

## **Medicaid Innovation Accelerator Program Webinar**

### **Strategies for Connecting Justice-Involved Populations to Substance Use Disorder Treatment**

**July 30, 2019**

ROXANNE DUPERT-FRANK: (Slides 1-4) Today's webinar will provide participants with strategies to connect justice-involved individuals with substance use disorder to treatment services, with a spotlight on Arizona's healthcare cost containment system. Participants will learn about strategies to connect the criminal justice population with substance use disorder services including data exchanges to suspend and reinstate state Medicaid involvement, care coordination with managed care organizations, and regional behavioral health authorities and other targeted insurance.

(Slide 5) On the agenda for today we will first do introductions followed by our facilitator, Gina Eckart, followed by the state experience from Arizona, have a discussion break, and review key takeaways.

(Slide 6) I'd like to introduce Gina Eckart. Gina is a managing principal at HMA and a licensed mental health counselor with over 25 years of experience in the public behavioral health field. Until December 2011 Gina served as the Alcohol and Drug Abuse Authority for the Indiana Division of Mental Health and Addiction with responsibility for policy inenting of the public, mental health and addiction system of care across the state. In addition, Gina oversaw the successful proposal and implementation of Indiana's AHCCCS to Recovery grant program, collaborating with stakeholders to establish professional licensure for SUD for the substance use disorder workforce, and in Indiana partnered with the Legislature to create clinical programs and quality assurance within methadone clinics and transitioned funding for long-term state substance use disorder hospital beds to community-based substance use disorder provider programs.

Prior to joining the state of Indiana, Gina served in various clinical and leadership roles at Midtown Community Mental Health Center. Since joining HMA, Gina has assisted clients with strategic planning and evaluation of both substance use disorder and mental health programs. Gina earned both her master's and bachelor's degree at Indiana University.

GINA ECKART: (Slide 7) I have the honor kicking off with introductions of our Arizona team. Gabrielle Richard has been working in the field of substance abuse prevention and treatment since 2012. Ms. Richard has a Bachelor of Health Sciences degree in addiction studies with an emphasis on prevention and treatment from the University of South Dakota and a Master's of Prevention Science degree from the University of Oklahoma. Ms. Richard is also a certified prevention specialist with the International Credentialing and Reciprocity Consortium. Ms. Richard has worked at multiple health and human services agencies in Arizona, Texas and Washington focused on development, implementation and evaluating behavioral health programs related to substance abuse prevention and treatment. In her current role at the Arizona Healthcare Cost Containment System, Ms. Richard oversees substance abuse treatment and prevention contracts, manages federal grants, and represents Arizona as the National Prevention Network

representative for the National Association of State Alcohol and Drug Abuse Directors, otherwise known as NASADD.

Keith Martir currently coordinates the substance abuse block grant and works on several key projects addressing substance use and misuse as an implementation manager with Arizona healthcare cost containment system, otherwise known as AHCCCS. Keith comes from a community-based opioid treatment program where he served as a substance use disorder counselor, clinical manager, and a community programs product management specialist. Keith has an extensive history working with opioid use disorder treatment, criminal justice and reach projects, drug courts, grant management, and project management. Keith served an integral role in opening the country's first Center of Excellence providing opioid use disorder treatment 24 hours a day, 7 days a week. Keith was also responsible for opening mediation units in rural areas of Arizona in Casa Grande and Stafford as well as several MAC clinics in central and southern Arizona. Keith was born and raised on the island of Guam, has a master's degree in Healthcare Administration through the University of Phoenix and a bachelor's degree in Psychology from the University of Arizona.

Finally, Michal Rudnick is a project manager with Arizona's Medicaid agency. She has focused much of her efforts over the last years on implementing policies and processes to aid vulnerable individuals who are exiting incarceration. Her focus is to connect releasing individuals to community providers to address significant mental health and substance use disorders and physical health needs. Ms. Rudnick has the privilege of collaborating with subject-matter experts and stakeholders from Arizona who also work to improve reentry.

(Slide 8) But before we hear from these speakers, we're going to begin our conversation today by providing some context around the issue of substance use disorder within criminal justice-involved populations and of course the intersection with Medicaid, as states search for ways to address their population's needs. We will also touch on opportunities available under the SUPPORT Act to assist states with these efforts.

(Slide 9) So why the focus on justice-involved populations as it relates to substance use disorder? Recent studies show that there is a high prevalence of SUD among the justice-involved population, in particular, those incarcerated in both state Department of Corrections settings as well as local jails. Specifically, one study by the National Center on Addiction and Substance Use found that almost two-thirds of incarcerated individuals met clinical criteria for a substance use disorder. However, many of these individuals are not receiving services for their substance use disorders while incarcerated. A recent Department of Justice study highlighted this fact, finding that less than one-third of individuals identified with a SUD while incarcerated actually received services. This finding was consistent within both state prisons as well as local jail settings.

(Slide 10) With the prevalence of SUD, also of concern is access to needed services upon reentry to the community. This is a priority in reducing recidivism, but also in improving health outcomes for justice-involved populations. Both past and more recent studies have shown that individuals with substance use disorder are at higher risk for overdose. This has often been attributed to reduced tolerance combined with the individual's returning to pre-incarceration levels of use upon release. This heightens the need for linkage and access to treatment immediately upon reentry regardless of services received or not while

they were incarcerated. It is at this intersection that Medicaid authorities can play a role in addressing state mortality rates associated not only with opioids but with other substances as well.

(Slide 11) CMS released guidance in April 2016 specific to Medicaid eligibility for individuals who are incarcerated. CMS indicated in their guidance that being incarcerated does not disqualify an inmate from being determined Medicaid eligible. In fact, state Medicaid agencies must accept applications from inmates to enroll in Medicaid or to renew Medicaid enrollment during the time of their incarceration. Lastly, if the individual meets all the applicable Medicaid eligibility requirements, the state must enroll or renew the enrollment of the individual effective before, during or after the period of time spent in the correctional facility.

(Slide 12) CMS also acknowledged in their guidance that while individuals may be eligible for Medicaid, while incarcerated Medicaid does not cover the cost of care with the exception of inpatient services. With this in mind, states have the ability and, in some cases, have chosen to place an enrolled inmate in a suspended status during the period of incarceration. Facilitating enrollment prior to release may allow for more streamlined referral and engagement with community providers, eliminating delays that sometimes occur while individuals begin or complete the enrollment process after release.

(Slide 13) This table represents data from the state Medicaid agencies as part of the annual Kaiser Family Foundation 50-state Medicaid budget survey. This survey data covers state fiscal years 2017 and 2018. The table shows that nearly all states are providing coverage for inpatient care to incarcerated individuals in both jails and prisons. Fewer states, but greater than half, have policies and programs that provide outreach and/or assistance to facilitate enrollment in Medicaid prior to release, as well as to their parolees. Finally, several states have policies to suspend as opposed to terminate Medicaid eligibility for enrollees upon incarceration.

(Slide 14) We're going to touch on a couple of opportunities under the SUPPORT Act before we invite our speakers from Arizona to share their initiatives across enrollment as well as care coordination upon release from incarceration. We want to take a few moments to highlight elements under the SUPPORT Act applicable to state's efforts with justice-involved populations. As many of you are aware, the SUPPORT Act was signed into law in October of 2018. One provision of the Act requires CMS to provide guidance on how states can leverage 1115 waiver demonstrations to improve healthcare transitions from correctional settings to reentry in the community. This provision generally applies to the eligibility of juveniles who become inmates of a public institution on or after October 24, 2019, and allow for assistance with Medicaid enrollment and coverage of services 30 days prior to release. HHS is in the process of convening a required stakeholder meeting to gather input on best practices related to these efforts.

(Slide 15) Also, under the SUPPORT Act states are prohibited from terminating eligibility for enrolled juveniles and are able to instead suspend coverage for these youths during their incarceration. It is noteworthy that these provisions apply to those over the age of 21 or former foster care youth up to age 26, and eligibility must be redetermined prior to release without an application. States must restore eligibility when applicable upon release.

(Slide 16) Now we'd like to take a moment to hear from you attending the webinar. We would like you to participate in a polling question so we can understand if there are any initiatives focused on justice-

involved populations planned or currently underway in your state. We ask you to take a moment to respond to this question and then I'll share the results with everyone. *Are there any justice-involved population initiatives currently active in your state? Yes, we have active initiatives. No, but we are planning initiatives. No, but we are considering initiatives.*

Here are results. Looks like the majority of folks on the webinar today do have active initiatives. Some of you have not started initiatives but are in the planning stages and some of you it looks like are attending today to get some idea about initiatives that you might consider within your state. We appreciate your participation in the poll.

(Slide 17) Now our team from Arizona:

KEITH MARTIR: (Slide 18) We're bringing in two perspectives. What we're going to do today is discuss Arizona's connection to care system with the criminal justice. We have me, Keith Martir, Gabrielle Richard, and Michal Rudnick.

(Slide 19) We're bringing in two perspectives. Prescription opioids and illegal opioids like heroin are addictive and can be deadly. More than two people die every day from opioid overuse in Arizona. Due to an alarming increase in opioid deaths in 2016, Arizona's Governor Doug Ducey declared a state of emergency on June 5, 2017, which set in motion substantial action to prevent opioid addiction and reduce opioid overdoses in Arizona. With completion of the emergency response deliverables and implementation of the Opioid Action Plan, and the Opioid Epidemic Act, Governor Ducey officially called an end to the public health emergency on May 29, 2018. While the official emergency has ended the fight to save lives and turn the tide on the opioid epidemic continues.

(Slide 20) Here in Arizona from June 15 to currently July 25, there have been over 3,000 suspected opioid overdose deaths, over 23,000 suspected opioid overdoses and over 53,000 naloxone doses dispensed with over 15,000 reported naloxone doses administered. Here in Arizona drug overdoses take more lives than car crashes. One thing to also look into, four out of 10 Arizona adults know someone addicted to prescription painkillers.

(Slide 21) With our high-risk population, the populations Arizona has been looking at typically are the travel community, the veterans, high morphine milligram equivalents and polypharmacy, Medicaid populations, criminal justice populations, in addition to trauma, depression and anxiety. The trauma community, the travel community, are more than three times likely to (account) for drug-related overdoses. Veterans are 55% increased with OUD in the past five years. Our average morphine MME, morphine milligram equivalent, is currently 45.4. And with our Medicaid population they are two times more likely to be prescribed an opioid. In criminal justice one out of every five overdose deaths occur within 24 hours of release from prisons and jails.

(Slide 22) Also to put this in perspective, Arizona has the fifth highest rate of drug incarceration here in the United States. It also has the fourth highest rate of female incarceration and in addition to the 34% of violent offenses, 20% of those are related to drug-related offenses, accounting for the largest number of the Arizona prison population. Seventy-seven percent of inmates assessed at intake indicate a substance use disorder; 3% were receiving substance use treatment services at any given time.

MICHAL RUDNICK: (Slide 23) I'll be talking about the current initiatives for the justice-involved that will include data exchange, connections to care, suspending and reinstating enrollment, managed care organizations and the RHBA coordination, target investments, criminal justice initiative, Governor's executive order including an Opioid Act and the SAMHSA-funded programs, STR and MAT-PDOA.

(Slide 24) As far as data exchange, in Arizona we did partner through an intergovernmental agreement with 12 of our 15 counties along with the state of Arizona's Department of Corrections to suspend as opposed to terminate enrollment in Medicaid, and then we automatically reinstate that coverage, so we get a daily booking and release file that comes over from the jails and prisons across the state that we cross match against our MMIS system. This also helps to system identify individuals who are not currently enrolled.

We do have a few different ways we offer prerelease applications so for those individuals that become incarcerated who didn't already have Medicaid, anyone releasing from one of our state prisons including the private prisons has an opportunity to apply for Medicaid up to 30 days prior to their release from incarceration. That particular application is facilitated by a correctional officer within the prison walls. They're able to key information into our online Medicaid application, which we call Healthy Arizona Plus, and those applications then go into our system and when the correctional officer goes back in to confirm that the individual has been released, that application is then finalized by our team with the Department of Economic Security. This group is focused on the criminal justice population so they're able to facilitate processing these applications quickly as well as understanding CMS guidance around individuals being eligible for coverage when they're released from incarceration, so they're able to determine that release date and align that with the date that we can cover.

In addition, this is the Mosaic Program. My colleagues will talk more about that. In the past it was a drug treatment program through Maricopa County Jail.

KEITH MARTIR: The Mosaic Program, essentially it was going through different phases of treatment and inmates or offenders were able to go through a program where it helps them prior to release assist with jobs, anything regarding treatment coordination. They're able to work towards relapse recovery, so that was the Mosaic Program and how it was implemented for individuals who were going to be released, so hopefully they can reduce recidivism rates as well as relapse rates.

MICHAL RUDNICK: The last bullet talks about enrolling those pending trial, and in Pima County we're able to divert from incarceration because of getting that Medicaid application approved pretrial.

(Slide 25) Suspending and reinstating enrollment. As I mentioned we do have intergovernmental agreements with all our counties and the Department of Corrections, and that we review that daily booking and release file. To give an idea what a big impact that makes, in state fiscal year 2018 we were able to suspend enrollment approximately 120,000 times versus terminating coverage. So those aren't necessarily unique individuals, some of them may have been incarcerated multiple times, but that's a significant number of people that didn't have to start over with the brand new Medicaid application when they become released to the community.

As another note, the process we've set up here also helps in AHCCCS avoiding millions of dollars, in fact over \$42 million in state fiscal year 2018, for the capitation save that's not paid for these individuals as we are primarily a managed care state.

KEITH MARTIR: (Slide 26) Coordination of care with MCOs and RBHAs, managed care organizations and regional behavioral health authorities. Though we do not directly oversee these projects we work in tandem with main department divisions within AHCCCS and state agencies to focus on this population as well as contractors. Here in Arizona there are three RBHAs, or as some individuals might know them, MCOs. In Northern Arizona we have Stewart Health Choice of Arizona and then for Central Arizona we have Mercy Care and in Southern Arizona we have Arizona Complete Health. Though AHCCCS, MCOs and RBHAs are contractually required to provide reach-in care coordination. They are also required to submit detailed reach-in plans and auto assign individuals to the same MCO/RBHA upon release. Arizona works on a 3-tier system where Arizona contracts with each of these RBHAs and then each of these RBHAs contract with their assigned providers within their geographic area.

GABRIELLE RICHARD: (Slide 27) I'm going to chat about initiatives and projects at an agency level. While we are presenting on all the work being done here, we don't officially oversee all this work. If we had everybody who worked on these projects this webinar would have 50 different speakers, so if you guys do have questions about some of the initiatives that we don't work super closely with we'll be sure to get you in touch with the people who oversee that project.

One of the initiatives I'll discuss today is our Targeted Investments Program, which is for our Medicaid population. The Targeted Investment Program is AHCCCS's strategy to provide financial incentives to eligible AHCCCS providers to develop systems for integrated care. In accordance with the 1115 waiver, managed care plans provide financial incentive to eligible Medicaid providers who meet certain benchmarks for integrating and coordinating physical and behavioral healthcare for Medicaid beneficiaries.

The one we're looking at in particular has the area of concentration of adults transitioning from the criminal justice system. The provider that utilizes this specific Targeted Investment is again our RBHAs and the selective providers, and the objective of this Targeted Investment is to integrate primary care and behavioral health services for the purposes of better coordination of the preventative and chronic illness care for adults with behavioral health needs transitioning from the criminal justice system.

One way that AHCCCS has gone about doing this is trying to get colocation of integration care clinics in and near probation and parole offices. The core components of this program were developed by AHCCCS and the program went into effect on October 1, 2017 so we are coming up to our 2-year mark, so I'm sure we'll probably have some pretty good data coming in here the next couple of months to show how we're doing with this program.

(Slide 28) Also we mentioned this previously but Arizona is lucky to have very strong support from our current governor, Governor Doug Ducey. The Governor has made it a central focus of his office to make sure that we are fighting the opioid crisis and that the state is getting the resources it needs to fight the opioid crisis. One of the items he has done to help address the opioid crisis is the State of the State that addressed issues related to recidivism and substance use disorder, and he has also signed many executive

orders but a couple that pertain directly to this population include the executive order that established a substance use disorder program for individuals exiting prison, which established a pilot program allowing inmates to be treated with the opioid blocking drug Vivitrol before leaving prison in order to help their transition be more successful.

In addition, we also have the enhanced surveillance advisory and the Arizona Opioid Epidemic Act. This executive order from the Governor requires those encountering opioid overdose-related events to send their data to Arizona Public Health within 24 hours of the event, and those required to participate in the enhanced surveillance include licensed healthcare providers, administrators of a healthcare institution or correctional facility, EMS and ambulance staff, which also includes first responder agencies, ground and air ambulance services, medical examiners, and pharmacists. The executive order also directs multiple agencies to share information with the Arizona Department of Health Services (DHS) to allow better coordination of opioid prevention activities statewide. And the specific health conditions that are being reported include suspected opioid overdoses, suspected opioid deaths, naloxone doses administered in response to either condition, naloxone dosages dispensed, and neonatal abstinence syndrome.

In addition to the 24-hour reporting requirement, the Arizona DHS public health laboratory has begun testing all blood samples from suspected opioid overdose deaths, and the toxicology screening currently has been helping us bring more information about the kinds of opioids that are causing these severe outcomes in Arizona. If you are interested in looking at this data, we do have an amazing dashboard available on the Arizona DHS website where the data is as close to real time as possible, so we're very lucky to have the support of many different agencies and at the governor level to help us combat this crisis.

(Slide 29) Another initiative that some of you may be familiar with is the Opioid State Targeted Response Grant, which is from SAMHSA, also known as the Substance Abuse and Mental Health Services Administration. I will be calling it STR from now on but I want to make a note that we do also have the State Opioid Response Grant Funding, also known as SOR, but we also wanted to present on our STR initiative, which has been around a little longer and showing some great promise in this population. This particular project focuses more on non-Medicaid populations. That being said, the information and sources being provided do have a pretty wide-reaching health approach as well so we do anticipate pretty much the entire population to be benefiting from some of these initiatives.

One initiative we're talking about with our STR is the Opioid Diversion and Incarceration Alternative Project. This project is to increase access to medication-assisted treatment or MAT and avoid costly incarceration of individuals who present with an opioid use disorder or OUD. We have this working through a minimum of five jurisdictions identified through an AHCCCS needs assessment previously done based on the areas of high need and high prevalence of opioid use in those areas. This project implements a pre- and post-booking diversion process that navigates low-level OUD drug offenders to community-based treatment instead of incarceration. This took a lot of work. There was a lot of training that had to be done. We had to work with law enforcement, peer support, community stakeholders. A lot of different people came to the table to ensure that this project was successful. It's important to note that there's a care coordinator involved who the person in need of services is diverted to, and the care coordinator is also required to ensure that the individual has been provided naloxone education and has access to the kit either through prescription or through the AHCCCS community distribution network, which is

something we oversee as well. We try to distribute as much naloxone as possible to try and prevent opioid overdose deaths.

There is also peer support, and the peer support and the care coordinator work together to arrange follow-up care for a treatment plan and peer supports also help the individual begin the process of navigation through the system and basically just trying to hook that person up with the services they need instead of sending them to jail or consequently to prison.

(Slide 30) We're going to talk about some of our numbers that we have. We have some information regarding our STR effort. You can see for year one we were able to serve 6,143 people unduplicated, and we have them broken out by numbers of persons served for OUD recovery support services and numbers of persons served for OUD treatment services. You'll see that some of those overlap but we wanted to show you how we did with grant year one.

(Slide 31) We also wanted to show you year two. We were able to pretty much double the amount of people we serve, which is excellent, so we have a total unduplicated account of 13,195 people served during year two of the STR grants. Then again, we have them broken up by number of persons served for OUD recovery support services and number of persons served for OUD treatment services.

(Slide 32) Next, I'll talk about another initiative focused more on the Medicaid populations. We have a discretionary grant from SAMHSA. We have a grant called MAT-PDOA, which stands for Medication-Assisted Treatment Prescription Drug Overdose Addiction. It's a discretionary grant from SAMHSA and we chose to focus on the criminal justice population. Our overall goal with this grant is to create a bridge between criminal justice involved individuals with OUD and access to MAT and outpatient services. Another goal was to increase the number of incarcerated individuals with an OUD enrolled in MAT services. We want to decrease illicit opioid use. We want to decrease re-incarceration, and we also work to decrease the stigma of MAT use for those involved in the criminal justice population. It is important to note that the providers who get these dollars from us were able to begin induction for members while they were incarcerated and provide that in-reach and help them to get assessed and placed into treatment as soon as they were out so that we reduce the chance of recidivism or potentially opioid overdose. Again, I also want to note that this grant didn't specifically pay for additional services but the funding and the dollars went towards additional staff, to the related providers, to provide additional services and to provide additional staff, including peer support.

(Slide 33) Then we have an excellent evaluator we use here in Arizona called Wellington Group Consulting, and every quarter they give us infographics for our work that's being done on our MAT-PDOA program. They're not quite our latest, we just got our new ones the other day, so these are our second to newest infographics but they're still relevant. We can see in the past 30 days the number of arrests of individuals enrolled in the MAT-PDOA program, we've seen a 33% reduction in arrests at 6-month follow-up, and then we've also seen a 38% reduction in drug arrests also at a 6-month follow-up.

(Slide 34) Additionally we've also seen numbers of crimes committed with a 56% reduction at 6-month follow-up, and then when it comes to looking at nights in jail in the past 30 days, we've also seen a 57% reduction in nights spent in jail.



(Slide 35) We also decided to look and see which substances individuals were using and the percent of individuals reporting using substances. Again, if we look at the orange bar, we can see what they were asked when they were assessed at intake, and then the blue bar below it is the 6-month percent use. So, we've seen a pretty drastic reduction in all of these substances being used in the past 30 days when we follow back up with the individual at six months.

(Slide 36) Arizona also has some amazing providers that allow us to have this amazing data but they also allow us to have a really pretty great follow-up rate. I believe our follow-up rate is a little bit higher but this is still pretty great. So, we have a 75.25% follow-up rate as of April 15, 2019, and we can also show that we have the amount of active versus the discharges for April 15<sup>th</sup> as well.

(Slide 37) We also track some of the social determinants of health such as employment. We want to see how they're doing at intake versus their 6-month follow-up, so we've seen a 28% reduction of unemployment and an 85% increase in employment. (Slide 38) Then we're also looking at housing and we know that after the individuals enrolled in the MAT-PDOA program more clients were permanently housed at six months than at intake, and we've seen a 43% increase in permanent housing at our 6-month follow-up.

(Slide 39) What did these results tell us? Based on all the information we provided, while we do have some great initiatives going on, there is still the need to increase access to evidence-based treatment and prevention services in the state of Arizona. We also know that we need to increase education and awareness for individuals currently incarcerated prior to their release so they can be connected to those services as soon as possible. We also know we need to enhance coordination for individuals being transitioned into the community and ensuring the appropriate level of placement upon release.

(Slide 40) We also know that we need to increase cross-sector collaboration. We do have a lot of great collaborations going on right now but there's always room for more communication and more collaboration across the agencies. We also need to continue efforts to change the framework of behavioral health and address the underlying cause of substance use disorders.

(Slide 41) We do have our references which we hope you look at and play around with. I had mentioned the Arizona DHS website listed here, as well as some of our other information. Pretty much everything we discussed today is available on our AHCCCS website so feel free to look around. If you want to look at our newest MAT-PDOA infographics I believe they were just loaded online as well. (Slide 42) Thanks for listening to us today.

GINA ECKART: Before transitioning questions, I wanted to highlight that the speakers from Arizona did provide some links and resources with some information on their initiative that was presented today as well as their contact information. For those without access to the Q&A box there were questions about copies of the slides being available as well as a recording of the webinar and they will be posted to Medicaid.gov. If you are a registered participant you will get an email from CMS when those items are available on the website.

(Slide 43) We have time for questions. The first question: *How long does it take to remove suspension of benefits from members' records?* This comes from Louisiana, where they say 7-10 days but between

release and activation of benefits, members can't always access services and that causes problems in particular for participants in drug courts.

MICHAL RUDNICK: In most cases that's going to happen within 24-48 hours of the individual's release. I mentioned earlier that we expect a file of the booking and releases from each jail or prison by 5 o'clock each evening Arizona time. So, depending on the time we get that file from them, it goes into our system overnight. Again, it typically takes between 24 and 48 hours. One of the other things, though, we've done to assist with that is the AHCCCS online system we use that providers are able to utilize to determine eligibility for their patients as they arrive. We've actually included messages for those individuals who are part of this process and the message on the system doesn't indicate that they've been released from prison or jail but it does tell the provider that this individual has had a temporary enrollment of their coverage so essentially if they're presenting in front of you then they are eligible and the coverage will go back to the date of the service.

GINA ECKART: The next question is specific to the care coordination efforts happening with your MCOs and RBHAs. *How are gaps in care coordination through the transition monitored or fixed when the MCOs report unable to contact that particular member?* I don't know if you guys have issues with your MCOs having trouble with engagement and if you are able to track that.

MICHAL RUDNICK: There's a few different ways we've gone about doing what we just generally call reach-in, but we do have contractual requirements for each of our health plans to have a full-time justice liaison on staff as well as a full-time court liaison. What these justice liaisons have done in partnership with state agencies, counties and AHCCCS is we've identified contacts within each of the jails and the prisons and we share a joint contact list. So, we're able to tell the health plan that their member was either incarcerated or in the instance they're released, they get that on their daily enrollment roster, and on their 834 file, so the health plan is notified when a member becomes incarcerated. And that way, if they identify that that member is at high risk, because that's really what we want them to focus on is those individuals that were in a course of care that needed continued care, then they're able to make that contact with the jails and prisons. And in many cases, they can either do a face to face or a video visit with our member prior to their release from incarceration, and that typically happens within 30 days of their release, the health plan is reaching out, and then they're obligated to get our member an appointment within 7 days of their release from incarceration.

GINA ECKART: A related question: *Can you review what you receive with the daily booking and release files? Do eligibility staff match these with currently Medicaid-certified individuals to suspend or reinstate benefits, and how large are the daily booking and release files?*

MICHAL RUDNICK: We've included on our website, and I don't think it's one of the direct links here but there is a link to the AHCCCS target investments, so if you're on the AHCCCS website we have a dedicated justice page and, on that page, we include the specs and the technical requirements of that daily file. So, the way we approached it is we made it very simple so that it's a daily flat text file that comes over, and the fields that the county or state prison are reporting are in the same order. It's some general demographic information as well as when they became incarcerated and when they become released obviously. But it has to come over in that same format. It's an automated process and it comes over daily in a secure file transfer and then we're able to automate that match against our MMIS system. Like I said

if there's a perfect match, then it's suspended enrollment or reinstated, depending on whether they're booked or released.

GINA ECKART: A couple of questions related to the evaluation and the data you were sharing on your initiative. *Does this evaluation compare the intervention group's results to a control group's experience or is this only pre-post for the same individual?*

GABRIELLE RICHARD: Great question. The information that our evaluator looks at is our individuals at intake and then the individuals at the 6-month follow-up. So, they're not compared to a control group or anything like that. It's really just the clients who are enrolled in our MAT-PDOA system and then we just look at the data at the six months and do an analysis of where they were versus where they are now.

GINA ECKART: *What is the definition of intake? Is it the same as their incarceration date?*

KEITH MARTIR: The date of intake, so individuals who go into treatment, they need to do paperwork essentially called a GPRA, so when they step into services that is the date of intake, when they do that paperwork that is allowing these individual to be on the MAT-PDOA grant in a way to receive services when they are not covered by Medicaid services.

MICHAL RUDNICK: Just to piggyback off Keith, the majority of people on this call are aware that we can't use federal dollars to provide services to someone who is currently incarcerated so it literally would be the day that they step out of incarceration and like Keith said, sign that paperwork to become enrolled into services.

GINA ECKART: A question around payment structure. *Do you have any kind of incentive payment structure for the providers that do follow-up?* I think this is related to linking folks when they're coming out.

GABRIELLE RICHARD: As far as MAT-PDOA, which is one of our non-Medicaid initiatives, we do not. I'm going to look at Mikell to see if we have anything for Medicaid enrollees.

MICHAL RUDNICK: No, and if someone's interested in talking about this offline, I'm happy to go into it in more detail. But for the reach-in we have our health plan doing for those individuals that have a complex health need, that is money that's coming out of their profit, and we made it very clear that there aren't federal dollars available to do that. But our health plans acknowledge that the return on investment in doing that reach-in was going too far outweigh the cost associated with these members ending up in an emergency room or then losing them within the system and then having to begin their care all over again. So, we've actually been lucky in that way to be very collaborative.

GINA ECKART: *In terms of the data you've been showing, are you guys using an evaluation contractor or is the evaluation of these initiatives being done by state staff?*

GABRIELLE RICHARD: I wish we were great evaluators like Wellington but we actually contract out to Wellington Group Consulting. They are based in Arizona but I believe they have projects all over the U.S. but they're the ones who do our evaluation for us. They do our follow-ups for our providers for the GPRAs, and they really ensure that our services are being evaluated appropriately and as per our federal grant guidelines.

GINA ECKART: *Do any of your individuals receive healthcare and substance use disorder or other behavioral health services at community health centers in Arizona?*

MICHAL RUDNICK: Yes. We have of course federally qualified health centers. They offer a lot of that care. Not so much community health center but considered a health home, the targeted investment clinics we touched on earlier are dedicated to serving individuals on probation and parole, and we've set those up as sort of a one-stop shop type scenario and we've got 13 of those across the state where that individual can receive the full array of healthcare services, whole healthcare, and MAT onsite, as well as seeing their probation or parole officer.

GINA ECKART: *Are MCOs paid a higher capitation rate for justice-involved new members? Do they get a medical download from the person's prison medical records? And I would imagine jail records.*

MICHAL RUDNICK: As far as capitation goes, no, we're not paying at this point in time a higher rate for justice-involved members. That is something we've certainly talked about and explored and revisit. But at this point in time we don't offset the costs for that population. What was the second question?

GINA ECKART: *Do they get information from the jail or prison in terms of the medical services they received while incarcerated? Does that information transfer to the receiving provider?*

MICHAL RUDNICK: For our population of individuals with a serious mental illness, when there's that designation, there is a direct jail data sharing link between our regional behavioral health authorities and the jails and prisons to share information about individuals with a serious mental illness. It gets to be more complicated of course when you're talking about part 2 protected substance use information. So, there are a lot of individual releases of information that are happening. Often, it's a very manual process. There are, though, some jails and even the Department of Corrections that are looking to get connected to the health information exchange, and our vendor here in Arizona has Health Current. Some of them have started that process and are loading information into that system from their jail. So, our health plans in some cases are able to access that but it's not all jails or all prisons across the board.

GINA ECKART: *Do you suspend as soon as someone is booked in jail, or do they have to be in jail for a certain number of days before Medicaid is suspended?*

MICHAL RUDNICK: They've got to be considered incarcerated at least 24 hours and have had their first pretrial hearing. So, the example for that is say you're in and out in seven hours, for loitering or something to that effect, which we know there's a large percentage of folks that are released in under 24 hours, those wouldn't come over on that daily file.

GINA ECKART: *Do your county jails have a statewide system for intakes and releases?*

MICHAL RUDNICK: No.

GINA ECKART: I think they mean to say a statewide data system, so they're county by county?

MICHAL RUDNICK: Yeah, my understanding is they've got JMS systems that are, at least from what I've heard, very siloed, separate.

GINA ECKART: *Are all jails in Arizona participating in this process or just the ones in the 12 counties? Have you added jails?*

MICHAL RUDNICK: We have the luxury of having only 15 counties in Arizona so there are three counties that we do not have intergovernmental agreements for, but just to clarify on that, they're three very, very small counties, very rural, and have a small population of people that end up in a jail, as well as you can imagine an even smaller number that are Medicaid-eligible. So, it really wasn't worth it to those counties to establish an automated process because the numbers were so low. So, we have actually looked at and determined that over 95% of people that would ever become incarcerated in the state of Arizona at the jail or prison level would be benefited by the enrollment suspension process, because we're covering the vast majority of our incarcerated population.

GINA ECKART: A question around MAT-PDOA. *Does your claims processor deny claims for date of services that equate to the date of release? So, any issues when you're unsuspending Medicaid and services may be received on the date of release.*

GABRIELLE RICHARD: I might need additional clarification. I just want to say that for someone to be eligible for the MAT-PDOA services they cannot be Medicaid-eligible. So, if they were Medicaid-eligible they would move over into Medicaid services. If they weren't Medicaid-eligible but still needed additional help for services that's where MAT-PDOA would come in. So, the question regarding whether their start date of services would be the day that they were released, that's a good question. I might have to go back and double check. I think the dates can coincide and I don't think that's something we get too deep into.

KEITH MARTIR: So, individuals who have their Medicaid suspended cannot be qualified to be on the MAT-PDOA grant. Their eligibility essentially has to be declined or there was no history of an individual being on or applying for Medicaid. So that was the only way that an individual could be appropriate for the MAT-PDOA grant was to make sure that their AHCCCS or their Medicaid was not suspended or they never had it at all.

GABRIELLE RICHARD: Hopefully that clears that up but if that person wants to type in the chat box to clarify we'll answer it somewhere.

GINA ECKART: *Are any Arizona jails or the Department of Corrections initiating any MAT during incarceration except for Vivitrol?*

MICHAL RUDNICK: At last check I was told no.

KEITH MARTIR: Correct. So, lots of individuals who are going to Department of Corrections, if they are receiving MAT, many times this individual, unless they're pregnant, are essentially tapered off of the MAT treatment. At this point in time besides the individual being released to the community, I think only Vivitrol at this time is started at induction.

MICHAL RUDNICK: A quick note on that. So, Arizona sees about 18,000 or so people released each year in this community from the Department of Corrections so from prison, and then there's over 100,000 roughly that are released into our communities from the county level, so there are counties that are

incorporating MAT pre-release for pregnant women, for example, and other populations they're exploring. But for the state prison system it's just Vivitrol.

GABRIELLE RICHARD: Yeah, and to piggyback again on my colleagues' comments, this is something we know would be a best practice for helping these individuals who need these services, so if there are any other states or people on the phone that have been successful in doing this, please reach out to us using our contact information. We'd love to hear how you're successful in this because this is definitely something we see as a need that we are trying to move forward as best we can.

GINA ECKART: Regarding Medicaid reinstatement, *what happens to the data files that are an almost match but not a direct match? Does someone review those to see if it is a Medicaid-certified individual?*

MICHAL RUDNICK: That's exactly right. They come up on a partial match list and fortunately it's a low enough number that we actually have someone that looks at those daily and is able to reconcile if they can. And we're returning that file to the jail and prison, whoever sends it to us, letting them know who we were able to match, who we weren't, and when their Medicaid renewal date is.

GINA ECKART: Thank you so much for your time. Please stay on to take a survey. But we're going to end the webinar with some key takeaways (Slides 44, 45 and 46):

- As we stated earlier, the justice-involved population has been shown through studies to have higher rates of substance use disorder, definitely a population that states are paying attention to.
- Upon release from the criminal justice system, these individuals have been shown through studies to have higher rates of overdose deaths, so those states that are focusing on overdose deaths may want to pay some particular attention to the population.
- We also talked about, and Arizona is doing an amazing job with suspending rather than terminating Medicaid enrollment during incarceration so that folks can have quicker access to services once they are released, which obviously helps with that overdose risk they're under.
- Connections to or continuation of substance use disorder treatment upon release from either prison or jail does improve outcomes such as substance use, reincarceration, housing and employment rates, which Arizona shared with us with their data today.

If you registered for the webinar by email you will receive an email when the recording of the webinar and slide deck is available on Medicaid.gov.

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