shadac

STATE HEALTH ACCESS DATA ASSISTANCE CENTER

Targeting Justice-Involved Populations through 1115 Medicaid Waiver Initiatives: Implementation experiences of three states

FINAL REPORT

Supported by:

The Robert Wood Johnson Foundation Research in Transforming Health and Health Care Systems grant #76111

Co-Principal Investigators Lynn Blewett, PhD, and Emily Zylla, MPH, University of Minnesota

Prepared by:

State Health Access Data Assistance Center (SHADAC)

Division of Health Policy and Management

University of Minnesota, School of Public Health

December 23, 2019

TABLE OF CONTENTS

ACKNOWLEDGEMENTS

This project was conducted by the State Health Access Data Assistance Center (SHADAC) at the University of Minnesota, School of Public Health, Division of Health Policy and Management. It was funded by a Robert Wood Johnson Foundation (RWJF) Research in Transforming Health and Health Care Systems grant. The views expressed here do not necessarily reflect the views of the Foundation. Report authors were Emily Zylla, MPH; Colin Planalp, MPA; Tyler Winkelman, MD, MSc; and Lynn Blewett, PhD.

We would like to thank the key informants in Illinois, Texas, and Washington for sharing their time and insights about their experiences implementing justice-involved initiatives in their respective states. We would also like to recognize Andrea Stewart for her work reviewing and proofing the report, and Lindsey Lanigan and Kristen Godwin for their work on the layout, exhibits, and production of the report.

INTRODUCTION

More than six and half million people (approximately 1 in 38 adults) are under some form of supervision by the United States correctional system during the year; many of whom are poor, unemployed, or homeless.[1,2] Historically, most of this justice-involved population was uninsured. Following implementation of the Affordable Care Act (ACA), however, states that elected to expand Medicaid found that many justice-involved individuals were newly eligible for Medicaid upon release.

This large increase in coverage provides new opportunities and challenges for Medicaid agencies to serve the unique and complex needs of justice-involved populations, as well as reduce racial and ethnic disparities in health care and outcomes.[3] One mechanism increasingly used by states to test new approaches to serving individuals with criminal justice involvement is a Section 1115 Medicaid waiver. Under Section 1115 of the Social Security Act, states have the opportunity to apply for demonstration waivers to test policies in their Medicaid programs that federal rules typically do not allow. The Centers for Medicare and Medicaid Services (CMS) authorizes these waivers as time-limited demonstration projects, typically for a period of five years.[i,4] Although each state is required to carry out a program evaluation for their 1115 waiver, these evaluations typically focus on high-level impacts on program costs and beneficiary experiences, and often do not address lessons learned about the process of implementing individual waiver initiatives, such as the administrative burden or challenges faced.[5] In addition, the use of 1115 waivers to support non-health-related activities, such as addressing the social needs of a specific population like the justice-involved, is relatively new and untested, and little is known about how states are finding the capacity to provide these new services.

Criminal justice-involved individuals include individuals who have recently served sentences in prisons or jails, who are awaiting trial or sentencing, and those under community supervision, such as parole or probation.

The purpose of this study was to understand how three diverse states—Illinois, Texas, and Washington—implemented justice-involved initiatives under Section 1115 waivers. Specifically, we were interested in documenting how these states approached the development, launch, and ongoing management of their justice-involved programs, and to provide insight into issues such as:

- What factors drove state decisions to include justice-involved initiatives in their 1115 waivers? What were the pros and cons of doing this work under an 1115 waiver?
- What expected and unexpected implementation challenges arose? How were those challenges addressed?
- How are stakeholders thinking about sustainability of justice-involved initiatives once 1115 waivers end?

It is critical to document these implementation details as states operationalize new programs in order to inform other state policy makers and stakeholders who may be interested in pursuing similar programs. Detailing the facilitators, barriers, and program participation characteristics of these strategies will help states assess the ultimate value of such programs against any reported future outcomes.

To address these questions, SHADAC reviewed states' 1115 waiver applications, related waiver documentation, relevant grey and peer reviewed literature, and conducted interviews with both state agency and local programmatic staff involved in the implementation of waiver programs across the three study states. The following report provides background information on the waiver program elements implemented in each of the three states; and key themes identified through discussions with study interviewees regarding the facilitators, challenges, and future sustainability concerns around continuing this work.

[i] While 1115 waivers are time-limited, they may be extended upon approval by the Secretary of Health and Human Services.

BACKGROUND

Individuals with criminal justice involvement often have significant unmet physical, behavioral, and social needs.[6] Evidence suggests that approximately 70 percent of justice-involved individuals have a substance use disorder (SUD) or mental health issue, but receive inadequate treatment due to lack of insurance, trouble navigating the health care system, and other barriers.[7] The opioid crisis also appears to be having a major impact on individuals' involvement with the criminal justice system, as a recent national analysis found that more than half of individuals with a prescription opioid use disorder or heroin use in the past year reported contact with the criminal justice system.[8] In addition, researchers report that as the level of opioid use increases, involvement in the criminal justice system correspondingly increases, even after accounting for sociodemographic, health, and substance use differences.[9]

Significant racial and ethnic disparities also exist among individuals with criminal justice system involvement, as Black, Latino, American Indian, and Alaska Native individuals are disproportionately more likely to be incarcerated than their White counterparts.[10] For example, the incarceration rate of Blacks in 2017 was 616 per 100,000 Black U.S. residents as compared to 187 per 100,000 White U.S. residents, resulting in a black-to-white incarceration ratio of 3.3 to 1.[11] Research shows that this uneven distribution of incarceration is a significant contributor to racial health disparities.[12]

Following the ACA many states initially focused on simplifying Medicaid enrollment efforts for the justice-involved. They took advantage of policies to cover inpatient care under Medicaid for incarcerated individuals and suspended, rather than terminated, Medicaid coverage for enrollees who became incarcerated—making it easier to reinstate coverage quickly once an individual is released.[13] Research shows that this increased access to care may be associated with improved outcomes for people recently released from jail or prison, such as fewer hospitalizations and reduced emergency department use.[14] Additionally, Medicaid coverage for people exiting the criminal justice system with mental illness and substance use disorder has been associated with decreased recidivism.[15] Encouragingly, recent data shows that following Medicaid expansion, uninsurance among justice-involved individuals declined by 9.7 percent nationwide.[16]

Enrollment in Medicaid, while an important first step in improving the health status of the justice-involved, is often not enough.[17] States are recognizing that in order to improve health outcomes, reduce health disparities, and potentially reduce costs, further strategies are needed to address the social determinants of health (i.e., the circumstances in which people live).[18,19] In recent years, Medicaid departments across the country have become increasingly interested in providing coordinated health and non-health services in order to better serve high-risk populations, such as individuals involved with the criminal justice system.[ii,20]

In general, there are three main routes to covering services in Medicaid that help to address social factors that affect health: State plan amendments (such as Health Homes or 1915(i) options), Medicaid waivers (such as Section 1115 or 1915(c) Home and Community-Based Service Waivers), and Medicaid managed care contract requirements.

[ii] Generally, Medicaid is the payer of health care services for eligible and enrolled individuals who are subject to parole and probation, while correctional institutions, including federal and state prisons and local jails, must pay for health care costs while individuals are confined to their facilities. (Medicaid and CHIP Payment and Access Commission [MACPAC]. [2018]. Medicaid and the Criminal Justice System. Retrieved from https://www.macpac.gov/wp-content/uploads/2018/07/Medicaid-and-the-Criminal-Justice-System.pdf)

Additional Mechanisms to Serve Justice-Involved Populations through Medicaid

Health Homes State Plan Amendments (Section 2703 of the ACA). Health Homes are a Medicaid state plan option that provides time-limited enhanced federal funding to provide six core services designed to promote the coordination of care: care management, care coordination, health promotion, transitional care and follow up, individual and family support, and referral to community and social services. These health home services can be provided to enrollees diagnosed with either chronic conditions or with a serious and persistent mental health condition. New York is one state that has designed health homes focused on individuals with a history of incarceration.

Home and Community-Based Service Waivers (Section 1915(c)). Home and Community–Based Service (HCBS) waivers allow states to provide medical and non-medical services that can help divert and/or transition individuals from institutions to their homes and community. Under HCBS waivers, states can provide targeted sets of services to specific populations including, for example, justice-involved individuals. This waiver can help provide supported employment and housing-related activities and services. HCBS waivers are generally approved for three years.

Medicaid Managed Care Contracts. States can include provisions in their Medicaid managed care contracts that require, or provide financial incentives to support, managed care plans conducting care coordination for justice-involved populations prior to discharge. For example, New Mexico requires Medicaid managed care plans to participate in care coordination efforts for justice-involved individuals leaving prisons, jails, and other detention centers in order to support their re-entry.

There are pros and cons to each strategy that states must take into account.[21] For example, establishing health homes requires a financial commitment from states. Medicaid waivers, while federally funded, are required to be budget-neutral to the federal government and must go through a public-notice process. Provisions in managed care contracts can require health plans to engage with eligible people; however, health plans cannot receive a capitated payment for those services while an individual is incarcerated, so the plans have to be willing to take on that risk.

Of all the Medicaid authorities states can use to offer additional services, Section 1115 waivers offer the greatest flexibility. However, they also have the most rigorous approval criteria, generally take longer to obtain than other waivers, and include a required research or evaluation component.[22] In addition, CMS requires states to provide detailed Special Terms and Conditions (STCs) that include descriptions of the program, reporting and financial requirements, and how the budget neutrality will be monitored. These STCs are unique to Section 1115 waivers, and are not included in other types of waivers.[23] While research examining various ways to improve the health of justice-involved individuals exists, less is known about states' efforts to do this work under Section 1115 waivers.[24]

Section 1115 demonstration projects with justice-involved initiatives

At the time of this report, ten states currently have initiatives targeting individuals with criminal justice involvement in their 1115 waivers, and another five states and Washington, D.C. have pending waivers with justice-involved provisions. Table 1 provides an overview of the approaches that states have taken in these waivers to serve justice-involved populations. Under federal law, services provided to incarcerated individuals cannot be paid for with federal Medicaid funds. This is commonly referred to as the "inmate exclusion."[25] To date, no state has been successful in receiving a waiver of the inmate exclusion (although Washington, D.C., and New York currently have pending 1115 waivers that would address this). States have been successful, however, in using 1115 waivers to provide presumptive eligibility for the justice-involved, to target Medicaid eligibility and services (such as behavioral health or substance use disorder [SUD] case management) to justice-involved individuals, and to provide transitional care for individuals at re-entry from an institution back into the community. Of the ten states that have expanded Medicaid benefits for justice-involved populations beyond those available in state benefit packages, six have used 1115 authority to provide transitional care for re-entry services.

Table 1. State Initiatives Targeted at Justice-Involved Populations via 1115 Waivers

Waiver Provision	Approved	Pending
Presumptive eligibility	MD	-
Targeted Medicaid eligibility	UT	SC, VA
Targeted behavioral health services	TX	-
Case management	IL	-
Transitional/Re-entry support	AZ, CA, NH, NC, RI, WA	DC, TN
Housing and employment supports	WA	VA
"In-Reach" services provided in the jail/prison setting	-	DC, NY

Source: SHADAC analysis of approved and pending 1115 waivers.

Study States: Illinois, Texas, and Washington

For this study we explored the experiences of three diverse states who were all at different points in the implementation process of their justice-involved initiatives: Illinois, Texas, and Washington. These three states have varying population sizes, political environments, and coverage status (see Table 2 below).

Table 2. General State Characteristics

		National	Illinois	Texas	Washington
Governor		--	J.B. Pritzker, Democrat (2019-present)	Gregg Abbott, Republican (2015- present)	Jay Inslee, Democrat (2013- present)
Legislative Control		--	Democratic (2014-2019)	Republican (2014-2019)	Democratic House, Republican Senate (2015- 2016); Democratic (2017-2019)
State Population[1]		--	12,854,526	27,419,612	7,169,967
Coverage Types[2]	**Uninsured**	8.7%	6.8%	17.3%	6.0%
	Employer	51.9%	54.6%	50.0%	55.6%
	Individual	6.6%	6.2%	6.1%	6.1%
	Medicare	17.2%	16.1%	13.3%	16.4%
	Medicaid	15.7%	16.2%	13.3%	15.9%
Population Under 138% FPL & Uninsured*[3]		15.1%	11.8%	28.2%	10.7%
Expansion Status[4]		--	Adopted in 2014	Not adopted	Adopted in 2014

* Individuals with income below 138% of the federal poverty level are eligible for Medicaid under expansion.
Sources: 1. United States Census Bureau American Fact Finder. (n.d.). Community Facts: 2013-2017 American Community Survey 5-Year Estimates [Data set]. Available from https://factfinder.census.gov/faces/nav/jsf/pages/community_facts.xhtml
2. State Health Access Data Assistance Center (SHADAC), State Health Compare. (n.d.). *Health insurance coverage type: 2017* [ACS Data set]. Retrieved from http://statehealthcompare.shadac.org/map/11/health-insurance-coverage-type-by-total#5/24/21
3. State Health Access Data Assistance Center (SHADAC), State Health Compare. (n.d.). *Health insurance coverage type by poverty level: 2017* [ACS Data set]. Retrieved from http://statehealthcompare.shadac.org/map/23/health-insurance-coverage-type-by-poverty-level#32,10/24/45
4. Henry J. Kaiser Family Foundation (KFF). (2019, November 15). *Status of state action on the Medicaid expansion decision* [Data set]. Available from https://www.kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/

These states also have significantly different criminal justice populations and approaches to providing health care for this population (Table 3). For example, the correctional control rate[iii] in Texas (2,611 per 100,000 people) is considerably higher than both Illinois (1,683 per 100,000 people) and Washington (1,873 per 100,000 people), as well as the national average (2,045 per 100,000 people). All three states experience racial and ethnic inequities in their incarceration rates to varying degrees.

[iii] Correctional control rate includes state prison, federal prison, local jail, youth confinement, involuntary commitment, Indian Country jails, parole, and probation populations.

Table 3. Criminal Justice Populations

		National	Illinois	Texas	Washington
Incarceration Rate[1]		698 per 100,000 population	564 per 100,000 population	891 per 100,000 population	480 per 100,000 population
Incarceration Rates by Race/Ethnicity, 2010[2]	**White**	450 per 100,000	258 per 100,000	768 per 100,000	392 per 100,000
	Hispanic	831 per 100,000	472 per 100,000	972 per 100,000	601 per 100,000
	Black	2,306 per 100,000	2,128 per 100,000	2,855 per 100,000	2,372 per 100,000
	American Indian/ Alaska Native	895 per 100,000	821 per 100,000	Not Reported	1,427 per 100,000
Correctional control rate[3]		2,045 per 100,000	1,683 per 100,000	2,611 per 100,000	1,873 per 100,000
Total correctional health care spending[4]		$7,679,772,000	$144,039,000	$581,555,000	$119,253,000
(Healthcare) per inmate prison spending[5]		$5,720 (49 state median)	$3,619	$4,077	$6,705
Eligibility during incarceration[6]		--	Terminated (jail); suspended (prison)	Suspended (jail and prison)	Suspended (jail and prison)
Enrollment Assistance Prior to Release[7]		--	Yes	No	Yes
Presumptive Eligibility		--	No[8]	No[9]	No[10]

Sources: 1. PRISON Policy Initiative. (n.d.). *50 state incarceration profiles* [Interactive map]. Available from https://www.prisonpolicy.org/profiles
2. Jones, A. (2018). Correctional Control 2018: Incarceration and supervision by state. Available from https://www.prisonpolicy.org/reports/correctionalcontrol2018.html
3. Jones, A. (2018). Correctional Control 2018: Incarceration and supervision by state. Available from from https://www.prisonpolicy.org/reports/correctionalcontrol2018.html
4. Pew Charitable Trusts & John D. and Catherine T. MacArthur Foundation. (2014). *State prison health care spending: An examination*. Retrieved from https://www.pewtrusts.org/~/media/assets/2014/07/stateprisonhealthcarespendingreport.pdf
5. The Pew Charitable Trusts. (2017, December 8). Prison Health Care Costs and Quality [Data table]. Available from https://www.pewtrusts.org/en/research-and-analysis/reports/2017/10/prison-health-care-costs-and-quality
6. Henry J. Kaiser Family Foundation (KFF). (n.d.). *States reporting corrections-related Medicaid enrollment policies in place for prisons or jails: SFY 2019* [Data set]. Available from https://www.kff.org/medicaid/state-indicator/states-reporting-corrections-related-medicaid-enrollment-policies-in-place-for-prisons-or-jails/
7. Henry J. Kaiser Family Foundation (KFF). (n.d.). *States reporting corrections-related Medicaid enrollment policies in place for prisons or jails: SFY 2019* [Data set]. Available from https://www.kff.org/medicaid/state-indicator/states-reporting-corrections-related-medicaid-enrollment-policies-in-place-for-prisons-or-jails/
8. Illinois Department of Healthcare and Family Services. (n.d.). Medicaid Presumptive Eligibility. Retrieved from https://www.illinois.gov/hfs/MedicalProviders/ProviderPrograms/Pages/MedicaidPresumptiveEligibility.aspx
9. Texas Health and Human Services Commission. (2018). *Texas Medicaid and CHIP Reference Guide* (Twelfth Ed.). Retrieved from https://hhs.texas.gov/sites/default/files/documents/laws-regulations/reports-presentations/2018/medicaid-chip-perspective-12th-edition/12th-edition-complete.pdf
10. Washington State Health Care Authority. (2019). Hospital Presumptive Eligibility. Retrieved from https://www.hca.wa.gov/health-care-services-supports/apple-health-medicaid-coverage/hospital-presumptive-eligibility

Illinois

Illinois' Section 1115 Substance Use Disorder waiver, the *Better Care Illinois Behavioral Health Initiative*, began on September 1, 2018, and will run through June 30, 2023. The decision to focus the waiver on behavioral health was informed by the state's *Healthy Illinois 2021* Plan, the State Innovation Model (SIM) grant, and the State Health Improvement Plan, all of which identified behavioral health as a priority for the state. As the state explained in its waiver application rationale: "Behavioral health was chosen due to the urgency of the issue as well as the potential financial and human impact. There is also a large financial payoff in improving behavioral health: Medicaid members with behavioral health needs represent 25 percent of Illinois Medicaid members but account for 56 percent of all Medicaid spending."[26]

Illinois' waiver granted the state the authority to conduct 10 statewide pilot projects, including a **Substance Use Disorder (SUD) Case Management Pilot** targeting justice-involved individuals. Under this pilot Medicaid beneficiaries with an opioid or substance use diagnosis that qualify for diversion into treatment from the criminal justice system are eligible to receive case management services to assist with accessing medical, social, educational, and other services. Licensed providers receive a per-member, per-month Medicaid reimbursement for providing these case management services to Medicaid beneficiaries. Prior to the waiver, SUD case management was not a covered service in the Medicaid State plan. Providers performing this work instead received reimbursement through state general revenue grant funds. The pilot is capped at 2,040 people statewide in the first fiscal year of the waiver (July 1, 2018 through June 30, 2019) and rises to a cap of 2,835 people by the fifth year.

Spotlight on TASC

Provider Description: Treatment Alternatives for Safe Communities (TASC) is a nonprofit organization providing case management and jail diversion services throughout Illinois.

Project Goal: Ensure access to opioid and substance use treatment services for Medicaid beneficiaries across a continuum of care, and improve care coordination and transitions between levels of care.

Program Intervention: Under Illinois's 1115 Behavioral Health Transformation Waiver, TASC provides case management and jail diversion services for Medicaid beneficiaries with a diagnosed opioid or substance use disorder (SUD). SUD case management services can include: comprehensive assessment and periodic reassessment of individual needs; monitoring service delivery to ensure beneficiary access to services and the service delivery system; and patient advocacy, linkages to physical and mental health care, transportation, and retention in primary care services. TASC providers work with law enforcement and states' attorneys' offices to screen individuals for program eligibility. If an SUD is suspected, individuals are assessed by case managers to determine treatment and service needs. In addition to substance use services, clients often receive Medicaid enrollment assistance, mental health treatment, housing services or support, and connections to education or employment services.

Target Population: Medicaid beneficiaries with a diagnosed opioid use or substance use disorder who are eligible for criminal justice diversion. As of June 2019, TASC had provided case management services to 148 individuals under the waiver.

Key Partners: TASC has long-standing existing relationships with courts and criminal justice systems that they leveraged to continue providing these services to Medicaid beneficiaries.

Payment Model: TASC receives a $132.22 per-member, per-month payment in demonstration year 1 for Medicaid beneficiaries.

Evaluation Measures: Evaluation measures specific to the SUD Case Management Pilot were not publically available at the time of this report.

Texas

Texas' Delivery System Reform Section 1115 Waiver, the *Texas Healthcare Transformation and Quality Improvement Program*, was initially approved by the Centers for Medicare and Medicaid Services (CMS) on December 12, 2011, and was renewed on February 14, 2018, through September 30, 2022. The waiver has two main components: it expands the Medicaid managed care model statewide and it creates two statewide pools to reimburse providers for uncompensated care. The first is an uncompensated care pool (UCP) exclusively for hospitals, and the second consists of a $10.83 billion delivery system reform payment pool (DSRIP) for providers to transform the delivery of care. Unique to Texas, the state's 1115 waiver allows qualifying organizations to use DSRIP funds to provide services to low-income and uninsured individuals who were not eligible for Medicaid coverage.

Texas was the first state to require providers to work together and form a collaborative entity in order to receive DSRIP funding.[27] The state's 254 counties are divided into 20 regions, called Regional Healthcare Partnerships (RHPs), which are comprised of hospitals, community mental health centers, local health departments, and other providers. RHPs oversee the development and coordination of plans to identify community needs, and then choose DSRIP projects and investments to address those needs. Each RHP can choose from a menu of projects with corresponding metrics and milestones approved by CMS and the Texas Health and Human Services Commission. As of February 2018, there were 1,451 approved DSRIP projects in Texas.[28]

Spotlight on Bluebonnet Trails Community Services (BTCS)

Provider Description: Bluebonnet Trails Community Services is a designated local mental health authority in Texas serving eight counties (Bastrop, Burnet, Caldwell, Fayette, Gonzales, Guadalupe, Lee, and Williamson) in 25 office locations. Under Texas' Healthcare and Transformation and Quality Improvement Program, BTCS is implementing multiple projects to reduce the unnecessary use of criminal justice services for people with behavioral health needs, working within several different Regional Health Partnerships (RPH 6, 7, and 8).

Project Goal: Provide early intervention and treatment to individuals in pre-trial detention (i.e., awaiting trial/not sentenced) and to reduce multiple arrests by providing behavioral health treatment that stabilizes behavior, improves functioning, and reduces social deficits.

Program Intervention (RHP 8): Screening, assessment, and diversion for adults and youth involved in the justice system in Burnet and Williamson counties.

Target Population: Adults and youth in contact with law enforcement, arrested or in the process of booking, and those on probation, parole, or otherwise released from detention in these two Counties who are also diagnosed with behavioral health disorders, including substance use disorders. BTCS expected to serve 75 individuals a year.

Key Partners: Jail staff, local law enforcement, prosecutors, and judges.

Payment Model: In phase one of the waiver (demonstration years 1 – 6) providers, like BTCS, earned incentive payments for achieving goals, including serving greater numbers of Medicaid and low-income/uninsured individuals, and for achieving process milestones as well as at least one outcome metric. In demonstration year 6 for example, BTCS received $285,043 for infrastructure development and program innovation and redesign activities, and $159,174 for achieving an outcome measure.[31]

Evaluation Outcome Measures: Decrease in mental health admissions and readmissions to criminal justice settings such as jails or prisons.

Outcomes: BCTS reported an overall recidivism rate of 1.3 percent for program participants (compared to a reported overall rate of individuals receiving mental health services who become incarcerated at 17.0 percent in Burnet County and 15.0 percent in Williamson County).[32]

Under the overarching category of program innovation and redesign projects, one program option (project 2.13) is **"an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specified setting,"** which includes the criminal justice setting. This project is meant to be multisector community-based intervention focused on decreasing avoidable outcomes such as inpatient admission or criminal justice involvement. Examples of possible interventions participants could select include coordination of health care and social services, peer support, specialized therapies, and residential options. A review of DSRIP projects in the 2.13 category indicated there were 16 active justice-involved related projects across 12 RHPs in Demonstration Year 6 (October 2016 through September 2017). Individual RHP projects served anywhere between 30 and 7,549 justice-involved individuals that year. In phase one of the waiver (demonstration years 1 – 6), project participants received incentive payments for achieving progress measures (such as serving a certain number of Medicaid and low-income/uninsured individuals), followed by incentive payments for achieving at least one specified outcomes. In phase two, (demonstration years 7 – 11) the payment model evolved from project-level reporting to provider system-level reporting. Targeted measure bundles were developed for specific providers, such as hospitals and community mental health centers, which consist of measures that share a unified theme, apply to a similar population, and are impacted by similar activities.[29]

Washington

Washington's Delivery System Reform Section 1115 waiver, the *Medicaid Transformation Project*, was approved January 9, 2017, and runs through December 31, 2021. The waiver includes three major initiatives:

1. Transforming the Medicaid delivery system through Accountable Communities of Health (ACHs)
2. Expanding options for long-term services and supports
3. Foundational community supports: supportive housing and supportive employment

Both initiatives 1 and 3 have programs focused on justice-involved populations. Initiative 3 is a direct service benefit providing supportive housing and employment services for specific target populations, including people coming out of jails and prisons. However, for this study, we focused on the implementation of justice-involved programs occurring under initiative 1, transforming Medicaid through Accountable Communities of Health (ACHs).

Washington's 1115 waiver authorizes up to $1.125 billion in funds for the establishment and implementation of DSRIP projects through Accountable Communities of Health. ACHs are self-governing organizations that align with Washington's regional service areas for Medicaid purchasing. Like RHPs in Texas, ACH organizations oversee local needs assessments and receive DSRIP funding, but do not deliver care directly. Members of ACH's include managed care organizations, public health, and providers and community organizations who work in collaboration with community stakeholders to respond to community needs.

The state's 1115 waiver requires ACHs to implement at least four projects across three domains: healthy systems and community capacity building, care delivery redesign, and prevention and health promotion. Though there are some required projects, ACHs are able to choose the ones most relevant to their community needs. Within the care delivery redesign domain, there are two relevant justice-involved projects that ACHs can choose from:

- **Optional Project 2B. Community Based Care Coordination** promotes care coordination across the continuum of health for Medicaid beneficiaries, ensuring those with complex health needs (including justice-involved) are connected to the interventions and services needed to improve and manage their health. "Pathways HUB" was selected as the designated model under this project.[iv]

[iv] The Pathways Community HUB uses community organizations for care coordination and risk assessment to address health care, housing, food stability, education, employment, and other possible needs. Payment is pay-for-performance and completed when care coordination team indicates a need ("pathway") is fulfilled for the client.

- **Optional Project 2C. Transitional Care** provides care management services to Medicaid beneficiaries exiting intensive care settings such as acute care, supportive housing, inpatient care for serious mental illness, or incarceration (prison or jail).

A review of all ACH proposed care delivery redesign projects indicated that five (out of nine) ACHs are currently working on either a Project 2B or 2C focused on justice-involved individuals.[31] ACHs are eligible to earn incentive payments for completing project milestones, reporting on implementation metrics, and, eventually, demonstrating improvement in health outcomes.[32]

Spotlight on HealthierHere Accountable Community for Health[35]

Provider Description: HealthierHere ACH covers King County and the Cowlitz, Muckleshoot, and Snoqualmie tribes.

Project Goal: Implement an integrated whole person model of care that ensures safe and successful transitions from jails back into community settings; and expand community-based support services for high-risk individuals leaving jails, including those individuals who experience homelessness.

Program Intervention: HealthierHere is implementing a transitional care program (Project 2C) designed to facilitate Medicaid enrollment, connections with health care providers and social supports, and the development of a personalized care plan. The transitional care program will use the APIC (Assess, Plan, Identify, Coordinate) model for case management. Community Health Workers (CHWs) and/or peer support specialists, as well as people with lived experience in the criminal justice system or behavioral health recovery will meet beneficiaries at release and take them to their first appointments. Projects are expected to run for one or two years.

Target Population: Medicaid beneficiaries who are returning to the community from jail and who have complex health and behavioral health conditions that necessitate care coordination and/or disease management.

Key Partners: Have not been selected at the time of this report.

Payment Model: HealthierHere established a $2.7 million Innovation Fund to support partner-led innovations that aim to establish or expand advanced care models, improve community-clinical linkages, and achieve outcome metrics. To date, HealthierHere has identified four potential projects (including a transitional care program for justice-involved individuals) for 2019 implementation based on partner input, partner and project readiness to launch, and potential impact on patient experience of care. Partners who are interested in implementing a transitional care project can apply for Innovation Fund funding.

Evaluation Measures: Follow up after Emergency Department visit for alcohol or other drug dependence; Follow up after emergency department visit for mental health; Follow up after hospitalization for mental illness; Percent homeless in at least one month over the past year.

Driving forces that led states to target justice-involved populations

Each of the three study states faced unique financial, political, and economic dynamics when designing their 1115 waivers. However, stakeholders to whom we spoke all identified several similar factors that drove decisions to include justice-involved initiatives in their states' respective Section 1115 waivers.

Growing opioid crisis

The growing opioid crisis impacted all three states' decisions to include justice-involved initiatives in their Medicaid waivers. State decision makers were looking for innovative ways to serve the rapidly growing numbers of people who were both struggling with an opioid use disorder and interacting with the justice system. Law enforcement and public safety advocates were especially vocal about the need to identify and implement additional options to address opioid use disorders. In Illinois, for example, law enforcement's increasing desire to divert people to treatment rather than correctional facilities was an impetus to test providing case management services to help facilitate getting people into treatment through the 1115 waiver.

One stakeholder from a community partner organization felt strongly that the demographics of the opioid crisis—including the growing impact specifically on the Caucasian population—was also a factor in the willingness by a broad array of stakeholders to address opioid addiction as a health problem rather than exclusively as a criminal justice problem, explaining: "Urban centers have been impacted by heroin for 40, 50 years. But it is a fact that white folks are dying from what started as a prescription drug abuse program to now a heroin problem to now an overdose from fentanyl problem. That has absolutely moved the needle on the court system's willingness, prosecutor's willingness, and the public's willingness, to expand the alternatives available."

Recognition that justice-involved individuals are a high-cost, vulnerable population

The complex medical and social needs, and related high-costs, experienced by justice-involved populations was another driving force in states' decisions to include programs that would serve these individuals. In Texas, for example, there was a recognition that using DSRIP funds to support program options that address behavioral health needs of justice-involved individuals would potentially help RHPs decrease their overall health care costs. As one Texas stakeholder explained, "A significant percentage of public sector adult mental health clients are not Medicaid eligible but are at significant risk for poor health outcomes and earlier institutionalization in Medicaid qualifying institutions such as nursing facilities. It's not just criminal justice system involvement, but it's also unnecessary admissions and readmission to the hospital. Our community mental health centers have analysis that shows that [waiver interventions] decrease costs not just to them, but to all parties involved in managing this population."

In several cases, decision makers came to see the justice-involved population as a microcosm of the broader health care system—one where approaches designed to serve a high-need, but not well-engaged, population could be tested on a smaller scale through the waiver before being rolled out to everyone. In Illinois, for example, one stakeholder speculated that the state wanted to test whether SUD case management resulted in cost savings, but that rolling out that benefit to all Medicaid enrollees (not just justice-involved individuals) would have been cost prohibitive, commenting: "Rather than open up substance use case management to the broadest population out there, [the waiver] was a way to limit that test and cap the enrollment and cap the financial risk. That was why they picked this subgroup of people, they probably wanted a balance that included justice and corrections populations."

Increased focus on the integration of primary care and behavioral health

Respondents in both Illinois and Washington highlighted the work their respective states were already doing to integrate primary care and behavioral health as a catalyst for targeting justice-involved individuals in their waiver initiatives. In both states, the justice-involved were recognized as an important target population if efforts to better integrate care were ultimately going to be successful. During the Illinois waiver planning process, for instance, an extensive stakeholder input process identified several remaining "pain points" that existed in the quest to better integrate primary care and behavioral health, two of which specifically call out justice-involved populations.[34]

In Washington, the state had begun moving toward increased integration of primary care and behavioral health through the State's Innovation Model (SIM) grant. As a result of that work, the state legislature directed the state's Division of Behavioral Health and Recovery in 2014 to move into the Washington State Healthcare Authority (the state's Medicaid agency). That transition prompted state leaders to adopt a "whole person" approach to providing care, which focused more holistically on all of the potential services a person needs to be healthy rather than carving out specific target populations based on circumstances. As one Washington stakeholder explained, "I don't necessarily think of the 1115 waiver as just having a justice-involved focus. I think it has a whole-person focus that also includes people that have justice involvement. There's also a lot of other things happening in our state to address individuals with justice involvement. And [the waiver is] really weaving all of those things together."

Similar to Washington, Texas stakeholders indicated that they viewed their work through a lens of providing improved behavioral health care services to low-income and uninsured individuals, not necessarily as specifically targeting justice-involved individuals, per se. Unlike Illinois and Washington, however, Texas has not expanded Medicaid, so there was a more limited opportunity for justice-involved individuals to be connected with Medicaid upon release. Instead, DSRIP funds provided an opportunity for regional partnerships to address issues and test solutions for both Medicaid and low-income populations, such as justice-involved individuals. One Texas stakeholder explained, "It is more useful to think of the population as one with significant behavioral health conditions that contribute to a range of issues such as incarceration, homelessness, early disability, and premature death."

IMPLEMENTATION EXPERIENCES: KEY THEMES

As interviewees from the three study states reflected on the activities implemented and challenges faced as they operationalized justice-involved initiatives within their states' 1115 waivers, they identified several key themes.

Facilitators

Stakeholders were asked about the factors that have facilitated the implementation of their justice-involved initiatives and the progress they have made thus far. While some facilitators were unique to individual programs, several were common among multiple initiatives. This section summarizes these key themes.

Ongoing and frequent communication among partners, and close coordination with law enforcement. Extensive amounts of communication and coordination between entities responsible for implementation were required to implement justice-involved programs. This communication often occurred in the form of regular, in-person meetings (often monthly) among multiple stakeholders—as well as weekly, individual, internal organizational staff meetings to ensure that people knew their roles and responsibilities and to keep the project on track.

Law enforcement representatives were repeatedly noted as critical stakeholders to the success of justice-involved initiatives, both as these programs were being planned and implemented. Several stakeholders mentioned that, especially in rural counties, local sheriffs were frequent partners in identifying and articulating the needs of the community. Their presence also lent credibility to the importance of addressing the justice-involved population as stakeholders advocated for these programs to be included in 1115 waivers. For example, one stakeholder noted, "In Texas, hats and guns mean a lot. So having a sheriff on your side and by your side when you're making the case was instrumental to our success. It was the sheriffs that really had the voice in this more than the local mental health authorities did." Interestingly, stakeholders noted that state department of corrections representatives were often not at the table as these initiatives were being designed.

Previous experience with justice-involved grants. Another major facilitator of states' work to implement justice-involved focused projects through an 1115 waiver were the data and learnings that had been accumulated from prior grants. Both Illinois and Washington stakeholders felt that their ability to draw from lessons learned from previous Substance Abuse and Mental Health Services Administration (SAMHSA) and Department of Justice grants aimed at this population helped them jump-start work under the 1115 waiver. SUD case management for justice-involved individuals in Illinois had also previously been funded by a state appropriation through grants to providers. Through that program, the state had collected data on the utilization of services by enrollees and their interactions with the justice system at one site—a review of which showed a growing demand for these services, which they realized could be potentially expanded to all Medicaid enrollees statewide through a Medicaid waiver. "We had a body of work," a stakeholder recalled, "And there's been some evaluations of these justice-involved case management services through national organizations, that we drew on in terms of what would make sense for moving it into the Medicaid program."

Tailoring program design to build on existing initiatives and provider infrastructure. In addition to learning from previous grant opportunities, states also focused on leveraging previously established organizations and infrastructure in order to get waiver programs implemented quickly. For example, Illinois already had an existing Designated Program license, which allows the state's Department of Substance Use Prevention and Recovery to certify that an organization can provide screening, assessment, referral, and tracking services for individuals with SUDs. This existing licensure process provided an infrastructure that allowed the state to be able to quickly and easily identify and on-board providers who could expand this work to include the justice-involved population. In many cases, these providers already had relationships with the courts and had been doing similar work under the license for many years. The license was a way to reassure the courts that the providers were prepared to understand the population, understand best practices for interacting with this population, and would be able to create an effective treatment plan for a justice-involved individual. As one stakeholder explained, by "choosing [an organization that already does this work], understands all those people and players, we sort of skipped over all of that learning process and took a path of relative least resistance and said, 'They're already there. They're doing it. Let's try and implement a waiver via that strategy and that model,' as opposed to trying to invent or create or design something from scratch or new."

Fostering SUD subject matter expertise within Medicaid. Stakeholders also spoke to the value of developing subject matter expertise within Medicaid specifically for SUD issues in order to effectively implement justice-involved initiatives. Because SUD and Medicaid agencies historically have worked in silos, Medicaid officials have not always understood what behavioral health or SUD services are available and how they are delivered. Having specific knowledge of the unique needs and challenges that justice-involved populations face helped program administrators implement programs efficiently and address challenges as they arose. As previously mentioned in Washington, efforts to restructure Medicaid to incorporate representatives of the Division of Behavioral Health and Recovery brought some of that specific SUD expertise to Medicaid. In Illinois, the former Director of the State Authority for Substance Use Disorder, who had been in the position for over 20 years, took a position as the Senior Policy Advisor for Adult Behavior Health in the state Medicaid authority. That individual was then specifically brought over to work on the Medicaid side to help with the implementation of the 1115 SUD pilots.

Challenges

Stakeholders reported many of the same common barriers and challenges in the implementation of their justice-involved initiatives, a list of which (though not exhaustive) we explore below.

Aligning the goals of multiple sectors. Aligning the goals of multiple diverse stakeholders continues to be a challenge for those undertaking this work, often slowing down progress. Extensive communication and coordination is required to ensure that all of the right stakeholders are at the table, that everyone understands the motivations and goals of the various parties, and that everyone understands both the intended and potential unintended consequences of any new processes. One stakeholder pointed out the challenges they faced in bringing together diverse sectors: "The court has its own goals and agenda. The public defender has its own goal and agenda. The clinicians have a goal, which is access to best quality services available to people. The sheriff has a goal of determining appropriate custody placement. The justice system is adversarial for a reason and a purpose. And so everyone has a different goal and a different measure of effectiveness. And until all of those are sort of clearly understood, it's really hard to insert new processes and insert new goals and strategies."

Getting into jails. Related to the challenge noted above, the logistics of actually getting workers into jails to implement these programs was another commonly mentioned complication. Delays in approval for care coordinators' or case managers' background checks, or getting security clearances, resulted in what one stakeholder characterized as "a culture of forced barriers" in the jails. In Washington, a secondary challenge

arose from union issues inside of the actual jail itself. One program's community health workers weren't allowed to access anyone in the jail because the jails were concerned about duplication of services—a challenge that had not been anticipated as the program was being designed. As one stakeholder noted, "No one said anything until we were already moving, essentially, and then it became like, 'Oh wait, you can't outreach them.' And so our ability to engage individuals obviously dropped significantly."

Staffing. Hiring and training culturally competent staff, who understand the cultural diversity and the realities of the populations being served, is vital to the successful implementation of a program. Several justice-involved programs noted that even when they got programs in place, they struggled with high rates of staff turnover when they tried to use staff that didn't have previous experience working with the justice-involved population. One stakeholder explained, "Having an employee from a managed care organization who is familiar with providing care coordination and care management may not be the best fit for providing care management and care coordination for individuals who are being released from jail. There's a different level of cultural needs and familiarity that needs to be addressed, that you can train on, but it really takes a special person that is mission driven." Extensive training and ongoing support for staff were two strategies stakeholders put in place to try and minimize staff turnover on these projects. One organization in Texas, for example, developed written training guides and processes for new staff, which helped them feel increasingly confident about the project requirements and processes as well as their specific roles. This organization also established a mentorship program, pairing an established forensic case manager with a new forensic case managers in order to provide a more in-depth training experience and stronger support network for new staff.

Other justice-involved initiatives tried to overcome staffing challenges by using peer supports or community health workers who either have lived experience with the criminal justice system or are from communities that are affected by this system. But organizations faced challenges in implementing that staffing model as well. Stakeholders in Washington noted that it is difficult to get someone who has any kind of criminal legal background licensed as a peer support in the state, which is important in order to reimburse them. It was also difficult to secure entry into the jails for any peer support worker who had a previous criminal record. These logistical staffing challenges notably slowed both planning and implementation activities as programs were trying to get off the ground.

Data sharing. Difficulty exchanging data between multiple partners was one of the most common challenges stakeholders faced when implementing a new program aimed at justice-involved populations. In many cases partners faced technology barriers—simply getting information from different systems into a format that could allow it to be shared. But stakeholders also faced difficulties navigating legal issues surrounding data exchange, especially as it related to confusion about what information could be shared with jails. For example, one program in Washington is working on setting up a common data-sharing platform as part of their waiver initiative. The technology piece has been solved, but privacy and security questions remain. A stakeholder explained, "We have a platform that can share whether an individual is in the emergency department, who their primary care provider might be, what their medications might be. And the jails have been given read-only access to this, which has helped them in their care coordination. But there is still some concern about letting them document within the system because of that concern around what can and cannot be shared. And really, a number of individuals are also concerned about health data getting into the hands of a legal team that could end up using that [information] against individuals."

Calculating return on investment. Stakeholders that wanted to perform any kind of cross-sector data matching in order to track outcomes, like the overall return on investment of these initiatives beyond just Medicaid costs, faced multiple barriers. Securing analyst time and mapping data elements across different technology platforms is an expensive, time-consuming proposition. As one stakeholder explained, "To remap all of the data elements from two different data sets would have required the investment on the part of the

Department of Adult and Juvenile Detention and our Public Health Department. And to get analyst time, which is a hot commodity, you need it to be a political priority and it just kind of wasn't."

Community organizations themselves often didn't have the ability to perform sophisticated data analysis, such as calculating return on investment. One stakeholder commented, "I just wish, if they really wanted return on investment, [the Medicaid agency] would have either given us more funds to provide such a high level of sophisticated analysis or they themselves would have done it. But we're already in motion now and you can't go back and there's just not enough funding to do such a high level of that, so that's been a little frustrating."

Housing. Once programs were successfully in place to begin working with justice-involved populations, the most common barrier organizations faced while providing services was helping justice-involved clients secure affordable housing. Once service provider illustrated the challenges their clients face: "I'm working with somebody now who has a job making $14 an hour. He has been at his job for a year and is taking his first paid vacation ever. And he's homeless. He rides the train and the bus for an hour and 45 minutes from downtown Chicago to a suburb to work overnight five nights a week in the suburb…training and bussing back in the morning. So he spends over 3.5 hours on public transportation as a homeless person to go work in the suburbs, and he can't find a place to live***."***

The inability of service providers to help justice-involved individuals secure housing can sometimes have adverse financial consequences under value-based payment models where providers are paid for outcomes. For example, in Washington, one ACH's jail-transition program reimburses providers for every "pathway" (i.e., risk factor such as employment, health insurance, housing, education, etc.) that they are able to close for their client. However, as one stakeholder explained, "A community health worker could spend literally their entire time only doing the housing pathway and never close it, which then eliminates their ability for success in that value-based payment model."

Pros and cons to conducting this work under an 1115 waiver

As stakeholders reflected on their work, they cited both pros and cons to conducting initiatives focused on the justice-involved population within the framework and requirements of an 1115 waiver. These factors can be important considerations for other states weighing whether to test interventions for the justice-involved through an 1115 waiver, or via another mechanism.

Pros

Waiver resources allowed for new types of investment that can be used help identify disparities.

States' 1115 waivers provided an opportunity for organizations to not only invest in automating processes that had been previously been performed manually, but to simultaneously support the national public health goal of reducing health disparities. For example, many of the pre-existing grant programs aimed at identifying justice-involved individuals for program services relied on self-referrals from jail staff. Additional waiver resources to automate referral mechanisms, however, helped participants identify racial inequities in who was receiving services. One stakeholder explained, "As we started to kick [the program/project] off, we recognized that of the first 25 people we had enrolled, we had two people who were identified people of color. And it obviously didn't sit well with any of us. So the county built an IT algorithm through the jail roster that runs everyone in the jail through our eligibility criteria, and then does an additional scan of who's currently sitting in the jail, and then does a racial proportionality disbursement." This automation of referral processes helped scale a program that had previously relied on individual discretion to identify and refer perspective individuals for services.

Waiver funds are also being used to help organizations invest in infrastructure that will support population health analysis, like risk stratification or electronic health records. One initiative in Washington has made all partners, including the jails, eligible for "pay for progress" milestones. This payment mechanism allows partners to earn a certain amount of funding for investing in infrastructure that supports partners' ability to use data to identify high-needs, high-cost patients (i.e., "hotspotting").

Waivers increased collaboration. Stakeholders felt that their 1115 waiver forced people to be more collaborative than they would have had to be otherwise. One individual explained, "The interesting thing about the waiver is we don't get to allow people to sit and just blame the system for not being great. Like the system fundamentally was designed to fail people, and we have the once in a lifetime opportunity to change that. So it would really be a disservice to the waiver dollars and to our community if we just sat and continued to look at the problem rather than think creatively or work together. And I think for some, that's really, really challenging when that's not their everyday role."

Stakeholders' reported strengths of the 1115 waiver also highlighted emphasis waivers put on public-private partnerships.[35] According to an evaluation report of Texas' 1115 waiver released in 2017, there was a 25 percent increase in the number of "collaborative inter-organization relationships" across the state's 20 RHPs from 2011 to 2016, and the evaluation findings highlight "intersectoral collaboration, not just within the RHPs, but also among other organizations that were not eligible to serve as performing providers." Of these "other organization" partners reported, the number of law enforcement/criminal justice partners are the fourth highest (of twelve) with 49 collaborations/partnerships recorded as part of 1115 waiver projects.[36]

Infrastructure created by the waiver facilitated cross-sector learning opportunities. Both Texas and Washington established learning collaboratives that allowed participants from various sectors, organizations, and ACHs or RHPs to learn from each other and discuss the successes, challenges, and outcomes achieved. Stakeholders with whom we spoke found these collaboratives to be extremely useful, and this was especially true for stakeholders who were operating in smaller or less resourced areas. One Texas stakeholder explained, "One good thing is that nobody had to start from scratch. You were welcome to learn and borrow and use any of the forms or projects or anything that another [RHP] had that would be helpful."

Waiver programs expanded access to services. Ultimately, stakeholders felt any effort to expand services available to the justice-involved population was a worthwhile endeavor, even with the challenges of implementing new programs. This was especially true in Texas, where the state's 1115 waiver is structured to support providers that serve uninsured individuals, as well as Medicaid enrollees. One stakeholder explained, "From our perspective, the justice system is about 80 percent male. And the Medicaid system is not designed to serve adult males. In my opinion, anything we can do to increase access to care for adult males, whether it's through the justice system or some other vehicle, is a really important thing for us to do. And if Medicaid is one of the ways to finance that, I think it's essential."

Cons

In states with optional justice-involved projects, the waiver reimbursement methods impacted whether or not an organization chose to focus on individuals with criminal-justice involvement. RHPs in Texas and ACHs in Washington both had the option to choose to work on justice-involved initiatives from a menu of other delivery reform projects. As opposed to a grant program, DSRIP funds are strictly performance-based***.*** Organizations were therefore not paid to provide the service directly, but instead received DSRIP incentive funds if they could meet various process and outcome measures. This led groups to do their own analyses of where the highest possibility for reimbursement would come, and in some cases that meant justice-involved initiatives were passed over for other priorities. Stakeholders expressed some regret about this, noting that although key decision makers recognized the value in serving this population, there was concern that outcome measures tied to this population would make it difficult to achieve maximum financial performance payments.

Justice-involved initiatives were a tiny piece of overall waiver activities. Stakeholders sometimes had difficulty articulating both the status and the impact of their justice-involved initiatives because the target population was relatively small compared to the size of the overall waiver population. In Illinois, the target population for the SUD case management pilot is only 2,040 individuals. And although the pilot is technically operating statewide, some rural courts don't have the volume of cases necessary to justify putting a case manager in place. In both Texas and Washington, justice-involved individuals were just subpopulations within projects. In one ACH in Washington, for example, the goal is to enroll 200 justice-involved clients in their transitional care program over the five-year waiver (in 2018 there were 136,000 individuals in Washington's criminal justice system). The small size of the target population meant that specific justice-involved issues were not necessarily at the forefront of waiver discussions. Stakeholders reported that there hasn't necessarily been strong state support (e.g., technical assistance, training, guidance, etc.) specific to justice-involved issues throughout implementation.

The 1115 waivers for all three of our study states are complex, and have multiple initiatives and target populations. In addition to 1115 waivers, providers—especially medical and behavioral health providers —are facing significant shifts in their payer landscapes. This can make it difficult for potential providers to understand how one, specific justice-involved initiative fits within all of the other payment reforms that are occurring. A stakeholder in Washington noted, "I think that ACHs have done great work, but I think that one area that they could improve is providing more clarity for our whole community about what is happening and…who is doing what and getting paid for it and what is the goal. There's not a lot of clarity for me, and I've been pretty involved with it over time."

Waiver evaluations do not have good mechanisms to measure success specific to justice-involved populations. Every state is required to conduct an evaluation of its 1115 waiver initiatives. Currently most states' outcomes measures are related to Medicaid costs and health care utilization, such as emergency room visits or hospital stays. Stakeholders were concerned, however, that these measures don't adequately define success for a justice-involved initiative. There was a strong desire to look at indicators besides just saving Medicaid money or even recidivism—things like equity and health disparities, culturally appropriate and respectful care, clients' engagement, quality of life, retention in treatment, or increased collaboration among different sectors. A stakeholder explained, "I wish that we had the ability or the language to capture systems change. Like how do we capture how big of a deal it is that now CHWs can do upstream processes [in jails]? [The waiver] is designed to look at things from a quantitative perspective and not a qualitative perspective, so it is really difficult to capture success. What does that mean for the individuals who are receiving those services? While I care that they are not recidivating, has their quality of life improved? We could argue that if they're staying out of jail, the hope would be that their quality of life has improved, but how are we measuring that?"

There was also concern that state Medicaid departments and CMS are only focused on indicators of success that can be calculated at the state level, whereas a significant amount of the actual waiver activity and impacts might actually be felt at the county level. One stakeholder noted, "The county funds health care. It funds criminal justice. It funds corrections and jails. So it can look at cost savings across multiple systems and realize the benefit of investing in one system in order to realize cost savings in another system. For example, investing in health care saves money in court and corrections. The county level is excited by that. The state level is not. And the state doesn't have any interest in jail data, really."

Additionally, stakeholders cautioned that it would likely take more than just one year for any outcomes to be realized with this population, adding: "For this really complex population, it's important to look over the course of several years, because the changes that need to happen take a long time with these very entrenched social determinant and health issues. We know that from our previous small pilots over the years at that it takes two, three years before you really start seeing outcomes. And our attention span is not that long in the Human Services world sometimes. And so it's tough to have the care for these super complex, high cost individuals measured from metrics that are annual."

Required waiver reporting was administratively complex and burdensome for community partners. In all three states, community provider organizations who were offering the waivered services to justice-involved individuals were required to track and report program data and outcomes in a format specific to the waiver reporting. In many cases, these organizations did not have prior experience collecting that type of information and had to set up time-intensive, manual processes for doing so. Community organizations also had to invest time and resources in training staff to both perform the required data collection and complete and submit the required waiver reports.

LOOKING FORWARD

Sustainability Challenges

Ensuring the sustainability of any justice-involved initiative implemented under a state's 1115 waiver was a major focus of all the stakeholders. Participants voiced concerns about structuring a staffing model that could be supported after the waiver ends, collecting the information needed to conduct return-on-investment analyses that would prove the initiative's value, securing the participation of other payers (e.g., managed care plans), and setting up an adequate reimbursement structure and value-based payment bundles that reflect the actual needs of the population. One stakeholder explained, "The challenge is that balance between how do you invest in system-level tests of innovation, but doing that in a way that doesn't set up a system for creating a great service that goes away at the end of the waiver. So that we're really thinking through…what's the sustainability path and…making sure that we have the stakeholders onboard, and always thinking about what are the mechanisms that would make this either billable or in a bundled payment and so forth."

Stakeholders advocated bringing together multiple parties early and often to discuss sustainability of the project—even bringing in a neutral facilitator in order to keep discussions productive and avoid circuitous discussions, such as described by one Washington stakeholder: "We typically have had discussions that sound like this: 'I wonder how the ACHs are going to sustain this work?' The ACHs will go, 'Well, we're going to get the health plans to pay for it.' The health plans will then say, 'Well, we would pay for it, but we're under contract, so the Medicaid authority would need to change our contracts.' And then Medicaid will sit and say, 'Well, we can't change our contracts until the ACHs show us a proof of concept. And as soon as the ACHs show us that these things are productive and effective, then we'll talk.' Well then you've got like, I don't know, a six- or eight-year lag between the end of the ACH work and a legislative approval to move forward. But we've been in these very circular conversations."

While Illinois and Washington are just starting to think about sustainably as they begin implementing their justice-involved initiatives, Texas is approaching the end of its projects and DSRIP funding (which will drop to zero by 2022). Since the first iteration of the state's 1115 demonstration waiver, Texas stakeholders reported struggling with the issue of sustainability. Both providers and stakeholders in Texas viewed sustainability without DSRIP funding as a predominant challenge and that this uncertainty "affected the degree to which they were willing to innovate" with regard to activities planned and initiated through DSRIP.[37] Stakeholders with whom we spoke in Texas were still uncertain about the sustainability of the justice-involved DSRIP initiatives they had implemented.

One strategy some behavioral health organizations in Texas are considering is seeking a Certified Community Behavioral Health Clinic designation.[v] This state certification provides a prospective payment system, along with bonuses for high-value outcomes, designed to support an "integrated health home" approach to serving populations for which care is fragmented, including justice-involved populations.[38] While this potential state funding would be helpful to continuing the work begun under the 1115 waivers, stakeholders were wary that funding would be inadequate (forcing them to continue to seek grants to fill funding gaps), and were concerned

[v] Texas participated in the SAMHSA Certified Community Behavioral Health Clinic (CCBHC) planning grant in 2015, but was not selected as a national demonstration site. The state decided to continue to explore this model thorough the development of state CCBHC standards.

about taking on an outcome-based payment system. One individual cautioned, "The risk is we will lose all of our current general fund revenue for these opportunities, but we can earn more than would have if we are successful in our outcomes. So it's kind of like a balloon. You lose all your general revenue, but you may be in a position to draw down the funding thorough a demonstration of outcomes."

In October 2019, Texas published its second Draft Transition Plan to CMS, describing how it will further develop its delivery system reform efforts without DSRIP funding.[39] After soliciting and incorporating feedback from key stakeholder work sessions, the state has finalized several focus areas for moving forward, including behavioral health; rural health care; and sustaining access to critical health care services, among others. It appears that some of the current justice-involved initiatives will likely continue under the banner of the three aforementioned focus areas. The Texas Health and Human Services Commission plans to review all ongoing and proposed programs within the final two years of the DSRIP waiver, and make recommendations to CMS as to which ongoing programs should continue, which proposed programs will be funded, and which new programs (if any) the state believes should be created. Finalized recommendations for current, proposed, and future programs are due to be submitted to CMS by September 2021.

SUPPORT Act

On October 24, 2018, the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT Act) was signed into law. It's likely this law will have major impacts on efforts to bridge Medicaid connections for justice-involved populations. All states will be required to determine how to effectively deliver care to people leaving prison and jail and address the numerous barriers to securing housing, food, and other social supports that affect health outcomes. CMS is currently convening stakeholders to create a report for best practices for transitional services for people leaving jail or prison as well as waiver practices for the transition period, which is expected to be released shortly. The new law also prohibits the termination of Medicaid eligibility for people under the age of 21 or 26 if formerly in foster care if they become involved with the criminal justice system. Additionally, states must also suspend eligibility, rather than terminate and reinstate without a new application at release.[40]

In-Reach

Research has shown that "in-reach" before inmates are released can be an effective strategy for ensuring continuity of care. In-reach services are designed to help establish relationships with a primary care provider prior to release, identify health conditions, set up community-based care, and address housing issues and other social determinants of health.[41] Although some states require their Medicaid managed care plans to provide in-reach services to justice-involved populations, to date, no state has received 1115 demonstration authority to provide that coverage 30 days pre-release.[vi] Two localities (New York and D.C.), however, have pending Medicaid 1115 waivers before CMS requesting to provide a limited set of services to incarcerated individuals 30 days prior to release from a county jail or state prison. If approved, these waivers could have major implications on states' abilities to coordinate (and pay for) health care services for justice-involved populations as they transition back into the community.[42]

[vi] As mentioned previously, however, some states are providing in-reach services to justice-involved populations through other mechanisms, such as through managed care contract requirements.

New York's 1115 In-Reach Waiver

Demonstration Goal: To provide in-reach transitional services in order to ensure high-risk justice-involved populations receive needed care management, physical and behavioral health services, medication and medication management, and critical social supports upon release into the community.

Intervention: In -reach services will be conducted prior to release on site or through Medicaid-covered telehealth services via prison video-conferencing facilities. Identifying the eligible populations will largely be done in-house by medical personnel in the prisons. The state will also create shared systems of communication between to facilitate linkage to Health Homes. Eligible individuals will receive a limited scope of Medicaid-covered services through Health Home providers, including the following:

- Care management to include a care needs assessment, discharge care plan, plus referrals to and appointments scheduled for physical and behavioral health providers, and linkages to other critical social services and peer support;
- Clinical consultation services provided by community-based medical and behavioral health practitioners to facilitate continuity of care post release; and
- A medication management plan and certain higher priority medications

Target Population: Medicaid-eligible incarcerated individuals scheduled for release within 30 days from county and state facilities. Eligible individuals must have: (1) two or more chronic physical/behavioral health conditions; or (2) one of the following qualifying conditions - either a serious mental illness, HIV/AIDS, or an opioid use disorder. The initial target population will include those who are in a Medicaid suspension status. *(For county jails the state requested that providers be allowed to engage individuals in county jails within the first 15 days of incarceration, as the average length of stay is often brief—less than two weeks.)*

Key Partners: The state will leverage its five existing, state-funded criminal justice Health Home pilots for the purposes of this waiver. Health Homes will work with Medicaid managed care plans to enroll individuals in a plan prior to release.

Evaluation Measures: Reduction in emergency department use, reduction in inpatient hospitalizations, and reduced Medicaid expenditures. The state will also asses additional health outcomes, including a reduction in overdose rates and deaths.

Additional State Plan Amendments: The state will seek State Plan Amendments to: (1) reimburse peer services for justice-involved populations prior to release; and (2) add opioid use disorder (OUD) as single qualifying condition for Health Home enrollment.

CONCLUSION

Initiatives designed to address the specific needs of justice-involved populations through Section 1115 waivers are currently a small, but growing, focus of states' efforts. The extremely small size of the target populations served through the programs studied here (in some cases only several hundred individuals), as well as unique state contextual factors, make it difficult to draw generalizable conclusions about the best way to implement any specific program. However, the experiences of stakeholders in Illinois, Texas, and Washington can be helpful to other states as they consider whether to implement programs aimed at individuals involved in the criminal justice system via Section 1115 Medicaid waivers.

Implementation of justice-involved initiatives in all three study states involved significant coordination among multiple stakeholders, including state Medicaid officials, behavioral health and substance use disorder specialists, community health providers, social service providers, law enforcement, prosecutors, judges, and others. Fostering close coordination with law enforcement, drawing on stakeholders' previous experience with justice-involved grants, and leveraging existing provider infrastructure were all common facilitators cited in the successful implementation of programs. Stakeholders also faced many challenges in carrying out their work, including: aligning goals of the multiple sectors that interact with justice-involved populations; placing culturally competent program staff in criminal justice settings, addressing privacy and security concerns related to sharing data among various sectors; calculating a return-on-investment analysis that could prove the value of the work; and providing housing services.

Stakeholders in the three study states identified both pros and cons to conducting programs for justice-involved populations under a Section 1115 waiver. Some individuals were especially hopeful that investing waiver resources in new infrastructure would help identify and reduce health disparities that have long existed in this population. Although there was concern that waiver reimbursement methods and corresponding and evaluation metrics wouldn't adequately reflect the success of a justice-involved initiative, stakeholders ultimately felt that efforts to undertake such programs were worthwhile because the waiver expanded access to services that would not otherwise be available to a high-need population.

REFERENCES

[1] Kaeble, D., & Cowhig, M. (2018). *Correctional populations in the United States, 2016* [NCJ 251211]. Retrieved from https://www.bjs.gov/content/pub/pdf/cpus16.pdf

[2] Committee on Causes and Consequences of High Rates of Incarceration, Committee on Law and Justice, Division of Behavioral and Social Sciences and Education, & National Research Council. (2014). *The growth of incarceration in the United States: Exploring causes and consequences*. S. Redburn, J. Travis, & B. Western (Eds.). Washington, D.C.: The National Academies Press.

[3] Binswager, I.A., Redmond, N., Steiner, J.F., & Hicks, L.S. (2011, September 14). Health disparities and the criminal justice system: An agenda for further research and action. *J Urban Health*, *89*(1), 98-107. https://link.springer.com/article/10.1007/s11524-011-9614-1

[4] Centers for Medicare and Medicaid Services. (n.d.). Section 1115 Demonstrations [PDF file]. Available from https://www.medicaid.gov/medicaid/section-1115-demo/index.html

[5] Klabunde, M. (2019, October 14). SHADAC resource on required evaluation plans for DSRIP/Delivery System Reforms through 1115 waivers [Blog]. Retrieved from https://shadac.org/news/shadac-resource-required-evaluation-plans-dsripdelivery-system-reforms-through-1115-waivers

[6] Gates, A., Artiga, S., & Rudowitz, R. (2014). *Health coverage and care for the adult criminal justice-involved population*. Retrieved from https://www.kff.org/wp-content/uploads/2014/09/8622-health-coverage-and-care-for-the-adult-criminal-justice-involved-population1.pdf

[7] Winkelman, T.N.A., Kieffer, E.C., Goold, S.D., Morenoff, J.D., Cross, K., & Ayanian, J.Z. (2016, September 16). Health insurance trends and access to behavioral healthcare among justice-involved individuals—United States, 2008-2014. *J Gen Int Med*, *31*(12), 1523-1529. doi: 10.1007/s11606-016-3845-5

[8] Mallik-Kane, K., & Visher, C.A. (2008). *Health and prisoner reentry: How physical, mental, and substance abuse conditions shape the process of reintegration.* Retrieved from http://www.urban.org/sites/default/files/alfresco/publication-pdfs/411617-Health-and-Prisoner-Reentry.pdf

[9] Winkelman, T.N.A., Chang, V.W., & Binswager, I.A. (2018, July 6). Health, polysubstance use, and criminal justice involvement among adults with varying levels of opioid use. *JAMA Netw Open*, *1*(3), e180558. doi:10.1001/jamanetworkopen.2018.0558

[10] Binswager, I.A., Redmond, N., Steiner, J.F., & Hicks, L.S. (2011, September 14). Health disparities and the criminal justice system: An agenda for further research and action. *J Urban Health*, *89*(1), 98-107. https://link.springer.com/article/10.1007/s11524-011-9614-1

[11] Zeng, Z. (2019). *Jail inmates in 2017* [NCJ 251774]. Retrieved from https://www.bjs.gov/content/pub/pdf/ji17.pdf

[12] Wildeman, C., & Wang, E.A. (2017, April 8). Mass incarceration, public health, and widening inequality in the USA. *Lancet*, *389*(10077), 1464-1474. https://www.clinicalkey.com/#!/content/playContent/1-s2.0-S0140673617302593?returnurl=null&referrer=null

[13] Gifford, K., Ellis, E., Coulter Edwards, B., Lashbrook, A., Hinton, E., Antonisse, L., & Rudowitz, R. (2018). *States focus on quality and outcomes amid waiver changes: Results from a 50-state Medicaid budget survey for state fiscal years 2018 and 2019*. Retrieved from http://files.kff.org/attachment/Report-States-Focus-on-Quality-and-Outcomes-Amid-Waiver-Changes-Results-from-a-50-State-Medicaid-Budget-Survey-for-State-Fiscal-Years-2018-and-2019

[14] Guyer, J., Serafi, K., Bachrach, D., & Gould, A. (2019, January 11). *State strategies for establishing connections to health care for justice-involved populations: The central role of Medicaid.* Retrieved from https://www.commonwealthfund.org/sites/default/files/2019-01/Guyer_state_strategies_justice_involved_Medicaid_ib_v2.pdf

[15] Plotkin, M.R., & Blandford, A. (2017). *Critical connections. Getting people leaving prison and jail the mental health care and substance use treatment they need: What policymakers need to know about health care coverage.* Retrieved from https://files.csgjusticecenter.org/critical-connections/Critical-Connections-Full-Report.pdf

[16] Winkelman, T.N.A., Kieffer, E.C., Goold, S.D., Morenoff, J.D., Cross, K., & Ayanian, J.Z. (2016, September 16). Health insurance trends and access to behavioral healthcare among justice-involved individuals—United States, 2008-2014. *J Gen Int Med*, *31*(12), 1523-1529. doi: 10.1007/s11606-016-3845-5

[17] Jannetta, J., Marks, J., Dorn, S., Serafi, K., Kurs, E., Guyer, J., Reginal, T., & Cantrell, C. (2018). *Strategies for connecting justice-involved populations to health coverage and care.* Retrieved from https://www.urban.org/sites/default/files/publication/97041/strategies_for_connecting_justice-involved_populations_to_health_coverage_and_care.pdf

[18] Bachrach, D., Guyer, J., & Levin, A. (2016, July 25). *Medicaid coverage of social interventions: A road map for states* [PDF file]. Available from https://www.milbank.org/publications/medicaid-coverage-social-interventions-road-map-states/

[19] Office of Disease Prevention and Health Promotion. (2019, December 19). Social determinants of health. Retrieved from https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health

[20] National Association of Medicaid Directors (NAMD). (2018). *State Medicaid operations survey: Sixth annual survey of Medicaid directors FY 2017*. Retrieved from http://medicaiddirectors.org/wp-content/uploads/2018/09/NAMD-Survey-Report_General_FINAL.pdf

[21] Medicaid and CHIP MAC Learning Collaboratives. (2017, August 17). *Medicaid and justice-involved populations: Strategies to increase coverage and care coordination* [PowerPoint slides]. Retrieved from https://www.medicaid.gov/state-resource-center/downloads/mac-learning-collaboratives/justice-involved-populations.pdf

[22] Office of the Assistant Secretary for Planning and Evaluation (ASPE). (2010, October 29*). Understanding Medicaid home and community services: A primer* [2010 edition; PDF file]. Available from https://aspe.hhs.gov/report/understanding-medicaid-home-and-community-services-primer-2010-edition/section-1115-waivers

[23] Substance Abuse and Mental Health Services Administration (SAMHSA). (2013). *Medicaid handbook: Interface with behavioral health services* [SMA-13-4773]. Retrieved from https://www.nasmhpd.org/sites/default/files/Medicaid-Handbook-Interface-with-Behavioral-Health-Services%281%29.pdf

[24] Freudenberg, N., & Heller, D. (2016). A review of opportunities to improve the health of people involved in the criminal justice system in the United States. *Ann Rev Pub Health*, *37*, 313-333. https://doi.org/10.1146/annurev-publhealth-032315-021420

Spillman, B., Clemans-Cope, L., Mallik-Kane, K., & Hayes, E. (2017). *Connecting justice-involved individuals with Health Homes at reentry: New York and Rhode Island.* Retrieved from https://www.urban.org/sites/default/files/publication/88031/clean_health_homes_2.pdf

Kennedy-Hendricks, A., Huskamp, H.A., Rutkow, L., & Barry, C.L. (2016). Improving access to care and reducing involvement in the criminal justice system for people with mental illness. *HealthAffairs*, *35*(6), 1076-1083. https://doi.org/10.1377/hlthaff.2016.0006

Guyer, J., Serafi, K., Bachrach, D., & Gould, A. (2019). *State strategies for establishing connections to health care for justice-involved populations: The central role of Medicaid.* Retrieved from https://www.commonwealthfund.org/sites/default/files/2019-01/Guyer_state_strategies_justice_involved_Medicaid_ib.pdf

Howell, E., Kotonias, C., & Janetta, J. (2017). *Case management for justice-involved populations: Colorado.* Retrieved from https://www.urban.org/sites/default/files/publication/88061/final_clean_case_management_1_09_17.pdf

Heiss, C., Somers, S.A., & Larson, M. (2016). *Coordinating access to services for justice-involved populations.* Retrieved from https://milbank.org/wp-content/uploads/2016/09/MMF_CoordinatingAccess-FINAL-1.pdf

Dorn, S., Peters, R., Cheeks, M., Casanova, P., Eckart, G., & Lutterman, T. (2016, November 30). *The use of 1915(I) Medicaid plan option for individuals with mental health and substance use disorders* [PDF file]. Available from https://aspe.hhs.gov/basic-report/use-1915i-medicaid-plan-option-individuals-mental-health-and-substance-use-disorders

[25] 42 CFR § 435.1010.

Centers for Medicare and Medicaid Services. (2016, April 28). To facilitate successful re-entry for individuals transitioning from incarceration to their communities [SHO #16-007]. Retrieved from https://www.medicaid.gov/federal-policy-guidance/downloads/sho16007.pdf

[26] Illinois Department of Healthcare and Family Services. (2016, August 26). Illinois' Behavioral Health Transformation: Frequently asked questions (FAQs). Retrieved from https://www.illinois.gov/hfs/SiteCollectionDocuments/20160826_FAQs_vF.pdf

[27] Heider, F., Kartika, T., & Rosenthal, J. (2017). *Exploration of the evolving federal and state promise of Delivery System Reform Incentive Payment (DSRIP) and similar programs*. Retrieved from https://www.macpac.gov/wp-content/uploads/2018/03/Exploration-of-the-Evolving-Promise-of-DSRIP-and-Similar-Programs.pdf.

[28] Texas Health and Human Services. (2018, February 28). *DSRIP Amounts by RHP* [Data set]. Available from https://public.tableau.com/profile/texashhsc#!/vizhome/TexasDSRIPDashboard_02-26-2018/DSRIPAmountsbyRHP

[29] Texas Health and Human Services Commission. (2019). Draft DSRIP Transition Plan. Retrieved from https://hhs.texas.gov/sites/default/files/documents/laws-regulations/policies-rules/Waivers/medicaid-1115-waiver/1115-medicaid-waiver-tools-guidelines-regional-healthcare-partnership-participants/draft-dsrip-transition-plan.pdf

[30] DSRIP Amounts by RHP. (2018, February 28). *DSRIP Amounts by RHP* [Data set]. Available from https://public.tableau.com/profile/texashhsc#!/vizhome/TexasDSRIPDashboard_02-26-2018/DSRIPAmountsbyRHP

[31] SHADAC review of Washington Health Care Authority's Accountable Communities of Health individual transformation project plans.

Washington State Health Care Authority. (n.d.). Medicaid Transformation resources: ACH submitted documents [PDF file]. Available from https://www.hca.wa.gov/about-hca/healthier-washington/ach-submitted-documents

[32] Washington State Health Care Authority. (2019). *Delivery System Reform Incentive Payment measurement guide.* Retrieved from https://www.hca.wa.gov/assets/program/mtp-measurement-guide.pdf#page=15

[33] HealthierHere. (2019, April 8). *Clinical summary transitions of care from jail.* Retrieved from https://www.healthierhere.org/wp-content/uploads/2018/07/Care-Transitions_Jails_04.8.19_final.pdf

[34] Illinois Department of Healthcare and Family Services. (2016, October 5). *Illinois' Behavioral Health Transformation Section 1115 Demonstration Waiver.* Retrieved from https://www.illinois.gov/hfs/SiteCollectionDocuments/1115%20Waiver%20for%20CMS%20Submission_final.pdf

[35] Hogg Foundation for Mental Health. (2018). *A guide to understanding mental health systems and services in Texas* [4th edition]. Retrieved from https://hogg.utexas.edu/wp-content/uploads/2018/11/Mental-Health-Guide_4th-Edition.pdf

[36] Texas Health and Human Services. (2017, May 30). *Evaluation of the 1115(a) Texas Demonstration Waiver – Healthcare transformation and quality improvement.* Retrieved from https://hhs.texas.gov/sites/default/files/documents/laws-regulations/policies-rules/1115-docs/tool-guidelines/Evaluation-Texas-Demonstration-Waiver.pdf

[37] Texas Health and Human Services. (2017, May 30). *Evaluation of the 1115(a) Texas Demonstration Waiver – Healthcare transformation and quality improvement.* Retrieved from https://hhs.texas.gov/sites/default/files/documents/laws-regulations/policies-rules/1115-docs/tool-guidelines/Evaluation-Texas-Demonstration-Waiver.pdf

[38] Texas Health and Human Services Commission. (n.d.). Texas CCBHC Demonstration Application. Retrieved from https://hhs.texas.gov/sites/default/files/documents/doing-business-with-hhs/providers/health/ccbhc/ccbhc-demonstration-application-narrative.pdf

[39] Texas Health and Human Services Commission. (2019, September 30). *Draft Delivery System Reform Incentive Payment (DSRIP) Transition Plan.* Retrieved from https://hhs.texas.gov/sites/default/files/documents/laws-regulations/policies-rules/1115-waiver/waiver-renewal/draft-dsrip-transition-plan-cms.pdf

[40] State Health & Value Strategies. (2019, June 18). *Leveraging Medicaid to establish meaningful health care connections for justice-involved populations* [PowerPoint slides]. Retrieved from https://www.shvs.org/wp-content/uploads/2019/05/Justice-Involved-Populations-6_18_19.pdf

[41] Guyer, J., Serafi, K., Bachrach, D., & Gould, A. (2019). *State strategies for establishing connections to health care for justice-involved populations: The central role of Medicaid.* Retrieved from https://www.commonwealthfund.org/sites/default/files/2019-01/Guyer_state_strategies_justice_involved_Medicaid_ib.pdf

[42] New York State Department of Health. (2019, August 9). Medicaid Redesign 1115 Demonstration Amendment Application: Continuity of Coverage for Justice-involved Populations. Retrieved from https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/special_populations/docs/cj_cms_amendment_final.pdf