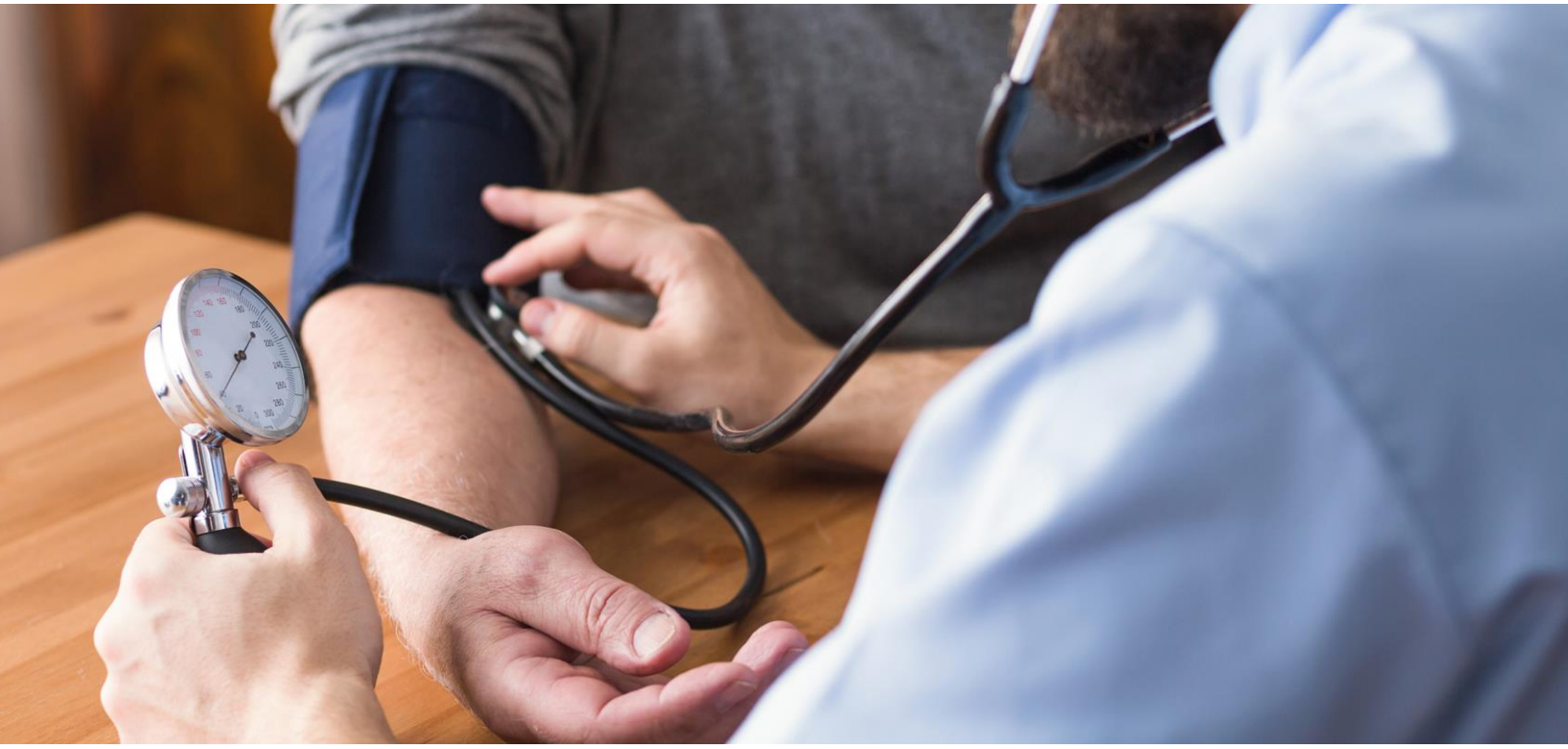

RESEARCH REPORT

Using Jail to Enroll Low-Income Men in Medicaid

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Contents

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Executive Summary

This report describes the implementation and outcomes of a pilot study in Connecticut to enroll people who were arrested and detained pretrial into Medicaid so they would have health coverage upon release. Jails can offer a "public health opportunity" (Greifinger 2007) to connect otherwise hard-to-reach, low-income people with health insurance. People in jail have substantial health needs, including behavioral health conditions that can contribute to a cycle of relapse and reoffending. Medicaid enrollment has the potential to increase access to physical and behavioral health services upon release. However, most people in jail are pretrial detainees who have brief and unpredictable lengths of stay, making it challenging to conduct outreach and provide assistance in time for their reentry to the community.

Connecticut's experience served as a case study of the increased coverage availability under the Affordable Care Act. Connecticut was an early adopter of Medicaid expansion under the act and has provided coverage to low-income childless adults since 2010, including individuals nearing their release from prison.

Beginning in 2013, the Urban Institute, the Connecticut Department of Correction, and the Connecticut Department of Social Services conducted a pilot demonstration project and research study to extend Medicaid enrollment efforts to pretrial detainees in jail. Doing so required adapting existing processes in the prison setting and contending with the difficulty of planning for pretrial detainees' uncertain release dates. This report describes the implementation of Connecticut's jail intake-based approach to Medicaid enrollment and uses state Medicaid agency data to examine this effort's success in enrolling pretrial detainees and connecting them to postrelease coverage and care.

People who left jail with Medicaid coverage typically accessed care on release. However, many who enrolled in Medicaid subsequently lost coverage during their time in jail. Further, implementation challenges made it difficult to enroll a large number of people.

Connecticut's long history of Medicaid expansion suggests that, over time, increasing numbers of people will enter jail with Medicaid coverage. Without a process to suspend and reactivate benefits, many of these people risk losing coverage during their time in jail. A loss of coverage is both harmful at the individual level and a waste of the program resources used for the original enrollment.

Connecticut's experience offers implementation lessons and policy considerations for other jurisdictions to get people enrolled and keep them covered. But although it is important to learn how to enroll the jail-involved population in Medicaid, it is equally important to develop policies and systems to keep them from losing coverage. This change will require attention to Medicaid policy, information technology systems, and information sharing between local corrections and state and local Medicaid agencies.

Using Jail to Enroll Low-Income Men in Medicaid

Medicaid's Potential as a Jail Reentry Intervention

High Health Needs Contribute to Poor Postrelease Outcomes

There are 11.4 million admissions to jails each year in the United States (Minton and Zeng 2015; Solomon et al. 2008). Jail populations are characterized by high health needs and historically low rates of insurance coverage. Incarcerated people suffer from chronic, infectious, and mental illnesses at higher rates than the general population (National Commission on Correctional Health Care 2004), with prevalence rates for HIV/AIDS two to ninefold greater; tuberculosis, fourfold; hepatitis C, up to tenfold; schizophrenia, fourfold; and bipolar disorder, twofold (Davis and Pacchiana 2004). They are also much more likely to use controlled substances. Two-thirds of the jail population meets DSM-IV criteria for substance abuse or dependence, compared to 9 percent of the general US population (Karberg and James 2005; Solomon et al. 2008).

The postrelease period is particularly risky. Research to date has focused on people leaving prison, but people in jail are likely to have similar experiences. People often receive health care while incarcerated, but once released, their health status and health care utilization drop substantially (Mallik-Kane and Visher 2008). The first two weeks after release are associated with a twelvefold increase in mortality (Binswanger et al. 2007). Eight to 10 months after release, chronic physical and mental illnesses and substance abuse are associated with poor housing and employment outcomes and with more criminal activity, rearrest, and reincarceration (Mallik-Kane and Visher 2008). Interrupted care for chronic illness imposes considerable costs in the community and, for those reincarcerated, greater costs in corrections (Wakeman, McKinney, and Rich 2009).

Medicaid as a Reentry Intervention

Medicaid is a joint state-federal program that provides health coverage, including mental health and substance abuse services, to qualifying low-income people. Improving the health coverage of people

upon their release from jail could considerably improve public health and reduce costs, and it may also improve employment outcomes and reduce reoffending. Medicaid eligibility criteria, as they pertain to the jail-involved population, are discussed at length further below.

The beneficial effects of Medicaid coverage are likely to be greatest among people with the greatest need for continuing health care, and the greatest potential public safety benefits involve those whose health care needs are most related to offending (e.g., substance abuse) and disruptive to stable employment and community reintegration (e.g., mental illness). A study of people in jail with serious mental illness found that those who enrolled in Medicaid at release accessed more services, received them more quickly, utilized them for longer, and were less likely to return to jail in the 12 months following release than those without Medicaid (Morrissey et al. 2006; Morrissey et al. 2007). Other studies describe limitations and challenges to Medicaid enrollment efforts, including peoples' willingness to participate and the effectiveness of benefits specialists (Moses and Potter 2007a, 2007b).

Availability of Postrelease Medicaid Coverage for People Leaving Jail

Most people incarcerated in jails are low-income men (National Commission on Correctional Health Care 2004, 15–26; Solomon et al. 2008), a population that has historically lacked access to Medicaid health coverage. Despite being poor, many have not traditionally been eligible for Medicaid, which only covered adults who were either very low-income parents or disabled.[1]

The Affordable Care Act's (ACA) 2014 expansion of Medicaid to so-called childless adults made nearly all adult citizens with incomes below 138 percent of the federal poverty level newly eligible for coverage regardless of meeting traditional eligibility criteria such as disability, in states that chose to participate in the expansion. Recent federal efforts have focused attention on Medicaid enrollment among low-income men (Howard et al. 2016; McKay et al. 2016),[2] and jails offer a "public health opportunity" to conduct outreach with a segment of this often hard-to-reach population (Greifinger 2007). With limited exceptions, Medicaid generally does not cover health services while someone is in jail or prison, but under the ACA, many people newly qualified for Medicaid upon release (CSG Justice Center 2013).[3]

The Medicaid program has an "inmate exclusion" that prohibits payment for services while people are incarcerated, regardless of whether they are held pretrial or after a conviction. Efforts to enroll people in jail are complicated by this statutory restriction on service coverage during incarceration and by Medicaid's historic connection to other Social Security Act programs with similar restrictions. Before

the Affordable Care Act expanded Medicaid coverage for low-income adults, Medicaid coverage for poor adults was often contingent on eligibility for Supplemental Security Income (SSI). When states terminated or suspended SSI because of incarceration, Medicaid was also terminated (Bazelon Center for Mental Health Law 2009). Although federal guidance encourages states to evaluate such cases against other criteria that might allow for continuation of eligibility,[4] states can be penalized if they bill for Medicaid services while someone is incarcerated (OIG 2004).

As a result, states have been understandably cautious in linking this population to Medicaid coverage. Newly issued federal Medicaid guidance reaffirms that states can allow incarcerated people to (re)apply for coverage while incarcerated and that states can enroll them while they are incarcerated as long as the state suspends or uses other administrative mechanisms to avoid improper payments during incarceration (Wachino 2016). At present, however, most states have established processes for terminating benefits on entry to prison or jail, but relatively few states have systems to reestablish benefits when someone is released (Gates, Artiga, and Rudowitz 2014). Specific requirements and practices vary considerably across states and are in flux.

Jails and Prisons Need Different Medicaid Enrollment Approaches

For Medicaid to improve postrelease outcomes, people leaving jails and prisons must be able to access health care immediately after release, when health and recidivism risks are greatest (Grattet, Petersilia, and Lin 2008; Langan and Levin 2002; National Research Council 2008; Uchida et al. 2009). Reentry planning, including Medicaid application assistance, involves considerably different challenges in jails and prisons.

In most states, jails and prisons serve fundamentally distinct criminal justice functions that translate into very different lengths of stay. Jails are primarily used for pretrial detention, short sentences, and a variety of other needs, such as probation and parole violations and time awaiting transport to prison. Prisons, however, are typically reserved for people with sentences of one year or longer. The implication for release planning is that prisons have longer periods to identify needs, conduct programming, and identify strategies to meet postrelease needs. By contrast, jails are characterized by unpredictable release dates and rapid turnover; fewer than 20 percent of people in jail stay for more than one month (Beck 2006; Minton and Zeng 2015).

Nationwide, the majority of people in jail are pretrial detainees waiting on the disposition of their criminal charges (Sabol, Minton, and Harrison 2007). As a result, the exact timing of their release

depends on bail and court processes and is difficult to predict. Some pretrial detainees spend just a few days in jail before they are released on bail or their charges are dismissed. Others may remain incarcerated for several months if they cannot afford or are denied bail. Adding a layer of complexity, the location of release may also vary. Some pretrial detainees are released from the jail facility, but others may be released directly from the courthouse. Programming and reentry planning resources are often limited, and reentry resources must be triaged (Solomon et al. 2008).[5]

Design of an effective Medicaid application assistance intervention must take these realities into account. Assistance in a prison could capitalize on the ability to plan for and anticipate the timing of release, but the combination of short stays and unpredictable release dates makes discharge-based planning very challenging in a jail. Medicaid enrollment near the time of admission may therefore be a more promising option for jails.

About This Pilot Study: Connecticut's Medicaid Enrollment Procedure for Pretrial Detainees

In 2012 and 2013, the Urban Institute (Urban), the Connecticut Department of Correction (DOC), and the Connecticut Department of Social Services (DSS) collaboratively developed and tested a jail intake–based procedure for Medicaid enrollment as part of a research study sponsored by the US Department of Justice and US Department of Health and Human Services.[6] Through this pilot study, pretrial detainees were enrolled in Medicaid soon after admission. We then tracked Medicaid enrollment, coverage, and health care utilization up to 12 months after release.

This section describes the development and design of Connecticut's Medicaid enrollment procedure for pretrial detainees. We detail Connecticut's Medicaid policy, collaborations between the DOC and DSS, key steps of the Medicaid enrollment procedure, and characteristics of the jail population targeted for enrollment. Later, we describe the extent to which pretrial detainees applied for Medicaid, successfully enrolled, and received care upon release.

Connecticut's Medicaid Program for Childless Adults

Connecticut was an early adopter of Medicaid expansion for childless adults under the ACA. Since 2010, Connecticut residents could qualify for Medicaid coverage through the state's Husky D program if their income was below 56 to 68 percent of the federal poverty level.[7] Eligibility was open to US

citizens and legal residents. Medicaid benefits include prescription medication; medical, mental health, substance abuse, dental, and vision care; and wrap-around services like case management and medical transportation. Although Medicaid dollars generally cannot be used to pay for services while people are incarcerated, it is permissible to enroll people while they are incarcerated so that coverage is in place upon release.

Connecticut's History of Prerelease Enrollment in Prisons

Connecticut's DOC and DSS have collaborated since 2004 to enroll justice-involved people in Medicaid so they would have health coverage once released to the community. Initial efforts focused on people with severe medical and mental health needs. When the Medicaid program expanded to cover childless adults, the collaboration began offering application assistance to all soon-to-be-released people in prison. A longstanding goal has been to ensure the continuation of any medications prescribed in prison so that people could refill their prescriptions at local, community-based pharmacies upon release.

People leaving prison are routinely offered Medicaid application assistance within 30 days of their expected release during reentry preparation classes. DOC reentry teachers explain the benefits of Medicaid coverage, distribute paper applications, and provide assistance with filling them out. People with high health needs receive both application assistance and case management services from DOC-based medical discharge planners. All applications are faxed to DSS for an eligibility determination prior to release.

Connecticut's DOC and DSS developed several innovations to maximize Medicaid enrollment in time for prison release:

- **An expedited application and eligibility determination process for incarcerated people.** DSS developed an abbreviated two-page form for the sole purpose of evaluating Medicaid eligibility. DSS's standard 16-page application is designed to evaluate eligibility for multiple public assistance programs, including but not limited to Medicaid, but completing this long form proved difficult for incarcerated people, who lack access to necessary supporting documentation. Further, because people leaving DOC custody typically have no income, DSS developed an expedited eligibility determination process (Bandara et al. 2015). By cross-referencing other government databases, such as immigration and unemployment insurance, DSS can provide an eligibility determination within one to two business days.

- **A dedicated, centralized unit for processing applications from the criminal justice system.** Starting in 2004, DSS established a centralized prerelease entitlements unit whose chief responsibility is to process applications from the criminal justice system.[8] DOC has provided funding to partially support the five dedicated eligibility specialists in this unit since 2009. This configuration provided DOC-based discharge planning staff with a single point of contact in DSS and helped DSS staff build specialized knowledge about the needs of the justice-involved population. Previously, Medicaid applications were processed by DSS's geographically based district offices.
- **Information sharing.** DOC gave DSS prerelease entitlements unit staff limited access to its management information system to verify applicants' anticipated and actual release dates.

Connecticut's Jail Intake–Based Medicaid Enrollment Procedure

Understanding that discharge-based enrollment would not be feasible in the jail setting because the majority of people in jail are pretrial detainees with unpredictable release dates, DOC and DSS partnered with Urban in 2012 to adapt the Medicaid application process for prison into an intake-based process for pretrial detainees in jail. Medicaid application assistance was then offered between February and May 2013 as a pilot study at the Hartford Correctional Center.[9] Consenting participants agreed to apply for Medicaid and granted Urban's research team permission to access their Medicaid enrollment and health care utilization records.

The same DOC and DSS personnel who designed Connecticut's procedure for enrolling the soon-to-be-released prison population developed the admission-based process for the jail. This arrangement would not have been possible in most states because local jails are usually administered separately from the state prison system. However, Connecticut is one of six states with a unified system, in which all prisons and local jails are operated by the state DOC (Solomon et al. 2008). As a result, the jail-based enrollment effort benefited from the experience, personnel, and interagency partnerships established through the prison-based enrollment work.

DOC, DSS, and Urban designed the jail intake–based process to enroll pretrial detainees during their first week in jail, targeting their fifth day of incarceration. DOC staff felt that people would not be receptive to enrollment any sooner because the days immediately after incarceration can be traumatic, and people tend to be focused on their legal situation and securing release. In addition to being upset, afraid, and angry, many people are high or inebriated at the time of arrest and may undergo withdrawal

from drugs and alcohol or suffer a disruption from prescription medication routines. Five days after admission allowed enough time for people to become settled, undergo the jail's detox protocol, and adequately consent to both Medicaid application assistance efforts and the study's request for access to their enrollment and health care utilization records.

The first 7–10 days after jail admission form the orientation period, during which newly admitted people are typically housed in dormitory-style units while undergoing classification screenings and assessments. This was an opportune but brief time to convene groups of newly incarcerated men; once these classification assessments were completed, people would be moved to more specialized housing units and potentially transferred to other DOC facilities.

INITIAL DESIGN OF THE MEDICAID ENROLLMENT PROCEDURE

The project originally planned to outstation dedicated DSS eligibility specialists at the jail with a laptop computer to conduct real-time screening, application assistance, and eligibility determination, as well as individualized education on Medicaid benefits. However, DOC and DSS encountered two insurmountable administrative and technological obstacles. Under the state's personnel and union rules, DSS eligibility specialists could not be outstationed at the jail because of their current employee classifications. Their positions would need to be reclassified to receive "unpleasant pay" because of the job's location at the jail. Further, the jail building had poor wireless Internet reception, even with commercial cell phone cards, impeding access to the DSS eligibility management database.

MEDICAID ENROLLMENT AS IMPLEMENTED

Once it became clear that it would not be possible to use a computerized enrollment process with dedicated DSS eligibility specialists outstationed at the jail, the project team developed a paper-based procedure similar to the one used at discharge in the prison setting. Because of the study's limited time frame, DOC deployed existing health services staff to conduct outreach and application assistance. These tasks were in addition to their routine responsibilities, as the study did not have funding to support additional staff. The key steps of this paper-based enrollment process were as follows:

- **Identification of people in need of Medicaid.** DOC staff queried the jail's management information system to identify all people admitted during the previous five days. DOC further screened this list to identify pretrial detainees.[10] DSS staff then screened this list to identify people in need of Medicaid coverage. Lists were generated and screened in this manner up to three times each week throughout the pilot study period.

- **Outreach and Medicaid application assistance.** Two to three times each week, a DOC-based health services staff member coordinated with custody staff to assemble those identified as needing Medicaid in one of the jail's meeting spaces. During these group meetings, the staff member described the benefits of Medicaid coverage, offered application assistance, and discussed people's questions. Because enrollments were being conducted as part of this research study, the staff member also requested informed consent from people to access their Medicaid enrollment and utilization records. Participation was voluntary, and those who consented to the study filled out the expedited, two-page paper application form (with help from staff as needed). They then received educational materials on how to use Medicaid benefits in the community and were told to expect Medicaid cards sent to the address on their applications. After meeting with these individuals, the DOC staff member faxed completed applications to the Medicaid agency.
- **Medicaid eligibility determination and activation.** DSS conducted its eligibility determination process within one to two business days and activated approvals within its database so that coverage would be available upon release. Because of the rapid turnover in jail populations, DSS granted approvals on the presumption that people are typically released within 30 days, but it could rescind approval for longer periods of incarceration. Like many other state Medicaid agencies, DSS's practice was to deactivate Medicaid and other public benefits[11] after 30 days of incarceration. However, study participants could be flagged for a temporary exception from this process.[12]

About the Jail Population in This Pilot Study

Between February and May 2013, a total of 1,363 men were admitted to the Hartford Correctional Center as pretrial detainees (table 1).[13] The median length of stay was 21 days, meaning half the men were released within three weeks. Entering pretrial detainees had significant physical and behavioral health needs as determined by DOC's intake assessment and classification process, which rates medical, mental health, and substance abuse treatment needs on a scale from one to five. Two-thirds of incoming pretrial detainees met DOC's threshold for service needs (i.e., having at least one score of three or above). Twenty-six percent of incoming pretrial detainees had medical needs,[14] 25 percent had mental health needs,[15] and 47 percent had substance abuse treatment needs.[16] Approximately one in eight of the men had co-occurring mental health and substance abuse treatment needs.

TABLE 1

Characteristics of Men Entering Pretrial Detention at the Hartford Correctional Center, February–May 2013

Age at admission (mean)	33.3 years
Race	
White	36.3%
Black	32.5%
Hispanic	30.3%
Asian	1.0%
Educational attainment	
Less than high school	45.2%
High school graduate	44.0%
Any postsecondary education	10.7%
Length of stay in custody	
Mean	49.2 days
Median	21.0 days
Physical and behavioral health needs	
Any physical or behavioral health needs	66.0%
Any behavioral health needs	59.6%
Specific health needs	
Medical needs	26.1%
Mental health needs	25.1%
Substance abuse treatment needs	46.9%
Co-occurring mental health and substance abuse treatment needs	12.4%
Current offense	
Person or violent	15.9%
Property	11.1%
Drug	14.3%
Parole or probation violation	20.7%
Other[a]	38.0%

Source: Based on the 1,363 pretrial detainees identified during the study period.

Notes: Physical and behavioral health needs were determined during the Department of Correction's intake assessment and classification process. Medical, mental health, and substance abuse treatment needs were each rated on a scale from one to five. Any scores of three and above met the Department of Correction's threshold for service provision during incarceration.

[a] Other offenses included public order offenses, failures to appear, immigration offenses, weapons offenses, violations of a protective order, and motor vehicle offenses.

Implementation Findings

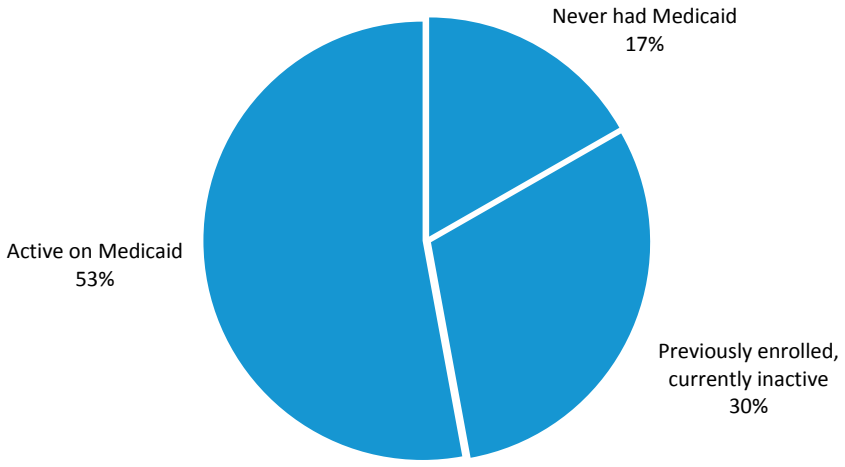
Urban's research team linked DOC and DSS administrative data from February 2013 to April 2015 to quantify how many entering pretrial detainees participated in Medicaid application assistance efforts, enrolled in Medicaid, maintained coverage, and used health services after release.

Individuals Entering Jail with Active Medicaid Coverage

Over half of the pretrial detainees admitted to the Hartford Correctional Center had active Medicaid coverage when they entered the jail. Almost one-third previously had Medicaid, but their coverage had lapsed. Only 17 percent had never received Medicaid coverage (figure 1).

FIGURE 1

Medicaid Coverage Status of Men Entering Pretrial Detention



Source: Based on the 1,363 pretrial detainees identified during the study period.
Note: The "Active on Medicaid" group included people with pending applications.

This unexpectedly high rate of coverage on jail entry prompted Connecticut to implement a screening process so that DOC and DSS staff could target enrollment assistance to men in need.[17] DOC and DSS staff exchanged lists of men entering pretrial detention so that DSS could inform DOC about their coverage status. This screening procedure helped to increase the efficiency of the enrollment process, but it required both time (about two business days) and significant coordination. Once a screening procedure was implemented, DOC staff focused their outreach on pretrial detainees who either never had Medicaid or whose coverage had lapsed.

Pretrial detainees who entered jail without Medicaid coverage had appreciable health needs (table 2). Over half (56 percent) had at least one physical or behavioral health concern rated as a three or above during DOC's intake assessment and classification process, meeting DOC's threshold for service

provision. Nearly half had behavioral health treatment needs, including 8 percent with co-occurring mental health and substance abuse treatment needs.

By comparison, people who already had Medicaid coverage as they entered jail had even greater health needs, with 75 percent meeting the DOC's threshold for service provision. This finding was true across all types of physical and behavioral health needs.

TABLE 2

Physical and Behavioral Health Needs of Men Entering Pretrial Detention, by Medicaid Status

	Did not have Medicaid[a]	Had Medicaid[b]
Any physical or behavioral health needs	55.9%	75.0%
Any mental health or substance abuse treatment needs	49.2%	68.8%
Specific health needs		
Medical needs	19.2%	32.3%
Mental health needs	19.2%	30.4%
Substance abuse needs	38.3%	54.5%
Co-occurring mental health and substance abuse treatment needs	8.3%	16.1%

Notes: Differences between people who did and did not have Medicaid were statistically significant at the 99 percent confidence level. Physical and behavioral health needs were determined during the Department of Correction's intake assessment and classification process. Medical, mental health, and substance abuse treatment needs were each rated on a scale from one to five. Any scores of three and above met the Department of Correction's threshold for services during incarceration.

[a] 642 pretrial detainees.

[b] 721 pretrial detainees.

Challenges in Accessing Pretrial Detainees for Application Assistance

After screening, the study team found 642 pretrial detainees lacked Medicaid coverage, meaning they either never had Medicaid or their coverage had lapsed (figure 1). DOC staff met with 57 percent of the pretrial detainees without current coverage. Many pretrial detainees were unavailable to meet on staff members' scheduled outreach days. There is considerable movement within the jail population and many reasons why pretrial detainees may not be available on a given day. Common reasons included being at court or attending programming. Additionally, people with disciplinary infractions or other security concerns might not be permitted to move through the facility to meet with the study staff member. Because existing DOC staff conducted outreach and application assistance on top of their routine responsibilities, they were unable to make repeated attempts.

Occasionally, facility lockdowns made it necessary to suspend outreach activities. Movement within the jail facility was severely limited on such days. The reasons ranged from staff in-service days to severe weather events.

On average, DOC staff met with people eight days after their admission to jail. By this time, some pretrial detainees had been transferred to another facility or released altogether from custody. The median length of incarceration among people the study accessed was 30 days, compared to 8 days for those whom the study could not reach. Length of stay was the only factor that distinguished pretrial detainees who could and could not be accessed; the groups were otherwise comparable with respect to age, health status, and offense characteristics (data not shown).

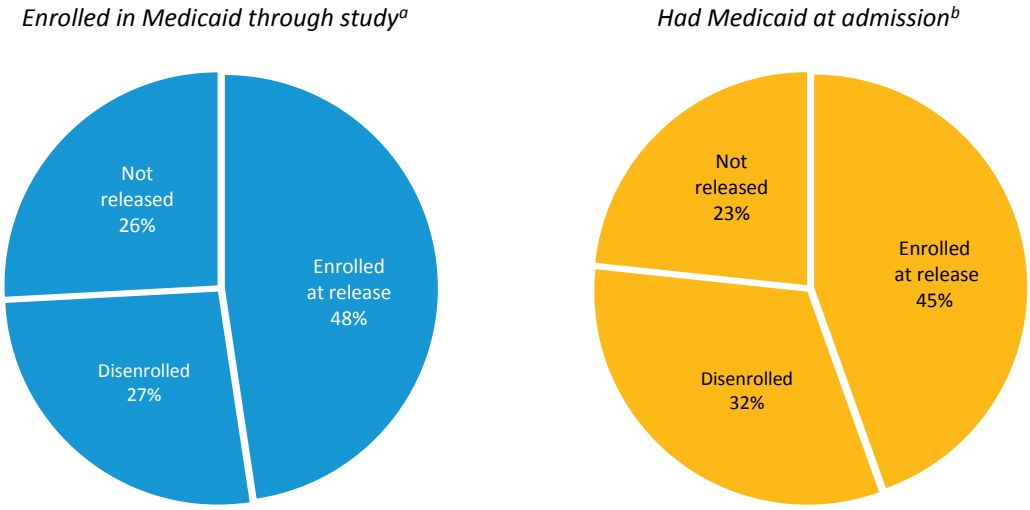
Retaining Medicaid Coverage at Release

Of the 369 pretrial detainees DOC staff approached, 179 (49 percent) consented to the research study and applied for Medicaid (figure 2). This reflected their willingness to participate in the study (which involved granting access to Medicaid health records) and their interest in obtaining Medicaid coverage. As described above, DSS used an expedited application review process and established eligibility on the presumption that people in jail typically met the income threshold and were to be released soon. As a result, all applicants but one were granted eligibility; DSS could not verify that applicant's immigration status.

Less than half (48 percent) of the men who enrolled retained active Medicaid coverage status when they were released; 27 percent were disenrolled before release and 26 percent were still in jail after 9–13 months (figure 2). We compared the Medicaid enrollment status of pretrial detainees with those who entered jail with active Medicaid coverage. The proportion that remained enrolled at release and those peoples' lengths of stay in jail were similar (data not shown).

FIGURE 2

Medicaid Coverage Status at Release



Notes: Release status was measured on March 3, 2014, approximately one year after jail admission. Data exclude people whose Department of Correction records could not be matched to Department of Social Services eligibility status records. Percentages may not sum to 100 because of rounding.

[a] 147 pretrial detainees.

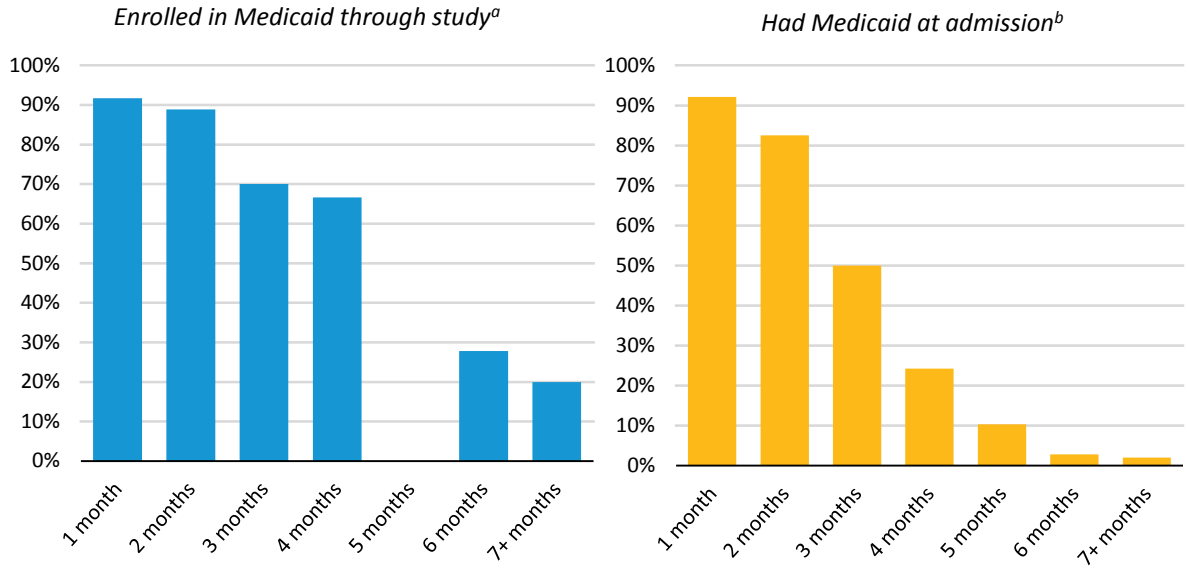
[b] 566 pretrial detainees.

Disenrollment often occurred during prolonged jail stays. Recall that DSS granted Medicaid eligibility at intake on the presumption that pretrial detainees were likely to be released within 30 days. Because Medicaid cannot cover services during incarceration, the DSS central processing unit had an established process to disenroll people after 30 days of incarceration. Eligibility specialists in the DSS prerelease entitlements unit could flag study participants to temporarily, but not indefinitely, exempt them from disenrollment.

Most people with short jail stays of two months or less were released with Medicaid coverage intact (figure 3), regardless of whether they enrolled through the study (91 percent remained enrolled) or already had coverage when they entered the jail (90 percent remained enrolled). Disenrollment rates increased the longer people stayed in jail. People who gained coverage through the study tended to remain enrolled unless their jail stay exceeded four months. By contrast, people who entered jail with Medicaid coverage typically lost coverage if they stayed for longer than two months.

FIGURE 3

Active Medicaid Coverage at Release, by Length of Jail Stay



Notes: Data shown exclude people who were not released from Department of Correction custody by March 3, 2014, and those whose records could not be matched to Department of Social Services eligibility status records.

[a] 109 pretrial detainees.

[b] 434 pretrial detainees.

The majority of men who were disenrolled while awaiting release ultimately regained coverage within a year, with varying time lags. Thirty-nine men who originally enrolled through the study were disenrolled, but 30 (77 percent) regained coverage in the year after release. Of these, 60 percent regained coverage within one month. This pattern of reenrollment was similar among men who were disenrolled after entering jail with Medicaid coverage (data not shown).

Postrelease Use of Medicaid Coverage

The majority of men who enrolled in Medicaid at intake and returned to the community with active coverage accessed health care (table 3). The Urban research team examined postrelease Medicaid claims data and found that 49 of 70 men (70 percent) with coverage at release used health services at least once in the year after leaving jail.[18] A similar percentage of men with DOC-identified health needs accessed Medicaid health services after release, promoting continuity of care for high-need people.[19]

TABLE 3

Health Services Received by Men Who Enrolled in Medicaid in Jail and Retained Coverage at Release

	All Men[a]		Men with Health Needs[b]		Men without Health Needs[c]	
	n	%	n	%	n	%
Received any health service	49	70.0	27	71.1	22	68.8
Received any behavioral health service	29	41.4	18	47.4	11	34.4
Service type						
Pharmacy	32	45.7	21	55.3	11	34.4
Outpatient services	49	70.0	27	71.1	22	68.8
Emergency department	26	37.1	15	39.5	11	34.4
Lab services	26	37.1	19	50.0	7	21.9
Mental health services	20	28.6	14	36.8	6	18.8
Substance abuse services	9	12.9	5	13.2	4	12.5
Inpatient hospital stay	5	7.1	4	10.5	1	3.1

Notes: Physical and behavioral health needs were determined during the Department of Correction's intake assessment and classification process. Medical, mental health, and substance abuse treatment needs were each rated on a scale from one to five. Any scores of three and above met the Department of Correction's threshold for services during incarceration.

[a] 70 pretrial detainees.

[b] 38 pretrial detainees.

[c] 32 pretrial detainees.

Many men accessed health care soon after their stay in jail—58 percent within the first month (data not shown). Notably, of the 49 men who accessed care, 59 percent (29 men) received substance abuse or mental health treatment services. Among men with identified health needs who accessed care, 66 percent (18 of 27) accessed such behavioral health services.

Consistent with their greater health needs, men who entered jail with active Medicaid coverage used services at even higher rates if they retained coverage at release (table 4). Nearly all (90 percent) utilized some health services, including 63 percent who accessed substance abuse or mental health treatment services.

Looking separately at men who were disenrolled from Medicaid while awaiting release, we observed that they, too, had a high rate of health service utilization when they ultimately reenrolled. Among men who enrolled through the study, were disenrolled, and subsequently reenrolled, 97 percent utilized some services; this figure was 90 percent for men who entered jail with Medicaid, were disenrolled, then reenrolled (data not shown).

TABLE 4

Health Services Received by Men Who Had Medicaid at Intake and Retained Coverage at Release

	All Men[a]		Men with Health Needs[b]		Men without Health Needs[c]	
	n	%	n	%	n	%
Received any health service	227	90.1	155	89.6	72	91.1
Received any behavioral health service	158	62.7	117	67.6	41	51.9
Service type						
Pharmacy	187	74.2	130	75.1	57	72.2
Outpatient services	226	89.7	154	89.0	72	91.1
Emergency department	173	68.7	119	68.8	54	68.4
Lab services	132	52.4	98	56.6	34	43.0
Mental health services	90	35.7	66	38.2	24	30.4
Substance abuse services	46	18.3	34	19.7	12	15.2
Inpatient hospital stay	47	18.7	43	24.9	4	5.1

Notes: Physical and behavioral health needs were determined during the Department of Correction's intake assessment and classification process. Medical, mental health, and substance abuse treatment needs were each rated on a scale from one to five. Any scores of three and above met the Department of Correction's threshold for services during incarceration.

[a] 252 pretrial detainees.

[b] 173 pretrial detainees.

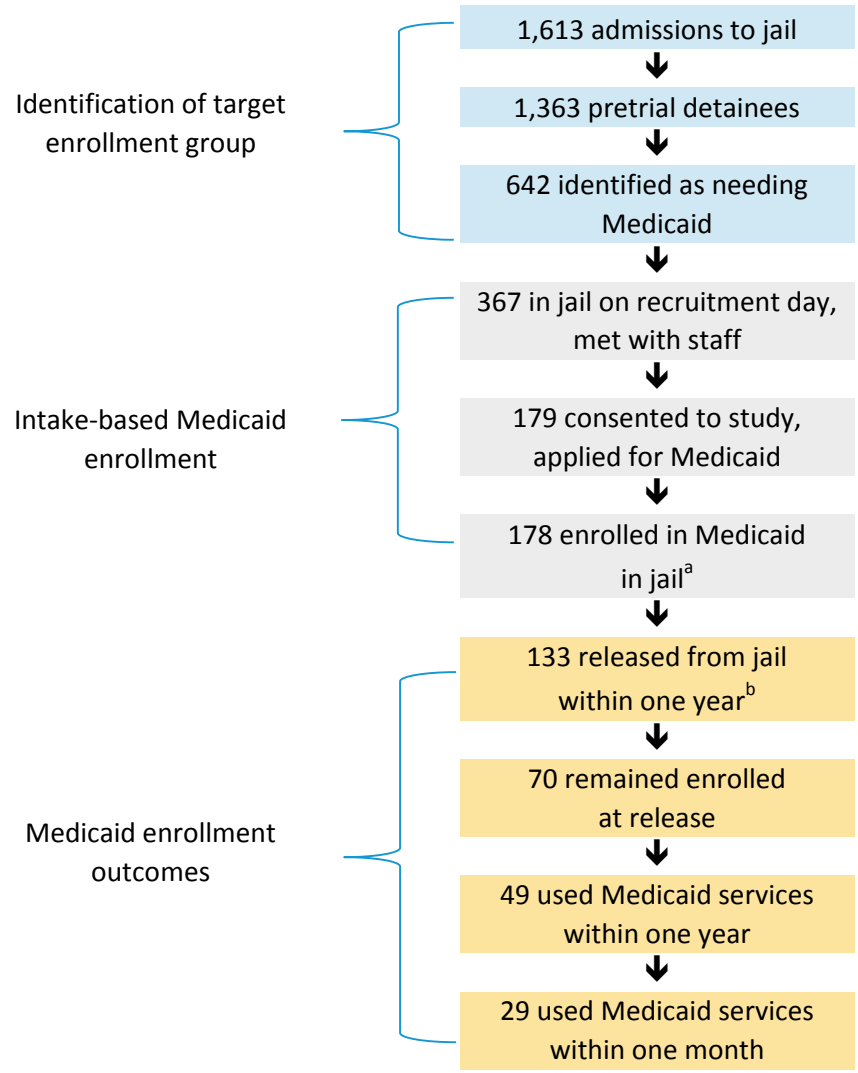
[c] 79 pretrial detainees.

Enrolling the Jail Population in Medicaid

The number of men leaving jail with Medicaid coverage was small relative to the size of the target enrollment population because of the challenge in reaching and enrolling people, and many people who enrolled ended up losing coverage before release (figure 4). Continuity of care from jail to the community has the potential to interrupt cycles of relapse and recidivism through better management of chronic physical and behavioral health conditions. However, continuity of care is unlikely to have a widespread effect unless sufficient numbers of people are released from jail with coverage.

FIGURE 4

Jail Intake–Based Enrollment Process



Sources: Counts of individuals are from Department of Correction records. Counts of enrollment outcomes at release are from Department of Social Services eligibility status records.

Notes: Percentage calculations of enrollment outcomes are not directly comparable to figure 2 because some records could not be matched across the two agencies' data systems. Records that did not match were excluded from computation of the data in figure 2.

[a] 31 of these people could not be matched to Department of Social Services eligibility status records.

[a] 24 of these people could not be matched to Department of Social Services eligibility status records.

Identifying and reaching the target enrollment population during the first week of incarceration was challenging, given the high level of existing Medicaid coverage. Although focusing staff efforts on the population without coverage was logical, screening introduced a trade-off between targeted and early enrollment. DOC staff first identified people who had been in jail for five days, then provided this

list to DSS to screen for Medicaid status. The time needed to screen and return the list added one to two business days until DOC staff could attempt to locate people for application assistance. On average, DOC offered Medicaid application assistance eight days after jail admission. People who remained in jail at this time were more likely to have a longer jail stay and, therefore, be at higher risk of disenrollment before release.

Recognizing the need to conduct both early *and* targeted enrollment, DOC and DSS staff originally designed a more efficient, real-time electronic screening and enrollment process. But despite considerable support and buy-in from leadership and staff at both agencies, this electronic approach could not be implemented during the study's limited time frame. As described above, the team learned that DSS eligibility specialists did not have the correct state employee classification to work on-site at the jail. Further, the jail building had poor wireless Internet reception, making it very difficult to connect to the DSS eligibility management database. Both issues required considerably more time to resolve than the study's time line permitted.

In response, DOC and DSS staff rapidly adapted the paper-based enrollment process reserved for prisons to the jail setting, including the exchange of lists to identify the target enrollment population. There were no funds for staffing, so DOC-based staff conducted outreach and application assistance activities on top of their routine responsibilities—a testament to their commitment to the project and to obtaining coverage for the jail-involved population. Fifty-seven percent of the study's target population had the opportunity to meet with a study worker and apply for Medicaid; reaching all the men in need would have required more staff.

Additionally, it was a challenge to enroll people even after they were reached for recruitment. However, it is much more likely that refusal to enroll reflected an unwillingness to consent to the study (which involved giving the researchers access to Medicaid health care records) rather than a lack of interest in applying for free Medicaid coverage. Regardless, these reasons were indistinguishable in practice, so future enrollment rates—outside the context of a research study—must be observed by jail and Medicaid staff.

Implementation Lessons

Connecticut's experience includes a number of successes and important takeaways. It also raises questions of how to get more people enrolled and how to keep them covered. Various implementation challenges affected this pilot project's ability to reach sufficient numbers of people and enroll them, and

a combination of implementation issues and policy constraints affected the ability to keep people covered once they were enrolled. Our key findings from the project include the following:

- **Access to Medicaid for low-income people in general and existing criminal justice enrollment initiatives reduced the number of people who lacked coverage at jail entry.** Connecticut's early adoption of Medicaid expansion for childless adults in 2010 resulted in a high level of existing Medicaid coverage in 2013. Half the men entering jail already had coverage and were more likely to have self-reported high health needs.
- **Screening procedures with reasonable turnaround times were feasibly developed.** DOC and DSS successfully collaborated to develop a screening process to identify people entering jail without current Medicaid coverage. Using a paper-based information exchange process, this screening took one to two business days.
- **Staff commitment and buy-in helped to accomplish outreach, especially without additional funding**. Despite a lack of dedicated funding for outreach, DOC staff met with and offered application assistance to 57 percent of the target enrollment population.
- **Research requirements likely affected program results.** The research consent process, rather than the Medicaid enrollment process, likely reduced participation in the study. Almost everyone who consented to the study and wanted Medicaid coverage was enrolled in Medicaid.
- **A track record of collaboration between agencies was helpful.** Enrollment was accomplished within one to two weeks of jail intake. This high and rapid enrollment was a result of the expedited application and eligibility determination processes developed by DOC and DSS over many years of enrolling the sentenced prison population as part of reentry planning.
- **Having intact coverage at release depended on the length of incarceration.** Nine of 10 pretrial detainees who enrolled in Medicaid through the study remained covered if they stayed in jail for two months or less, similar to men who entered jail with coverage. However, those who entered jail with Medicaid, and therefore did not interact with the pilot study, lost coverage after two months. In contrast, pretrial detainees who enrolled in Medicaid through the study were likely to maintain coverage for up to four months because DOC and DSS could temporarily exempt them from disenrollment.
- **Medicaid enrollment was associated with postrelease services**. People who retained or regained Medicaid coverage at release typically accessed health services in the community during the first year after release, and most did so within the first month. Timely receipt of

health services is important given the heightened vulnerability to negative outcomes upon release from incarceration.

Enrollment Considerations for Other Jurisdictions

The implementation challenges Connecticut experienced highlight considerations that other jurisdictions should take into account when developing systems to connect people leaving jail with Medicaid coverage and services. Although certain details were particular to Connecticut and this research study, they point to broader concerns:

- **Timing of Medicaid application assistance relative to admission and length of stay.** Connecticut personnel sought to strike the right balance between early attempts at Medicaid enrollment and premature outreach, when people would still be adjusting to jail. Factors for any jurisdiction to weigh are pretrial detainees' lengths of stay, the timing of jail admission procedures (including any screenings and assessments), detoxification protocols, and the ability of participants to consent to and complete the Medicaid application procedure.
- **Screening to target Medicaid enrollment efforts.** Half of entering pretrial detainees in Connecticut had active Medicaid coverage because of the state's long experience of extending Medicaid benefits to childless adults. Jurisdictions should consider the extent of prior coverage and decide whether screening would be valuable to target enrollment efforts. In Connecticut, the screening procedure added calendar time and created a trade-off between early enrollment and staff efficiency. DOC and DSS chose to screen out people who entered with Medicaid coverage to target their limited staff resources toward those in need of coverage. However, the need to wait for this information decreased enrollment among soon-to-be released people. Those who remained in jail and were available for later enrollment had longer lengths of stay and a higher risk of disenrollment.
- **Staffing capacity for Medicaid application outreach and assistance.** Dedicated staff time is vital to reach all people in need of coverage. Despite the inability to outstation DSS staff in the jail and limits to DOC's staff capacity, Connecticut was able to conduct outreach with 6 of 10 pretrial detainees in need. Outreach efforts would have been even higher with more trained staff on site.
- **Collaboration between the jail and the Medicaid agency.** Connecticut's jail enrollment procedure built on a long-term collaborative relationship between DOC and DSS. Developing

the jail enrollment procedure in less than one year was possible because of existing interagency agreements and procedures. Jails in other states would typically be administered at the local level and may need to build relationships with the state Medicaid agency. Key elements of Connecticut's DOC-DSS collaboration were

  - » an abbreviated Medicaid application and expedited eligibility determination process for the jail population;
  - » dedicated, centralized DSS staff to process Medicaid applications from DOC; and
  - » information sharing between DOC and DSS, including the exchange of jail intake and release dates, Medicaid enrollment status, and Medicaid eligibility.

- **Technological capacity and constraints.** Jurisdictions will need to assess computer availability, connectivity, and any related security concerns (including the physical security of staff and equipment, as well as the electronic security of information collected). Connecticut found that a real-time, computerized Medicaid enrollment process could not be implemented because DSS laptop computers were unable to connect to the Internet because of poor wireless Internet reception inside the jail.

- **State Medicaid policy to expand Medicaid benefits to childless adults.** Connecticut was an early adopter of Medicaid expansion. Nearly all jail applicants qualified for coverage as childless adults. In states that have not expanded Medicaid, relatively fewer incarcerated people would be expected to qualify for coverage. In Washington State, for example, 20 percent of the criminal justice population qualifies for Medicaid through disability and other traditional eligibility criteria (Somers et al. 2014).

In addition, several logistical considerations apply when providing services in a jail environment:

- **Availability of suitable meeting space.** Finding a sufficiently quiet and appropriate location to conduct Medicaid application assistance may be challenging. Meeting space is often scarce, and there is competition from other programs (e.g., orientation meetings or counseling groups). On occasion, staff resorted to using the gym or dorms but found it difficult to hold the men's attention and engage them.

- **Security and movement in jail facilities.** Security is of paramount importance in jail facilities, and Medicaid application assistance efforts must coordinate with custody staff. The logistics of bringing incarcerated people and Medicaid enrollment staff together in the same room can be complex. Depending on the facility and target population, custody staff may need to escort

people to the Medicaid enrollment area and wait for them. The distance and travel time from housing units to the Medicaid enrollment area can be significant, especially if crossing wings within the facility. Additionally, custody staff may determine that certain people must be kept apart from others (e.g., members of rival gangs).

- **Staff qualifications and classification.** DSS eligibility specialists were not classified to work in a jail setting. Further, employees within DOC have different qualification and classification levels that govern how many people they can convene, the classification levels they may work with, and the jail areas in which they may work.
- **Scheduling.** Medicaid application assistance activities must fit into the jail's regimented daily schedule of mealtimes, programming, staff shift changes, and routine counts of people within their housing units. Scheduling conflicts may be minimized by integrating Medicaid application assistance into existing processes.

Keeping Medicaid Coverage Active Once People in Jail Are Enrolled

Many state Medicaid programs, including Connecticut's, were historically configured to terminate eligibility and benefits upon incarceration. As described above, many federal programs prohibited payment of benefits or coverage of services during incarceration, and states such as Connecticut managed this restriction through policies and practices to globally deactivate all benefits after incarceration.

Although the DSS prerelease entitlements unit worked with DOC's health services unit to enroll people in Medicaid, it did so in a system in which the standard operating procedure was to terminate benefits upon incarceration. A separate, longstanding central processing unit received monthly data from DOC's management information system unit to globally terminate benefits. The DSS prerelease entitlements unit had some discretion to flag people for a temporary exclusion from disenrollment, but it could not be delayed indefinitely.

Two important findings with regard to disenrollment emerged from this study:

- Only half of the people who were enrolled during the demonstration retained coverage by the time of their release (figure 2). For 27 percent of the enrolled population, disenrollment occurred because they remained in jail at least one year after enrollment. However, an

additional 26 percent of enrolled people were also disenrolled even though they were released from jail in less than a year.

- A similar proportion of people who entered jail with Medicaid also lost coverage, and this was a population with higher health needs compared to those who entered without Medicaid. Men who entered jail with Medicaid had similar lengths of stay as those who did not, but among those released, nearly one-third (32 percent) lost coverage to the disenrollment process.

Developments in Connecticut since the Pilot Study

After the pilot period for Medicaid enrollment concluded in 2013, Connecticut developed an administrative mechanism to effectively suspend Medicaid benefits for people incarcerated for short periods of time.[20] People entering jail can now remain active on Medicaid for 90 days. People who are incarcerated for more than 90 days are moved to an alternate benefits package that restricts payment for all but the limited service types that incarcerated people may receive under federal Medicaid regulations, such as stays in an inpatient hospital of 24 hours or more. Medicaid benefits are terminated only if someone is sentenced to three or more years in prison. These changes were accompanied by increased DOC and DSS data sharing. DOC now incorporates peoples' DSS client ID numbers into its data system and communicates their release dates to DSS so that they revert to full Medicaid benefits upon release.

Policy Implications

Connecticut's experience suggests the need for two complementary systems so that people cycling in and out of jail can access Medicaid coverage upon release: one to enroll eligible people in Medicaid and another to prevent disenrollment. A system to prevent disenrollment will grow in importance as more people enter with Medicaid coverage because the risk of disenrollment affects all people in jail—those who enter with existing coverage (and possibly greater health needs) and those who are enrolled during incarceration. Although intake-based enrollment may be a complex endeavor, it appears necessary to reach the entire jail population. Discharge-based assistance would miss most people incarcerated in jail, who are pretrial detainees with unpredictable release dates and release locations.

A comprehensive system for insuring the jail population may need to begin with a screening process to distinguish people who need Medicaid from those at risk of losing coverage. Half of pretrial detainees

in Connecticut entered jail with active coverage, suggesting that the level of existing coverage in other states will increase as Medicaid expansion becomes established. A screening process may help target scarce correctional and Medicaid resources, but policymakers and practitioners should balance this need with the time and effort required.

Two complementary mechanisms are needed to effectively provide coverage to the jail population:

- **A suspension mechanism for people who already have Medicaid.** This mechanism is particularly important because Connecticut's experience suggests that the people entering jail with Medicaid coverage are more likely to have chronic physical and behavioral health needs. Federal Medicaid policy allows for benefits to be suspended instead of terminated on jail entry and reactivated at release. Some states have passed legislation to create a suspension mechanism (McKee et al. 2015), but others have done so through administrative mechanisms, like Connecticut's alternative benefits plan or Ohio's incorporation of edits in its Medicaid claims processing system (CSG Justice Center 2013). These alternatives allow the Medicaid agency to ensure that services are not billed inappropriately to Medicaid during incarceration. States will need to evaluate the appropriate timing for suspending Medicaid benefits (i.e., length of time after jail admission) and share intake and release dates between corrections and Medicaid agencies to ensure that benefits are reactivated upon release.
- **Enrollment *and* suspension mechanisms for people in need of Medicaid.** People without Medicaid coverage should be targeted for application assistance. Once enrolled, these people would need to be placed in a suspension status, as described above, so that Medicaid coverage is not terminated soon after it is granted. Instead, newly enrolled people could be temporarily suspended and then reactivated upon release. As above, states will need to evaluate the appropriate timing for suspending Medicaid benefits. Additionally, jails must consider their intake procedures and lengths of stay to determine how soon they can provide Medicaid application assistance to enroll as many people as possible.

Overall, the lessons learned from this pilot study to enroll pretrial detainees in Medicaid have provided important insight into practices and policies that, if implemented, should increase coverage, health service utilization, and continuity of care for some of the nation's highest-risk low-income populations. Suspension rather than termination of Medicaid benefits is important to help pretrial detainees maintain coverage, and Connecticut was able to achieve that goal subsequent to our pilot study. This achievement suggests that enrolling uncovered people at jail intake is a promising approach for a population with considerable health needs and recidivism risk. Our pilot study uncovered

implementation challenges in the jail setting, some of which can be addressed by dedicating resources to staff time and improved technology. The pilot also demonstrated that when men reenter the community with Medicaid coverage, they tend to access health care, including care for behavioral health conditions, in a timely manner. In addition to the benefits to individual health and well-being, these outcomes are important for public safety and fiscal reasons: people who receive prompt and adequate health care may experience more promising reintegration outcomes and reduce the financial strain caused by preventable emergency room visits, new crimes, and reincarceration.

Notes

1. Low-income women without children—or those who have lost custody of their children—are also less likely to have Medicaid coverage. Women make up almost 15 percent of the jail population, and the number of women in jail increased 48 percent between 1999 and 2013 (Minton et al. 2015).
2. US Department of Health and Human Services, "Linking Low-Income Men to Medicaid and the Health Insurance Marketplace: Identifying Promising Strategies for Outreach and Messaging," Request for Task Order Proposal/Solicitation #13-233-SOL-00452, 2013.
3. There are limited exceptions where Medicaid rules allow service coverage during incarceration, such as an overnight stay in an inpatient hospital. For the most part, however, the medical expenses of "inmates of a public institution" are considered the responsibility of the correctional system.
4. Judith D. Moore, letter to state Medicaid directors, April 22, 1997, https://www.medicaid.gov/Federal-Policy-Guidance/downloads/SMD042297.pdf.
5. Jeff Mellow, Gayle E. Christensen, Kevin Warwick, and Janeen Buck Willison, "Transition from Jail to Community Online Learning Toolkit," Urban Institute, October 2015, http://tjctoolkit.urban.org/index.html.
6. Study sponsors were the US Department of Health and Human Services, Assistant Secretary for Planning and Evaluation; and the US Department of Justice, National Institute of Corrections (NIC Award 11AD10GKI0).
7. The exact percentage depends on a person's residential location within the state. This percentage is lower than the ACA's 138 percent of the federal poverty level income eligibility threshold because Connecticut's expansion was state-funded and preceded the ACA.
8. The prerelease entitlements unit originally focused on processing applications from people in DOC custody. Now it also processes applications received through the Court Support Services Division from individuals released on bail and individuals under probation supervision.
9. Procedures were initially implemented, tested, and refined at the Bridgeport Correctional Center between October and December 2012.
10. A limited number of sentenced individuals and people with other legal statuses were also included in enrollment efforts if DOC expected they would be released to the community within 30 days.
11. DSS administers Medicaid as well as Temporary Assistance to Needy Families, the Supplementary Nutrition Assistance Program, emergency cash assistance, and other public assistance programs (Connecticut Department of Social Services 2013). A separate central processing unit within DSS receives monthly data files from DOC's management information system unit and is responsible for disenrolling incarcerated individuals in accordance with federal program rules.
12. For example, DSS staff coordinate with DOC-based discharge planners to extend the Medicaid eligibility of individuals whose release was temporarily delayed.
13. These 1,363 men represent 85 percent of the 1,613 men in total who were admitted to the jail during this time. Pretrial detainees were the focus of this intervention. The remainder of the jail population included sentenced individuals and those with "other" legal status (e.g., people awaiting transportation to a federal facility).
14. According to DOC's medical classification guidelines, these are individuals who need daily, predictable access to nursing care for either chronic or acute care conditions.
15. According to DOC's mental health classification guidelines, these are individuals who have active mental health disorders. They may or may not be on psychiatric medications.

16. DOC's substance abuse classification scores are based on both clinical and criminogenic factors. Colleen Gallagher, Quality Improvement Program Director, Health and Addiction Services, Connecticut Department of Correction, personal communication, February 19, 2016.
17. DSS began screening DOC's list of entering pretrial detainees after an initial test of the Medicaid enrollment procedure was underway at the Bridgeport Correctional Center between October and December 2012. Prior to this screening, DOC-based staff reported that many individuals refused Medicaid application assistance because they already had coverage. Further, DSS staff found they were receiving completed applications from individuals who already had active coverage. Both of these perceived redundancies prompted the implementation of a screening procedure.
18. The study received data on all payments through the claims cycle of April 24, 2015.
19. This rate is substantially higher than the rate of healthcare utilization observed in a previous study of men released from Ohio and Texas prisons in 2004 and 2005, 48 percent of whom accessed health care in the community 8–10 months after release (Mallik-Kane and Visher 2008).
20. Colleen Gallagher, Quality Improvement Program Director, Health and Addiction Services, Connecticut Department of Correction, personal communication, March 10, 2016.

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