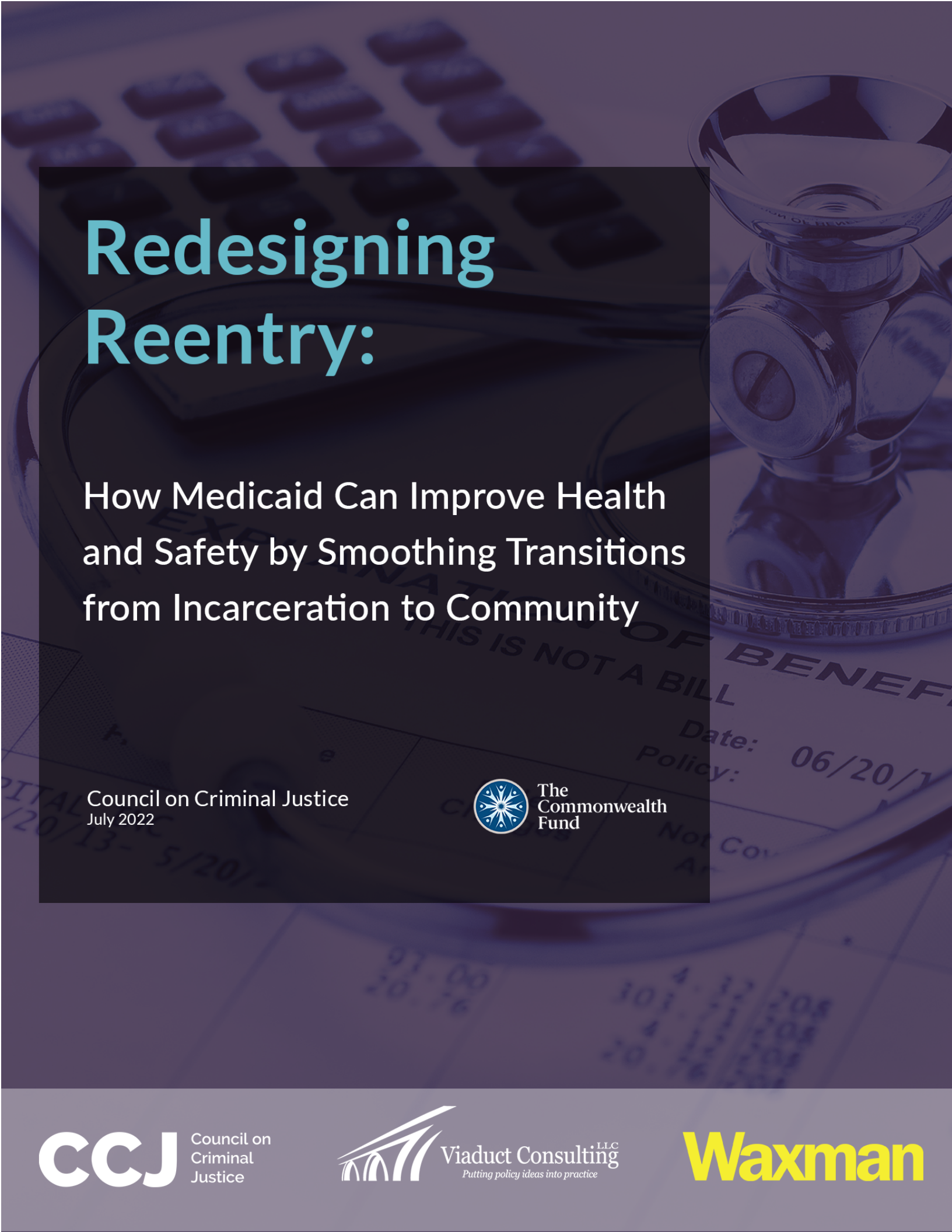


Redesigning Reentry:

How Medicaid Can Improve Health and Safety by Smoothing Transitions from Incarceration to Community

Council on Criminal Justice
July 2022

The Commonwealth Fund

CCJ Council on Criminal Justice

Viaduct Consulting LLC
Putting policy ideas into practice

Waxman

ABOUT THE COUNCIL

The Council on Criminal Justice is a nonpartisan criminal justice think tank and national invitational membership organization. Its mission is to advance understanding of the criminal justice policy choices facing the nation and build consensus for solutions based on facts, evidence, and fundamental principles of justice.

The Council does not take policy positions. As part of its array of activities, the Council conducts research and convenes independent task forces composed of Council members who produce reports with findings and policy recommendations on matters of concern. The findings and conclusions in this research report are those of the authors alone. They were not subject to the approval of the Council's Board of Directors or its Board of Trustees.

For more information about the Council, visit counciloncj.org

ABOUT THE HEALTH AND REENTRY PROJECT

The Health and Reentry Project (HARP) is a collaboration between the Council on Criminal Justice, former Deputy Administrator for Medicaid and CHIP Services Vikki Wachino, now of Viaduct Consulting, LLC, and Waxman Strategies.

Its goal is to help states, the federal government, local governments, and relevant stakeholders maximize the benefits of proposed Medicaid policy changes for public health and public safety. As part of its work, the project is convening actors across the health and criminal justice systems, as well as affected individuals and stakeholders, to discuss how to carry out the potential reforms.

HARP is staffed by: Olivia McLarnan and Abby Walsh of the Council on Criminal Justice; Vikki Wachino of Viaduct Consulting; and, Silicia Lomax and John Sawyer of Waxman Strategies.

ACKNOWLEDGMENTS

Dedicated support for this issue brief was provided by The Commonwealth Fund, a national, private foundation based in New York City that supports independent research on health care issues and makes grants to improve health care practice and policy. The views presented here are those of the author and not necessarily those of The Commonwealth Fund, its directors, officers, or staff.

Support for the Health and Reentry Project is provided by the California Health Care Foundation, The Commonwealth Fund, the Rx Foundation, the Charles and Lynn Schusterman Family Philanthropies, and by the Council on Criminal Justice's general operating contributors.

Suggested Citation

Health and Reentry Project. Redesigning Reentry: How Medicaid Can Improve Health and Safety by Smoothing Transitions from Incarceration to Community. Washington, D.C.: Council on Criminal Justice, March 2022.

THE HEALTH AND REENTRY PROJECT

In April 2022, the Health and Reentry Project issued its first brief, *Medicaid and Reentry: Policy Changes and Considerations for Improving Public Health and Public Safety*. That report discussed:

- Medicaid and its role in the United States health care system;
- Corrections and health care in the U.S. criminal justice system;
- Medicaid's role for people who are incarcerated;
- Recent and potential changes to Medicaid's role in supporting reentry; and,
- Key implementation challenges and questions.

This report builds upon that prior analysis by synthesizing stakeholder feedback and identifying key principles, a reentry care model, and essential elements for successful implementation of Medicaid reentry policies.

Introduction

In 2020, more than 500,000 people returned to communities after leaving prison, and millions more were released from jails.[1]

This transition is a critical point in people's lives, affecting their health and safety and that of their families and communities. Individuals leaving incarceration face many overlapping challenges, and basic needs such as housing, food, employment, and health care can be hard to meet. People experience extremely poor health outcomes after being released from prison or jail, and rates of overdose deaths among reentering individuals far outpace those of the general population.

Some jurisdictions have made progress connecting people at the point of reentry to health care or other services, but the degree of assistance available to those rejoining communities varies and generally falls far short of the need. This gap in support can contribute to higher rates of untreated mental illness, substance use disorders, mortality, and crime.

Policymakers at the federal, state, and local levels have long worked to improve reentry. Recently, momentum has grown around new policy proposals to expand health care access in support of successful reintegration into the community. Medicaid, the nation's public insurance program for people with low incomes, has the potential to connect eligible people leaving incarceration to services that can maintain or improve their health, financial security, and ability to participate fully in their families, their communities, and the workforce. Medicaid coverage, including the increase in access to mental health and substance use disorder treatment Medicaid makes possible, has been associated with positive public safety outcomes, including reduced recidivism.[2]

Although some state and local governments have strengthened connections to Medicaid coverage and services for people after they leave prison or jail, federal law has historically prohibited Medicaid from covering health care services provided during incarceration. Federal policymakers are currently considering two pathways to lift this restriction:

- **Legislative:** Several proposals are under consideration by Congress, most notably the Medicaid Reentry Act. This bill would allow Medicaid to cover health care services in the 30 days preceding release from prison or jail.

- **Administrative:** Nine states have proposed demonstration waivers under Section 1115 of the Social Security Act, an authority through which states can depart from Medicaid law, subject to federal approval. The coverage period and other specifics of 1115 reentry waiver proposals vary by state.

Whether carried out by administrative or statutory means, a change allowing Medicaid to cover health services during incarceration would introduce a powerful new federal financing source for health services during incarceration, an expense that has primarily been shouldered by state and local governments.[3] In theory, having Medicaid finance services both in the community and before an individual is released would enhance the ability of state Medicaid programs to manage the health of beneficiaries who experience incarceration. Specifically, it could increase incentives for Medicaid-financed systems to connect people to services and invest in the health of their incarcerated patients. It could also reduce cost shifting between correctional and community health systems.

Realizing these potential benefits hinges upon the successful implementation of any new policies that emerge. To explore the question of *how* these potential new policies should be implemented, the Health and Reentry Project (HARP) reached out to a broad cross-section of stakeholders. HARP partners synthesized feedback from that effort to produce this issue brief, which identifies:

- key principles for changing Medicaid's role at reentry
- a health care service delivery model to support people who are reentering, and
- essential elements of successful implementation to advance the principles and care model.

This issue brief is intended to inform state, federal, and local public officials who are implementing these changes, including those working in the institutional and community corrections systems as well as policymakers, health care and reentry service providers, managed care organizations, advocates, and people and communities who have experienced impacts of the current, limited system of supporting people at reentry.

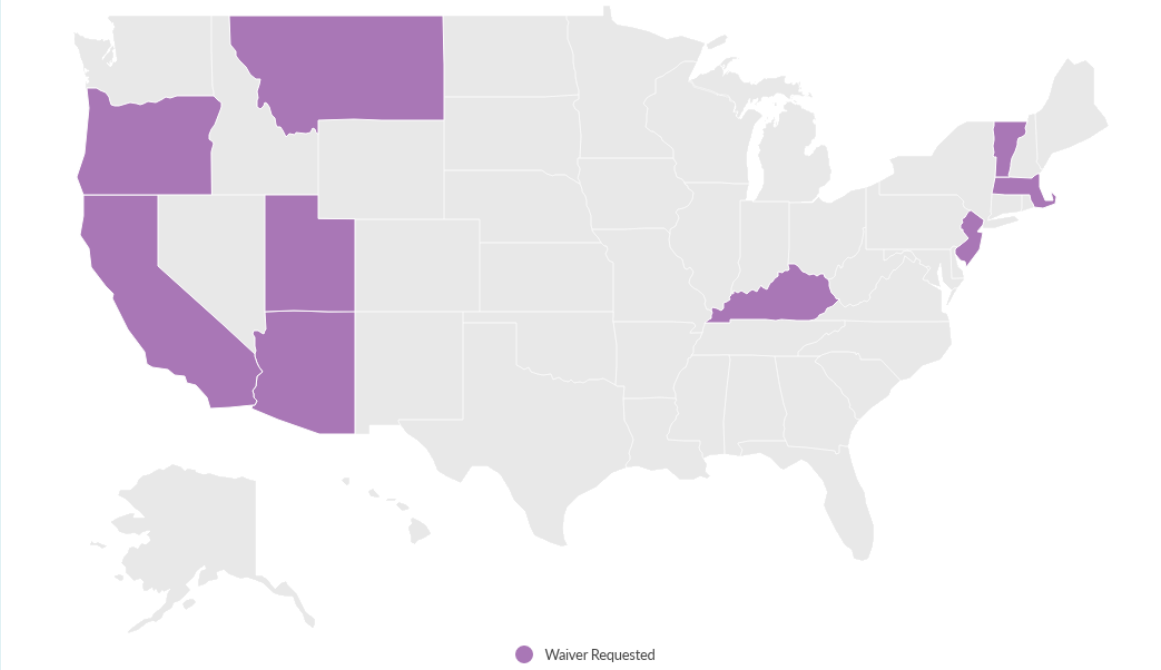
STAKEHOLDER ENGAGEMENT

HARP employed three primary means of engaging experts and stakeholders between January and May of 2022:

- **Individual Interviews:** The HARP team interviewed individuals from 16 organizations across the health care and criminal justice sectors. Those interviewed included health care providers, researchers, law enforcement and corrections officials, and formerly incarcerated people.
- **Multisector Convening:** In March 2022, the HARP team convened more than 70 people with various perspectives on the health care and criminal justice systems for a half-day discussion of how potential changes to Medicaid's role can best advance public health and public safety. Participants included formerly incarcerated individuals, representatives of health care consumers and providers, state and federal Medicaid agency staff, health plans, criminal justice reform advocates, social service and reentry provider organizations, current and former corrections officials, philanthropic organizations, academic researchers, and racial justice advocates.
- **The HARP Advisory Committee:** The committee is made up of 11 cross-sector leaders, including several people who are formerly incarcerated. It met three times during the project period to discuss the challenges facing people as they rejoin communities and how potential Medicaid policy changes can best achieve health and public safety goals.

The principles, care models, and essential elements presented in this issue brief are a synthesis. The brief is not intended to provide a comprehensive summary of all stakeholder feedback, but instead highlights areas of consensus, promising reforms, areas of emphasis and caution, and elements of implementation that stakeholders identified as significant.

FIGURE 1: STATES REQUESTING 1115 WAIVERS



Guiding Principles for Changing Medicaid's Role at Reentry

The stakeholders HARP engaged identified key ways in which proposed changes to Medicaid can advance public safety and public health. They described the potential for Medicaid reentry policies to:

- address the high rate of mental health and substance use disorders among people in prisons and jails, including reducing overdoses and overdose deaths among those recently released from custody
- support successful community reintegration and reduced recidivism, and
- positively impact high-need populations, including people of color, women, housing-insecure people, and those with HIV and other infectious diseases.

To achieve these goals, stakeholders recommend that implementation of Medicaid reentry policies be rooted in the following six principles:

1. **Strengthen Continuity of Care.** Stakeholders view the primary benefit of changing Medicaid's role at reentry as improving the continuity of health care services before and after people leave prison and jail. Because of its potential to improve outcomes, they argued that this should be a primary goal of implementation.

2. **Help People Return to Communities "Healthy and Whole."** Implementation of any new Medicaid policies should aim to actively improve people's health. It should also address the costs and trauma that incarceration can impose on people and communities, and support people in becoming functional and successful community members.

3. **Advance Equity.** Significant racial and economic disparities exist in justice system involvement, health service access, and health outcomes. Stakeholders urged that equity be prioritized at every stage of implementation of any new Medicaid reentry policies.

4. **Support Evidence-based, Clinical Services.** Stakeholders prioritized empowering health care professionals to make health care decisions based on clinical needs rather than correctional concerns, and support advancing evidence-based practices proven to improve community health. Many expressed concern about the quality of correctional health services, the lack of trust that many justice-involved people have in those services, and the risk of investing in systems that they perceived as harmful. They also recommended that people who have been under correctional control play a central role in policy development and implementation.

5. **Increase Access to Community Services.** Many stakeholders said that untreated health conditions, especially behavioral health conditions, contribute to high incarceration rates and strain the criminal justice system's ability to effectively serve as mental health and substance use providers. They suggested that any new reentry policies include efforts to expand access to community services. By increasing the quality and availability of community-based mental health and substance use treatment, policymakers, health care providers, and insurers can potentially reduce reliance on the criminal justice system as a behavioral health service provider and strengthen continuity of care at reentry.

6. **Reinvest state and local savings generated by new policies in services.** Allowing Medicaid to pay for services provided in prisons and jails at reentry would reduce expenses for states and localities that currently fund such services. Stakeholders recommend that state and local savings be reinvested in expanding health care services, including community services, and strengthening services provided before release, a change that would require operational changes in prisons and jails.

A New Care Model to Support Successful Reentry

When asked to describe their goals for the development and implementation of potential Medicaid policy changes, stakeholders outlined an approach to health care delivery that focuses on the specific needs of people leaving incarceration. Based on their comments and vision, a new care model emerged for providing Medicaid-supported services to individuals both before and after release. This model has five critical elements:

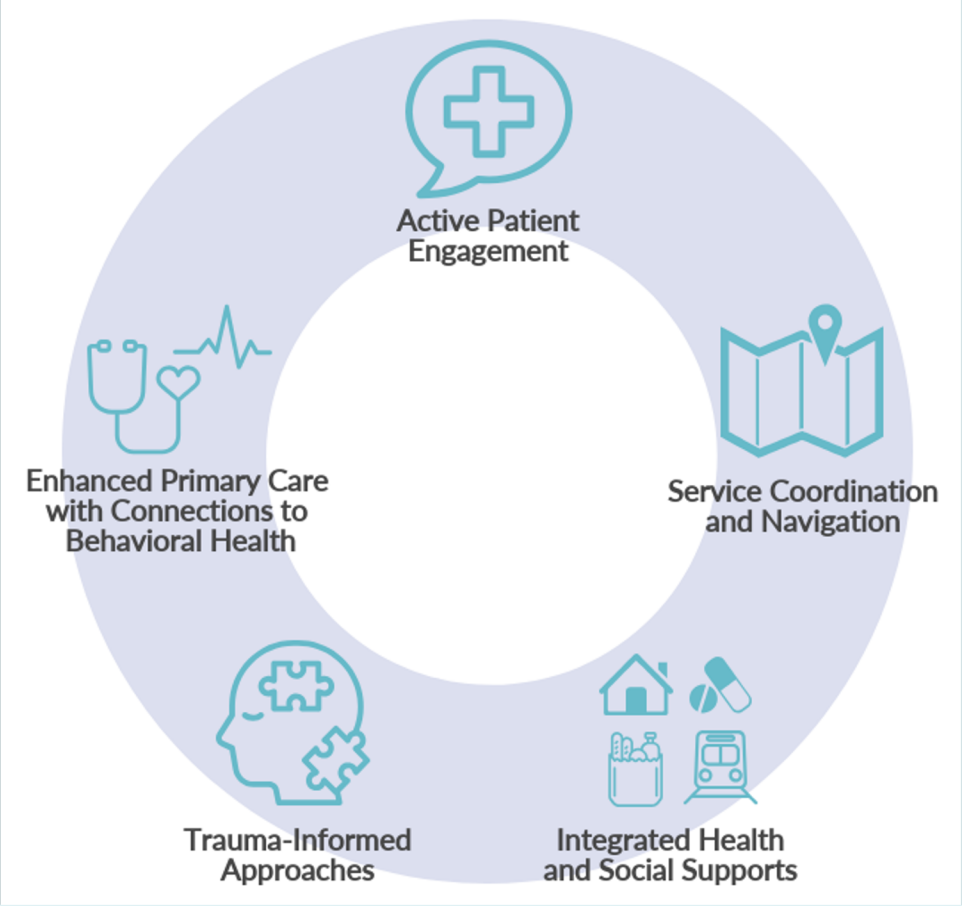
- **Enhanced primary care and connections to behavioral health.** Although many people leaving prison and jail have significant health conditions, they access primary care and mental health services at a lower rate than the general population.[4] Access to primary care, which emphasizes prevention of health conditions and coordination of services, can improve outcomes, promote care coordination, and reduce the use of more intensive and expensive health care services.[5] Primary care that is integrated with or otherwise facilitates seamless access to mental health and substance use services has been shown to reduce barriers to service use and treatment for people leaving incarceration. New York and Rhode Island have provided integrated primary care and behavioral health services to people leaving correctional facilities through Medicaid health homes, which integrate health and behavioral health services for people with chronic conditions.[6]

- **A commitment to active patient engagement.** People exiting prison and jail have medical needs that differ from those of the general population. Many have not accessed health care services regularly during their lifetime and suffer from higher rates of many chronic conditions. Many also have complex social needs, including a lower than average level of health literacy.[7] To be effective, health care models must foster trust between patients and providers and support people seeking to access services using Medicaid or other insurance as coverage. The Transitions Clinic Network, which operates in 14 states and Puerto Rico, is one model that

includes patient engagement in its services for reentering people. The network has been associated with increased access to primary care, reduced preventable hospitalizations, and reduced future justice involvement.[8]

+ **Service coordination and navigation.** Most reentry and health service systems are fragmented and difficult to navigate, often including programs and service providers with different eligibility requirements and processes. Community health workers, probation, parole and pretrial supervision officers, and other professionals can play a key supportive role for returning individuals seeking to identify, connect with, coordinate, and leverage available health and social services.[9] State Medicaid programs can authorize care coordination services through Medicaid benefits such as rehabilitative services and targeted case management options. Professionals who have been incarcerated themselves may be particularly effective in supporting people leaving correctional facilities.

FIGURE 2: REENTRY CARE MODEL



- **Trauma-informed approaches.** People leaving prison or jail are more likely than other members of society to have experienced past trauma, which can negatively affect their functioning, health, and likelihood of engaging in risky health behaviors.[10] Trauma stems from events or circumstances that cause physical or psychological harm and have long-term impacts on an individual's functioning and well-being. Trauma-informed care includes clinical and organizational approaches that train practitioners to recognize trauma, support recovery from it, and build trust between patients and providers. Untreated trauma is associated with an increased probability of developing physical and behavioral health conditions.[11]

- **Integrated social and health supports.** In addition to health care, many people returning to communities following incarceration need housing, transportation, food assistance, a stable income, and support securing employment.[12] To the extent possible, these and other relevant services and programs should be integrated, with access and key connections provided in a coordinated fashion at release.[13] Medicaid can be used to cover a range of supportive services and benefits for those leaving prison or jail, increasing the odds of successful reentry.

Implementing Medicaid Reentry Policies: Seven Essential Actions

Successfully advancing the key principles and reentry care model that stakeholders described depends on implementation. HARP identified seven essential actions public officials should take as they translate new Medicaid policy into effective practice.

1. ALIGN HEALTH CARE SERVICES PROVIDED IN CORRECTIONAL SETTINGS WITH COMMUNITY-BASED STANDARDS OF CARE.

Care delivered in the community that is paid for by Medicaid or other insurers generally meets a set of underlying standards concerning provider licensure, accreditation, quality, program integrity, and oversight. These standards are generally set and overseen by state Medicaid and other agencies. They determine whether a provider is qualified to provide services, how providers are paid, and how access to and the quality of services are overseen.[14]

These standards would ensure a clinical basis for - and patient trust in - health care decision-making, which is a key principle identified by stakeholders. To honor this principle, services that Medicaid covers in prisons and jails should generally accord with the standards that apply to comparable services provided in the community. Full parity of services may not be possible in every instance. For example, specific approaches may be needed in correctional settings to ensure the security of patients and providers.[15] Given such realities, Medicaid agencies and managed care organizations should develop standards and oversight approaches in close coordination with criminal justice system officials.

2. ACCOUNT FOR KEY DIFFERENCES BETWEEN PRISONS, JAILS, AND JUVENILE JUSTICE FACILITIES.

The Medicaid Reentry Act and many state waiver proposals would authorize coverage of services during a set pre-release period, ranging from 30 days in the federal legislation to 90 days in some state proposals. These time periods do not take into account key differences between state and federal prisons, local jails, and juvenile justice facilities. Unlike prisons, which typically house individuals for at least one year, jails are characterized by short stays. While the average length of stay is 28 days, many are far shorter, and often subject to a high level of unpredictability.[16] Health service delivery also varies significantly in prisons and jails, reflecting the different lengths of stay and individual needs. The care required by someone serving a multi-year prison sentence, for example, is not necessarily the same as that needed by an adult being detained in jail or an adolescent serving time in a juvenile facility.

State and federal policymakers should develop policies that accommodate the diverse circumstances of jails, prisons, and juvenile justice facilities. Oregon is a useful model. In its proposed 1115 waiver, Oregon proposes to provide Medicaid-covered services to people across different types of facilities but adjusts the care that is covered and the service coverage period between prisons, jails, and juvenile facilities.[17]

3. INVEST IN SYSTEMS AND INFRASTRUCTURE TO PROMOTE CONTINUITY AND QUALITY OF CARE.

Stakeholders identified data systems that communicate and share information between prisons and jails, state Medicaid agencies and managed care plans, and across community and correctional providers as the “technological backbone” of continuity of care. Systems should be capable of automating Medicaid eligibility information and sharing information

on service use across providers. In many counties and states, however, information sharing is not routine and paper record keeping is the norm.[18] Differing rules governing data privacy in the health and justice systems is another key challenge.

State and federal grant funds, as well as local resources and philanthropic dollars, could support needed infrastructure investments that Medicaid, which generally does not fund start-up costs, cannot. For example, in advance of implementation of its proposed Medicaid reentry program, California recently established a program that awards planning, infrastructure, and capacity-building grants for counties to operationalize Medicaid eligibility processes and information exchange prior to release from prison.[19]

All relevant federal health and justice agencies could play a role in targeted grantmaking. The Department of Justice, the Centers for Medicare and Medicaid Services, the Substance Abuse and Mental Health Services Administration, and the Health Resources and Services Administration should all explore ways to support system modernization and data sharing.

4. INCREASE INVESTMENTS IN COMMUNITY-BASED HEALTH CARE SERVICES.

Fundamentally, reentering individuals need greater access to community-based health care, mental health treatment, and substance use services, particularly in the wake of COVID-19.[20] Additional investment is needed to expand the availability of such services, which can help those leaving incarceration avoid future justice system involvement by addressing key factors that drive criminal behavior.

State, local, and federal policymakers should accelerate efforts to increase these key services, particularly in low-income communities where rates of crime and justice involvement are high. Recent policies to integrate behavioral health into primary care and expand certified community behavioral health centers, community health centers, and the use of telehealth appointments are among those that government officials, insurers, and providers can leverage to expand service access. On a related track, managed care organizations and health care providers should prioritize recruiting providers and locating services where they are most needed by justice-involved populations, which may include rural communities where prisons are often located.

5. STRENGTHEN THE WORKFORCE TO MEET THE NEEDS OF PEOPLE LEAVING INCARCERATION.

To access the services they need to successfully reintegrate into society, people leaving prison and jail must rely on a variety of professionals inside and outside the criminal justice system. Ensuring that the workforce has adequate resources will increase the odds that reentering individuals will thrive, and, in turn, enhance public safety.

Toward that end, policymakers, providers, and managed care organizations should fortify the workforce to expand and improve reentry services. Ensuring that a cadre of primary care providers and specialists develop expertise in the needs and circumstances of people who have been involved in the justice system is essential. Expanding access to nonclinical health care professionals, such as community health workers, can also serve as a key support for those reentering society. Using formerly incarcerated people as community health workers is another option,[21] and peer support providers, who typically help people with mental health and substance use issues with recovery, should also play a greater role.[22] In Ohio, incarcerated people have been trained to serve as peers, helping others behind bars learn how to use coverage and access services after they are released.[23] More broadly, jurisdictions should focus on expanding the capacity of their behavioral health workforce, which is critical to successful reentry and has been significantly strained by the COVID-19 pandemic. Expanding workforce development programs, including educational loan repayment, and expanding the use of nonclinical providers also can help remedy workforce challenges.[24]

The community supervision workforce has a role to play as well. Parole and probation officers should be trained to help people transitioning from jail or prison obtain health care, a connection that can support successful reintegration and benefit public safety. Like health care providers, these officers need adequate funding and instruction to assume any increased responsibilities related to Medicaid policy changes. On a related note, the provision of medical and mental health services should be configured in ways that simplify access for those under supervision. Arizona, for example, has located health care clinics in some probation and parole offices to facilitate people's ability to obtain services.[25]

6. LEAD COORDINATION BETWEEN HEALTH, JUSTICE SYSTEM, AND DIRECTLY IMPACTED STAKEHOLDERS.

Ultimately, responsibility for crafting Medicaid reentry policies and the requirements surrounding their implementation lies with health policymakers. But critical knowledge about what services are needed, how to operationalize these policies, and how to achieve

public safety goals is held by multiple other stakeholders, from the courts to law enforcement, corrections, nonprofit service providers, health and behavioral health agencies, employment and housing agencies, and more. Engaging them in a coordinated fashion is critical to successfully developing these Medicaid policy changes, carrying them out, and tracking their effects.

At the outset, state and federal policymakers should develop a system to coordinate stakeholders and lead policy development, system implementation, and governance. Leaders must have credibility across the health and criminal justice sectors, with community organizations that assist people who have been involved with the justice system, and with community members. Formerly incarcerated individuals, in particular, must be meaningfully and continually engaged.

Federal grantmaking could advance stakeholder collaboration. The U.S. Department of Justice's Justice and Mental Health Collaboration Program, which promotes coordination between state, local, and tribal behavioral health, criminal justice, and law enforcement officials, provides a compelling model[26]

7. COMMIT TO MEASURING AND EVALUATING THE IMPACT OF NEW MEDICAID POLICIES.

Evaluating the impact of any new Medicaid policies – and the various delivery models proposed by states – on both health and public safety is essential. State and federal agencies developing and enacting new Medicaid reentry policies should incorporate evaluation into their implementation plans from the start and actively use results to govern, adapt, and improve programs. State Medicaid programs and managed care plans could consider tying payment to achieving process and outcome measures, as they have increasingly done for other covered services.

Assessing the impact of any new Medicaid reentry policies may require developing specific measures outside of typical health indicators. Health agency leaders should coordinate with criminal justice counterparts and stakeholders to identify and access metrics that capture the impact of any new policies on recidivism and public safety. Outside researchers can supplement this work with independent evaluations, paying particular attention to the policies' cross-sector impact. This research has strong potential to shape future policymaking on health and public safety.

Conclusion

HARP was launched in pursuit of a critical goal: to promote continuity of care between correctional and community settings and maximize the benefits of potential Medicaid policy changes for public health and public safety. The need is clear. In the period following release from jail or prison, formerly incarcerated people are 12 times more likely to die than are other people, from causes that range from heart disease and cancer to homicide and suicide. Rates of death from overdose, in particular, are extremely high in the period immediately following incarceration, and the opioid epidemic and COVID-19 pandemic have only intensified the need for services for those leaving custodial settings. Reentering people face a multitude of other overlapping challenges, from housing instability to the struggle to find employment. Helping people overcome such obstacles and obtain health care, mental health services, and substance use treatment increases the odds of their success and, in turn, enhances public safety.

Earlier this year, the HARP team engaged a wide range of stakeholders to identify priority steps to ensure Medicaid policy changes maximize health and safety benefits for all. Stakeholder feedback was robust, forming the foundation for the care model, guiding principles, and essential actions outlined in this brief. While the challenge of translating new Medicaid reentry policies into practice is complex, navigating it successfully is achievable – and critical.

As policymakers and stakeholders chart their course forward, coordination – among people from multiple sectors, backgrounds, and perspectives – will be key. Ensuring correctional care aligns with community standards, expanding access to services, creating technological infrastructure to allow information sharing, and fortifying a supportive workforce are all vital steps. Actively evaluating outcomes and continually engaging reentering people in their care creates opportunities to improve health and public safety outcomes while closing critical gaps in equity.

With this brief, HARP establishes a framework for progress – but much work remains to ensure the success of proposed Medicaid reentry policies. HARP and the field at large must focus on strategic policy implementation, intensive analysis of key remaining questions, and advancing service delivery innovations to realize health and public safety benefits for formerly incarcerated people and our communities.

1 Carson, E, Prisoners in 2020 – Statistical Tables, U.S. Department of Justice, December 2021.https://bjs.ojp.gov/content/pub/pdf/ji20st.pdf

2 Aslim, Erkman, Mungan, Murat, Navarro, Carlos, and Yu, Han, The Effect of Public Health Insurance on Criminal Recidivism, Journal of Policy Analysis and Management, 2022. https://onlinelibrary.wiley.com/doi/epdf/10.1002/pam.22345.

Wen, H, Hockenberry, J, Cummings, J. The effect of Medicaid expansion on crime reduction: evidence from HIFA-waiver expansions, Journal of Public Economics, October 2017. https://ideas.repec.org/a/eee/pubeco/v154y2017icp67-94.html

Badaracco, Nico, Burns, Marguerite, Dague, Laura, The effects of Medicaid Coverage on Post-Incarceration Employment and Recidivism, Health Services Research, September 2021, https://onlinelibrary.wiley.com/doi/abs/10.1111/1475-6773.13752;

Volger, J., Access to Health care and Criminal Behavior: Evidence from the ACA Medicaid Expansions, Journal of Policy Analysis and Management, July 2020. https://onlinelibrary.wiley.com/doi/abs/10.1002/pam.22239

3 The federal government funds health care services provided in the federal Bureau of Prisons.

4 Wang, Emily, Western, Bruce, Backes, Emily and Schuck, Julie, Decarcerating Correctional Facilities During COVID-19: Advancing Health, Equity and Safety, National Academies of Science, Engineering and Medicine, 2020. https://nap.nationalacademies.org/catalog/25945/decarcerating-correctional-facilities-during-covid-19-advancing-health-equity-and

5 Shi L. The impact of primary care: a focused review. Scientifica (Cairo). 2012 https://pubmed.ncbi.nlm.nih.gov/24278694/

6 Spellman, Brenda, Clemans-Cope, Lisa, Mallik-Kane, Kamala and Hayes, Emily, Connecting Justice-Involved Individuals with Health Homes at Reentry: New York and Rhode Island, Urban Institute, January 2017. https://www.urban.org/sites/default/files/publication/88031/clean_health_homes_2.pdf

7 Wang, Emily, Western, Bruce, Backes, Emily and Schuck, Julie, Decarcerating Correctional Facilities During COVID-19: Advancing Health, Equity and Safety, National Academies of Science, Engineering and Medicine, 2020. https://nap.nationalacademies.org/catalog/25945/decarcerating-correctional-facilities-during-covid-19-advancing-health-equity-and

8 Ibid.

9 Ali-Faisal, Sobia, Colella, Tracey, Medina-Jaudes, Naomi and Scott, Lisa Benz, The effectiveness of patient navigation to improve health care utilization outcomes: A meta-analysis of randomized controlled trials, Patient Education and Counseling, October 2016. https://www.sciencedirect.com/science/article/abs/pii/S0738399116304839

10 Jäggi LJ, Mezuk B, Watkins DC, Jackson JS. The Relationship between Trauma, Arrest, and Incarceration History among Black Americans: Findings from the National Survey of American Life. Soc Ment Health. 2016 Nov;6(3):187-206. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5079438/

11 SAMHSA (2014). SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach SAMHSA's Trauma and Justice Strategic Initiative, http://store.samhsa.gov/product/SAMHSA-s-Concept-of-Trauma-and-Guidance-for-a-Trauma-Informed-Approach/SMA14-4884

Maul, Alexandra and Menschner, Christopher, Key Ingredients for Successful Trauma-Informed Care Implementation, Center for Health Care Strategies, April 2016. https://www.samhsa.gov/sites/default/files/programs_campaigns/childrens_mental_health/atc-whitepaper-040616.pdf

12 Wang, Emily, Western, Bruce, Backes, Emily and Schuck, Julie, Decarcerating Correctional Facilities During COVID-19: Advancing Health, Equity and Safety, National Academies of Science, Engineering and Medicine, 2020. https://nap.nationalacademies.org/catalog/25945/decarcerating-correctional-facilities-during-covid-19-advancing-health-equity-and

13 Aminawung, Jenerius, Berthold, Timothy, Birnbaum, Nathan, Busch, Susan, Fishman, Amie, Greenberg, Scott, Shavit, Shira, and Wang, Emily, Transitions Clinic Network: Challenges And Lessons In Primary Care For People Released From Prison, NIH, June 2017. https://pubmed.ncbi.nlm.nih.gov/28583958/

14 In states that use managed care, state Medicaid agencies delegate some of these functions to managed care organizations.

15 Khatari, Utsha and Winkelman, Tyler, Strengthening the Medicaid Reentry Act—Supporting the Health of People Who Are Incarcerated, New England Journal of Medicine, January 26, 2022, https://www.nejm.org/doi/full/10.1056/NEJMp2119571

16 Minton, Todd and Zeng, Zeng. Jail Inmates in 2020 – Statistical Tables. U.S. Department of Justice. December 2021. https://bjs.ojp.gov/content/pub/pdf/ji20st.pdf

17Brown, Kate and Hittle, Dana OHP 1115 Waiver Application, February 2022, https://www.oregon.gov/oha/HSD/Medicaid-Policy/Documents/2022-2027-Waiver-Application-Final.pdf

18 Malli-Kane, Kamala and Wishner, Jane, Information Sharing Between Medicaid and Corrections Systems to Enroll the Justice-Involved Population: Arizona and Washington, The Urban Institute, February 2017; https://www.urban.org/research/publication/information-sharing-between-medicaid-and-corrections-systems-enroll-justice-involved-population-arizona-and-washington

19 California Department of Health Care Services, Design Parameters for PATH funding to Support Implementation of Justice Involved Medi-Cal Pre-release Eligibility and Enrollment Processes, March 2022. https://www.dhcs.ca.gov/provgovpart/pharmacy/Documents/CalAIM-Justice-Involved-Advisory-Group-032422.pdf

20Bandara, Sachini, Barry, Colleen, Li, Wenshu, McGinty, Emma, and Saloner, Brendan, Trends In The Use Of Treatment For Substance Use Disorders, 2010–19, Health Affairs May 2022. https://www.healthaffairs.org/doi/10.1377/hlthaff.2021.01767

21 Kangovi, Shreya, Mitra, Nandita, Grande, David, and Long, Judith. Evidence-Based Community Health Worker Program Addresses Unmet Social Needs and Generates Positive Return on Investment. Health Affairs. February 2020. https://www.healthaffairs.org/doi/10.1377/hlthaff.2019.00981

22 Smith, Dennis. Guidance to states interested in peer support services under the Medicaid Program [Memorandum]. Centers for Medicare and Medicaid Services. August 2007

https://downloads.cms.gov/cmsgov/archived-downloads/smdl/downloads/smd081507a.pdf

23 Wachino, Vikki and Artiga, Samantha, "How Connecting Justice-Involved Individuals to Medicaid Can Help Address the Opioid Epidemic," Kaiser Family Foundation, June 2019. https://files.kff.org/attachment/Issue-Brief-How-Connecting-Justice-Involved-Individuals-to-Medicaid-can-Help-Address-the-Opioid-Epidemic

24 Frank, Richard, Wachino, Vikki and Aguilar, Karina. Tackling Unfinished Business and Taking On Current Challenges: Putting Biden's Mental Health Proposals in Context. April 2022. https://www.brookings.edu/blog/usc-brookings-schaeffer-on-health-policy/2022/04/04/tackling-unfinished-business-and-taking-on-current-challenges-putting-bidens-mental-health-proposals-in-context/

25 Substance Use Prevention and Treatment Initiative. How States and Counties Can Help Individuals With Opioid Use Disorder Re-Enter Communities. Pew Charitable Trusts. April 2020. https://www.pewtrusts.org/en/research-and-analysis/issue-briefs/2020/04/how-states-and-counties-can-help-individuals-with-opioid-use-disorder-re-enter-communities

26 Thomas, Demetrius, Upton, Allison, and Wurzburg, Sarah, Justice and Mental Health Collaboration Program, Council on State Governments, n.d. https://csgjusticecenter.org/projects/justice-and-mental-health-collaboration-program-jmhcp/