

State Strategies for Establishing Connections to Health Care for Justice-Involved Populations: The Central Role of Medicaid

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ABSTRACT

ISSUE: With many states expanding Medicaid eligibility, individuals leaving jail or prison are now often able to enroll in health coverage upon release. It is increasingly clear, however, that coverage alone is insufficient to address the often complex health and social needs of people who cycle between costly hospital and jail stays.

GOALS: To identify emerging trends in the care delivery models that state Medicaid programs use for former inmates.

METHODS: Literature review and interviews with state officials, plans, and providers.

KEY FINDINGS: The care delivery models for individuals leaving jail or prison provide comprehensive primary care, typically including: data exchange to ensure providers are notified when someone is leaving jail or prison; “in-reach” to help inmates establish a relationship with a primary care provider prior to release, identify health conditions, and set up community-based care; strategies for addressing housing issues and other social determinants of health; use of a peer-support specialist who has experienced incarceration; and specialized training for primary care providers and specialists who work with the formerly incarcerated.

CONCLUSION: With a foundation of insurance coverage, states have developed a range of promising, replicable approaches to providing care to people leaving jail or prison.

TOPLINES

- ▶ States that have expanded Medicaid are finding that most of their incarcerated populations are eligible for enrollment; they are using a range of tools to ensure that people have coverage immediately upon release.
- ▶ State primary care Medicaid models for people leaving incarceration feature data exchange with providers, “in-reach” to help inmates connect with providers before they leave jail or prison, and solutions for housing and other social issues.



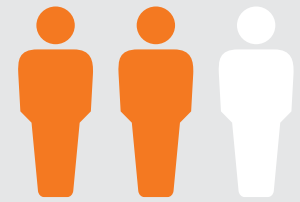
INTRODUCTION

Before the Affordable Care Act (ACA), most adults leaving prison or jail — despite their poverty and poor health — were not eligible for Medicaid because coverage generally was not available to most childless low-income adults. But as of June 2018, 33 states and the District of Columbia had expanded Medicaid to all adults with incomes below 138 percent of the federal poverty level (FPL), creating a significant opportunity to provide coverage to people after their release from jail or prison.¹ Many states have focused on enrolling eligible adults into Medicaid before they leave, ensuring that coverage begins immediately upon release.² As states gain more expertise enrolling these individuals into Medicaid, it is becoming clear that simply signing people up for coverage is not enough. To take full advantage of the opportunity created by Medicaid expansion, it is important to determine how to effectively deliver care to people leaving prison, especially given their high rates of mental illness, substance use disorders, and physical health problems, as well as the numerous barriers to securing housing, food, and other social supports that affect health outcomes (Exhibits 1 and 2). Such strategies can help to reduce recidivism and related costs — average annual cost per prison inmate was \$33,274 — and unnecessary emergency department visits and hospitalizations.³

Exhibit 1. Significant Medical and Behavioral Health Needs Among Individuals with a History of Incarceration

- An estimated 80 percent of individuals released from prison in the United States each year have a substance use disorder, or chronic medical or psychiatric condition.⁴
- Incarcerated individuals have four times the rate of active tuberculosis compared to the general population, nine to 10 times the rate of hepatitis C, and eight to nine times the rate of HIV infection.⁵
- Correctional facilities in Los Angeles County, New York City, and Cook County, Illinois, have become the three largest mental health care providers in the country.⁶

2 of 3
inmates have
a substance
use disorder

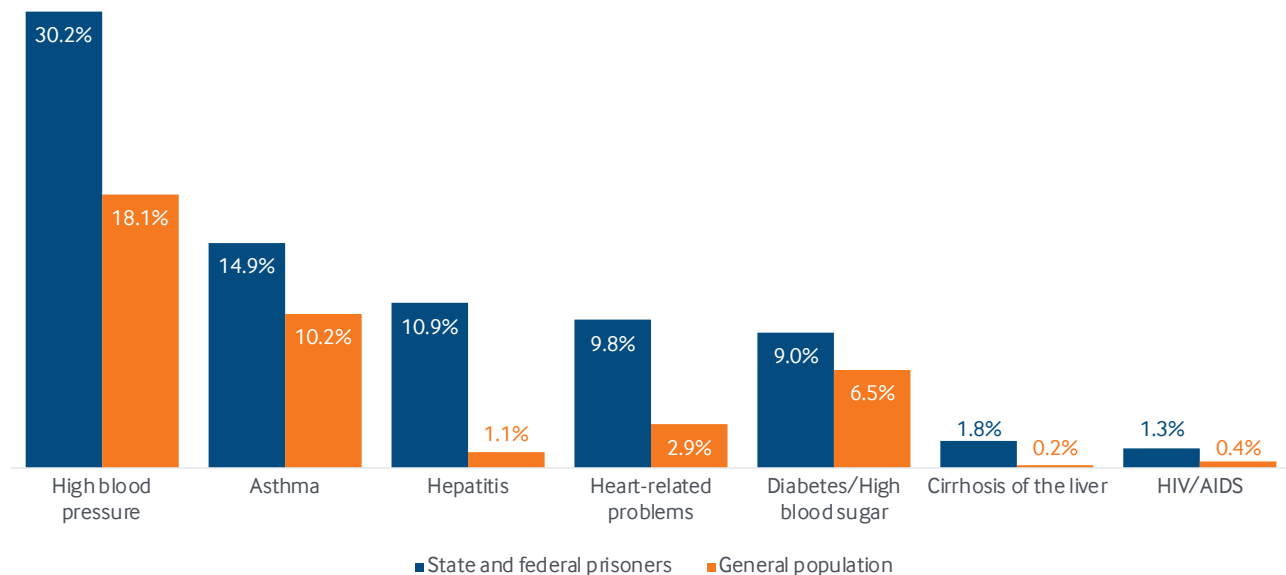


Source: National Center on Addiction and Substance Abuse, *Behind Bars II: Substance Abuse and America's Prison Population*, Feb. 2010.

This issue brief first discusses the impact of Medicaid expansion on coverage and then describes the latest developments in comprehensive primary care delivery models for people leaving jail or prison and the role that Medicaid can play in financing and supporting such models. The models are designed to improve health outcomes and reduce unnecessary costs associated with people cycling in and out of hospitals, homelessness, and jails. Often they are part of broader efforts in Medicaid to better manage the cost of high-cost, high-risk individuals. The opioid epidemic has added urgency to this work, spurring states to design better care delivery for people with substance use disorders. The work varies among states, but the comprehensive primary care models routinely include the following key elements:

- **Data exchange** to promptly identify when someone is leaving jail or prison so that a plan or provider is prepared for them when released to the community.
- **Jail or prison “in-reach”** to help inmates, even before release, establish a relationship with a primary care provider, identify health conditions, transition medical records, and set up community-based care.
- Strategies for addressing **housing issues and other social determinants of health** in the days and weeks after release; these are the major concern of many leaving jail or prison regardless of the severity of their health conditions.
- Use of a **peer support specialist** who has been incarcerated to help the beneficiary navigate health care and related social service resources.

Exhibit 2. Rates of Chronic Physical Health Conditions for State and Federal Prisoners as Compared to the General Population



Data: Laura M. Maruschak, Marcus Berzofsky, and Jennifer Unangst, *Medical Problems of State and Federal Prisoners and Jail Inmates, 2011–12* (U.S. Department of Justice, Bureau of Justice Statistics, Feb. 2015, revised Oct. 4, 2016).

- **Primary care providers and specialists with training and expertise** working with individuals who have been incarcerated, including behavioral health staff who can address mental health issues and substance use disorders.

MEDICAID COVERAGE FOR PEOPLE LEAVING JAIL OR PRISON

Under a provision of federal law known as the “inmate exclusion,” Medicaid is banned from financing the care of anyone committed to a jail, prison, detention center, or other penal facility unless an inmate is treated in a medical institution outside the prison or jail for 24 hours or more.⁷ Medicaid can finance the cost of services provided to eligible individuals after release. Expansion states are finding that the vast majority of those incarcerated are eligible for Medicaid. New York and Colorado, for example, estimate that 80 percent and 90 percent of their prison populations, respectively, are likely eligible for Medicaid upon release.⁸ States are deploying a range of tools to ensure that individuals have Medicaid coverage immediately upon release from jail or prison (Exhibit 3).

Exhibit 3. State Strategies for Initiating or Maintaining Medicaid Coverage for Incarcerated Individuals⁹

- Instead of terminating Medicaid coverage when individuals enter prison or jail, states are suspending or reclassifying coverage. Then, upon release and via data-sharing, the justice agency notifies the state Medicaid agency to unsuspend or reclassify coverage, enabling them to access health care services immediately upon release.
- If an individual is not enrolled in Medicaid when incarcerated, he or she can be enrolled at any time prior to release, including at initial intake into the jail or prison. State Medicaid and justice agencies then coordinate to suspend or reclassify coverage until release.
- Enrollment may be part of the release planning process. Many states begin enrolling individuals 30 to 45 days before their release date.
- States can use application assistors — including Medicaid or justice agency staff or community-based enrollers — to help uninsured individuals apply for and enroll in Medicaid prior to release.

KEY ELEMENTS OF COMPREHENSIVE PRIMARY CARE DELIVERY MODELS FOR JUSTICE-INVOLVED POPULATIONS

States are increasingly developing or expanding comprehensive primary care delivery models in Medicaid for people leaving jail or prison. Although details vary, the promising models typically include the common elements discussed in this section, which reflect the often complex health and social needs of beneficiaries and unique issues raised by incarceration.

Data Exchange to Identify When an Individual Is Released

As a key first step in connecting people to care, health care providers and plans need to know when someone is about to be released or has just been released from jail or prison. Advance notice allows a plan or provider to reach out to the beneficiary, provide them with medications, and establish community-based supports in the critical days and weeks after release. Indeed, in the two weeks after release from prison, individuals have 12.7 times the normal mortality rate, with overdoses driving much of the disparity.¹⁰

To support advance notice, some states are establishing data exchanges between prisons and jails and their Medicaid agencies. Originally designed to allow the state agencies to turn benefit coverage on and off as people go in and out of incarceration, these data exchanges increasingly are being used for purposes of care delivery. States are relying on the data to alert both managed care plans and health homes when a member or patient has been released (Exhibit 4).



64% of jail inmates, 56% of state prisoners, and 45% of federal prisoners were found to have a mental health problem.

Source: U.S. Department of Health and Human Services, *The Importance of Medicaid Coverage for Criminal Justice Involved Individuals Reentering Their Communities*, ASPE Issue Brief, Apr. 2016.

Exhibit 4. Using Data Exchange Systems to Alert Plans and Providers of Release from Jail

- Arizona's Data Exchange System.* The Arizona Medicaid agency, known as AHCCCS, uses an automated data exchange system to identify when a Medicaid beneficiary is released from jail. When it launched in a single county in 2004 (Pima County), the initiative relied on an Excel spreadsheet to exchange data. Now the initiative covers 95 percent¹¹ of the incarcerated population in the state and relies largely on daily or even more frequent electronic data transmissions. Notably, the data are not used simply to suspend and reinstate coverage, but also are shared daily with managed care plans to support better care delivery.¹²
- Data Exchange with Health Homes in New York City.* Health homes in New York City exchange enrollment data with Correctional Health Services — the New York City agency responsible for providing health services in the city jail — to identify any incarcerated members and their projected release dates. After learning of projected release dates, a health home can initiate outreach, including using staff members to visit individuals in their home after release to begin care planning.

In-Reach into Jails and Prisons

Some states, including Florida, New Mexico, and Ohio, use their Medicaid managed care contracts to require plans to conduct “in-reach” into jails or prisons to connect the people released with comprehensive primary care (Exhibit 5). A plan or provider will send a clinician, such as a social worker or nurse, into a jail or prison to meet with an inmate prior to his release. The meetings with the inmate can be held inside the institution or via a video conference, which can be more efficient for the clinician. During the meetings, the clinician typically assesses an inmate’s physical and behavioral health status, determines current medication usage, establishes where the inmate intends to live when released, and develops a postrelease care plan that identifies how the person will receive health care and related social services.

Exhibit 5. In-Reach Models in Ohio and New Mexico

- *In-Reach by Ohio's Medicaid Managed Care Plans.* Ohio enrolls eligible inmates into Medicaid approximately 90 days prior to their release and has them select a Medicaid managed care plan. As required in their contracts, each of Ohio's five plans then conducts in-reach with inmates to assess needs and identify a primary care provider.¹³ All inmates who are enrolled must receive some level of care coordination; for inmates with a serious illness, the plans conduct a prerelease assessment, establish a care plan, and set up provider appointments for after release.
- *Pilot In-Reach Project in New Mexico.* In its Medicaid managed care contract, New Mexico requires plans to participate in care coordination efforts for justice-involved individuals leaving prisons, jails, and other detention centers to support their reentry. This includes returns to tribal communities and reservations. Each plan also must designate a person to serve as the point of contact for communication with prisons, jails, and detention centers. Molina Healthcare, in New Mexico, established an in-reach pilot project with the Albuquerque jail. The plan's care coordinators are trained to work in the jail, provided with a security clearance, and meet with inmates twice a week. The initiative has contributed to reducing the recidivism rate from 57 percent to 16 percent since its 2015 launch, as well as with reducing emergency department use after release by 64 percent.

Addressing Social Determinants of Health

Despite the serious health conditions affecting many recently released individuals, they often are far more concerned with finding a home and food than securing medical treatment or filling prescriptions. As a result, Medicaid managed care plans and health homes emphasize linkages with social supports (Exhibit 6). They will conduct a comprehensive assessment that includes detailed questions on social and economic issues, provide linkages to social supports and case management, and,

in some instances, operate or participate in a network of community-based organizations that can directly provide services. Housing tends to be the most pressing issue confronting people leaving jail or prison because they often have little or no income, have lost contact with family and friends who might be able to help them, and find that their incarceration history discourages landlords from renting to them.

Exhibit 6. Brooklyn Health Home Focuses on Housing and Social Issues

- New York's Brooklyn Health Home network, operated by Maimonides Medical Center, serves Medicaid beneficiaries with significant behavioral health issues and chronic conditions, including a large population of people with a history of incarceration. The health home deploys 400 community-based care managers who spend 70 percent to 80 percent of their time in the field working directly with clients, helping to find housing, filling out applications, and, as pressing social and economic issues are addressed, providing assistance navigating medical treatment. Given the importance of housing, the Brooklyn Health Home has established formal relationships with housing organizations and trained its care managers to help with housing applications through New York City's Human Resources Administration system.

Using Peer Support Specialists

A peer support specialist shares a common experience or background with a Medicaid enrollee, and draws on this experience to provide assistance.¹⁴ Historically, states have used peer support specialists to provide services for mental health and substance use disorders. Peer support specialists can be an important component of care delivery teams for justice-involved individuals. The Transitions Clinic Network, an initiative aimed at improving primary care for people leaving jail, uses an interdisciplinary team model that is built around peer support specialists. (In the Transitions Clinic model, they are referred to as community health workers [Exhibit 7].)

Exhibit 7. The Role of the Community Health Workers in the Transitions Clinic Network

- Community health workers with a history of incarceration are essential to the Transitions Clinic Network’s approach to providing primary care to people leaving jail. These community health workers find patients who would be well-served by a Transitions Clinic by reaching out to parole officers, hospital emergency rooms, drug treatment programs, and faith-based organizations, as well as visits to homeless encampments.¹⁵ Once people are engaged in care, the community health workers make referrals to physical and behavioral health services, accompany people to appointments,¹⁶ provide advice on reentry, assist in securing housing and employment, and help them adhere to the conditions of their release (e.g., showing up for court hearings). On average, they meet with each patient five times in nonclinical encounters.¹⁷ In a randomized two-year study (2007–2009), Transitions Clinic Network clients had 50 percent fewer hospital emergency department visits during their first year in the program compared to people in a control group.

Specialized Training and Expertise

Medicaid beneficiaries with a history of incarceration face a number of special issues. For example, participating in a mental health or substance use program may be a condition of their parole. They may have few friends and family members if they have been incarcerated for an extended period, affecting their housing and employment prospects. Providers who have worked with former inmates often note that they tend to be wary of engaging with health care providers, reflecting a mistrust of institutions and authority figures. Many of the delivery models reviewed for this analysis conduct specialized training for their care managers, social workers, and other clinicians (Exhibit 8). In some instances, training was paid for through health homes or managed care plans, which can use capitation funds.

Exhibit 8. Examples of Specialized Training for Workers

- *Security Training for In-Reach Workers.* Care managers who go into the Albuquerque jail to conduct in-reach on behalf of Molina Healthcare are provided with the same training as correctional officers, allowing them to receive a security clearance and to move around the jail with a greater measure of confidence. Molina finances this expense with Medicaid managed care capitation funds.
- *Certification of Community Health Workers.* In San Francisco, where the first Transitions Clinic was established, the Network collaborated with a local community college to develop a post-prison community health worker certificate program. Now, community health workers throughout the country can take an online course through the City College of San Francisco to receive a post-prison health worker certification.¹⁸

CONCLUSION

Medicaid expansion has provided states with a powerful tool to address the health care needs of justice-involved individuals — a population that suffers with especially high rates of physical and behavioral health problems, as well as barriers to housing, jobs, and other social needs that can affect health. Medicaid expansion makes most individuals coming out of prison or jail eligible for coverage. States are taking full advantage, putting in place policies and processes to ensure that coverage is effective prior to release. Of course, coverage is necessary but not sufficient. With coverage as a foundation, states have developed a range of promising models — often as part of larger initiatives aimed at high-risk, high-cost populations — that tend to include key elements that can be identified and potentially replicated by other states. These elements can be included as requirements in Medicaid managed care plans, provided as part of health homes, or disseminated in other ways. The challenge going forward is to solidify coverage upon discharge, maintain it, and connect people leaving the prison system with the comprehensive health care, social supports, and care management they need.

HOW WE CONDUCTED THIS STUDY

The brief is based on a literature review of Medicaid's role in serving individuals with a history of incarceration and interviews with state officials, Medicaid managed care plans, and health care providers in Ohio, New Mexico, and New York — three states with a relatively long track record of focusing on the care provided to people leaving incarceration. In addition, we interviewed the Transitions Clinic Network, which supports primary care clinics in 11 states and Puerto Rico in treating recently released individuals.¹⁹ Although there is a large amount of literature on reentry after jail or prison, very little addresses the role that Medicaid can play in connecting individuals to health care and related social services. This analysis is designed to help fill this gap. The [Appendix](#) describes in detail the Medicaid tools available to finance such efforts.

APPENDIX. MEDICAID TOOLS AND FINANCING

States are using a range of Medicaid tools and financing strategies as part of their goal to improve care for justice-involved individuals. These tools are closely related to the Medicaid approaches used to provide care to high-cost, high-need enrollees overall.

Benefits and Enhanced Federal Funding

The federal government provides states with enhanced federal Medicaid funding for low-income adults covered under Medicaid expansion, including eligible individuals who recently have left jail or prison.²⁰ The enhanced matching rate was set at 94 percent for calendar year 2018, and is 93 percent for 2019 and 90 percent for 2020 and future years. Like other adults enrolled in Medicaid, people leaving jail or prison receive a benefit package that covers a broad array of services, including physician care, hospital care, lab and x-rays, medications, mental health benefits, and substance use disorder treatment. At the discretion of a state, Medicaid beneficiaries also can receive case management services to help them identify, apply for, and enroll in social support programs. Additionally, states can cover “rehabilitative” services in their benefit packages, a term defined broadly in Medicaid to include peer support specialists.²¹ The enhanced federal Medicaid matching rate and comprehensive benefit package mean that states have significant federal financial support in providing comprehensive health and linkages to social services. Notably, though, federal law generally precludes states from providing a benefit to people leaving jail or prison that is not also offered to other Medicaid beneficiaries.²²

Administrative Funding

The federal government provides states with a 50 percent matching rate for most administrative expenses incurred by states when operating Medicaid, but offers a 90 percent matching rate for the development of a state’s eligibility system and Medicaid Management Information System and 75 percent rate for maintenance and operations.²³ A 90 percent matching rate is available for activities associated with supporting Medicaid providers in engaging in the meaningful use of electronic health records. States increasingly are using Medicaid administrative funds to build a data exchange between a state’s Medicaid program

and prisons or jails, facilitating the timely exchange of information with plans and providers about when an inmate is released.

Medicaid Managed Care

Thirty-eight states and the District of Columbia use managed care as their dominant delivery system in Medicaid.²⁴ Some states are including provisions in their Medicaid managed care contracts that require plans to provide care to justice-involved individuals in a manner specified by the state. For example, some states are requiring their Medicaid managed care plans to conduct “in-reach” to inmates prior to release. That is, the plans conduct in-person visits or teleconferences to begin to set up the health care resources that the inmate will require upon release. This function is part of the plan’s care coordination obligations and is funded under the administrative component. More generally, the cost of services provided to an eligible Medicaid beneficiary who recently has left jail or prison can be included in a benefit component of the capitation rate as long as the services are part of a covered benefit in Medicaid or part of a plan’s care management obligations.²⁵

Health Homes

Established by the ACA, health homes are used to coordinate medical care, mental health and substance use services, long-term services and supports, and community-based social services, and provide transitional care between inpatient and outpatient settings for one or more groups of Medicaid beneficiaries with complex health care needs.²⁶ States receive a 90 percent federal matching rate for up to eight calendar year quarters for health homes, at which point they then can receive the regular Medicaid matching rate.²⁷ To be eligible, individuals must be enrolled in Medicaid and be diagnosed with a serious mental illness, or have two or more chronic conditions, or have one chronic condition and be at risk of developing a second.²⁸ States can design health homes to serve a specific population within a certain geographic area or with certain health conditions, including health homes focused on high-need individuals with a history of incarceration as New York and Rhode Island have done.²⁹

NOTES

1. [Status of State Medicaid Expansion Decisions: Interactive Map](#) (Henry J. Kaiser Family Foundation, updated June 2018).
2. [Medicaid Expansion Enrollment: FY 2017](#) (Henry J. Kaiser Family Foundation, n.d.).
3. Chris Mai and Ram Subramanian, *The Price of Prisons: Examining State Spending Trends, 2010–2015* (Vera Institute of Justice, May 2017). Eight states have an average annual cost per inmate above \$50,000: Alaska, California, Connecticut, Massachusetts, New Jersey, New York, Rhode Island, and Vermont.
4. Shira Shavit et al., “Transitions Clinic Network: Challenges and Lessons in Primary Care for People Released from Prison,” *Health Affairs* 36, no. 6 (June 2017): 1006–15.
5. Jhamirah Howard et al., *The Importance of Medicaid Coverage for Criminal Justice Involved Individuals Reentering Their Communities* (U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, Apr. 2016); Doris J. James and Lauren E. Glaze, *Mental Health Problems of Prison and Jail Inmates* (U.S. Department of Justice, Bureau of Justice Statistics, revised Dec. 14, 2006); *Behind Bars II: Substance Abuse and America’s Prison Population* (National Center on Addiction and Substance Abuse at Columbia University, Feb. 2010); Lois M. Davis and Sharon Pacchiana, *Prisoner Reentry: What Are the Public Health Challenges?* (RAND, May 2003); Henry J. Steadman et al., “Prevalence of Serious Mental Illness Among Jail Inmates,” *Psychiatric Services* 60, no. 6 (June 2009): 761–65; and Jennifer C. Karberg and Doris J. James, *Substance Dependence, Abuse, and Treatment of Jail Inmates, 2002* (U.S. Department of Justice, Bureau of Justice Statistics, July 2005).
6. Jonah Frohlich et al., *Communities in Crisis: Local Responses to Behavioral Health Challenges* (Robert Wood Johnson Foundation and Manatt Health, Oct. 2017).
7. 42 CFR § 435.1010; and Centers for Medicare and Medicaid Services, Letter to State Health Officials, “[To Facilitate Successful Re-entry for Individuals Transitioning from Incarceration to Their Communities](#),” CMS, Apr. 28, 2016.
8. Government Accountability Office, Letter from Carolyn L. Yocum to Hon. Fred Upton and Hon. Joseph Pitts, “[Medicaid: Information on Inmate Eligibility and Federal Costs for Allowable Services](#),” GAO, Sept. 5, 2014.
9. Jesse Jannetta et al., *Strategies for Connecting Justice-Involved Populations to Health Coverage and Care* (Urban Institute and Manatt Health, Mar. 2018).
10. Ingrid A. Binswanger et al., “[Release from Prison — A High Risk of Death for Former Inmates](#),” *New England Journal of Medicine* 356, no. 2 (Jan. 11, 2007): 157–65.
11. Arizona Health Care Cost Containment System, *Support for Individuals Transitioning Out of the Criminal Justice System* (AHCCCS, n.d.).
12. Jane B. Wishner and Jesse Jannetta, *Connecting Criminal Justice-Involved People with Medicaid Coverage and Services: Innovative Strategies from Arizona* (Urban Institute, Mar. 2018).
13. Jesse Jannetta, Jane B. Wishner, and Rebecca Peters, *Ohio’s Medicaid Pre-Release Enrollment Program: Medicaid Areas of Flexibility to Provide Coverage and Care to Justice-Involved Populations* (Urban Institute, Jan. 2017).
14. For a lengthier discussion of the role of peer support specialists in providing care to justice-involved individuals, see, Matt Bechelli, *Medicaid-Funded Paraprofessional Services for Criminal Justice Populations* (Community Oriented Correctional Health Services, Nov. 2014).
15. Interview with Dr. Shira Shavit, Executive Director, Transitions Clinic Network, Feb. 9, 2018.

16. Interview with Dr. Shira Shavit, Executive Director, Transitions Clinic Network, Feb. 9, 2018.

17. Shavit et al., “Transitions Clinic Network,” 2017.

18. Interview with Dr. Shira Shavit, Executive Director, Transitions Clinic Network, Feb. 9, 2018.

19. The Transitions Clinic Network works in Alabama, Arkansas, California, Connecticut, Massachusetts, Maryland, New York, North Carolina, Puerto Rico, Texas, and Washington using a combination of federal, state, and local funding; philanthropic dollars; and revenue from technical assistance.

20. Note that not all eligible individuals leaving jail or prison will qualify for Medicaid as low-income adults for whom the enhanced matching rate is available; some may not qualify for Medicaid and others may qualify under a different eligibility category (e.g., as a disabled person or as a parent) to which a lower matching rate applies.

21. Deborah Bachrach, Jocelyn Guyer, and Ariel Levin, *Medicaid Coverage of Social Interventions: A Road Map for States* (Millbank Memorial Fund, July 2016); and Deborah Bachrach et al., *Enabling Sustainable Investment in Social Interventions: A Review of Medicaid Managed Care Rate-Setting Tools* (Commonwealth Fund, Jan. 2018).

22. One exception is that states can waive the requirement to provide benefits throughout an entire state (“statewideness”) and to provide the same benefit to all types of beneficiaries (“comparability” with respect to case management services). For example, some states elect to provide case management services to only a subset of Medicaid beneficiaries, as allowed under a provision of federal law providing for targeted case management services.

23. Federal financial participation (FFP) for design, development, installation, or enhancement of mechanized processing and information retrieval systems. 42 CFR § 433.112.

24. *Share of Medicaid Population Covered Under Different Delivery Systems* (Henry J. Kaiser Family Foundation, as of July 1, 2018).

25. Bachrach et al., *Enabling Sustainable Investment*, 2018). States can include nonclinical services, such as care management, in capitation rates as a way to incentivize plans to offer those services.

26. Centers for Medicare and Medicaid Services, Letter from Cindy Mann to State Medicaid Directors and State Health Officials, “*Health Homes for Enrollees with Chronic Conditions*” (CMS, Nov. 16, 2010).

27. In states that have expanded Medicaid, health home services provided to expansion adults continue to be financed at an enhanced rate because of the federal Medicaid matching rate for Medicaid expansion.

28. Centers for Medicare and Medicaid Services, “*Medicaid and Justice-Involved Populations: Strategies to Increase Coverage and Care Coordination*” presentation for the Coverage Learning Collaborative, Aug. 17, 2017.

29. Brenda Spillman et al., *Connecting Justice-Involved Individuals with Health Homes at Reentry: New York and Rhode Island* (Urban Institute, Jan. 2017).

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