



HEALTH AND JUSTICE: BRIDGING THE GAP

Lessons from New York State Initiatives to Provide
Access to Care After Incarceration



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EXECUTIVE SUMMARY

Treating chronic medical conditions is key to ending an all-too prevalent and vicious cycle of incarceration and illness, especially in low-income communities of color. Failure to treat people has filled our prisons and jails, strained our hospitals and emergency rooms and overwhelmed our homeless shelters. These shortcomings have made communities sicker, not safer, reinforced racial and class disparities and wasted public funds.

The financial and moral costs of failed policies have created a growing reform movement. In New York City and State, and across the country, communities are re-examining sentencing laws and monetary bail policies and seeking alternatives to locking people in prisons and jails. While those initiatives are vitally important, we cannot truly end mass incarceration and all its direct and collateral damage without addressing the health and health care disparities that have coincided with criminal justice involvement for millions of people, mostly black and brown.

Yet very few proposals for criminal justice reform acknowledge or address health as a critical element.

We need to replace the failed policies of the past with new ones that prioritize health over punishment and achieve that goal by linking individuals to health insurance and coordinated health care in the community. Through its Medicaid expansion, the Patient Protection and Affordable Care Act of 2010 (ACA) provides a singular opportunity to insure the justice-involved, the vast majority of whom are low-income. It also encourages care coordination to improve health outcomes and lower skyrocketing costs. In addition, the ACA and the Mental Health Parity and Addiction Equity Act require that Medicaid and private insurance equitably cover services and medications for substance use disorders and mental health—conditions that, untreated, have led to or exacerbated criminal justice involvement for 60-85 percent of people in our criminal justice system.

Since 2008, some jurisdictions have seized these opportunities to test promising practices related to Medicaid enrollment and care linkages for this population so that individuals can disentangle themselves from the criminal justice system and re-immense themselves in their families and communities. While coordinating the services of two large and complex systems like criminal justice and health has not been simple, innovative jurisdictions understand that treating people not only makes individuals healthier and more productive, it also reduces crime and recidivism, makes communities healthier and safer, and saves money in both the health care and criminal justice systems.

New York is one of those leaders in innovation. Recognizing the critical importance of access to care for both the health and safety^{1,2} of its residents, New York State has made noteworthy reforms for its justice-involved population. New York City is pursuing similar goals. All communities in New York State should follow suit.

Although individual jurisdictions will certainly face their own unique opportunities and challenges, utilizing recent Medicaid reforms that are available in all states and the ACA Medicaid expansion that has now been adopted by 34 states (including D.C.) to enroll the eligible justice-involved population in Medicaid and then link individuals to needed care are linchpins of successful reform. States that expand Medicaid will reap substantial savings since federal (not state and local) funds will cover, in perpetuity, up to 90 percent of costs for this population's care.

While a substantial operational and logistical challenge, we have found that insurance enrollment is actually the “easier” task; there are even more systemic barriers to engaging and retaining in care justice-involved individuals as they exit incarceration. New York’s experience proves that while obstacles may be formidable, they are not insurmountable. Lessons learned are instructive for policymakers around the country seeking tools and strategies for criminal justice reform.

This report discusses the overlap between community and correctional health. It provides a detailed description of: 1) how New York has leveraged new laws and opportunities into innovations, 2) what outcomes have been achieved, 3) how obstacles have been overcome and 4) what challenges remain.

Based on this experience, we offer recommendations for policymakers and other stakeholders on the basic principles and mechanisms that can help any jurisdiction begin to successfully address insurance enrollment and care linkage challenges for people in the criminal justice system as they move from punishment to health.

Our over-arching recommendations are to follow New York State’s lead and:

Priority 1: Enroll Eligible Incarcerated Individuals in Medicaid Prior to Release

Priority 2: Assess Justice-Involved Individuals and Link Them to Community-Based Care Prior to Release

To achieve these critically important goals, we make the following process and operational recommendations:

- ✓ Establish Close Working Relationships Between the Health and Criminal Justice Systems, Beginning At the Highest Levels, to Ensure Maximum Buy-In and Support
- ✓ Make the Cross-Sector Benefits Clear to Both Systems from the Outset
- ✓ Leverage Policy and Funding Opportunities
- ✓ Invest in Data Sharing and Infrastructure
- ✓ Evaluate Progress and Outcomes

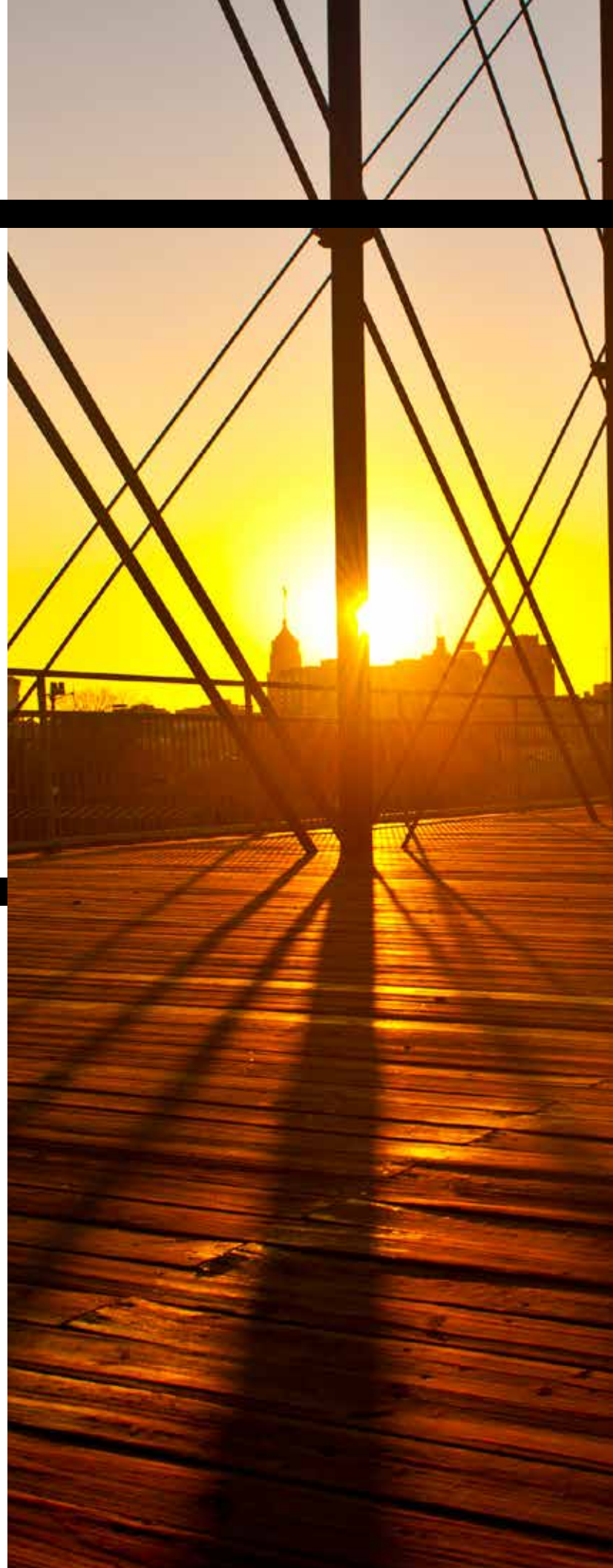
We also make the following policy recommendations:

- ✓ Do Not Terminate Medicaid Enrollment of Incarcerated Individuals
- ✓ Ensure Active Medicaid 30 Days Prior to an Individual’s Release from Incarceration
- ✓ Give People Physical Proof of Coverage At or Before Their Release From Incarceration
- ✓ Use an Individual’s Medical History to Determine Care Needs During Incarceration and Upon Reentry
- ✓ Use a Person’s Incarceration to Determine Eligibility for Intensive Care Coordination and Enhanced Medicaid Reimbursement

PART I.

**THE
IMPERATIVE IS
CLEAR.
THE TIME IS
NOW.**

***THE CASE FOR PRIORITIZING
HEALTH FOR CRIMINAL
JUSTICE-INVOLVED
INDIVIDUALS***





CORRECTIONAL HEALTH = COMMUNITY HEALTH

The poor health of most individuals in prisons and jails mirrors that of the communities from which they come and to which 95 percent will return. Whether or not incarcerated individuals receive effective treatment inside correctional facilities, when they reenter their communities they are at high risk of exacerbating existing conditions – particularly addiction and mental health issues – that were often integral to their criminal justice involvement in the first place. Individuals in poor health are also less likely to find and keep employment and housing, further worsening their health and increasing the risk that they will again end up behind bars.

There is growing awareness that swift connections to health care in the community upon release from prisons and jails can help end this cycle, diminishing the prevalence of untreated substance use and mental disorders, the spread of communicable diseases and the risk of re-arrest and re-incarceration.³ Strengthening the connection between the health and criminal justice systems will improve public health and safety and reduce morbidity, mass incarceration and recidivism. Not only will this improve the lives of untold numbers of individuals and their families, but it also will save money, which should then be reinvested in the neglected communities from which most incarcerated individuals come.



Since more than 95 percent of prisoners eventually return to the community, correctional health care has the opportunity, and the obligation, to transform care for persons and communities most in need. Moreover, given that incarcerated populations are disproportionately from traditionally underserved and/or disadvantaged backgrounds and have a high burden of disease, these goals also hold the promise of reducing health disparities.⁹

–Dr. Josiah Rich, MD, MPH,
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HEALTH DISPARITIES AND MASS INCARCERATION

Deeply linked at the population level...but profoundly disconnected at the systems level

There is ample evidence that links poor correctional health and poor community health to mass incarceration. [4](#), [5](#), [6](#), [7](#), [8](#)

Despite the clear connection between community health and the health of incarcerated individuals, there historically has been little effort to link the two. Institutions and systems built in an era highly influenced by segregation and racism are largely to blame. Discriminatory health care and criminal justice systems in poor communities have also been largely siloed from each other, operating separately for decades.¹⁰ One researcher noted, “Often, the health care and health status of [people in prison] is regarded as something insular, something of no concern to, and uniquely disjointed from, the general population.”¹¹ Policies and programs have been crafted as though the population served by community health systems is completely distinct from the population inside prisons and jails.

In this context, few correctional settings have helped people leave incarceration with health insurance coverage or a plan for accessing needed health care in the community.

THE TOLL OF INJUSTICE

60% of individuals in prisons are people of color.



More people with substance use disorders are in the criminal justice system (**6 million**) than in treatment (2.3 million).



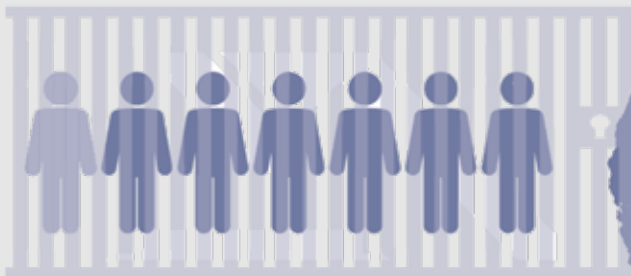
60-80% of people in the criminal justice system suffer from substance use disorders.



Unemployment among the formerly incarcerated costs an estimated **\$85 billion per year** in lost productivity.



54% of homeless individuals report having spent time in a correctional facility.



Despite comparable drug use, African Americans are incarcerated for drug-related crimes at nearly **six times** the rate of whites.



More than **70 million** people (21.4% of the U.S. population) now have an arrest or conviction history.

\$600,000,000,000

Untreated addiction costs an estimated \$600 billion per year in related crime, lost productivity, and health care spending.

In several states, incarcerated people diagnosed with chronic conditions, including but not limited to mental illnesses, receive a small supply of medication upon release. Without insurance or a community medical provider, however, they are often unable to obtain refills or access the medical supervision that should accompany a prescription. Health crises ensue with people ending up in hospitals, jails and emergency inpatient psychiatric settings.

Correctional health professionals across the United States share stories of released individuals who get rearrested purposely in order to regain access to medication. ^{12, 13}

In fact, many correctional institutions terminate people's Medicaid upon entering custody, leaving them without coverage when they are released.

In addition, largely due to a severe lack of resources, few programs exist to link people leaving jails and prisons to care in the communities to which they are returning. There is a growing awareness that the health problems of those who are released from incarceration affect the public health of the communities to which they return, perpetuating cycles of disparity.¹⁴ Movement is growing among policymakers and advocates to strengthen the links between the health and criminal justice systems.¹⁵

Reentry is a Key Point of Systemic Breakdown

While there is no doubt that quality of care on the inside prisons and jails is inadequate in most jurisdictions across the country, reentry is consistently the key point of systemic breakdown.

In fact, an individual is 12 times more likely to die, and 130 times more likely to die of an overdose, in the first two weeks after release from incarceration than people in the general population.

Reentry in fact presents the most immediate, and possibly the greatest, opportunity to improve public health and public safety outcomes. To improve reentry outcomes, however, we must: a) strengthen the linkages between corrections and community health, b) ensure that eligible people are screened for and enrolled in Medicaid upon release, c) create a health care plan for each individual before they return to their community, and d) utilize harm reduction strategies and peer supports.







Strengthening the nexus between the criminal justice and health care systems is critical to achieving several major goals:

It addresses high illness rates among people who will return to their

communities. Rates of HIV infection in jails and prisons are four to six times higher than among the general population, and one in three incarcerated individuals is estimated to have Hepatitis C. The prevalence of communicable disease can be from 4 to 10 times greater among incarcerated people than the general public. About 4.2 percent of all tuberculosis cases occur in correctional facilities, although less than 1 percent of the American population is incarcerated at any given time.¹⁶ Among other conditions, people in jails and prisons also have a higher likelihood of experiencing hypertension, asthma, arthritis, and cervical cancer than their non-incarcerated counterparts.¹⁷

Today's opioid epidemic – the worst in our nation's history – has put a spotlight on the prevalence of addiction in the criminal justice system. At [least a quarter](#) of the [nearly 2.3 million](#) Americans currently incarcerated have opioid use disorders.¹⁸ Very few incarcerated people who use opioids and/or other substances receive adequate health care, including being prescribed any of the three FDA-approved medications to treat opioid use disorder.* Nor upon release are they linked to a community treatment program that provides those services and medications.

It strengthens communities. Many studies cite employment as key to reducing recidivism and improving economic mobility. However, people too ill to work cannot be employed. In assessing people's readiness for employment, it is critical to assess their health. Facilitating successful reentry from incarceration therefore must include access to health care, which can then lead to higher rates of employment, stable housing, and positive contributions to the community. It also can reduce the rate of re-incarceration and emergency room utilization.¹⁹

At least 25 percent of the nearly 2.3 million Americans currently incarcerated have opioid use disorders.¹⁸

It saves money. It is expensive to incarcerate, on average costing \$31,000 per year²⁰ per person and \$50,000-\$60,000 in higher-cost states like New York.²¹ The expense of treating chronic health conditions such as HIV, Hepatitis C, asthma, diabetes and heart disease²² that are prevalent among the incarcerated is astronomical. Enrolling individuals in Medicaid prior to release from jails and prisons, and creating linkages to health care in the community will likely lower expenditures in the health care system by reducing the burden of uninsured care. Linkages to care upon reentry also promise criminal justice system savings primarily from lower recidivism. For example, with Medicaid enrollment and care linkages more people will access substance use disorder treatment, the benefits of which include reduction of drug use by half, reduction of crime by 80 percent and reduction in arrests by up to 64 percent.²³



HEALTH AND JUSTICE REFORMS CREATE NEW OPPORTUNITIES

Since 2008, several laws and reforms have created opportunities for better health care for individuals leaving incarceration.

The Mental Health Parity and Addiction Equity Act (“Parity Act”)

Passed in 2008, the [Mental Health Parity and Addiction Equity Act](#) prohibited discrimination in insurance coverage for people with substance use and mental disorders. It mandated that Medicaid managed care and private insurers cover treatment for these conditions no more expensively and no less comprehensively than they do other medical conditions, like diabetes and heart disease. Because of the high prevalence of mental health and substance use disorders in the justice-involved population, creating a framework for better private insurance and Medicaid coverage of these diseases was a vital first step to improved care.

The Affordable Care Act - Medicaid Expansion and Care Coordination

The Affordable Care Act (ACA), signed into law in 2010: 1) expanded Medicaid eligibility to millions of non-disabled, low-income adults without dependent children, 2) made substance use disorder and mental health coverage an essential health benefit to be covered at parity with other conditions (see left) and 3) encouraged coordinated and integrated care. Because so much of the justice-involved population consists of low-income adults with chronic illnesses, particularly substance use and mental health conditions, the ACA provided a path to coverage and coordinated care, often a first-time path, for many justice-involved individuals.²⁴ With the federal government covering 90 percent of costs for this population, states and localities that overcome the many complexities associated with Medicaid enrollment in prisons and jails can generate enormous cost-savings. Substantial savings come from immediate Medicaid reimbursement the day an individual leaves incarceration and visits a community health care provider, and, as explained below (see section on Medicaid’s Inmate Exception), in certain circumstances savings also can begin during incarceration.

The Substance Abuse and Mental Health Services Administration (SAMHSA) defines integrated care as “the systematic coordination of general and behavioral health,” stating that such integration “produces the best outcomes and proves the most effective approach to caring for people with multiple health care needs.”²⁵ Because so much of the justice-involved population has multiple chronic health conditions, particularly mental health and substance use disorders,²⁶ this approach provides a recipe for improving their care.

Criminal Justice Reforms

At the same time local, state, and federal agencies are implementing health care reform, there has been a growing awareness in the country about the impact of criminalization of people with substance use disorders,²⁷⁻²⁸ the resulting rise of mass incarceration,²⁹ the racial disparities in sentencing and imprisonment, and the need to reverse these trends through increased opportunities for treatment and recovery supports. **The Second Chance Act**, introduced with bi-partisan support in Congress and signed into law by President George W. Bush, included opportunities for funding to help individuals released from incarceration with substance use disorders find treatment and employment in their communities. Pending federal legislation aimed at reforming reentry and sentencing policies has bi-partisan support and may receive review in this Congress. As far back as 1994, the federal government began to fund drug courts aimed at diverting people with addictions from incarceration to treatment. In another sign that policymakers were beginning to see the broad impact of incarceration on health and vice versa, in 2011 the Obama Administration established the Attorney General’s Reentry Council to coordinate the work of federal agencies whose policies affect the millions of people released each year from incarceration. The Council, which has been re-configured by the current administration, includes both health and criminal justice agencies.



OVERCOMING REMAINING CHALLENGES TO CROSS-SECTOR CARE

Despite growing awareness of the link between criminal justice and health, and new opportunities to improve health care for justice-involved individuals, long-standing barriers remain. A provision of the Medicaid law called the “Inmate Exclusion,” and the historical siloes that have been built between the criminal justice and health care systems, are each significant obstacles to enrolling this population in Medicaid and linking it to care. While formidable, neither is insurmountable, as illustrated in this report’s description of the New York experience (beginning on page 28).

Medicaid's Inmate Exclusion

The Medicaid Inmate Exclusion³⁰ prohibits the federal government from paying for most medical care for incarcerated individuals. Unfortunately, many states have interpreted the Inmate Exclusion to mean that they must terminate people from Medicaid during incarceration. Not only is this a misinterpretation of the statute, terminating people in jails and prisons from Medicaid costs states money and decreases access to urgently needed care both during and post incarceration.

During incarceration: States lose money when they fail to take advantage of a key exception to the Medicaid Inmate Exclusion. The exception allows federal funding to cover costs for incarcerated individuals who require over 24 hours of care outside of jails and prisons in hospitals, nursing homes, juvenile psychiatric centers and intermediate care facilities.³¹ The exact federal contribution varies by state. If

an individual is covered by traditional Medicaid, between 50 percent and 75 percent of the total health expense is reimbursed; but if the incarcerated individual is covered under the Medicaid expansion, the more likely scenario, the federal contribution is 90 percent.³² Reimbursement for lengthy hospital stays for very ill individuals can be substantial, as can reimbursement for community-based nursing care for elderly incarcerated individuals, a growing percentage of the population in New York and many other states. (Even in states that have not expanded Medicaid under the Affordable Care Act, most elderly or disabled incarcerated individuals qualify for coverage under existing Medicaid rules, though, again, care can only be paid for if it is received outside of jail or prison.) Enrollment of Medicaid-eligible incarcerated individuals can potentially save states and localities many millions of dollars in health care costs that they currently bear entirely.³³

Post incarceration: Medicaid enrollment before release from incarceration can also save money, in addition to lives. When they are released from state prisons and local jails without active coverage, Medicaid-eligible individuals lose a crucial link to care and services. Most must either be recertified for Medicaid or re-apply at a time when they are at inordinately high risk of relapse, overdose and exacerbation of mental health and other chronic illnesses.³⁴ Many newly released individuals obtain neither coverage nor essential health care services,³⁵ making them more likely to recidivate, use expensive hospital and emergency room care and even die in the first weeks post-release.

MEDICAID ELIGIBILITY FOR PEOPLE LEAVING INCARCERATION IS SMART POLICY

Although the Clinton, George W. Bush and Obama administrations all urged states to employ Medicaid suspension, rather than termination policies, a number of states still terminate Medicaid as soon as an individual is incarcerated, including Colorado, Kansas, Oklahoma, Georgia and Virginia. Termination policies often result in a significant delay, sometimes for a period of months, in an individual being reenrolled in Medicaid.

However, since passage of the Affordable Care Act in 2010, and subsequent guidance from the federal Centers for Medicare and Medicaid Services (CMS), a number of states (including **Hawaii, Connecticut, and New Hampshire**) have worked to reform their policies so that Medicaid coverage is more seamless for justice-involved people.

- **INDEFINITE SUSPENSION**—States such as **Washington, New Mexico, Montana, Nebraska, Illinois, Michigan, Maine, Tennessee, Oregon** and **Rhode Island** indefinitely suspend Medicaid during the entire time an individual is incarcerated. This allows for individuals' Medicaid to be active upon their release from incarceration.
- **TIME-LIMITED SUSPENSION**—States such as **Pennsylvania, California, Arkansas, Iowa, Minnesota, Indiana** and **New Jersey** employ a time-limited suspension. For example, with a 30-day suspension, if an individual is released within that time frame, their Medicaid remains active and there is no need for reenrollment. Time-limited suspensions benefit individuals who are incarcerated for short periods, which includes much of the jail population. States that utilize time-limited suspension policies, however, still terminate Medicaid for individuals incarcerated longer than the suspension period. This is particularly harmful for people serving longer sentences, including those incarcerated in prison.
- **MIXED SUSPENSION AND TERMINATION**—Some states employ different policies for their jail and prison populations, utilizing Medicaid suspension for people in jail and termination for people in prison and vice versa.

States use different mechanisms to implement these varied policies including statutes, regulations and policy guidance from state Medicaid and correctional agencies. It can often be very difficult to access information about these policies.

Indefinite suspension of incarcerated individuals' Medicaid promotes better health care access and outcomes and also helps people successfully reenter the community. States should continue working toward indefinite Medicaid suspension for their incarcerated populations. States should also ensure that their policies on Medicaid and health care access for the justice population are clear, transparent and publicly available.

Medicaid termination is wholly unnecessary.

Since the early 1990s, and as recently as 2016, federal Health and Human Services officials have issued clarifying guidance to State Medicaid directors that:

1. Incarcerated people can be screened for Medicaid eligibility and enrolled in coverage.
2. States can suspend, instead of terminate, an incarcerated person's Medicaid eligibility.
3. Medicaid suspensions should be promptly lifted when the suspension status no longer applies.
4. State Medicaid agencies and correctional departments and institutions should work together to ensure that Medicaid-eligible people reentering the community from incarceration have timely access to health coverage.

States, however, have yet to uniformly heed those guidelines or take advantage of all these options. At present:

16 states plus DC suspend Medicaid for the duration of incarceration.

15 states suspend Medicaid for a specific period of time.

19 states terminate Medicaid coverage.³⁶

According to a 2016 survey by the Marshall Project and Kaiser Health News (KHN), about 375,000 people leave state prison each year in states that have minimal or

nonexistent Medicaid signup programs. Moreover, most of the state prison systems in the 31 states that expanded Medicaid either have not yet created large-scale enrollment programs or have uncoordinated programs that leave large numbers of individuals exiting incarceration — many of whom are chronically ill — without insurance.

Local jails, which process millions of individuals a year, many if not most of whom have substance use disorders and/or are severely mentally ill, often face even greater obstacles to helping people obtain health coverage.³⁷ Enrolling people in Medicaid while they are in jail is especially challenging because the average jail stay is less than a month, and it often is difficult to know in advance when those who are incarcerated will be released.³⁸

As discussed throughout this report, Medicaid termination should be replaced by the use of “suspension,” which can benefit jurisdictions during incarceration and the community upon release. This is a fundamental step to improving health outcomes while people are incarcerated as well as when they return to the community.



SILOED AND DISJOINTED SYSTEMS

Partly as a result of the Medicaid Inmate Exclusion provision, the nation's health and criminal justice systems have been historically siloed. Throughout our history, we have stigmatized, ignored and undertreated mental health and substance use conditions. In communities of color, we went a step further and criminalized people for these illnesses. The criminal justice system has therefore become the de facto health, mental health and substance use care provider for low-income black and brown communities.

Siloed systems present obstacles not only to Medicaid enrollment but also to the ultimate goal of such coverage: access to and retention in health care. Myriad systems are responsible for aspects of an individual's health while they are in the criminal justice system—law enforcement, courts, community supervision, prison and jail medical systems, etc. Each is a complex system in its own right. Few have modern electronic health records and data tracking capacity. Few coordinate with each other, and even fewer coordinate with community-based health care providers, leading to a system that is wholly lacking in continuity of care.

To successfully collaborate, these siloed systems must mitigate technological challenges involved in sharing health information. At the same time, they must also navigate confidentiality and privacy concerns related to an individual's health and to how health issues might affect a person's status within the criminal justice system. This is particularly true for individuals with substance use disorders whose underlying health issues have so often been criminalized.³⁹

Cross-sector coordination is possible, however, as proven by several states that have established care coordination during and post-incarceration for people with specific chronic conditions, including tuberculosis, HIV, and substance use disorder. The most effective linkage to care models have been a result of two circumstances that have forced coordination between correctional and community health systems and provided significant funding to achieve it:

1. Perceived public health emergencies
2. Legislation or litigation

As described in the next section, New York provides a model for how these linkages have come about. The early era of HIV/AIDS illustrates, for example, how marshaling resources and creating connections across sectors reached people at risk for contracting HIV, or those who were HIV positive. New York State and City also provide examples of forced cross-sector coordination through litigation or legislation.

Over time, New York has become enlightened. It has made much progress, with much more still to be done.

PART II.

**NEW YORK
STATE'S
INITIATIVE TO
IMPROVE
HEALTH CARE FOR
THE CRIMINAL
JUSTICE-
INVOLVED
POPULATION**

*OPPORTUNITIES
CHALLENGES
LESSONS LEARNED*





INTRODUCTION

Despite significant reductions in New York State and City's incarcerated populations over the past decade, New York State prisons and local jails still incarcerate over 77,000 individuals on any given day. Each year, over 22,000 people leave state prisons⁴⁰ and approximately 80,000 leave New York City's jail system. Another 36,000 are on parole.

Since 2007, New York State, New York City and other local jurisdictions have worked to simultaneously enroll incarcerated individuals in Medicaid and link them to coordinated community health care upon reentry from prisons and jails. The state established mechanisms—working groups, oversight agencies, etc.—that attempt to tackle both tasks at once, allowing each initiative to inform the other.

New York benefitted from a supportive Executive and growing buy-in from criminal justice and health care stakeholders and agencies, particularly once they grasped the potential cost-savings of Medicaid enrollment and linkage to care. The state also benefitted from several long-standing and prescient policies, including its choice to cover childless adults through Medicaid with state and local funds since 1966⁴¹ and its previous experience linking specific, though much smaller, portions of the justice-involved population to coordinated community care upon reentry—particularly incarcerated individuals with mental illness and HIV/AIDS.

New York, however, also has had to overcome significant challenges throughout its effort to link reentering individuals to care. One of the most consequential has been the fact that, unlike a handful of smaller states, New York does not have a unified correctional system, making it necessary to institute reforms at the state prison level as well as in independent city and county jails. Additionally, until recently, the state did not have a unified Medicaid enrollment system, although New York's new health care exchange ameliorated that obstacle.

This section will describe New York's successful efforts to enroll in coverage and link to care tens of thousands of justice-involved individuals since 2007, with an emphasis on how New York developed the necessary policies and protocols. We will describe New York's progress to date, challenges faced, lessons learned and tasks remaining in order to fully insure and link justice-involved individuals to the health care they need and promote successful reentry and safer communities, reduce recidivism and incarceration, and save money in both the health and criminal justice systems.

BUILDING ON EXISTING SYSTEMS

New York has been able to build its Medicaid coverage and care linkage efforts on successful policies and practices created over decades. These include the following:

Coverage of Single Childless Adults: Unlike the vast majority of states, New York has covered childless adults in its Medicaid program since 1966.⁴² As a result, the majority of individuals involved in the state's criminal justice system were Medicaid-eligible even before the Affordable Care Act was enacted, but the State had to pay the full cost of their coverage. The 90 percent match offered by the ACA created an enormous incentive for New York to maximize enrollment.

Initiatives for Incarcerated Individuals with Mental Illness or HIV: New York has had several programs that since the late 1980s have successfully addressed the health care needs of incarcerated individuals with certain chronic illnesses, namely mental health problems and/or HIV.

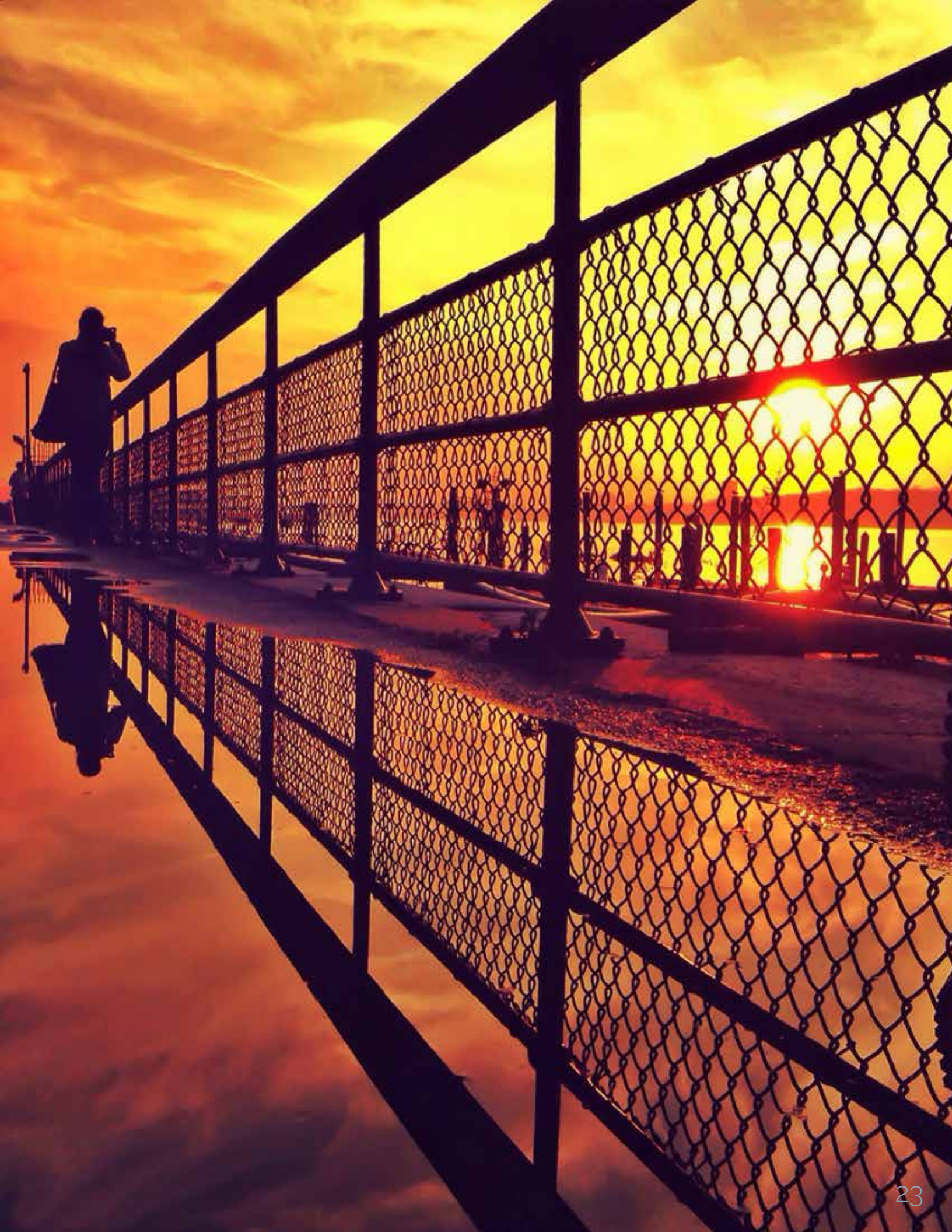
These programs provide a model and lessons for how to deliver evidence-based care during incarceration and maintain continuity upon release.

Mental Health: In New York State, Correction Law Section 401 ([Kendra's Law](#)) mandates health care for all people in state prisons and jails with serious mental illness. The State Office of Mental Health oversees screening, treatment and discharge planning for incarcerated individuals with serious mental illness. A state grant program also covers the cost of medications and medication-related services to ensure that individuals with serious mental illness who leave local jails, state prisons or hospitals do not run out of the medications while waiting for their Medicaid application to be approved. In New York City, meanwhile, services are provided as a result of a legal settlement reached in 2003 that has become known as [Brad H](#). These services include discharge

planning, medication, Medicaid and public assistance benefits, continuing mental health treatment and housing for approximately 13,000 individuals each year who received treatment for mental illness while incarcerated for at least 24 hours.⁴³

HIV: In New York State, the Department of Health AIDS Institute has been involved in the care of all HIV-infected or at-risk incarcerated and formerly incarcerated individuals since the 1980s. Its Criminal Justice Initiative includes transitional planning and support prior to community reentry.⁴⁴ The AIDS Institute also provides access to medications and free health care for uninsured and underinsured New Yorkers, including individuals who are newly released.^{45, 46} The federal Centers for Disease Control (CDC) provides funding to 16 correctional facilities across New York State to identify new and existing HIV-positive individuals and link them to treatment both during and post-incarceration. In New York City, H+H (Health and Hospitals) Correctional Health Services has a program called [Warm Transitions](#) that provides jail-based services at Rikers Island for approximately 2,500 people a year with HIV and AIDS and then links individuals leaving the jail to community-based services.

In 2009 New York State passed a Correctional Health Oversight Law, [the first of its kind in the nation](#), requiring the AIDS Institute to monitor the provision of HIV/AIDS, and hepatitis C (HCV) treatment in New York State jails and prisons to ensure quality treatment according to generally accepted medical standards. In 2011, the state received federal funding for the NYLinks program to improve linkage to care, retention in care, and viral load suppression for people living with HIV/AIDS (PLWHA).⁴⁷ The combined outcomes of these targeted programs and policies have been remarkable; 90 percent of people leaving NYS prisons who are virally suppressed and in care immediately post-release remain so six months later. In contrast, only 21 percent of individuals who left prison virally suppressed and fell out of care remained virally suppressed 6 months later.⁴⁸



LAC highlighted evidence indicating that New York State could potentially save \$89 million per year on certain inpatient service costs by enrolling incarcerated individuals in Medicaid.

RETURN ON INVESTMENT—LEGAL ACTION CENTER (LAC) HELPED MAKE THE CASE

New York's willingness to innovate was buttressed by a growing awareness of the potential return on investment for Medicaid enrollment and linkage to care.

In 2007, Legal Action Center (LAC) met with the state Division of Budget (DOB) to highlight how keeping individuals' Medicaid active during incarceration would make it easier for them to obtain needed medical care when they are released, and also save New York money by collecting the federal government's share of the cost. For decades, officials had terminated the Medicaid enrollment of people entering state prisons instead of leaving it in place so that it could be used immediately upon release. That year, New York became one of the first states to suspend rather than terminate Medicaid enrollment for incarcerated individuals and the only state to suspend Medicaid indefinitely.

In 2010, LAC recommended that the state take the next step and screen and enroll into Medicaid all eligible incarcerated people who were not enrolled when they entered prison. LAC pointed out that New York State could save a great deal of money by doing so, since the State could recoup the federal share for every incarcerated person enrolled in Medicaid who received inpatient care lasting over 24 hours outside of prison or jail in hospitals, nursing homes, intermediate care facilities and juvenile residential psychiatric facilities. New York had been doing so for those who came into prison with Medicaid, but had not focused on the great financial benefit that could come from enrolling everyone else who was eligible.

The State Division of the Budget (DOB) immediately ran a study of prison expenditures on health care services in New York, and found that in just under two years (between April, 2008 and March, 2010) the New York Department of Corrections and Community Supervision paid a total of \$230 million to community-based health care providers. Approximately \$89 million of this money, or 38 percent of the total cost, was for inpatient

services provided to incarcerated individuals that were potentially reimbursable by Medicaid. Separately, in a report⁴⁹ released in December 2012, the Office of the State Comptroller projected that New York State could save \$20 million annually if it used Medicaid to finance allowable inpatient services for incarcerated individuals.

LAC also discussed with DOB additional cost savings that could be reaped by creating systems to effectively link justice-involved individuals, including those leaving prisons and jails, to community-based health care, particularly substance use disorder (SUD) care. By pointing state officials to the impact of New York's 2009 Rockefeller Drug Law reforms, which gave judges the authority to divert individuals to SUD treatment in lieu of incarceration, LAC highlighted evidence for these savings. Diversion to treatment through drug law reform produced an 18 percent drop in recidivism within two years of treatment and a 50 percent drop in re-arrests for violent crime.⁵⁰ Based on this and other examples, in 2011 the Pew Center on the States estimated New York could save over \$42 million if it reduced recidivism by just 10 percent.⁵¹

Finally, New York's health and criminal justice systems also saw potential savings based on lower utilization of emergency and uncompensated care. Since 2014, there have been several studies on cost savings in states that expanded Medicaid enrollment for low-income adults, who have health profiles similar to that of individuals leaving prisons and jails. The Kaiser Foundation issued a brief that summarized findings from 153 studies on the impact of state Medicaid expansions under the ACA. The Foundation concluded that the Medicaid expansion was not only associated with increases in the number of people insured but also lower costs in health care.⁵²

Additionally, several studies have found associations between Medicaid expansion and lower levels of reported crime, and therefore savings in the criminal justice system. A University of Illinois [study](#) comparing counties in states that expanded and did not expand Medicaid found a 5 percent drop in reports of violent crime and a 3 percent drop in property crime in expansion states. A 1 percent gain in coverage correlated to a .7 percent drop in violent crime.⁵³



HEALTH CARE REFORM CREATED NEW OPPORTUNITIES IN NEW YORK STATE—MEDICAID REDESIGN AND HEALTH HOMES

In early 2011, New York State began a trailblazing and complex initiative to bring the country's biggest Medicaid program into "manageability," mostly through care coordination and pay-for-results reforms.

"It is of compelling public importance that the State conduct a fundamental restructuring of its Medicaid program to achieve measurable improvement in health outcomes, sustainable cost control and a more efficient administrative structure."

-Governor Andrew M. Cuomo, January 5, 2011

The Centers for Medicare and Medicaid Services (CMS) allowed states to apply for waivers if they could predict savings in their overall Medicaid budgets. New York State successfully requested an \$8 billion dollar waiver from CMS to implement its redesign. New York also capitalized on Section 2703 of the Affordable Care Act (ACA), which authorized the establishment of Health Homes to coordinate care for people with Medicaid who have chronic conditions. Health Homes create linkages to community and social supports and help physical health, mental health and substance use care providers communicate better in order to improve health outcomes for high-cost patients. Enhanced federal funding is available to finance eligible Health Home services. The Health Home initiative is not dependent on whether a state has expanded its Medicaid population under the ACA.

Because so much of the justice-involved population is low-income and has multiple chronic health conditions, both New York's [Medicaid Redesign](#) and [Health Home](#) initiatives had great promise for improving access to, and provision of, care to that population.

In 2010, Legal Action Center met with the New York State Deputy Secretaries of Public Safety and Health to discuss the opportunities created by Medicaid redesign and ACA implementation to improve health and criminal justice outcomes. The Deputy Secretaries established a workgroup, staffed and co-chaired by the Department of Health (DOH) and the Legal Action Center, to explore the best ways to coordinate health and criminal justice system policies and practices. DOH determined that the best place to start was with Health Homes.

Data soon confirmed that Medicaid costs for individuals with a criminal justice background who fit the Health Home eligibility profile are substantially higher than those for Medicaid-eligible individuals in the general population.

Data is based on research in 2011 that examined 2,055 unique Medicaid IDs belonging to individuals incarcerated on Rikers Island and the Medicaid costs associated with them in the previous year. 1,121 (55 percent) met criteria that would make them eligible for Health Homes (when those came into existence).⁵⁴

New York State Criminal Justice and Health Home Workgroup

The New York State Criminal Justice and Health Home Workgroup included Stakeholders from All Relevant Sectors

State Government officials:

Governor's Office, Commission of Corrections, Office of Mental Health, Department of Corrections and Community Supervision, Department of Health – Office of Health Insurance Programs, Office of Probation and Correctional Alternatives, Department of Criminal Justice Services

City and County Government officials:

NYC Mayor's Office of Criminal Justice, NYC Department of Health and Mental Hygiene

Health Homes:

HHUNY Western BestSelf Behavioral Health Inc., HHUNY Finger Lakes Huther-Doyle, Bronx Accountable Healthcare Network(BAHN), Brooklyn Health Home (BHH), Community Healthcare Network (CHN), Coordinated Behavioral Care

Counties and Community-Based Advocacy, Health and Human Service Organizations:

Correctional Association, John Jay College, CASES, Corporation for Supportive Housing, Legal Action Center

In 2011, the first meeting of the New York State Criminal Justice and Health Home Workgroup took place.

The workgroup eventually grew into a roster of more than 115 officials from New York State, city and county agencies, advocates and health and human service providers interested in addressing the health-related needs of the criminal justice population.

This statewide workgroup became an important vehicle to foster communication between agencies and stakeholders who had not until then often interacted. It was one of the few, if not only, opportunities for state, county and New York City governmental and nongovernmental health and criminal justice stakeholders to meet in the

same room, identify cross-system issues and try to address them. Together, this broad range of stakeholders began to understand current relationships, or the lack thereof, between correctional authorities and community-based health providers. With pivotal decision-makers deeply involved in the planning and invested in project outcomes, the workgroup helped establish key institutional commitments for reform.

By now acutely aware of the problem of siloed health systems, the workgroup quickly turned its focus to equipping Health Homes to work more closely with corrections and the criminal justice population. It identified six Health Homes in New York State to participate in a pilot program to identify justice-involved individuals and provide them with intensive care coordination.

MOMENTUM TOWARDS CRIMINAL JUSTICE REFORM CREATED NEW OPPORTUNITIES FOR CROSS-SECTOR HEALTH AND JUSTICE ADVANCES

Over the past decade, policymakers in New York, as in many other states, began to focus on the inequities of mass incarceration and the perpetual punishment that accompanies a criminal record in the form of obstacles to employment, housing, voting, education and other life needs. In 2014, Governor Cuomo formed the [New York State Council on Community Reentry and Reintegration](#) in order to address obstacles that formerly incarcerated people

face upon re-entering society. One of the official goals of the Reentry Council are to promote collaboration among state, local, and private agencies as well as community groups in order to address a wide range of issues pertaining to successful reentry, including housing, employment, health care, education, behavior change, and veterans' services.

Among its first set of recommendations, the Council, of which Legal Action Center is a member, in 2015 reiterated the need to:

“Increase the number of individuals leaving prison who are enrolled in health care coverage.”

The establishment of the Reentry Council, just as major changes in New York's health care landscape were underway, was opportune. The environment became ripe for innovative approaches to address the needs of people who frequently utilized health care services and found themselves entangled in the criminal justice system.

AVERAGE YEARLY MEDICAID COSTS FOR HEALTH HOME ELIGIBLE INDIVIDUALS

Each shape represents \$2,000 in yearly Medicaid costs per person.



Data is based on research in 2011 that examined 2,055 unique Medicaid IDs belonging to individuals incarcerated on Rikers Island and the Medicaid costs associated with them in the previous year. 1,121 (55 percent) met criteria that would make them eligible for Health Homes (when those came into existence).

WHAT NEW YORK DID

PRIORITY 1:

Enroll Eligible Incarcerated Individuals in Medicaid Prior to Release

New York State adopted a series of important reforms over the course of the past decade. These changes built upon promised cost savings, the work of the Criminal Justice and Health Home Workgroup, and the New York State Council on Community Reentry and Reintegration.

Stopped Terminating Medicaid: As noted previously, in 2007, New York became one of the first states to suspend rather than terminate Medicaid enrollment for incarcerated individuals. This was a departure from the practice in most states of terminating an individual's Medicaid enrollment immediately upon incarceration.

Initiated Medicaid Enrollment: In 2012, the State Department of Corrections and Community Supervision began screening for Medicaid eligibility and enrolling all eligible people in prison into Medicaid. In order to achieve this objective, DOCCS had 17 staff members trained as certified enrollment specialists, enabling them to enroll individuals into Medicaid. From September 2013 to March 2014, Medicaid Enrollment Clerks enrolled 2,932 people incarcerated in DOCCS. As of mid-2017, DOCCS was enrolling approximately 500 individuals each month.⁵⁵

New York City, meanwhile, moved to expand Medicaid enrollment during incarceration in its jail system to all those receiving discharge planning, including programs focused on special populations with chronic illnesses, e.g. HIV-positive or at-risk, severe mental illness, substance use disorders. In 2017, the City submitted an average of 213 applications for Medicaid enrollment each month for individuals in City jails.⁵⁶

And New York State

Pioneered Early Reactivation of Medicaid: In 2017, New York became the first state to begin reactivating Medicaid 30 days prior to release and providing Medicaid cards at discharge in order to ensure individuals can receive services immediately after the prison or jail door closes behind them. An outgrowth of the State Reentry Council's recommendation in Medicaid enrollment, this was a critical policy change. Even though New York was suspending, not terminating, coverage, the time frame for reactivation still left gaps in care. Activating Medicaid a month before discharge ensured that the NYS health department had sufficient time to reinstate full Medicaid coverage prior to release. Establishing early activation processes also allowed for the possibility of Medicaid paying for care coordination and other services for soon-to-be-released individuals should a federal policy change occur. (See page 38 for discussion of New York's proposal for a waiver to the Medicaid Inmate Exclusion provision.)



WHAT NEW YORK DID

PRIORITY 2:

Assess and Link to Care: Pilot Health Homes

As recommended by the Criminal Justice and Health Home Workgroup, New York State created a demonstration project that uses Health Homes to provide pre-release health care planning and services to incarcerated people, as well as coordinated post-incarceration care. The goal of this demonstration is to connect people in the criminal justice system to the health care they need most efficiently and effectively by identifying barriers and devising solutions to overcome them.

Six of New York's thirty-seven Health Homes were selected by the Criminal Justice and Health Home Workgroup co-chairs, DOH and LAC, as "criminal justice Health Homes" for the pilot project and tasked with enrolling justice-involved individuals with one or more of the following conditions: serious mental illness, two or more chronic conditions (including substance use disorder), and/or HIV/AIDS.

The Health Homes selected for the demonstration project included:

- Bronx Accountable Healthcare Network Health Home (BAHN)
- Bronx Lebanon Hospital
- Brooklyn Health Home
- Community Healthcare Network
- Coordinated Behavioral Care (CBC)-Bronx Health Home
- Health Homes of Upstate New York (HHUNY) Finger Lakes, Huther Doyle
- Health Homes of Upstate New York (HHUNY), Lakeshore/Horizon

Each site began working with criminal justice partners to identify and engage formerly incarcerated patients, with the process depending on the locality. Strategies included

working with the Division of Parole, drug and mental health courts, community-based agencies, County Sheriff and District Attorney's offices. New York City Health Homes began to collaborate with Transitional Health Services, which provides transitional supports for people with HIV leaving Rikers Island Correctional Facility. Early on, one Health Home placed a care coordinator on site at the Transitional Services office on Rikers Island to ensure connectivity, but found the cost and logistical barriers too great to sustain the position.

The Health Home pilots have found the following prevalent and expected needs among this population:

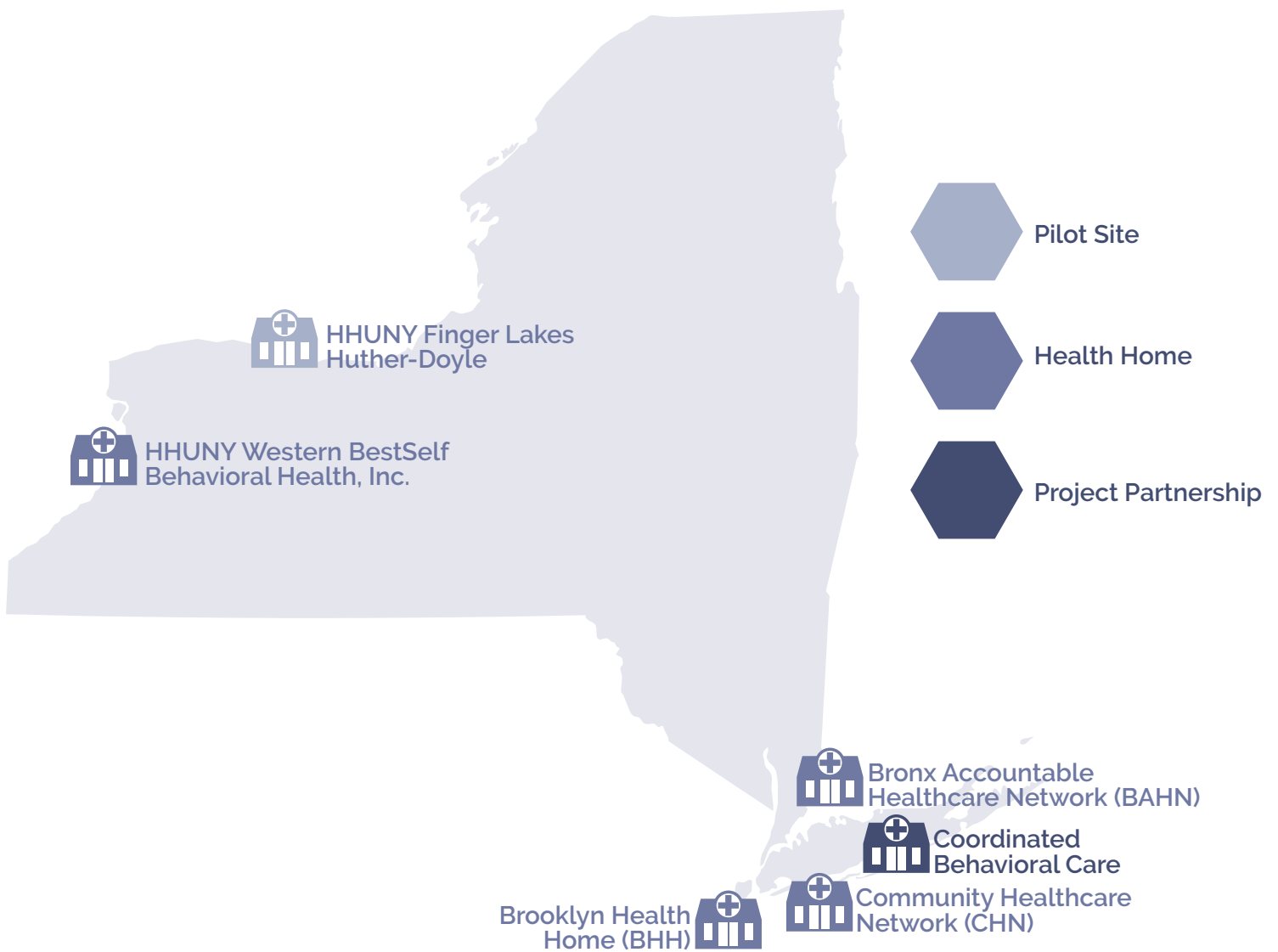
- Mental health/medical support, including medications
- Housing
- Family reunification
- Access to benefits/entitlements
- Vocational training

In response, the Health Homes have provided an array of services, although not every Health Home has been able to support the full complement of services, including:

- Enhanced care planning
- In-person support traveling to and from appointments
- Support completing housing applications
- Support filing for benefits/entitlements

Since their establishment in 2012, the pilot Health Homes have served hundreds of individuals returning to their communities from incarceration. Anecdotal information from a few of the Health Homes suggests a reduction in emergency room use. The Department of Health has developed a matrix of milestones and metrics to determine measurable impact. This data, including number of individuals served and whether interventions have affected health utilization, health outcomes and recidivism, is not yet available. (Please see challenges section immediately following.)

Health Homes and Criminal Justice Pilots



OVERCOMING CHALLENGES AND NEXT STEPS

As the State initiative to enroll eligible incarcerated individuals in Medicaid and link and retain them in coordinated care expanded, numerous implementation challenges emerged. A major problem from the outset has been an insufficient number of mental health and substance use disorder care providers to enable Health Homes to link many individuals to the most appropriate type and level of care. This problem pre-dates Health Homes and is not one that can be solved by this initiative.

The Health Home pilots also identified crucial challenges rooted at the heart of the criminal justice and health nexus, including:

A. Connecting Systems

B. Connecting Individuals

C. Finding Funding for Cross-Sector Efforts.

As discussed in this section, the Health Homes demonstration project has helped New York identify potential solutions to these problems and make significant progress in meeting and overcoming these challenges. Once the mechanisms have been perfected, the state will be able to scale its intervention statewide. The demonstration project's experiences and lessons learned should also prove invaluable to other states and localities eager to provide better care for millions of marginalized and chronically ill individuals throughout the country.

(A) Connecting Systems

Helping Health and Corrections Professionals Establish the Relationships Necessary to Work Together

Health Home pilot sites consistently identify building working relationships with local law enforcement, corrections departments, health care providers and other relevant institutions as key to the overall success of the initiative. In the absence of electronic modes of communication and restrictions on sharing data, having individual relationships with criminal justice system officials has proven invaluable. These connections are particularly important for ensuring that justice-involved individuals who need referrals and connections to care do not get lost navigating health and support systems immediately following release from incarceration. Health Homes also report that those whose staff have professional backgrounds in the criminal justice system are better able to establish relationships with current criminal justice system officials.

In addition, they indicate the need to educate all

stakeholders about the pilot program's existence, purpose, and potential benefits in order to establish buy-in from a large array of individuals and institutions that must work collaboratively to ensure better outcomes for reentering individuals.

As a result, all six Health Home pilots have established some form of memorandum of understanding with correctional facilities and other criminal justice, health and social service agencies in their service areas. [The Department of Health has developed and disseminated a variety of education materials](#) for Health Home-related audiences and holds regular webinars on specific topics. The Health Home pilots are also recruiting staff with criminal justice system backgrounds.

Next steps: The Health Homes are training staff to better understand criminal justice systems, including not just jail and prison systems but also courts, probation and parole. Health Homes are also striving to develop relationships with community-based organizations whose staff already work inside prisons and jails and alongside court, probation and parole systems.



Finding Medicaid Enrollment Solutions in Non-Unified Systems

Like the vast majority of states, New York has multiple corrections systems. It has also historically had multiple Medicaid enrollment systems. New York State correctional services are split between state prisons and county and city jails, the latter including Rikers Island Correctional Facility, New York City's largest jail and the second largest jail system in the country. Until recently, the state's Medicaid enrollment system was also split between multiple agencies, but is now moving toward a unified system through the state Health Exchange, New York State of Health (NYSoFH).

A major challenge to enrolling people in state prisons into Medicaid was that most Medicaid enrollment prior to the establishment of NYSoFH was done at the county level. Since many of the people incarcerated in any given prison were likely to return to a different county, prisons were unwilling to take on enrollment tasks.

As a result:

New York State: Initial enrollment efforts in the Department of Corrections and Community Supervision (DOCCS) were addressed by selecting and paying one county to enroll in Medicaid those incarcerated in all prisons throughout the state. The state issued a request for proposals and selected Clinton County to act as the "Corrections Department of Social Services" in order to process primarily paper Medicaid applications. Even this system was split, however. Clinton County only enrolled people who did not live in New York City prior to imprisonment.⁵⁷

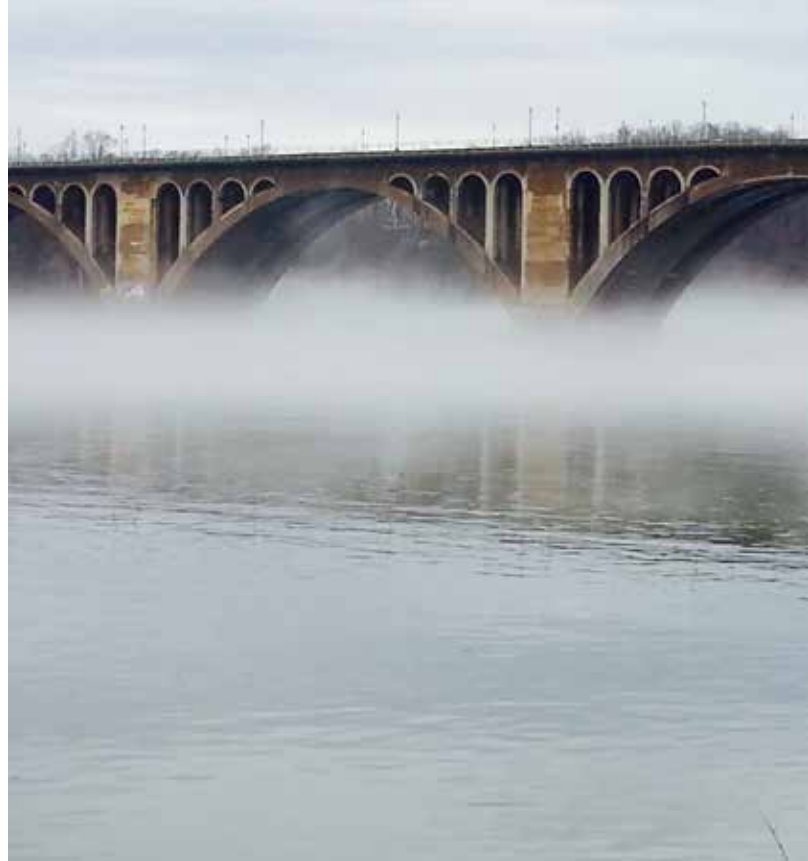
When NY created its ACA exchange, NYSoFH, it included criminal-justice-related capabilities, including the policies and procedures necessary to suspend Medicaid after 30 days of incarceration, reinstate individuals prior to release, and enroll those who were

eligible and had never had Medicaid coverage. Currently, however, only the state prison system is able to use NYSoFH to manage Medicaid coverage for incarcerated individuals. State prisons, unlike local jails, can share daily information about admissions and discharges with the Department of Health (DOH). Because DOH administers the Medicaid program, this agency is the critical link in any Medicaid enrollment and management system.

New York City: For decades, the City has determined eligibility for Medicaid through its Human Resources Administration and transferred this information to the state for coverage to begin. At approximately the same time the state stopped suspending Medicaid for people in state prisons, the City ceased suspending Medicaid for people in jails until a person had been incarcerated for 30 days.

New York Counties: At the county level, local departments of social services (DSS) are the point of entry for Medicaid enrollment. (They then feed this information to NYSoFH). However, most county jails do not inform their local social services department when a person is jailed. Many, but not all, county jails do submit release information to their local DSS.⁵⁸ Because each county follows its own, often confusing array of Medicaid enrollment steps, the system remains, as of this writing, disjointed.⁵⁹

Next Steps: Despite the fact that NYSoFH can now accommodate Medicaid enrollments, for the thousands of people NOT in state prisons, the enrollment process must still begin by identifying them while they are still in jail. City, County and State corrections staff are each developing their own protocols for identifying eligible individuals. One area for exploration is expanding software that currently allows county jails to communicate with each other statewide. Including access to the NYSoFH exchange in that software might facilitate enrollment for people in county-run systems.



Sharing Data: Sharing information among health and justice systems that have been historically siloed has proven extremely challenging but necessary in order to ensure continuity of care from incarceration into the community. It also is key to assessing the efficacy of New York’s efforts to improve public safety and health outcomes for reentering individuals. Among the most challenging and interrelated issues has been:

The inability to track individuals across systems.

New York’s extensive Medicaid coverage has meant that most people in jails and prisons have at some point been enrolled in Medicaid. The Medicaid system houses data about an individual’s health and health care while they are enrolled and living in the community. Jails and prisons house data about an individual’s health and health care while they are incarcerated; that information is almost exclusively kept in paper files. Among the state’s jails and prisons, only New York City’s Rikers Island has an electronic health record (EHR) system. That EHR system, however, is incompatible with EHRs used by medical providers in their home communities. In New York, there are therefore no established mechanisms to link Medicaid and correctional health data.

As a result, New York’s Departments of Health and Corrections and Community Supervision and the Division of Criminal Justice Services have discussed options for better tracking and sharing data for justice-involved individuals. The Governor’s 2018-2019 Executive budget funded for the first-time an electronic health record system for DOCCS.

In addition to pursuing compatible EHR systems, New York is implementing systems to facilitate cross-sector and wide-scale sharing of data about an individual’s health care and social service use. The justice-involved population, for example, frequently cycles in and out of the shelter system. The New York City Department of Homeless Services (DHS), which runs the shelter system, recently joined a RHIO (Regional Health Information Organization). The hope is to create the capacity to share Medicaid usage and public benefit information in addition to current addresses and facilitate connections to care. Implementation details are still in development, but the DHS-RHIO pairing is a promising model for sharing information across multiple systems, indicating the ability of jails and prisons to do the same.⁶⁰

Next Steps: To realize the promise of connecting people to care, New York must ensure that new EHR systems in jails and prisons are compatible with those used in the community.

Ensuring Confidentiality and Privacy of Both Health and Criminal Justice Records.

There are myriad state and federal laws governing how Medicaid data is handled and which entities are authorized to access it. Health care information is governed by HIPAA (Health Insurance Portability and Accountability Act) protections and regulations. Information about substance use disorder treatment is strictly protected by a federal law and its implementing regulations — 42 CFR Part 2. Correction and criminal justice entities are covered by the Part 2 requirements, although many of them may not be aware of it. [These privacy protections](#) are doubly important for the justice-involved population, which is at high-risk of re-arrest and criminalization for health issues, particularly SUD and mental illness.

As a result: Initiatives to facilitate communications between the health and criminal justice systems (including data sharing through electronic health records, regional and state health information systems), will have to ensure data sharing at the right time by the right people. Confidentiality requirements mandated by federal and state law play a role in protecting this population but can also mean vital information is difficult to share unless all the relevant parties understand the legal requirements. Systems must be developed that allow for data-sharing while complying with federal and state legal confidentiality requirements.

Next steps: New York must create policies compliant with state and federal law that allow for effective communication while still following confidentiality requirements.



*In New York,
there are **no
established
mechanisms** to
link Medicaid
and correctional
health data.*

(B) Connecting Individuals

Identifying incarcerated individuals with chronic health conditions is an essential first step to ensuring linkage and coordination between the criminal justice system and community-based health care providers. However, without linkage of Medicaid and criminal justice data and connectivity among different EHR systems, as referenced previously, identifying individuals leaving incarceration who could benefit from Health Home services has been a challenge.

As a result, each Health Home is currently only identifying potential enrollees in prisons and jails in its vicinity. Creative yet time-consuming solutions have sometimes depended on a Health Home having tracked an individual BEFORE incarceration. The Brooklyn Health Home, for example, sends copies of its patient roster to Rikers Island, where individuals manually look to see if any of the Health Home's patients have been sent to Rikers. While helpful, this system still does not identify incarcerated individuals who have never been Bronx Health Home patients.

Most Health Homes have therefore resorted to compiling (or asking corrections staff to compile) lists of individuals with chronic conditions in prisons and jails and their anticipated release dates.

Next steps: The combination of Medicaid enrollment 30 days prior to release and new EHR systems will vastly improve discharge planning for individuals leaving incarceration, particularly state prisons. When these systems are in place, next steps should include making recent incarceration an eligibility factor for Health Home services. At present, a person is required to have two or more chronic conditions from a selected list to be eligible for Health Home services. However, certain diagnoses such as HIV/AIDS and Serious Mental Illness, by themselves, are sufficient to make a Medicaid member eligible for Health Home services. Although health homes receive a higher reimbursement rate for people leaving incarceration, criminal justice involvement in and of itself is not an eligibility factor for health homes. Given the heavy disease burden affecting persons in the criminal justice system, it would be reasonable to make such involvement an eligibility factor. This would mean that a person with a single chronic condition such as substance use with a history of incarceration would then be eligible for Health Home services.⁶¹



Agreeing on Metrics: Historical siloes have conditioned the health and criminal justice systems to focus on different data points when searching for “proof of efficacy.” Correctional systems prioritize recidivism and re-incarceration data. Health care systems prioritize health care utilization and clinical markers.

As a result, the Criminal Justice and Health Home Workgroup devoted multiple sessions to creating a preliminary set of metrics for both health and criminal justice outcomes by which to judge project efficacy. The state recently developed a preliminary list of metrics for the criminal justice Health Home pilots. Individuals referred to Health Homes will be followed for 18 months. The state will begin collecting quarterly data in 2018, including:

- Number of days from release or referral to enrollment in the Health Home,
- Whether a participant returned to jail/prison,
- Whether the person is stably housed, and
- Whether the participant was actively engaged with an SUD, HIV or mental health provider.

Next steps: Collecting these data and evaluating them will be very valuable and a vast improvement over what is currently available. Further work will be needed to collect data on clinical markers and then evaluate whether individuals’ health outcomes actually improve and whether expensive health care utilization (i.e. emergency room use and hospitalizations) decreases when a person is linked to care through Health Homes post-incarceration. Evaluation of health outcomes will likely require private funding in the near term, either through grant-making foundations or managed care organizations interested in assessing the potential for overall health care cost reductions through investments in care coordination for this population.

Providing Timely Proof of Coverage: Health Homes find it challenging to book appointments and help people obtain necessary medications immediately upon release when individuals leave incarceration without active Medicaid enrollment. Even when people have been enrolled in Medicaid, if they do not have physical proof of coverage (a card), many health care providers are simply unwilling to treat them. Pharmacies are likewise averse to providing needed medications without physical proof of coverage. Lack of a Medicaid card or other physical proof of coverage has thus proven a major obstacle for individuals and for Health Homes trying to coordinate their care.

As a result, in 2014, the New York State Council on Community Reentry and Reintegration recommended that New York activate Medicaid (but not make it eligible for billing) 30 days prior to a person’s release to give the systems more time to ensure people leave incarceration with coverage.⁶² New York State has also decided to provide a physical card to every individual leaving incarceration with active Medicaid. Because of the often short turn-around time in jails, New York City’s Department of Health and Mental Hygiene is now providing individuals with a letter certifying either that: 1) their Medicaid application is in process or, 2) they have been enrolled and coverage will be activated within 2-4 business days after discharge. While the City has only recently begun handing out the letters, city officials have told Legal Action Center that the letters have helped individuals leaving jail secure appointments and medications. Together, the 30-day window and a physical card or letter have significantly diminished obstacles to health care for individuals exiting correctional systems.

Next Steps: Automatic Medicaid activation 30 days prior to release for individuals leaving state prison has been implemented statewide, reportedly with little to no difficulties and has become routine. Providing people with a Medicaid card or a letter saying coverage is in process must also become routine.

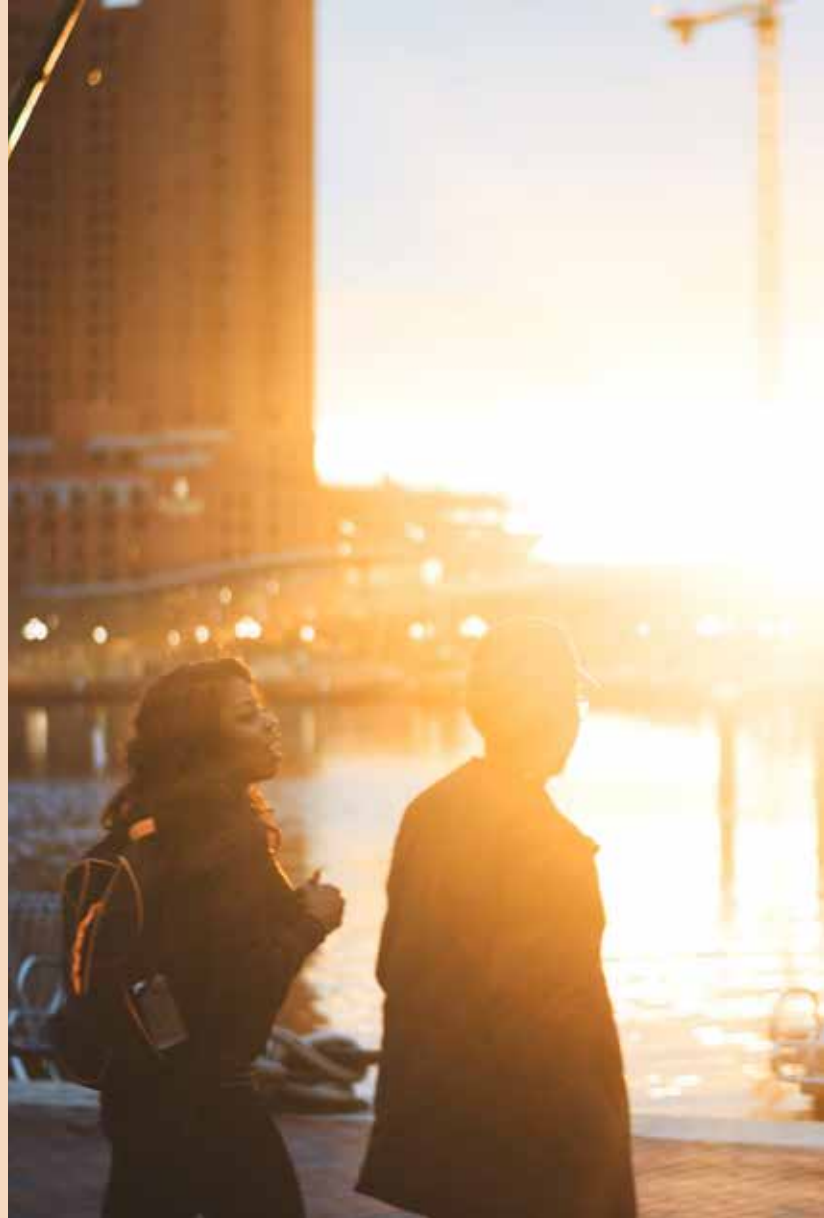
The Crucial Role of Formerly Incarcerated Peers:

Most reentry programs, including Health Homes, require an extensive consent process for participation and program data collection. Individuals in the criminal justice system are often distrustful of bureaucracies and wary of a public health system with a history of abuses toward people of color. Asking an individual for their consent while they are incarcerated is especially problematic. Additionally, justice-involved individuals often have little experience engaging in community health care. Many cycle through prisons and jails and receive a significant amount of their health care through the correctional system. Many have little experience successfully navigating our complex community health care and payment structures.

Moreover, when a person leaves prison or jail, they need to find housing and employment, reunite with family, apply for benefits, and navigate probation/parole systems. All these competing demands make keeping health care appointments less of a priority. Indeed, both individuals reentering the community and the providers who treat them are often unprepared to deal with how different health care in the community is from care delivery in the correctional setting.

Peers (individuals with their own criminal justice histories) can be invaluable in helping people understand and navigate community-based health care. Two of New York's criminal justice Health Home pilots are members of the [Transitions Clinic Network](#) (TCN), which employs peer navigators to help coordinate care for reentering individuals. Not only are peers often more successful in engaging reentering individuals in care, they possess the cultural competency needed to understand a reentering individual's many challenges, fears and hopes. Health Homes that make peers an integral part of their care management team appear to be the most successful.

As a result: More of the Health Home pilots are incorporating the TCN model by employing as case management assistants (CMAs) people with criminal justice histories who can build trust with people leaving incarceration. Others are working with New York State to build [cultural competency](#) among staff members through training and education. To better engage future patients, some CMAs communicate in writing or by phone with individuals during their last weeks of incarceration. Some actually meet people in person as they leave the jail or prison and take them to their first health care appointment or Health Home intake session, creating a "warm hand-off," which has been proven to better engage and retain individuals in [care](#).



On Rikers Island, Brooklyn Health Home CMAs are connected with discharge planners and engage in regular meetings with the Correctional Health Services Team, making the CMAs the critical link between institutions (the Health Home and the jail) and individuals reentering their communities. Health Homes are also helping individuals not just with health care but also with a wide array of their reentry needs. They have begun to collaborate with Alternatives to Incarceration and Reentry Providers with expertise in employment, benefits applications, and other essential services.

Next Steps: More Health Homes must fully integrate peers into their care management teams and equip them to communicate in real time with clients/patients and care providers. They must also develop policies, procedures, and tools to assist care managers in building and maintaining effective relationships with justice system staff and related stakeholders. Finally, Health Homes should facilitate peer participation in community health and social service network meetings so they can share information and stay abreast of changing best practices.

(C) Funding for Cross-Sector Efforts

Communities that are disproportionately targeted by the criminal justice system generally have poor health care infrastructure, as do jails and prisons. Underfunding these systems means that people with chronic and untreated illness cycle from communities with inadequate health care to prisons and jails and back to their underfunded community health systems. The ACA, with its Medicaid expansion, created a stream of funding that could strengthen community-based health care. It also incentivized community-based providers to focus on prevention and early intervention. Federal health reform did not however make any changes to financing health care during incarceration.

In the past, when chronic or communicable diseases like HIV and mental illness reached a crisis level, state policymakers created unique new funding streams to improve both care during incarceration and the transition to community-based care upon release. The systems they created led to better outcomes in both corrections and the community. As New York has looked to decrease incarceration and recidivism, improve health and save money in the last decade, it has tried to replicate these successes.

As a result, New York State and other stakeholders have pursued several strategies to pay for transitional expenses.

- **HEALTH HOME SELF-INVESTMENT AND FUNDRAISING**— Two criminal justice Health Home pilots invested their own funds and/or secured private grants to cover “in-reach,” sending staff into prisons and jails to meet people soon-to-be released in order to establish better connections with their clients.
- **\$5 MILLION FROM NEW YORK STATE FOR TRANSITIONAL SERVICES**—In 2017, following years of advocacy led by LAC, New York State distributed \$2.5 million to the six criminal justice Health Home pilots to help support transitional services. The State’s FY 2019 budget, despite the need to close a \$4.4 billion deficit, appropriated another \$2.5 million for this purpose.
- **\$15 MILLION FROM NYS TO ENHANCE EHRs**—New York has provided grants to Health Homes to help upgrade their EHR systems. DOH utilized \$15 million that it received in federal grants to make EHR funding available for Health Homes that lacked access to other funding sources.

- **NYS WAIVER APPLICATION**— In September of 2016, New York became the first state to propose having Medicaid pay for specific and limited transitional care inside prisons and jails. The state requested from the federal Centers for Medicare and Medicaid Services a waiver of the Medicaid Inmate Exclusion provision during a person’s final 30 days of incarceration. With such a waiver, Medicaid could provide a sustainable long-term funding stream for crucial transitional services that one-time public and private grants cannot. New York’s waiver application sought authority to use federal Medicaid dollars for a narrow array of health assessments, medications and care linkages inside jails and prisons prior to release. When submitted, the waiver amendment application was subject to public review. The application received more than 200 supportive comments from around the country. In January of 2017, however, New York withdrew its waiver amendment application. Jason Helgeson, the state’s Medicaid director expressed concern that the request would provide the new Trump Administration “wide authority” to re-negotiate the state’s existing multi-billion-dollar waiver.⁶³

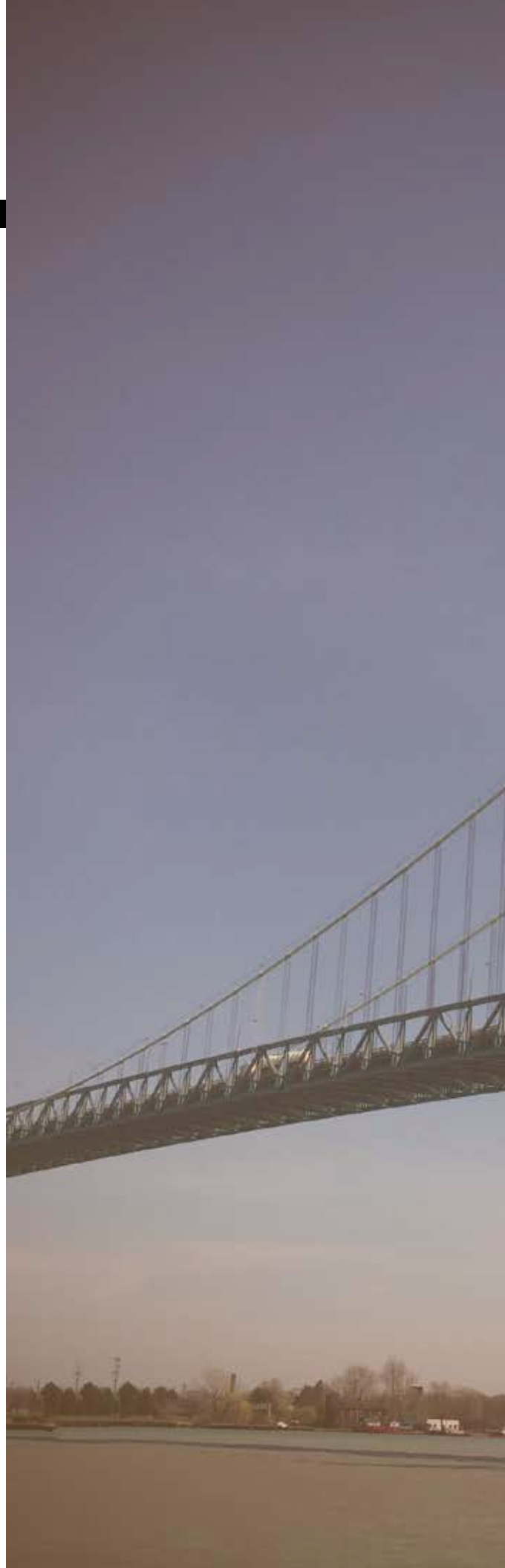
Next Steps: Obtaining [CMS waiver approval](#) to use federal Medicaid funds for pre-release services would provide ongoing funding at a level commensurate with the need for transitional care. An approved waiver would enable the State to fund care coordination services that are key to interrupting cycles of ill-health and incarceration, which perpetuate historical inequities that have long been ignored by public policy makers. Transitional care services for this population are also well-aligned with the goals of New York’s larger \$7.3 billion waiver to create a more efficient Medicaid system that produces better health outcomes. In the interim, individual Health Homes, New York State, the Legal Action Center and other stakeholders continue to pursue other government and private funding to help support in-reach services.



PART III.

KEY ELEMENTS FOR CONNECTING PEOPLE LEAVING INCARCERATION TO COMMUNITY HEALTH CARE

The following generalizable recommendations are based on the New York experience over the past decade as the state strives to improve health outcomes for individuals and communities with high criminal justice involvement while saving money and increasing public safety.





PRIORITIES & RECOMMENDATIONS

PRIORITY 1: **Enroll Eligible Incarcerated Individuals in Medicaid Prior to Release**

Many justice-involved individuals, and perhaps most who are incarcerated, are eligible for Medicaid under the Affordable Care Act's Medicaid expansion. All states should screen incarcerated individuals and enroll in Medicaid those who are eligible. In states that have adopted Medicaid expansion, the federal government covers 90 percent of costs for this population. States and localities that overcome the many complexities associated with Medicaid enrollment in prisons and jails can therefore generate significant cost savings. Ideally, individuals should have functioning Medicaid at least 30 days before release from incarceration and a Medicaid card in hand when the jail or prison doors close behind them. That way, they can be linked to and receive care immediately upon release.

PRIORITY 2: **Assess Justice-Involved Individuals and Link Them to Community-Based Care Prior to Release**

Before leaving incarceration, individuals should be assessed for chronic and acute conditions. Ideally, before release there will be: engagement with a community-based provider (warm handoff), development of a care plan, and the setting of an appointment to see that provider within days of release from incarceration. For individuals sent to jails, where stays are typically short, assessment can be done at arrest, arraignment or during pre-trial services.

PROCESS AND OPERATIONAL RECOMMENDATIONS

This section summarizes our recommendations for concrete steps to enroll individuals in Medicaid prior to release from incarceration, assess their health and link them to appropriate care.

ESTABLISH CLOSE WORKING RELATIONSHIPS BETWEEN THE HEALTH AND CRIMINAL JUSTICE SYSTEMS, BEGINNING AT THE HIGHEST LEVELS (GOVERNOR, MAYOR, ETC.), TO ENSURE MAXIMUM BUY-IN AND SUPPORT

Despite the fact that criminal justice and health systems have historically used different language and structured their work according to different priorities, these two systems must work together if we are to link community and correctional health care. Creating buy-in at the highest levels is essential; leadership from the top will make all the difference.

MAKE THE CROSS-SECTOR BENEFITS CLEAR FROM THE OUTSET

Health and criminal justice practitioners will be motivated to work together if they understand the likelihood of better outcomes, including: improved health and public safety associated with fewer health emergencies (and emergency room visits), as well as reduced crime and incarceration. Perhaps most importantly for many policymakers, connecting this population to health care will generate substantial cost savings in both systems.

LEVERAGE POLICY AND FUNDING OPPORTUNITIES

The federal Parity Act, the Affordable Care Act (with its Medicaid Expansion and care coordination emphasis), recent federal funds appropriated to address the opioid crisis, and criminal justice reform initiatives form the scaffolding upon which states and localities can build linkages between their health and criminal justice systems. Policymakers and advocates alike should learn about the opportunities these laws, new funding streams, and reforms create.

INVEST IN DATA SHARING AND INFRASTRUCTURE

The lack of a quality electronic health record (EHR) system inside many correctional systems presents numerous challenges to improving care quality and linkages, contributing to poor health care on the inside and difficulty linking individuals to health care on the outside upon release.

States that have not already done so should invest in EHR technology within their correctional facilities. EHRs on the inside will help ensure the continuity of care needed to 1) increase the likelihood of successful reentry, 2) allow better information sharing between correctional facilities and community health providers and 3) eliminate inefficiency in order to save money during care transitions by reducing staff time needed to learn critical information. EHR systems are also necessary to accurately evaluate outcomes of Medicaid enrollment and health care linkage programs for this population.

EVALUATE

To prove efficacy, jurisdictions must evaluate Medicaid enrollment and care linkage outcomes. Ideally, both health and criminal justice outcomes will be examined, including clinical markers and recidivism levels as well as cost savings. Although evaluation requires overcoming numerous barriers to sharing data between criminal justice and health systems, bringing needed reforms to scale is impossible without it.



POLICY RECOMMENDATIONS

✓ DEVELOP AND IMPLEMENT SYSTEMS TO SUSPEND, NOT TERMINATE MEDICAID ENROLLMENT DURING INCARCERATION

Medicaid can pay for inpatient stays of over 24 hours in certain community-based health care settings for incarcerated individuals, which can save states and localities millions of dollars each year. The time and effort it takes to reactivate Medicaid following incarceration is also a major obstacle to ensuring immediate access to needed services upon reentry. The federal government has repeatedly encouraged states to suspend Medicaid—they only restrict its use during incarceration.

States that insist on disabling Medicaid during incarceration as a precaution against fraud⁶⁴ should [suspend](#), rather than terminate, coverage. To facilitate reentry for individuals who are incarcerated for short periods, states should wait to suspend Medicaid until an individual has been incarcerated for 90 days or longer. **Lengthening the time until suspension or not suspending at all significantly minimizes disruptions in care for this population.**

✓ ENSURE ACTIVE MEDICAID AT LEAST 30 DAYS PRIOR TO RELEASE FROM INCARCERATION

Individuals are at greatest risk of SUD relapse and mental health crises in the first two weeks post-incarceration. Eliminate the gap in coverage that prevents immediate access to health care and vital medications, and confirm that people scheduled to leave jails and prisons have active Medicaid BEFORE they walk out the door. Leaving a 30-day window builds in the cushion often necessary to ensure success.

✓ USE AN INDIVIDUAL'S DOCUMENTED MEDICAL HISTORY TO DETERMINE CARE NEEDS DURING INCARCERATION AND UPON REENTRY

Because most Medicaid systems lack linkages to the health care systems that operate inside prisons and jails, Medicaid almost never takes into account an individual's medical history while incarcerated. Not knowing a person's most recent history makes it difficult to identify what their health needs will be once they return to the community, and community-based health care providers often underestimate a returning individual's true health care needs. Medicaid systems must work to access and evaluate individuals' medical histories during the time they were incarcerated.

✓ INCLUDE RECENT INCARCERATION AS AN ELIGIBILITY FACTOR FOR INTENSIVE CARE COORDINATION, HEALTH AND SUPPORT SERVICES

The experience of incarceration itself often results in negative health consequences, including psychological harm, such as PTSD, and physical damage, such as accelerated aging and early mortality. Medicaid does not currently recognize experience in the criminal justice system itself as a health factor—a social determinant of health⁶⁵—when evaluating health care needs. As a result, Medicaid does not deem many returning individuals as eligible for expanded or intensive services upon release, when they likely should be. Health systems, including Medicaid, should regard incarceration in and of itself as a significant risk factor that heightens the need for expanded and intensive services and enhanced reimbursement.

CONCLUSION

“Of all the forms of inequality, injustice in health is the most shocking and inhuman.”

- Dr. Martin Luther King, Jr.

Mass incarceration and a wholly inadequate health care system cannot be divorced from a society that has systematically discriminated against black and brown people and relegated those with addiction and mental illness to the ill-equipped criminal justice system rather than to the public health sphere. Societal failure to recognize substance use and mental disorders as the illnesses they are, and to view people with them as equally deserving of adequate health care, compounds these inequities.

As our nation begins to acknowledge the consequences of discrimination, we are seeing more discussion and fledgling reform efforts addressing the nexus of health and criminal justice. Passage of the Affordable Care Act, Medicaid expansion and new parity laws created the legal and policy framework necessary to begin to create long overdue change. Because these efforts remain in their infancy, there are few practical guides to help jurisdictions use these new laws as tools for building pathways out of the criminal justice system and into the public health realm. New York is one of the first states to do so. While the obstacles have been significant, the state has made real progress. Political will for reform and the willingness to back policy change with funding have been essential. The process described in this report has developed in real time and continues to unfold. Despite aspects of New York’s infrastructure that are unique to the state, the path it is pioneering can help guide other jurisdictions, as detailed in our recommendations. Following this road over the medium and long term will lead to a profound shift in both health and criminal justice policy that has the potential to make every community in the United States safer, healthier and more just.



POST SCRIPT

As this report is going to press, New York State's 2018-2019 enacted Budget included funding for a first-time electronic health record system for the state Department of Corrections and Community Supervision (DOCCS): \$3 million per year for the next three years, which the Department of Health has already collected through Medicaid reimbursements for this population.⁶⁶ The criminal justice and Health Home pilots were allocated \$2.5 million for another year. Also, the Criminal Justice and Health Home workgroup continues to hold regular meetings, co-chaired by the New York State Department of Health's Office of Health Insurance Plans (OHIP) and Legal Action Center. As New York State moves toward a Value Based Payment framework for health care, evidence that services for people transitioning out of incarceration are both medically and cost-effective should translate into more robust and secure funding for these services. New York State also remains interested in identifying solutions and securing funding to overcome the major barriers to criminal justice Health Home success and replication. Finally, the State has expressed interest in funding or partnering with a private funder to conduct a qualitative and quantitative evaluation of the Health Home pilots.

ENDNOTES

- 1 Chandler, Redonna K., Bennett W. Fletcher, and Nora D. Volkow. "Treating Drug Abuse and Addiction in the Criminal Justice System: Improving Public Health and Safety." *JAMA: The Journal of the American Medical Association* 301.2 (2009): 183–190. PMC. Web. 23 Apr. 2018. 2009 Jan 14; 301(2): 183–190. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2681083/>
- 2 Peters, Roger H., et al. "Co-Occurring Substance Use and Mental Disorders in the Criminal Justice System: A New Frontier of Clinical Practice and Research." *Psychiatric Rehabilitation Journal* vol. 38, no. 1, 2015, pp. 1–6.
- 3 Chandler, Redonna K., Bennett W. Fletcher, and Nora D. Volkow. "Treating Drug Abuse and Addiction in the Criminal Justice System: Improving Public Health and Safety." *JAMA: The Journal of the American Medical Association* 301.2 (2009): 183–190. PMC. Web. 23 Apr. 2018. 2009 Jan 14; 301(2): 183–190. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2681083/>
- 4 Fullilove, Robert E., Adaora Adimora and Peter Leone, An Epidemic No One Wants to Talk About, Washington Post. March 21, 2008, <http://www.washingtonpost.com/wp-dyn/content/article/2008/03/20/AR2008032003019.html>.
- 5 Brinkley-Rubenstein, Lauren. "Incarceration as a Catalyst for Worsening Health." *Health and Justice* 2013, 1:3 <https://healthandjusticejournal.springeropen.com/track/pdf/10.1186/2194-7899-1-3>
- 6 "Health and Incarceration: A Workshop Summary." Institute of Medicine and National Research Council, 2013 Washington, DC: The National Academies Press.
- 7 Cloud, David. "On Life Support: Public Health in the Age of Mass Incarceration." Rep. Vera Institute of Justice, Nov. 2014. Web. 25 Apr. 2018.
- 8 Bassett, Mary T. "#BlackLivesMatter — A Challenge to the Medical and Public Health Communities." *New England Journal of Medicine* vol. 372, no. 12, 2015, pp. 1085–1087.
- 9 Rich, Josiah D., Scott A. Allen, and Brie A. Williams. "The Need for Higher Standards in Correctional Healthcare to Improve Public Health." *Journal of General Internal Medicine* 30.4 (2015): 503–507. PMC. Web. 23 Apr. 2018.
- 10 Team Science Tackles Mass Incarceration. Columbia University Mailman School of Public Health 27 Sept. 2016. www.mailman.columbia.edu/public-health-now/news/team-science-tackles-mass-incarceration.
- 11 Macmadu, Alexandria, and Josiah D. Rich. "Correctional Health Is Community Health." *Issues in Science and Technology* 32, no. 1 (Fall 2015).
- 12 Jilani, Zaid. "Shame of America: Desperate Man Robs Store for One Dollar in Order to Go to Jail to Get Health Coverage." *ThinkProgress*, 20 June 2011, thinkprogress.org/shame-of-america-desperate-man-robs-store-for-one-dollar-in-order-to-go-to-jail-to-get-health-628d4d476e03.
- 13 Mezrich, Joshua. "On Purposely Getting Arrested, to Get Life-Saving Surgery." *The Atlantic*, 26 Feb. 2013. <https://www.theatlantic.com/health/archive/2013/02/on-purposely-getting-arrested-to-get-life-saving-surgery/273282/>.
- 14 Fox, Aaron D., et al. "Health Outcomes and Retention in Care Following Release from Prison for Patients of an Urban Post-Incarceration Transitions Clinic." *Journal of Health Care for the Poor and Underserved* vol. 25, no. 3, 2014, pp. 1139–1152.
- 15 Macmadu, Alexandria, and Josiah D. Rich. "Correctional Health Is Community Health." *Issues in Science and Technology* 32, no. 1 (Fall 2015), <http://issues.org/32-1/correctional-health-is-community-health/>.
- 16 "Hepatitis C and incarceration fact sheet." Atlanta, GA: Centers for Disease Control and Prevention; 2012, <https://www.cdc.gov/hepatitis/hcv/pdfs/hepcinccarcerationfactsheet.pdf>.
- 17 Binswanger IA, Krueger PM, Steiner JF. "Prevalence of chronic medical conditions among jail and prison inmates in the USA compared with the general population." *Journal of Epidemiology and Community Health*, 2009, 63(11):912–919.
- 18 Rich, Josiah D., and Sally Satel. "Access to Maintenance Medications for Opioid Addiction is Expanding. Prisons Need to Get on Board." *Slate*, 8 May 2018, <https://slate.com/technology/2018/05/opioid-crisis-prisons-need-to-expand-access-to-maintenance-medication.html>.
- 19 Freeman, Richard B. "Can We Close the Revolving Door?: Recidivism vs Employment of Ex-Offenders in the U.S." Rep. Urban Institute, 19 May 2003. Web. 25 Apr. 2018.
- 20 Mai, Chris, and Ram Subramanian. "The Price of Prisons: Examining State Spending Trends, 2010 - 2015." Rep. Vera Institute of Justice, May 2017. Web. 25 Apr. 2018.
- 21 Mai, Chris, and Ram Subramanian. "The Price of Prisons: Examining State Spending Trends, 2010 - 2015." Rep. Vera Institute of Justice, May 2017. Web. 25 Apr. 2018.
- 22 "Chronic Disease Prevention and Health Promotion." Centers for Disease Control and Prevention, 28 June 2017, <https://www.cdc.gov/chronicdisease/about/index.htm>.
- 23 "Coverage and Delivery of Adult Substance Abuse Services in Medicaid Managed Care." Medicaid Managed Care Information Resource Center, Centers for Medicare and Medicaid Services, May, 2014. <https://www.medicaid.gov/medicaid/benefits/downloads/cms-adult-substance-abuse-services-coverage.pdf>
- 24 Regenstein, M., and S. Rosenbaum. "What The Affordable Care Act Means For People With Jail Stays." *Health Affairs* vol. 33, no. 3, Jan. 2014, pp. 448–454.
- 25 Croze, Colette. "Healthcare Integration in the Era of the Affordable Care Act." Association for Behavioral Health and Wellness, July 2015, www.abhw.org/publications/pdf/IntegrationPaper.pdf.
- 26 Croze, Colette. "Healthcare Integration in the Era of the Affordable Care Act." Association for Behavioral Health and Wellness, July 2015, www.abhw.org/publications/pdf/IntegrationPaper.pdf.
- 27 Stauffer, Brian. "Every 25 Seconds: The Human Toll of Criminalizing Drug Use in the United States." *Human Rights Watch*, 12 Oct. 2016, www.hrw.org/report/2016/10/12/every-25-seconds/human-toll-criminalizing-drug-use-united-states.
- 28 Dumont, Dora M., et al. "Public Health and the Epidemic of Incarceration." *Annual Review of Public Health* vol. 33, no. 1, 2012, pp. 325–339.
- 29 "NIH Fact Sheets - Addiction and the Criminal Justice System." National Institutes of Health, U.S. Department of Health and Human Services, report.nih.gov/nihfactsheets/ViewFactSheet.aspx?csid=22.
- 30 "Medicaid and Financing Health Care for Individuals Involved with the Criminal Justice System." The Council of State Governments Justice Center. Dec. 2013. <https://csgjusticecenter.org/wp-content/uploads/2013/12/ACA-Medicaid-Expansion-Policy-Brief.pdf>.
- 31 "Medicaid and Financing Health Care for Individuals Involved with the Criminal Justice System." The Council of State Governments Justice Center. Dec. 2013. <https://csgjusticecenter.org/wp-content/uploads/2013/12/ACA-Medicaid-Expansion-Policy-Brief.pdf>.
- 32 "How and When Medicaid Covers People Under Correctional Supervision." The Pew Charitable Trusts, 2 Aug. 2016, <https://www.pewtrusts.org/en/research-and-analysis/issue-briefs/2016/08/how-and-when-medicoid-covers-people-under-correctional-supervision>.
- 33 Vestal, Christine. "For Aging Inmates, Care Outside Prison Walls." The Pew Charitable Trusts, 12 Aug. 2014, <https://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2014/08/12/for-aging-inmates-care-outside-prison-walls>.
- 34 Binswanger, Ingrid A., et al. "Release from Prison — A High Risk of Death for Former Inmates." *The New England Journal of Medicine* 356.2 (2007): 157–165. PMC. Web. 24 Apr. 2018.
- 35 Mallik-Kane, Kamala, and Christy A. Visher. "Health and Prisoner Reentry: How Physical, Mental, and Substance Abuse Conditions Shape the Process of Reintegration." *Urban Institute Justice Policy Center*, Feb. 2008, <http://www.urban.org/sites/default/files/publication/31491/411617-Health-and-Prisoner-Reentry.PDF>.
- 36 "Medicaid Suspension Policies for Incarcerated People: 50-State Map." *Families USA*, 21 July 2016, <https://familiesusa.org/product/medicaid-suspension-policies-incarcerated-people-50-state-map>.
- 37 Hancock, Jay, et al. "Signed Out Of Prison But Not Signed Up For Insurance, Inmates Fall Prey To Ills." *Kaiser Health News*, 6 Dec. 2016, <https://khn.org/news/signed-out-of-prison-but-not-signed-up-for-insurance-inmates-fall-prey-to-ills/>.
- 38 Hancock, Jay, et al. "Signed Out Of Prison But Not Signed Up For Insurance, Inmates Fall Prey To Ills." *Kaiser Health News*, 6 Dec. 2016, <https://khn.org/news/signed-out-of-prison-but-not-signed-up-for-insurance-inmates-fall-prey-to-ills/>.
- 39 "Defining and Implementing a Public Health Response to Drug Use and Misuse." *American Public Health Association*, 5 Nov. 2013, <https://www.apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2014/07/08/08/04/defining-and-implementing-a-public-health-response-to-drug-use-and-misuse>.
- 40 "About DOCCS." *NYS Department of Corrections and Community Supervision*, <http://www.doccs.ny.gov/doccs.html>

- 41 Holahan, Danielle. "Enrolling Childless Adults in Medicaid: Lessons from the New York Experience and Opportunities in Health Reform." Rep. Medicaid Institute at United Hospital Fund, Oct. 2010. Web. 24 Apr. 2018. <https://uhfnyc.org/assets/1369>.
- 42 Holahan, Danielle. "Enrolling Childless Adults in Medicaid: Lessons from the New York Experience and Opportunities in Health Reform." Rep. Medicaid Institute at United Hospital Fund, Oct. 2010. Web. 24 Apr. 2018.
- 43 New York City Law Department. Office of the Corporation Counsel. "New York City Law Department Announces Signing of Landmark Mental Health Agreement for Released Inmates." NYC.gov. N.p., 8 Jan. 2003. Web. 24 Apr. 2018.
- 44 "Services, Fees, Medicaid and Funding for ADAP." NYS Department of Health. <https://www.health.ny.gov/diseases/aids/general/resources/adap/services.htm>.
- 45 "HIV Uninsured Care Programs - Summary." NYS Department of Health. <https://www.health.ny.gov/diseases/aids/general/resources/adap/>.
- 46 "HIV Uninsured Care Programs - Summary." NYS Department of Health. <https://www.health.ny.gov/diseases/aids/general/resources/adap/>.
- 47 "Linkage, Retention and Adherence." NYS Department of Health. <https://health.ny.gov/diseases/aids/general/about/linkage.htm>.
- 48 Morne, Johanne E. et al., "Partner Services Data to Care Report, New York State (excluding New York City) 2015". Rep. New York State Department of Health AIDS Institute, 23 Jan. 2018. Web. 24 Apr. 2018.
- 49 The Citizen Staff. "Comptroller's Office: DOCCS Could save \$20 Million by Billing Medicaid." The Citizen. N.p., 5 Dec. 2012. Web. 24 Apr. 2018.
- 50 Parsons, Jim, Qing Wei, Christian Henrichson, and Ernest Drucker. "End of an Era?: The Impact of Drug Law Reform in New York City." Rep. Vera Institute of Justice, Jan. 2015. Web.
- 51 The Pew Center on the States. State of Recidivism: The Revolving Door of America's Prisons. Rep. N.p., Apr. 2011. Web. 24 Apr. 2018.
- 52 Antonisse, Larisa, Rachel Garfield, Robin Rudowitz, and Samantha Artiga. "The Effects of Medicaid Expansion under the ACA: Updated Findings from a Literature Review." Rep. Henry J Kaiser Family Foundation, 28 Mar. 2018. Web. 24 Apr. 2018.
- 53 Vogler, Jacob, "Access to Health Care and Criminal Behavior: Short-Run Evidence from the ACA Medicaid Expansions" Nov. 14, 2017. <https://ssrn.com/abstract=3042267>
- 54 Data source can be found at: https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/doc_by_cos_elig.pdf
- 55 Nelson, Marta (Executive Director of the New York State Council on Community Re-Entry and Reintegration). Email. 2017.
- 56 Martelle, Michelle (Senior Director of Health Information and Insurance, Correctional Health Services, NYC Department of Health and Mental Hygiene). Email. 2017.
- 57 New York State Department of Corrections and Community Supervision. "Medicaid Presentation" by Joanne Nigro, Director of Guidance and Counseling, 2014 PowerPoint presentation.
- 58 New York State Sheriffs' Association. "Notification to DSS of Inmate Admission Responses." 11 Sept. 2015.
- 59 Data source can be found at: https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/flowchart_for_county_jails.pdf
- 60 Email correspondence with Annette Holm, Chief Special Services Officer at NYC Human Resources Administration, July 2018
- 61 The Council was aware that this recommendation would require further adjustments to implement for local county jails.
- 62 Wisnieski, Adam. "Next 100 Days: State Drops Prisoner Medical Move Because of Trump Rhetoric." 01 May, 2017. <https://citylimits.org/2017/05/01/next-100-days-state-drops-prisoner-medical-move-because-of-trump-rhetoric/>
- 63 September 8, 2016 email from Marta Nelson, Executive Director of the New York State Council on Community Re-Entry and Reintegration. New York found this to be unfounded that instances of fraud were committed by incarcerated individuals or their families. Fraud was generally associated with providers.
- 64 Heiman, Harry J., and Samantha Artiga. *Beyond Health Care: The Role of Social Determinants in Promoting Health and Health Equity*. Issue brief. Henry J Kaiser Family Foundation, 4 Nov. 2015. Web. 25 Apr. 2018.
- 65 FY 2019 Enacted Budget, <https://www.budget.ny.gov/pubs/archive/fy19/enactfy19.html>



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