Washington State Health Care Authority

REPORT TO THE LEGISLATURE

Medicaid Coverage Suspension for Incarcerated Persons

Substitute Senate Bill 6430, Chapter 154, Laws of 2016

December 1, 2016

Medicaid Coverage Suspension for Incarcerated Persons

Washington State Health Care Authority

Medicaid Eligibility and Community Services
P.O. Box 45502
Olympia, WA 98504-5502
Phone: 360-725-1416
Fax: 360-586-9551
www.hca.wa.gov

Washington State Department of Social & Health Services
Transforming lives

Division of Behavioral Health and Recovery
P.O. Box 45330
Olympia, WA 98504-5330
Phone: 360-725-3700
Fax: 360-725-2280
www.dshs.wa.gov

Table of Contents

Executive Summary

Substitute Senate Bill (SSB) 6430, which took effect on June 9, 2016 as Laws of 2016 Chapter 154, directs the Health Care Authority (HCA) to suspend, rather than terminate, medical assistance benefits for persons who are incarcerated or committed to a state hospital, starting July 1, 2017. This is to provide continuity of care for individuals upon re-entry into the community.

SSB 6430 also requires HCA and the Department of Social and Health Services (DSHS) to:

- Identify care coordination and clinical best practices for the development of training materials for behavioral health organizations, managed care organizations, and behavioral health providers.

  Status: Beginning September 2016, HCA convened monthly workgroup meetings with stakeholders to identify care coordination and behavioral health best practices. Best practices in both areas have been identified and work is currently focused on narrowing the scope.

- Request expenditure authority from the federal Centers for Medicare & Medicaid Services (CMS) to provide behavioral health services to those incarcerated in local jails.

  Status: Language requesting this authority has been drafted and will be submitted to CMS in early 2017.

- Request permission from CMS to allow the state to cover individuals participating in a work release setting or other partial confinement programs under the state Medicaid program**.**

  Status: Clarification was received from CMS in the State Health Officer Letter SHO#16-007, dated April 28th, 2016 (see Appendix A). This guidance allows for those who meet the "freedom of movement" definition to receive full scope coverage. This is generally considered to be the work release population and in Washington this applies primarily to Department of Corrections (DOC) programs.

- Provide this progress report to Gov. Jay Inslee and the Legislature by December 1, 2016.

This progress report provides:

- A summary of the necessary resources to meet the intent of the bill which includes the cost associated with access to jail booking data, system changes, staffing and options if resources are not provided.
- An update on our progress and implementation plans to ensure that Medicaid suspension occurs for prisons and most city/county jail populations by July 2017.

- A summary of clinical best practices and care coordination models in Washington State as well as practices employed in two other states.
- An exploration of expanding existing care coordination models to include behavioral health treatment in jails both locally and nationally.
- The State's interpretation of CMS guidance on work release populations.

Much of the content of this report was provided by subject matter experts from various state agencies and managed care organizations, as well as county and state corrections staff, and other stakeholders.
Individuals from all sectors were allowed to self-select into three workgroups:

- Re-entry Workgroup (all members). Meeting regularly since December 2015.
- Suspension Policy. Met several times this summer to create the suspension policy.
- Outreach and Training. Started meeting in August 2016, and continues its work.

A list of participants is in Appendix D.

Suspension

Background

The federal Centers for Medicare & Medicaid Services (CMS) limits Federal Financial Participation (FFP) of Medicaid services for individuals while residing in correctional institutions (42 CFR 435.1009). The "inmate exclusion" prohibits Medicaid payments for care or services for any individual who is an inmate of a public institution.

CMS considers a justice-involved individual of any age to be an inmate if the individual is in custody and held involuntarily through operation of law enforcement authorities in a public institution. Correctional institutions include facilities operated by, or under contract with, the United States, a state, a county, or a Tribal nation for the confinement of individuals charged with or convicted of a crime.

In addition to the inmate exclusion, the Medicaid statute does not allow FFP for patients 22-64 years of age in Institutions for Mental Disease (IMDs), which includes residential treatment facilities of more than 16 beds that are primarily engaged in the diagnosis, treatment, or care of an individual with a mental disease (Western State Hospital, for example).

FFP is available for Medicaid-covered inpatient services provided in an inpatient hospital setting. An individual is not considered to be an inmate of a public institution or a patient in an IMD during the time of their inpatient hospital stay.

CMS guidance also reaffirms that individuals who are on parole, probation, or have been released to the community pending trial, including under pre-trial supervision, are not considered inmates. FFP is available for services provided to these individuals.

States must either terminate or suspend benefits for individuals who are incarcerated or in an IMD:

- Termination of Medicaid coverage means closing an individual's Medicaid coverage once the agency is aware of the individual's incarceration. If an individual is terminated from the state's Medicaid caseload due to incarceration or an IMD stay, he or she must submit a new application for Medicaid enrollment upon release.
- Suspension of Medicaid coverage permits an individual in a jail or IMD to remain enrolled in Medicaid in a suspended status, which retains his or her eligibility for Medicaid coverage but suspends benefits with the exception of qualifying inpatient hospitalization events. When an individual reenters the community, full Medicaid coverage is restored without the need for a new eligibility determination.

Current Environment

In Washington, we terminate all publicly funded assistance programs for individuals who are incarcerated, including Medicaid (in our state, the Medicaid program is called Apple Health; however, for purposes of this report we use the general term Medicaid).

Terminating Medicaid coverage for incarcerated individuals is a manual process, and relies on the state receiving notification. With the DOC, notification is received through an interface with the HCA. For city/county jails, the Department of Social and Health Services (DSHS) Juvenile Rehabilitation Administration (JRA) and IMDs notification occurs through a process of self-reporting to the HCA or DSHS. Upon notification HCA terminates coverage.

Washington's current Medicaid policy allows an individual to retain their Medicaid eligibility if their length of incarceration is anticipated to be less than 30 days in a correctional facility, or less than 15 days in an IMD. Correctional facilities and IMDs follow CMS guidance and do not bill Medicaid for services rendered to justice-involved individuals.

HCA accepts and approves Medicaid applications for individuals currently incarcerated in correctional and IMD facilities for inpatient hospital services. The individual must be program-relatable[1] and income-eligible in the month of the inpatient hospitalization.

DSHS currently processes applications for individuals with serious mental illness as well as other Classic Medicaid[2] SSI-related[3] cases.

House Bill 1290, passed in 2005, allows the state Medicaid agency to accept and process Medicaid applications from justice-involved individuals with significant mental health needs prior to their release from confinement. The goal was to have Medicaid in place by the date the individual is released so services could be accessed and coordinated by medical professionals.

With the expansion of Medicaid under the Affordable Care Act (ACA) a larger percentage of the adult population became Medicaid-eligible in Washington. HCA worked with DOC, city/county facilities, and IMDs to allow their staff to apply for Medicaid eligibility on behalf of their populations. Through a Memorandum of Understanding (MOU) with DOC and participating city/county facilities, enrollment activities can begin up to 30 days prior to an individual's release and for qualified inpatient hospitalization events. The MOU clarifies roles and responsibilities for the facility and HCA. Last year, DOC submitted 3,877 Medicaid applications for inmates prior to release; a number of city/county jails also participate in this enrollment activity.

[1] General Medicaid rules state an individual must be income and categorically eligible. For example: aged, blind, disabled, pregnant, an adult between the ages of 19-64, children under 19, etc.

[2] Washington State refers to its non-Modified Adjusted Gross Income Medicaid programs as "Classic".

[3] Individuals who meet at least one of the federal SSI program criteria including age and disability.

Moving to Allow Suspension Rather than Termination

SSB 6430 directs HCA to suspend, rather than terminate, Medicaid for individuals who enter a correctional facility beginning July 2017.

HCA will allow an individual to submit an application for medical coverage upon admission to a facility; suspension will be applied once eligibility has been determined and received.

The plan to move from termination to suspension of Medicaid coverage includes:

- **For individuals incarcerated in a DOC facility.** Using an existing HCA-DOC interface, HCA will suspend an individual's coverage when they become incarcerated in a DOC facility. HCA will control suspension in ProviderOne, our state's Medicaid payment system. Suspension will only allow payment for qualified inpatient hospitalizations during incarceration. Once an individual is released, full Medicaid benefits will be restored immediately. Cases with the suspended status will be auto-renewed by the eligibility system whenever possible. HCA anticipates using this same process for all institutions once a common communication method is developed.
- **For individuals incarcerated in local jails.** The Washington Association of Sheriffs and Police Chiefs (WASPC) administers the state-wide Jail Booking and Reporting System (JBRS). JBRS is a multi-jurisdictional database that provides criminal justice professionals instant, up-to-date access to booking records, incident reports, and other related data from agencies across the nation. The HCA is engaged in discussions with WASPC to produce a JBRS-based data file that emulates an existing data transfer between the HCA and the DOC. HCA is requesting funding in the 2017-2019 state operating budget to support this JBRS interface in ProviderOne.
- **For individuals incarcerated in tribal jails, juvenile detention centers, state hospitals and the DSHS Special Commitment Center.** These individuals are not included in the JBRS database. The workgroup is currently exploring ideas to determine the best way to suspend coverage for individuals in these facilities. Until we determine a way to automate data relating to admits and discharges from these facilities, the state will need to manually process Medicaid applications to ensure coverage upon booking and release.

Process development will be mindful of the unique populations in each setting. For example, recent CMS guidance regarding the 15-day rule for IMD patients ages 22-64 will shape manual suspension processes for this population.

Of the roughly 31,000 individuals held in confinement today across the state, the DOC interface captures 57 percent of the incarcerated population. Once the JBRS data is available and the necessary ProviderOne system changes are in place, HCA will have the ability to suspend coverage for 96 percent of the Medicaid-eligible population who are incarcerated.

Table 1: Incarceration Settings

Name of Setting	# of Facilities	Average Daily Population (FY 2016)	Access to Data	Data Source
1. DOC	12	17,421	Yes	OMNI Interface
2. City/County Jails [a]	57	12,014	In process	JBRS
3. Detention Centers [b]	32	373	No	TBD
4. Special Commitment Center	3	260	No	Other
5. Juvenile Rehabilitation Facilities [c]	12	491	No	Other
6. State Institutions for Mental Diseases [d]	4	Western State: >800 Eastern State: 287 Maple Lane: 30 Yakima 24	No	Other
7. Tribal Jails	8	Chehalis, Colville, Makah, Nisqually, Puyallup, Quinault, Spokane, and Yakama	No	TBD

a. City/County Jails average daily population value includes 1500 to 1800 individuals who are DOC violators.
b. Based on available data provided by JRA
c. The Juvenile Rehabilitation Facilities population value is a monthly average.
d. Bed counts for each Institution for Mental Disease are shown.

Staffing Required for Implementation

The resource requirements for implementing this bill were indeterminate at the time the fiscal note was drafted as anticipated system changes and other requirements were not defined. As these changes and requirements have been determined, the HCA is able to estimate the additional resources needed to support implementation. The HCA is asking for four additional FTEs to handle the anticipated workload increase in ProviderOne and the manual work needed to process information received from institutions that are not connected to the JBRS. We believe a percentage of the manual work related to MAGI eligible recipients cases may qualify for 75 percent enhanced FFP:

- Today, for the DOC interface, HCA employs one-half FTE to help with matching and alias reconciliation and one FTE to help with case modifications when other family members are impacted by the case closing. Moving to suspension rather than termination will add at least one new automated data feed with an increased need for client matching and possibly several other manual data feeds in the near future. This is anticipated to result in three times the current DOC workload and the need for 1.5 additional FTE.

- For the JBRS-supported work, HCA anticipates another 1.5 FTEs are needed.

- HCA also anticipates the suspension feature may start as a manual process with the state hospitals, JRA, DSHS/SCC, and tribal jails. This will increase the amount of manual work

significantly. For these entities not in the JBRS, HCA estimates that at least one more FTE will be needed.

If automation support is not available by July 1, 2017 DSHS Economic Services Administration (ESA) anticipates it will need 4.1 additional FTEs for the manual work needed to place Classic Medicaid recipients in and out of suspense status, and process required Classic Medicaid Eligibility Reviews for individuals who are incarcerated and in suspense status. ESA administers Classic Medicaid for individuals who are age 65 or older, blind, or disabled. Unlike other Medicaid cases, which can be auto-renewed based on reliable current information known to HCA, eligibility for Classic Medicaid (including those in suspense status), must be manually reviewed at least every 12 months under 42 CFR 435.916.

Over time, it is likely that the system interface and related external data quality for both Classic and MAGI Medicaid cases will improve, reducing the need for manual activity. However, if the additional funding and FTE resource is not approved, it may not be possible to implement suspension of eligibility for the non-DOC populations as existing system functionality will only be able to support DOC suspensions. However, it may be possible to proceed with the other requirements of the bill.

Systems Needs for Implementation

There are three automated systems that support Medicaid determinations in Washington. Here are those three systems and the potential changes needed for them to support suspension rather than termination of Medicaid coverage:

- **Healthplanfinder (HPF) is the Medicaid system for family-related eligibility.** Health Benefit Exchange (HBE) assumes that the changes to the HPF will be a Medicaid project funded through the Advance Planning Document process, which is subject to review and approval by CMS. Funding of the changes is assumed to reside in HCA's budget, as the single state agency for Medicaid, with no impact to the HBE budget. Any required changes to the HBE system should be minimal and, assuming CMS approves 90/10 match, the cost should also be minimal. HCA anticipates the HPF changes to be minimal which could be absorbed in our biennial IT budget.

- **The Automated Client Eligibility System (ACES) is the DSHS eligibility system of record for Classic Medicaid coverage.** HCA and DSHS are exploring the needed changes in ACES. The cost of the project in terms of hours is not yet known. Ongoing system maintenance and enhancements in ACES is supported through a cost allocation process approved by CMS and other federal partners. Because the changes are cost allocated and support the ongoing maintenance, no new staff will be hired. This effort will be prioritized and other needed system changes or maintenance will be delayed.

- **ProviderOne is the Medicaid payment system.** A one-time change to the system will include developing an interface to bring JBRS data into ProviderOne and create a suspension status. Changes to support suspension should qualify for 90 percent FFP as an activity that enhances ProviderOne functionality.

Other Automation Needs

JBRS is an automated system administered by WASPC and managed by a vendor contracted by WASPC. WASPC has proprietary ownership of the data that jails input into that system. WASPC receives its funding from the state to run this program. WASPC's current funding does not cover the costs to make entry and exit data available to HCA. It is assumed that costs would be covered by HCA.

JBRS is a vital link to HCA from the jails in Washington State. According to WASPC, JBRS was not fully funded for the 2015-2017 biennium. The funding gap for the current biennium is $82,108 per year, which is currently covered by WASPC. For fiscal years 2017 and 2018, the resource requirement for WASPC to deliver a fully funded JBRS is $1,075,679 per year. Currently the funding for JBRS is from the Washington Auto Theft Prevention Authority, which continues to decline and is not a stable funding source for this program. In order to administer a system that calls for Medicaid suspension, access to a fully functional JBRS is necessary.

Outstanding Issues

There are a number of issues that must be addressed to move to a system that suspends, rather than terminates, incarcerated individuals' Medicaid coverage. While none of the issues below will prevent the suspension initiative from moving forward, it is important to outline issues that may result in a phased approach.

- When the local facilities need to update their booking systems, they are offline from the JBRS network for up to 90 days; most are back online in a shorter period of time. Typically, two to three facilities require system updates each year.
- Due to the high volume of erroneous identifiers, such as aliases, HCA staff will need to manually validate data from both DOC and city/county jails.
- City/county jail stays are short. HCA must build a process to ensure unanticipated and unnecessary workloads are not created.
- DSHS determines eligibility for Classic Medicaid programs for those receiving long-term care services, as well as individuals who are age 65 or older, blind or disabled. Unlike other Medicaid cases, which can be auto-renewed based on reliable current information known to HCA, eligibility for Classic Medicaid must be manually reviewed at least every 12 months under 42 CFR 435.916. A mechanism will need to be created to support annual reviews for individuals who are incarcerated and in suspense status.

Enrollment and Care Coordination

Background

SSB 6430 requires HCA and DSHS to publish guidance and provide trainings to behavioral health organizations, managed care organizations, and behavioral health providers on how they may provide outreach, assistance, transition planning, and rehabilitation case management to those who are incarcerated, involuntarily hospitalized, or in the process of transitioning out of one of these services. This section provides an update on research the workgroup has done to date.

Serving the justice-involved individual in a correctional setting is challenging not only because of the setting but also because the justice-involved individual has more stress than most of the general population. Many justice-involved individuals are facing not just legal issues, but also resistance and denial issues, family-related turmoil, and often a long history of psychosocial problems that contribute to substance abuse and the inability to make and keep lasting relationships.

Offenders often have complex needs and multiple problems that require a multi-disciplinary response from professionals in corrections and other fields such as behavioral health. HCA continues to research and work with partners to expand our enrollment and care coordination efforts.

Care coordination is receiving increasing attention by federal and state governments, payers, and providers because it leads to better health outcomes, better value, and improvements in health care delivery. Care coordination is particularly challenging for incarcerated individuals as they transition in and out of facilities. In this section, we outline promising enrollment and care coordination models in Washington and around the nation.

Promising Practices in Washington

Preliminary data suggest coordination between facilities and managed care organizations (MCOs) has a positive impact on the individual following through on the referrals and gaining improved health outcomes. In these local models and the most successful programs in other states, the key to improved health outcomes is the communication of medical or treatment data between the jails and the provider network.

Promising practices in Washington include:

Washington Department of Corrections

Sixty days prior to release, individuals participate in a pre-release briefing where matters such as post-release housing and health care needs are discussed. At that time, individuals are screened for Medicaid eligibility. Over 60 percent of individuals choose to enroll. This process is completed in Healthplanfinder by DOC staff dedicated to Medicaid enrollment. The individual is also screened for and receives assistance with applications for other state or federal services such as Social Security

and Medicare. Every effort is made to approve applications and assign an MCO prior to release and, when possible, connect the individual to managed care.

Snohomish County Jail Program

This program is a local effort that centers on identifying individuals with behavioral health or acute medical issues and establishing a care model for them as they enter the facility. The program includes a business associate agreement between four MCOs (United Health Care, Molina Health Care, Community Health Plan of Washington and Coordinated Care) and both the Snohomish County Human Services Division, as well as, the Snohomish County Jail. As part of this program, the county funds a healthcare benefits facilitator who interacts with the justice-involved individual to:

- Determine insurance status.
- If uninsured, screen for Medicaid eligibility and enroll when eligible.
- Inform the individual of their new/current ProviderOne number and their assigned MCO.
- Screen for high-risk physical and/or behavioral health conditions.

If the justice-involved individual is currently a Medicaid client, the facilitator reviews the individual's jail medical record (electronic) to determine if the individual has behavioral health or other acute medical issues. A list of individuals is then sent to the care coordinator at the appropriate MCO with extra emphasis on those individuals with identified issues. The MCO researches prescription history and communicates that information back to the jail for continuity of care. If the individual has an identified primary care provider, that information is shared as well. The MCO sets up an appointment for a professional visitation with the individual at the jail. During these visitations, the MCO care coordinator and the facilitator discuss with the individual any concerns he or she has while they are detained, what might help with successful re-entry, and any needed community follow-up after release.

Additional coordination provided by the jail includes programs related to transition services, veteran's services, substance use disorder treatment, and housing.

King County Programs

Familiar Faces

The Familiar Faces initiative is a systems coordination effort for individuals who are high utilizers of the King County jail (defined as having been booked four or more times in a 12-month period) and who also have a mental health and/or substance use condition.

In 2013, King County, in partnership with community stakeholders, developed a plan for an accountable, integrated system of health, human services, and community based prevention referred to as the King County Health and Human Services Transformation Plan. Many of these individuals experience complex chronic health conditions including: histories of trauma, substance use disorders, mental health issues, and chronic homelessness. These individuals experience instability in many aspects of their lives and are familiar to the various service and provider crisis systems.

The Familiar Faces population was selected as an initial focus with the theory that if system improvements could be made that resulted in better health and social outcomes for these individuals, then the lessons learned would have much broader implications in how our region moves forward with the larger opportunities emerging as a result of the Affordable Care Act.

Transitional Care Pilot

Another King County initiative is a demonstration project for care coordination with United HealthCare of Washington and Jail Health Services (JHS) of King County. United Healthcare care coordinators conduct release-planning and transitional-care services for their plan members. Building on the Familiar Faces work to create a system of integrated care for populations with complex health needs, this pilot is testing innovative ways to coordinate and share data for common clients while seeking to ensure continuity of care and appropriate support needs.

The pilot is intended to create a common process and infrastructure for MCOs to work with their respective clients in jail facilities (King County jail or Score), while supporting existing JHS providers in the continuity of care for common clients.

Other States' Promising Practices

Illinois - Cook County

As a result of a Governor-appointed workgroup, individuals in Cook County under probation supervision, those involved with specialty courts, and those receiving Treatment Alternative for Safe Communities (TASC) services began to apply through the state Medicaid high-volume call center. Due to the success of the initial pilot, TASC and Cook County Adult Probation engaged all staff in the application process, which encompasses approximately 40,000 people under supervision. This program also includes state-funded application assisters in some of the probation offices.

In addition to using probation as an avenue for enrollment, the Cook County jail — the largest single-site jail in the country with 200-300 men and women admitted each day —began enrolling individuals. A single system was created in which applications are completed at intake and finger identification is used to document identity. The application is completed online by assistors from a community nonprofit via the Medicaid application website and jail management system records and takes approximately 10 minutes to complete.

Arizona

Nine out of 15 counties have established suspense agreements with the state Medicaid program, the Arizona Health Care Cost Containment System (AHCCCS). New enrollment in the jail setting is focused on individuals about to be released or those awaiting trial. Enrollment is completed with the help of nonprofits and the Regional Behavioral Health Authority (RBHA). For suspension, frequent daily data transmissions occur (three to four a day) between the jails and AHCCCS because of the high percentage that release within 12 hours. For example, in Pima County, 60 percent release within 12 hours. For this reason, suspension does not occur unless the individual is booked more than 24 hours and less than one year.

After suspension and upon release, AHCCCS notifies the enrollee's MCO and the Regional Behavioral Health Authorities (RBHAs). Additionally, jails and providers share information to foster continuity of care. For those individuals who were not enrolled prior to release, the community supervision department serves a key role in getting those individuals coverage.

Recommended Future State

The Outreach and Training workgroup is still examining best practices, and has not yet made recommendations. However, the workgroup agrees that at least two elements are necessary for any model to effectively stabilize and treat individuals in a jail setting and coordinate care upon release:

- Individuals need to have their health care needs assessed as they enter the jail facility, and
- Clinical staff must be able to access and share medical records quickly.

Next Steps

HCA continues to identify best practices for care coordination and enrollment, working to engage and support stakeholders to affect change. HCA is focusing on identifying inter- and intra-agency collaborations to help ensure duplication does not occur. Future meetings are planned with MCOs, Behavioral Health Organizations (BHOs), the Association of County Human Services, and the Association of County Commissioners to identify opportunities for coordination.

Outstanding Issues

The workgroup identified several outstanding issues that may hinder implementation of an effective model but should not prevent improved enrollment and care coordination practices. HCA continues to work with partners and stakeholders to resolve the issues:

- To meet the requirements of the bill, HCA is submitting proposals to CMS on several policy decisions, including seeking approval to begin Medicaid coverage and care transition services for incarcerated individuals prior to release. There is known risk that CMS could reject our request to obtain FFP.

- A successful care coordination and enrollment model hinges on having immediate access to Medicaid enrollment data and patient care data. Today there is no mechanism for MCOs, HCA, and jails to share that data.

- Medicaid Administrative Claiming (MAC) is a joint federal/state program that allows the State to reimburse contracted governmental agencies for performance of specific activities that support the Medicaid state plan. Reimbursement is approximately three quarters of the state salary costs.

  Claiming and reimbursement are labor-intensive processes, and most jails do not have full-time dedicated staff doing this work, so the reimbursement hardly covers their expenses. To make this funding source more valuable for city/county facilities, they may need to

consolidate or combine staffing to perform Medicaid enrollment and coordination functions. At this time, only DOC has dedicated staff to this function and will benefit from this funding source. HCA MAC staff members are working closely with DOC to establish a claiming process and get approval from CMS.

HCA and WASPC discussed enhanced use of MAC with our re-entry partners. The most common response from city and county facilities was that they didn't have staff time to do enrollments and did not feel they had the resources to pursue a viable MAC reimbursement model. HCA is moving forward with DOC and there is an open invitation for other facilities to participate when they are able. HCA is committed to making this resource available to any jurisdiction that does outreach and enrollment work.

Behavioral Health Treatment in Jail

Background

As part of the work to create guidance and training per SSB 6430, HCA and DSHS are directed in the bill to "champion best clinical practices, including, where appropriate, use of care coordination and long-acting injectable psychotropic medication."

Today, limited behavioral health treatment is done in jails. Challenges to offering behavioral health treatment in jail include a lack of resources, getting medical professionals into the facility, and the indeterminate nature of an individual's jail stay. Typically the only services available in jail settings are a medical screening examination and stabilization if an emergent medical need is discovered. With at least half of all arrestees leaving within three days, their stay is often not long enough for an evaluation. This is another situation where seamless transfer of medical records could be an effective tool in continuing a previous treatment program or getting a new one established quickly.

Current Practices in Washington State

There is not a single best practice regarding behavioral health treatment in jails. There are some promising practices emerging; the most successful are King County's Familiar Faces and the Snohomish County programs discussed in the previous section. These programs have a process for obtaining medical records, which assists clinicians in continuing existing treatment plans or establishing new ones.

Chelan County Jail Mental Health Treatment Program

Beginning in 2014, Chelan County Jail health care staff offered mental health treatment services multiple times to individuals housed separately from the main jail population. Information gleaned from these contacts is shared internally with jail staff and clinicians. The local provider begins working with the individual to provide a plan for services at release. This wrap-around process and relationship building helps to keep the individual engaged and increases the likelihood the individual will continue with treatment. The program is now expanding to include identifying inmates up to 45 days prior to release. This lead time ensures an assessment is completed and a re-entry plan is created prior to release.

Use of Promising Medications

Antipsychotics, antidepressants, attention deficient hyperactivity disorder drugs, anti-anxiety medications, and mood stabilizers are some of the most commonly used psychotropic drugs in this country. Antipsychotic medications are a fundamental part of successful treatment for many people with serious mental illness. In spite of this, a majority of people with serious mental illnesses will stop using their antipsychotic medications at least once during their lives.

People have many different reasons for stopping their medications. Some people might have difficulty remembering to take their medications, or may encounter challenges obtaining, and if not

on Medicaid, paying for them. Other people may not want to take their medications and choose to stop them. Whatever the reason is for stopping treatment, one of the most common reasons for symptom relapse and re-hospitalization for people living with chronic mental illness is medication discontinuation (also called medication non-compliance and medication non-adherence). Given these issues, individuals, based on a recommendation from their provider, may elect treatment with long-acting injectable psychotropic medications (LAIs).

People who elect treatment with long-acting medications are more likely to continue their treatment than people who take their medications on a daily basis by mouth. Studies show that people who elect treatment with LAIs are less likely to be hospitalized for their illness. This is likely because people who are on a stable antipsychotic medication regimen are less likely to experience symptom relapse.

The downside of this type of treatment, especially when other supports are not available such as stable housing, is there are fewer opportunities to check for side effects and adjust dosages. Use of these injectables should not be a first course of treatment. Only after a successful history of treatment with anti-psychotics in a pill form should an LAI be considered. Additionally the cost of these drugs is great but some are available through Medicaid. In order to identify a sustainable process for LAIs, more examination of the problem is needed. For some individuals this course of treatment is appropriate and has the potential to reduce unnecessary hospitalizations.

Next Steps

HCA continues to seek guidance and recommendations regarding best practices for behavioral health. In light of the recent Executive Order 16-09, "Addressing the Opioid Use Public Health Crisis", the agency will actively seek opportunities to collaborate on related initiatives, including programs currently in place or being piloted at the DOC, and other city/county jails. Once all best practices are fully identified and agreed upon, they will be matched with the appropriate population and work will begin to determine the best avenue for training and implementation.

Work Release

Current State

SSB 6430 directs HCA "to obtain any permissions from the federal government necessary to confirm" that persons participating in a work release program or other partial confinement programs at the state, county or city level which allow regular freedom during the day to pursue rehabilitative community activities such as participation in work, treatment, or medical care should not be considered inmates of a public institution for the purposes of exclusion from Medicaid coverage.

Prior to new CMS guidance issued in April, all work release was considered an institutional setting and individuals in this living situation were not Medicaid-eligible. The latest guidance introduced a new tenet described as "freedom of movement" regarding halfway houses—the most likely living situation for most DOC individuals who participate in work release. Most of the State-managed facilities in Washington now qualify as a living arrangement where FFP is available. This change allows several hundred additional individuals in work release settings to receive health care coverage through Medicaid. When inmates enter work release, DOC applies for Medicaid on their behalf.

Since CMS has already issued clarification regarding FFP for individuals in various justice-involved living arrangements, including work release and halfway houses, HCA is not pursuing a waiver for this population.

The new CMS guidance helps DOC, as the majority of their facilities are offsite from a traditional correctional setting. This differs from the county-managed work release programs, where participants must return to the county facility and are not permitted to leave outside of work hours, and thus do not meet the threshold of "freedom of movement." (See Appendix F for a complete list of qualifying work release facilities in Washington State.)

CMS issued a clarifying letter to the State Medicaid Directors earlier this year: (https://www.medicaid.gov/federal-policy-guidance/downloads/sho16007.pdf)

Conclusion

Providing better transition services to our justice-involved individuals is an important first step in improving their lives. Incarcerated individuals have disproportionally high rates of chronic health conditions, infectious disease, and behavioral health issues. Providing effective, equitable, and respectful care and services that are responsive to diverse cultural health beliefs, practices, preferred languages, and health literacy can help close the gap in health care outcomes.

The jails provide a unique setting for connecting individuals with health coverage and engaging in treatments that will benefit them for the rest of their lives. Investing in health care and behavioral health treatments is one way to reduce the cycle of repeated criminal activities and save communities money on health care and the justice system while increasing public safety.

Suspension is a key to addressing health disparities among justice-involved populations. Automating Medicaid suspension would place Washington at the forefront of this effort. As other states look to Washington for guidance, sharing best practices is imperative to contribute to a national effort around better health outcomes and decreased recidivism.

Implementation Vision: Recommend Two Phases

We recommend a phased approach to implementing SSB 6340. This plan may change as the project evolves.

Phase One: June 2016 – July 2017

- Enhance current HCA/DOC interface to accommodate suspensions by July 2017.
- Request ACES functionality to support suspension.
- Continue to work with WASPC on HCA/JBRS interface to accommodate suspension by July 2017.
- Develop policies/procedures surrounding suspension/reinstatement.
- Develop initial fiscal analysis to include:
    - Identify items that need funding such as manual processing of IMD, JR, Detention, and tribal data, and
    - Manual case processing of family coverage affected by incarceration.
- Gather clarification from CMS regarding policy changes.
- Create and deliver behavioral health best practices training.

Phase Two: July 2017 – TBD

- Identify additional funding needed to fully support automation.
- Develop/implement IMD, JR, Detention and tribal data interface.
- Apply lessons learned from DOC and JBRS interfaces.
- Update processes as appropriate.

Rationale for Recommendation

- DOC has an existing systems interface with HCA that requires minimal manual intervention.
- We anticipate that creating the new JBRS interface is manageable by July 2017.
- We anticipate that all the other facility interfaces will not be ready by July 2017 so a manual process will need to be created for these populations.
- In Phase 1, HCA will be able to serve the greatest number of individuals within existing resources.

Policy Considerations for Phase One

- Ensure families' Medicaid benefits are not inadvertently suspended/terminated when a head-of-household is incarcerated.
- Ensure that the need to redetermine eligibility per CFR is incorporated into processes.
- Identify behavioral health best practices for the medical community.
- Consider possible pilot projects to reduce recidivism and costs.
- Obtain feedback from CMS regarding:
    - Notifications – what is HCA's requirement for notification of coverage status,
    - Automatically recertifying inmates if their income (or resources for Medicaid Classic) is compatible, and
    - Waiver request to provide behavioral health treatment services prior to release.

Appendix A: State Health Official Letter 16-007

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

SHO # 16-007

RE: To Facilitate successful re-entry for individuals transitioning from incarceration to their communities

April 28, 2016

Dear State Health Official:

The purpose of this letter and its attachment is to provide guidance on facilitating access to covered Medicaid services for eligible individuals prior to and after a stay in a correctional institution. This State Health Official Letter with attached Questions and Answers (Qs & As) describes how states can better facilitate access to Medicaid services for individuals transitioning from incarceration to their communities.

As a result of changes states are adopting in their Medicaid programs, individuals in many states who were previously uninsured now are eligible for Medicaid coverage, including a significant numbers of justice-involved individuals. While the Medicaid statute limits payment for services for individuals while residing in correctional institutions, Medicaid coverage can be crucial to ensuring a successful transition following incarceration. Many individuals in the justice-involved population have a high prevalence of long-untreated, chronic health care conditions as well as a high incidence of substance use and mental health disorders. Facilitating enrollment in Medicaid and supporting access to services following incarceration has the potential to make a significant difference in the health of this population and in eligible individuals' ability to obtain health services that can promote their well-being. Such enrollment will also help individuals with disabilities obtain critical community services to avoid crises and unnecessary institutionalization.

As states consider eligibility and coverage issues, many have asked questions about the longstanding provision of the Medicaid statute that excludes Medicaid payment for services provided to inmates of public institutions, including correctional institutions, except for services provided as "a patient in a medical institution". We address them in the following Qs & As. The Centers for Medicare & Medicaid Services (CMS) Center for Medicaid and CHIP Services (CMCS) welcomes the opportunity to work closely with states to identify ways to improve access to needed health care for individuals returning to the community following incarceration.

If you have any questions regarding the information in the Qs & As, please send questions to CMCSMedicaidQAInmates@cms.hhs.gov.

Sincerely,

/s/

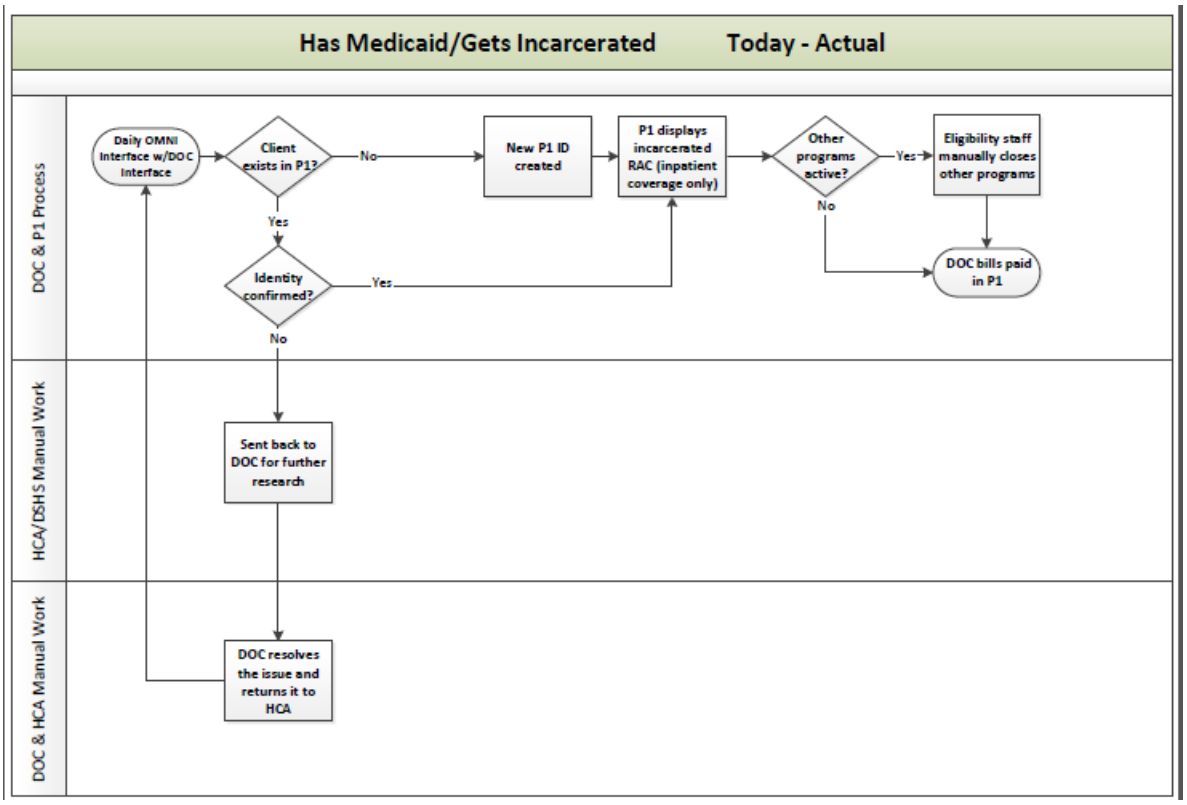
Vikki Wachino
Director

cc:

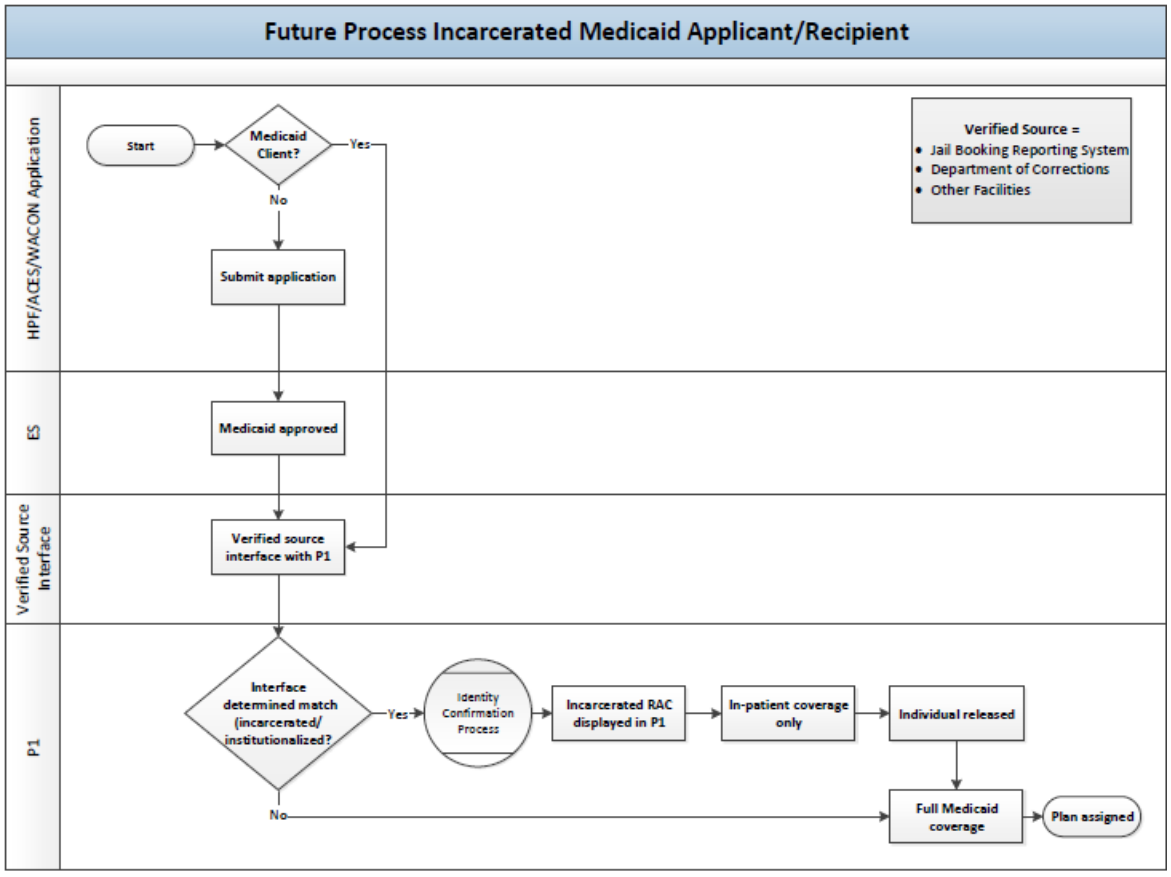
National Association of Medicaid Directors
National Academy for State Health Policy
National Governors Association
American Public Human Services Association
Association of State Territorial Health Officials
Council of State Governments
National Conference of State Legislatures

Enclosure:

Appendix B: Incarceration Flow Chart



Incarceration Flow Chart (continued)



Appendix C: Washington Association of Sheriffs and Police Chiefs Cost Estimate

Preliminary cost estimate from WASPC for JBRS data.

WASPC JBRS Data Access Cost Estimate		
Initial Report Development Cost: *WAIVED*		
Ongoing Extract / Data Feed	**Monthly Fee**	**Yearly Fee***
Daily	$44,100	$529,200
Weekly	$26,250	$315,000

*Note: A 3% yearly increase in fees is quoted by JBRS

Appendix D: Stakeholders

The following is a list of individuals that are involved with this work:

Agency or Association	Name
Chehalis Tribe	Charlene Abrahamson
Hoquiam Chief of Police	Jeff Myers
Clark County Corrections	Kenneth Clark Ric Bishop Randy Tangen
Community Health Plan of Washington (CHPW)	Sylvia Gil Siobhan Brown
Department of Corrections (DOC)	Ronna Cole Beth Goupillon
Department of Social and Health Services (DSHS)	Shane Riddle Chanda Fuller David Griffith Dan Schaub Catherine Kinneman David Johnson Ingrid Lewis Ahney King Monica Reeves
Franklin County Jail	Steve Sultemeier
Ferry County Jail	Shawn Davis
Health Benefit Exchange (HBE)	Joan Altman James Brackett
Health Care Authority (HCA)	Amy Johnson Mark Westenhaver Chris Stehr Francesca Matias Sarah Michael Barb Hansen Dineen Kilmer Alison Robbins Tammy Schroeder Todd Slettvet Jennifer Inman Jason Bergman Kali Klein Chuck Hitchings, Treinen Assoc.
King County Jail	Travis Erickson
Misdemeanant Association	Janene Johnson Patrick Gigstead Marion Davidson Molly Davidson

Agency or Association	Name
Northwest Health Law Advocates (NoHLA)	Ann Vining
Snohomish County Jail	Holly Shelton
Spokane County Jail	Justin Johnson
Thurston County Sherriff's Office	Holli Stewart
Whatcom County Sherriff's Office	Bill Elfo
Washington Association of Counties	Juliana Roe
Washington Association of Sheriffs and Police Chiefs (WASPC)	Mitch Barker Ned Newlin Raeanne Myers Jamie Yoder
Yakima County	Ed Campbell Carly Walker

Appendix E: Eligibility Reference Chart

Correctional Type	Inpatient Coverage	Full Coverage
Electronic Home Monitoring / House Arrest Offenders reside in their home and are monitored electronically for movement. The offender pays a fee to be on the program and does not occupy a jail or prison bed while on this program.	Yes	Yes
Day Jail / Day Reporting Offenders report at various assigned times throughout a 24 hour period OR offenders are placed on supervised work or community betterment programs during regular work hours. In either situation, the offender does not occupy a jail or prison bed.	Yes	Yes
Pre-Trial Supervision / Probation Pre-trial supervision staff monitors offenders who have been released from custody by the court pending the outcome of their trial and does not occupy a jail or prison bed.	Yes	Yes
District Court Probation District court probation officers monitor offenders who have been convicted of felony charges. The offender does not occupy a jail or prison bed.	Yes	Yes
DOC Community Supervision Community correction officers monitor offenders who have been convicted of felony charges. The offender does not occupy a jail or prison bed.	Yes	Yes
Drug Court A court-ordered program in which justice involved individuals with drug-related charges voluntarily choose to participate in chemical dependency treatment and counseling. Justice involved individuals may have their charges dismissed if they successfully complete the program. The offender does not occupy a jail or prison bed.	Yes	Yes
DOC Work Release Offenders are housed in a work release, jail, or corrections facility and are authorized to leave the facility for purposes of employment, education, and court ordered treatment or for medical treatment. The offender does not occupy a prison bed while on this program. Does not include city/county facilities.	Yes	Yes
Work Crews / Community Betterment A program offered to select minimum custody offenders for working in the community on various public entity or non-profit organization programs. There is no participation fee for this program. The offender does occupy a bed while on this program.	Yes	No

Appendix F: Qualifying Department of Corrections Work Release Facilities

Facility	Location
Ahtanum View	Yakima
Bellingham	Bellingham
Bishop Lewis	Seattle
Brownstone	Spokane
Clark County	Vancouver
Eleanor Chase House	Spokane
Helen B. Ratcliff	Seattle
Longview	Longview
Madison Inn	Seattle
Olympia	Olympia
Peninsula	Port Orchard
Progress House	Tacoma
Reynolds	Seattle
Tri-Cities	Kennewick