model itself and making sure that these youth have the necessary services that is sort of making sure that they stay out of the justice system and a big piece of it is that case management support and that mental health services in addition to all of the other pieces and support in the mentoring.

One of the things, when we had a chance to sit and reflect on the program and as I said, it's cyclical and a lot of it is contingent on funding, but when we started to look at sort of the youth in this program, we came up with anecdotal sort of lessons learned and I wanted to just share some of them, because it was really what helped us develop a program that we are currently operating. And we learned from this program and we have been running it since 2004, is that the youth had an enormous boost in self esteem from doing volunteerism in their communities. That was obvious from everyone that was working with them. It was a great piece of the program. We also realized that after 24 months, which is the typical life cycle of the program, that it wasn't enough. That the services sort of stopped depending on funding. So that could be difficult, they needed more support. We also know, obviously, from our work with employers that health careers is a high demand occupation. We also knew that many of the youth were typically uninsured in spite of the fact that many could access health insurance. We knew also that many of the youth needed more experience on their resume. Separate and apart, we knew that obviously health and work are linked inextricably and that if you don't have good health, you are not going to go to work on time. So we felt, wow, we need to really focus on this and develop a program that meets all of these needs. What we wound up doing was designing a program with the Americore, through CNCS, our Americore Health Living peer educators program, and I forgot to say one other piece that we knew from operating in our health division, is this concept of peer to peer community health outreach and so that was a piece of this as well and it wasn't on the slide. So, as of this year, we began recruiting these youth in four cities to become health educators. We are targeting 18 to 24 year olds and the idea is that they are going to work in support with other agencies to get out into their community, target their peers and increase their knowledge around healthy living, preventative health, with the goal of A) making sure that more youth become enrolled in health insurance, that they understand basic things around nutrition and risk factors, that they go to the doctor and that they in turn outreach

to 8,000 a year, their peers in the community, to get that across to them, because they felt that they were the ones that needed to have that message out there. But in turn, what is really great and why this program is so important to us, is that it also, for the 20 youth that are in the program, they get an income through the stipend and they are getting a career and they are maybe forging a career in the health sector and that is really important to us.

All of our youth members, they get this work experience, we provide all the content and the training, they do get health insurance for their term of service, they get student loan deferment, professional development and there is an opportunity for child care for those that have it. So that is just sort of one area where there is an intersection and remember, these were youth that were formally in the juvenile justice system.

So a program that is probably most relevant to the topic is our urban reentry jobs program and this is a program that targets adults and the typical age is really in their 30s and these are adults that are being released into work release programs, so they partner and they are enrolled in our -- in two of our Urban League affiliates, Chicago and New Orleans. And it's funded by the U.S. Department of Labor and we serve about 422 individuals, which is small, but it's a program that we are hoping to expand. And as I said, its in two cities, but we have operated this program and more, but in Texas, Ohio and Oklahoma as well. But what I wanted to point out was some of the core services that we offer in this program. Obviously it has the mentoring piece, which is critical to serving this population. There is a supportive services, there is obviously a real focus on jobs placement, but really more of the energy is placed on industry recognized credentials and scaling them up to get jobs. But the substance abuse counseling, the mental health counseling and the family counseling, those are all areas that are critical to the success of the adults. They have so many issues when they come into the program around substance abuse, around depression and so this is a critical piece of the model, it wouldn't work without it. And I think what's important is, we have been running this program since 2011, you know, we are even getting better at it now, but what is remarkable is our recidivism rate, it's been at 4%, which again speaks to the fact that there is a connection to these very deep wraparound services and returning and when I looked at your numbers, I thought, wow, this intensive service is really helping at least for this population in terms of going back to prison. So if you go back and go through the program. They were also commanding higher wages than sort of what the benchmark is for this population when the program was designed by U.S. Department of Labor. And then the other piece is that 99% of the individuals wound up with some type of industry recognized credential, which was really the focus of the first iteration of the program. So we started another program and we are currently in it, so these are not finalized data, but in terms of where we are today, we have managed to increase our average earnings and I think that has a lot to do with our focus -- we are really focusing on sectors and high demand occupations, so it's a little bit of a different twist in terms of the program. But again, there is a lot of a focus on that health/mental health sort of services and we believe that that is why our recidivism rates are still low. They are not -- at this point, I think they are about eight percent, but again, that's not a final number, that is just sort of where we are today and I think as we continue to enroll people, that number could go down. But I think our strength is in sort

of where we are placing the individuals, the types of services that they are getting and their wages and the credentials that mean that they are going to have longer term careers.

So just a few lessons learned. I think I went through them, but that the referrals to the general health services, mental health and substance abuse all contribute to those outcomes and then this integrated model is really critical. The Urban Seniors Job Program --

ED HOWARD: I don't want to cut you off, but we have a lot of questions that people have. As a certified senior, I wonder if we could try to elicit some of the questions and maybe we could get to the description of the senior program in the course of the Q&A, if that's alright with you.

SAROYA FRIEDMAN-GONZALEZ: That's perfectly okay.

ED HOWARD: Now you've got to come up with good questions to keep this conversation going. You can do it one of three ways. You can fill out the green card that is in your packet and hold it up. You can go to one of the microphones on the left and right side of the room or you can Tweet -- what is the hashtag? Re-entry. And we will get it up here to you. If you do come to the microphone, we ask you to be as brief as you can and identify yourself. So, why don't you start, sir?

AUDIENCE MEMBER: Carl Pulsner with the Center on Capital and Social Equity and I started the project six months ago to look at a couple things that probably won't go away and that capitalism and poverty and including more people into the system. My question is about -- it's sort of looking at it from the released prisoner's point of view. So you are a released prisoner and you have a health problem. You need a lot of medication or you have cancer and you need continuity of coverage. Especially with regard to federal inmates, do they have a choice of which state they are released in? How do they decide this in terms of scoping out their survivability prospects? Also, I know a lot of states contract with the private sector and put inmates in other states, so just how does that play out? I was trying to Google it and I couldn't find any information on it. With the Medicaid, given that they can't really undergo a large lapse in coverage and states that are going to have these Medicaid expansions are going to be better places possibly for them to go then the 20 that don't -- that kind of thing.

ED HOWARD: Matt, is that something you folks have looked at, at all?

MATT MCKILLOP: In general, it's not something we have looked at, because we focus primarily on state and local inmates. In terms of states that imprison or that utilize prisons in other states, my understanding is that those inmates do return to the original state before they are released. So they are released in the original state of origin rather than the state that they were sent to. But I'm not sure about federal prisoners.

AUDIENCE MEMBER: Good afternoon. Andrew Kessler with the International Substance Abuse Counselors and substance abuse and mental health came up for all the

speakers and the importance of services was highlighted. We are in the middle of a workforce shortage as it is, but my question is really for the National Urban League and maybe for others who can chime in. What we have found to make a large difference in the effectiveness of treatment is in cultural competencies in the fact that professionals have to understand that the consumer that they are dealing with and their backgrounds, whether it be racial, socioeconomic, whatever it may be. Do you make any effort to assure that the treatment that is being provided to the prisoners that are released is by professionals who understand these cultural competencies and are comfortable dealing with the populations that you represent?

SAROYA FRIEDMAN-GONZALEZ: The Urban League is a minority led organization and so all of the Urban League affiliates follow the same model. Given the populations -- and that is not to say that everyone being served by the National Urban League is African-Americans and in fact that is absolutely not the case. In fact, many of our affiliates serve urban residents, however it's a community based model, so by definition it is culturally competent. You have people speaking the languages and most of our affiliates are situated in urban areas that are high crime, high poverty. Also, we take great lengths, as we put together curriculum, to make sure they are not just like, off the shelf curriculum. We have a whole host of people reviewing and weighing in and we really spend a great deal of time, as we are preparing, for example, financial literacy curriculum, health curriculum. Our health curriculum was developed by Moorehouse. They helped put together the content and worked closely with our Health Division so that it addressed the needs. In fact, our whole health curriculum was really targeted towards the African-American community and it focuses on areas, specific risk factors that might be more prevalent in the African-Americans, but I think throughout, whether its our career readiness or any of the other mentoring, it's a real focus.

AUDIENCE MEMBER: Hi, my name is Lisa Updike, I am from the Government Accountability Office and I wanted to ask Kara if you could speak a little bit more about the process in which you got managed care plans to offer these multitude of services. Then also, in general, if anyone can speak to -- if you are supplying individuals with health insurance, how they are actually accessing care when they are back in the community?

KARA MILLER: So we were able to bring health plans on board because we own the contract with the plans, so we are able to put requirements in there for what we want health plans to do. But honestly, they are completely bought into this effort. We actually, during the month of an individual's release, we actually pay our plans a capitation payment and backdate the enrollment to the first of the month. So in essence, there is that -- there are those resources there for them to start providing that pre-release care management. It's just, they are not able to actually access services until the day of their release and afterwards. And I think our plans were also enthusiastic about this opportunity because many of these individuals just like many other Medicaid recipients are sometimes hard to reach and hard to engage in healthcare and here we are, connecting a plan care manager to these individuals, those who have high risk needs in the facility. So we are actually providing them with a captive audience, if you will, and we are doing

that -- we are helping them with that initial engagement effort. So the plans are very much invested in this effort.

ED HOWARD: Just following up, Kara, on the idea of the availability of the services themselves as opposed to the insurance card, we have come across in our research for this briefing, references to people who can get access to the right healthcare providers fairly quickly, but are having a particular problem with accessing prescriptions that are part of their care plan and apparently there is some -- at least in some places, a lag between the release and the actual enrollment in Medicaid on the one hand and the pharmacy benefit managers being able to process that eligibility and getting it to the local pharmacy. Have you come across instances of that being a problem in Ohio or have you heard it from any of your colleagues in places where these programs are also in place?

KARA MILLER: So, in Ohio I have not heard of any difficulties with accessing medications. For those individuals who are considered high risk or connected to the plan prior to their release, because we don't do that connection for everyone, it's just for those who are high risk. The Corrections Department does give a list of medications to the plan care manager so that they can start to put those arrangements in place and make sure that there is a pharmacy identified that will be in close proximity to where that person may be living post incarceration.

AUDIENCE MEMBER: Hi, my name is Glenn Chattel. I wanted to bring up two bills that I think would help prisoners being released from jail. One of them is the Excellence Act, which Mr. Howard was nice enough to mention before. I understand that the Alliance for Health Reform does not endorse specific legislation. As far as expanding the Excellence in Mental Health Program from eight to 24 states, which would involve Medicaid expenditures, for that I represent the National Council for Behavioral Health, which really would like that done as well as Congress, [unintelligible] Office. The other bill is Congressman Tim Murphy's bill. It is really the Murphy/Johnson Bill, the Helping Families of Mental Health Crisis Act -- also there is a companion bill in the Senate, which is a little different. The Cassidy/Murphy Bill and I just read there is an alternative bill that is going to be offered by the democrats on the House Energy and Commerce Committee. I really just want a comprehensive bill passed and I'm hoping that -- I consider this bipartisan legislation. So basically my question is, do you feel that these bills, the Excellence of Mental Health Demonstration Program state extension to 24 states and a comprehensive mental health reform and substance abuse bill will help re-entering prisons. Thank you so much.

MATT MCKILLOP: So, PEW does not have a formal position on either of those pieces of legislation, but I think both the prior question and your question, I think they both raise important points, which is that in terms of care continuity and the potential benefits that can come out of that with reduced recidivism and improve public health coverage -- health coverage -- whether through Medicaid or by other means is an important but insufficient element of that care continuity. And it's important, because historically 80% of people left prison or jail uninsured for various reasons. So, providing that coverage is important, but coverage doesn't necessarily mean healthcare. So, in addition to providing

the coverage, connecting inmates with providers, trying to ensure that treatment plans are continued, are important and another piece of that, which the legislation you are describing speaks to, I think, is making sure that there is sufficient capacity in the community for returning inmates and for other people in the community who need mental health treatment.

ED HOWARD: We seem to have, from our perspective, a left leaning audience as opposed to questions coming from the right. I'm sorry about the dimensions of the room, it sort of makes it difficult to make eye contact, but feel free to get to the microphone and bring yourself more to the mainstream.

AUDIENCE MEMBER: I'm going to continue the left lean trend. My name is Deborah Reed, I'm from the Legal Action Center. I have a question for Kara Miller about the pre-release program, specifically, can you tell us a little bit more about how you go about who identifies who should be in the peer to peer program, the training they go through and how do you solicit feedback from them to improve your peer to peer program?

KARA MILLER: That is an excellent question. I will try to provide my best perspective. I am not with the Corrections Department and they are the ones who are really responsible for that. So, it's my understanding that at each of the facilities, most of them are selected by the facilities staff. Most of the inmates to be the guides are selected by facilities staff and it's usually those who have a record of good behavior and really demonstrate that they care about the community. And so, it is dependent on the facility to pick those individuals. The number of individuals is based on the number of releases that the facility has per month and so we have started out with the largest releasing facilities and it's been anywhere between about four and ten guides who have been selected by facility. As far as the training that they go through, it actually is Medicaid staff and Corrections staff that do a joint presentation with these guides as we bring a facility online. So we bring a facility online, we actually go there and I personally have given the training, it's a Medicaid 101 presentation to say, this is what Medicaid is, this is why its important. In Ohio you get your benefits through a managed care plan, what does that mean? If you have certain health conditions, the individuals might be eligible for some of that pre-release care management. Then Corrections joins the presentation and actually gives -- they have a resource manual that is available for each of the guides and it is a really -- they do provide a lot of structure to these guides and then we make ourselves available after leaving. We don't expect the guides to be Medicaid experts, but we want to give them enough information so that as they are holding those enrollment classes, they are able to give the pitch for why it's important to have healthcare coverage for that continuity of care, re-entry to the community, things like that. As far as getting feedback, the Corrections Department actually -- and we have joined them, they have gone back to the facilities to ask the guides, "What kinds of questions are you getting asked by the inmates? What information do you need that you don't have?" So there is that constant looping back with the facilities to identify where we might be able to refine and strengthen our processes. And the one other thing I would say is, some of the guides are lifers that are in there and I know there is one facility where they have actually -- they have such a high turnover rate, I mean, they have individuals there with some of those

shorter sentences, so even though we have trained the first class of guides, they might be released in a few years. So, they are going to have to find a way to do a train the trainer, because it is not our goal to keep going back to all the facilities and providing training. So we have videos and other types of resources that they pretty much can keep orienting themselves to this information.

BEETA RASOULI: I think we can move on to the green question cards. Matt, maybe this question is for you. “Two-thirds of the inmates in jails are awaiting trial. Why is it that Medicaid considers them incarcerated? How much care for this population are localities bearing the cost with?” You might want to also distinguish between jails versus prisons and why it’s important to know the difference between the two and how the opportunities and challenges vary based on which one you are talking about.

MATT MCKILLOP: Sure. So, a distinction between jails and prisons. Jails are primarily county and city facilities where people are either awaiting trial or they have been convicted of misdemeanors that are generally -- have sentences of less than one year. Prisons are state or federal facilities where people have been sentenced of crimes of greater than one year. It’s important to distinguish between the two because especially in the context of Medicaid enrollment, jails and prisons face different challenges. A number of the examples I provided, including Ohio, where people are enrolled say, 30 days out or 90 days out or even six months out of release, in the context of a jail where sometimes people frequently are held for mere hours or days, the system for enrollment obviously then needs to be adapted somewhat. In terms of why CMS considers inmates held in jail who are pending disposition, meaning not yet convicted of a crime, that is just how the regulations have been drafted, but if you are in correctional facilities, you are not eligible to -- if you are enrolled in Medicaid for the state, to receive reimbursement. That said, those individuals are eligible to apply for health insurance through healthcare marketplaces or the exchanges that have also come out of the Affordable Care Act. In those cases, in addition to being able to apply, those people can receive assistance paying the premiums if their incomes are between 100% and 400% of poverty in states where they have not expanded Medicare and 138% and 400% in states that have expanded Medicaid. In terms of the costs born by the community when people return, I think that is part of the notion of enrolling people into Medicaid so that states and localities can share the costs as people return and even more so, try and, through that coverage and through a larger effort to preserve care continuity, prevent kind of uncoordinated and perhaps unnecessarily expensive cases of emergency room care and so on, when people reach the point of crisis. Not only can those costs be shared, but potentially contained overall for everyone involved.

BEETA RASOULI: Can anyone address family reunification and the role that may play in the role of reducing recidivism for inmates with kids?

ED HOWARD: Especially if you are starting with a female facility the way you did in Ohio. You don’t have to, if you don’t have any data. I didn’t mean to put you on the spot, Kara.

KARA MILLER: I'm sorry. That actually is not one question that I'm able to respond to.

ED HOWARD: Let me try, if I can stump you. I wonder -- my sense is that the advance enrollment mechanism, which is authority that every state has now, isn't really being used very widely besides in the few states like Ohio and the ones Matt mentioned in his presentation. And yet, it does seem, particularly in the 30 states and DC where they have expanded Medicaid, to be a no-brainer from the standpoint of dealing with prison health costs and Medicaid costs, as Matt was talking about, trying to avoid those emergency room visits and the chronic illness lapses if they don't get the care that they need. Have you had inquiries from some other states and do you sense a level of interest that would lead us to believe that next year at this time there will be more than 100,000 people enrolled in some of these programs, which is what I hear now?

KARA MILLER: Yes, so actually before I answer your question, in response to the reunification, that is part of the reason why we are doing this to help these individuals, because we want them to focus on reestablishing relationships with their family, with their friends and focus more on the reentry aspect of it and we wanted to take that one stressor away of having them apply for Medicaid and not even knowing where to start. So that is one response to that. As far as other states having interest in such a program, yes, we have received a lot of calls over prior months from several other states that are interested in hearing from Ohio about how we were able to pull this off. I don't know that our exact model could be replicated in other states, because states have their own challenges with systems and things like that, but I think working closely with an agency or agencies that you typically would not work with is really the first step in being successful.

BEETA RASOULI: Matt, earlier in your presentation, you went over suspensions versus termination policies. We have a question on the green card asking what the difference is between suspending Medicaid and stopping and starting it again.

MATT MCKILLOP: I'm not sure that there is a particular difference. My understanding, and please jump in -- so the difference between termination and suspension, as I said, is that if people enter a prison or jail having already been enrolled, that enrollment is terminated and to receive Medicaid coverage again, they have to reapply. If it is suspended, then as the word sort of implies, it is temporarily suspended during their stay in a jail or prison and then can be reactivated without having to reapply upon release. In fact, the key is that states and localities may not bill Medicaid for care delivered in prison, as I said. Only for in-patient care. So the termination or suspension is really just a tool to prevent that. To prevent any inappropriate care delivered within a correctional facility from being billed to Medicaid for people who are enrolled.

KARA MILLER: Right and I would just say, to me that is the primary distinction between termination and suspension. Just termination you close the case and the person has to reapply. Not only does it prohibit healthcare services from being billed, but also from a state that contracts with managed care plans, we are prevented then from paying capitation payments to individuals who really aren't or shouldn't be enrolled in Medicaid.

BEETA RASOULI: I think we have a question at the mic.

AUDIENCE MEMBER: This is actually not a question, I am here to try and help --

BEETA RASOULI: Can you identify yourself?

AUDIENCE MEMBER: Yeah, I'm State Senator Capri Cafaro from the State of Ohio and very proud of the work that we are doing and Kara did an excellent job speaking on behalf of our state. I also serve as the ranking member on the Senate Medicaid committee and I wanted to do my best to try to answer the question in regards to family reunification in the State of Ohio. I think there are two issues --one has to do with the suspension/termination. I have been in office long enough to know what it was like prior to having a little bit more of a seamless transition and what would happen as it relates to Medicaid and the family. The family that would be on Medicaid would sometimes be collateral damage, if you will, for the individual that would go inside. So if you had a family member that was subsequently incarcerated, you, still on the outside, not incarcerated, could potentially have lost your Medicaid benefits by virtue of the structural challenges associated with suspension versus termination and what is going to happen with you on the inside versus everybody else on the outside, which I'm sure contributed to challenges for the family as they were also losing potentially a source of income by an individual that was incarcerated. In regards to the reunification stuff, I would surmise from the work that I have done both training as a licensed social worker and our level one -- my community's level one trauma center as well as the work that I have done with managed care, is that depending on how the managed care plan is structured and what they do in regards to intensive case management and we only do, and I think you mentioned this, only a certain percentage of individuals do get that into sub case management, but I think for the incarcerated, those that are leaving are going to get this enhanced service. But for individuals that, because we do utilize managed care, sometimes, depending on how the managed care, whether it's Care Source or Buckeye or whomever and these are some of the providers in our state, they sometimes have as a part of their case management, when they do things like home visits, will also engage the family in one way, shape or form. And that might be, again, depending on how the benefit is designed, a help to the process of reunification as you are dealing with behavioral health and addiction issues too. So that is just sort of my two cents. And you may know better than I.

KARA MILLER: Thank you, Senator Cafaro, but I would agree with you that we do want the plans to be taking a very family and person centered approach to the care that they are providing and making those linkages and referrals for family members as well. Thank you.

BEETA RASOULI: Just a reminder that we only have a few minutes left. If you could take out your blue evaluation forms, if you haven't already, we will be making a donation to DC Central Kitchen if we receive at least 50% of participation, so that is an incentive

for you all to fill out your forms if you haven't already. It looks like we have another question at the microphone?

AUDIENCE MEMBER: This isn't a right wing question, but it is a business question, so maybe as close as we get. So, in terms of capitation and risk selection -- in Ohio this is voluntary, so you have to educate these folks coming back into society -- are the people that take up the coverage, sick? Do they tend to be people with health problems? As a result, how does the state price the coverage or the capitation rate? Is it significantly different than similar individuals?

ED HOWARD: And if I can add to the burden of the question, how many people do take it up versus not doing it?

KARA MILLER: Save the toughest question for last. I am not fiscally oriented at all, but I can tell you that we do not have a special rate cell for these individuals. I would say that these individuals, when they are released to the community, they would apply for Medicaid anyway and be found eligible. So like I said, we don't have a special rate cell for them and I don't have data on this population per se to say, are they any sicker than the individuals who are on the aged, blind or disabled program. I can tell you that 40% of them have a chronic condition, many of them have a mental health issue and about 80% of them have history or drug addiction issues, but I cannot -- right now I just don't have data to say, are they sicker than the rest of the Medicaid population? They probably have more challenges than the rest of the Medicaid population in that during that immediate transition to the community, and then as far as uptake, like I said, we have about 1900 individuals who, as of January 1st, 2016, will have an active enrollment with a Medicaid managed care plan. We are not up to scale yet, so maybe in a year we will have some more data to know really what is the uptake when all of our facilities are active. But we really are trying to encourage all of the individuals who are eligible to come through the program.

BEETA RASOULI: We have another question on the green card. We have spoken a lot about states and localities today. This question asks about the federal cost of states enrolling prisoners in Medicaid. Are any of you aware of research that has been done on that?

MATT MCKILLOP: So, the slide that I had that presented certain state's cost savings or estimated savings for care that was delivered outside of correctional facilities for inpatient care, that was federal money that the state received to offset the cost of their care. Beyond particular state examples, I have not seen an aggregate total for that care. I think it's important to recognize that while that is an important cost containment strategy and in fact, inpatient care tends to be some of the most expensive treatment that somebody would provide, it is just a portion of the overall total of care that states or localities would provide and spend.

BEETA RASOULI: Great. We have talked a lot about mental health services and addiction today and there is one question asking about examples of programs or states

that are supporting inmate's mental health beyond providing medications. Are any of you aware of any sort of initiatives that go beyond providing medication for those who are in need of mental health care?

MATT MCKILLOP: Certainly there is anecdotal evidence and accountings and case studies of places that provide, in addition to medication, will provide therapy and cognitive behavioral therapy and other treatment both for mental health and substance use disorder. Whoever the questioner is, feel free to come talk to me afterwards and I would be happy to help you find some examples, if that would be helpful.

ED HOWARD: One thing that I wanted to make sure to mention before we finish, just a couple of days ago, too late to be included in your materials, Health Affairs published an article that does an informal inventory -- it's the beginning of the research, I think, that PEW will probably, eventually, undertake. It at least identifies 60 or 65 programs around the country that do some sort of reentry program and the striking fact about it, to me anyway, and maybe some of our panelists have an explanation for this, that those programs are skewed almost exclusively in the Western half of this country. In fact, more than half of them are in California alone and I wonder what the potential is for the growth of kinds of programs that Ohio and some of the other places we have heard about, really is. Is this a growth industry, do you think?

MATT MCKILLOP: In general, I think you see more and more places acting in this regard. In terms of a study that you mentioned, I thought it was a very interesting study. I think part of the explanation for such a dominance in the West when they broke out these programs by region, is that in part of their methodology, they work with an organization in California to identify every place that was known about. And so part of it is that California is a very large state and part of it is that they probably achieved higher comprehensiveness in California than in the other states, which might have skewed it a bit.

ED HOWARD: Thanks Matt. Anything else? Well, thank you for contributing to the discourse in this program. I want to thank our first time co-moderator, Beeta Rasouli, for a good job. I want to thank Centene for allowing us to break down some of the barriers in those siloes that we have been talking about and finally I want to ask you to help thank our panel for exploring some of the real nuances of what I think is going to be a very fast risking issue over the course of the next couple of years. Thank you very much.

(Applause)