

Medicaid-funded Paraprofessional Services for Criminal Justice Populations

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At first glance, there is nothing unusual about the intake area inside the Pima County Adult Detention Center (ADC), in Tucson, Ariz. Law enforcement officers escort arrestees through the sally port, into the booking area, and on to the holding cells, where they wait to hear whether they will be released or admitted into one of the jail's housing units.

If you look closely, though, you'll notice the presence of peer support providers who reach out to new arrestees at what, for many, is one of the most difficult times in their lives.

These peer support providers are from HOPE, Inc., a provider of mental health and substance use disorder treatment services (collectively referred to as behavioral health services). All HOPE employees have either had a behavioral health disorder or assisted a family member or close friend with a behavioral health disorder—experience that they tap into to help their clients.

The peer support providers at HOPE who work with the justice-involved have something else in common with their clients: Not only have they dealt with behavioral health problems of their own, but they also have been involved with the criminal justice system.

HOPE's justice-focused peer support providers help people with behavioral health issues transition from jail to the community. Their services include:

- Providing transportation from the jail to the HOPE clinic,
- Calling and texting clients to remind them of upcoming court dates,
- Visiting clients in their homes, and
- Arranging transportation to court appearances.

The peer support providers draw from their lived experiences to help clients navigate and overcome the unique challenges that come with being arrested, incarcerated, or subject to community supervision—that is, probation or parole.

HOPE's goal is to give people re-entering the community their best shot at remaining in the community. For many people, this will mean both recovering from behavioral health disorders and complying with court-mandated conditions for their release. These may include keeping court dates, passing drug tests, remaining within specific locales, and other conditions.



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In recent years, behavioral health practitioners increasingly have emphasized the importance of recovery, which means focusing not only on treating symptoms, but also on improving overall health, wellness, and success in community settings. The predominant model for delivering recovery services is through peer support providers like those employed by HOPE, who have emerged as complements to traditional, non-peer behavioral health professionals.

Peer support providers are examples of paraprofessional health workers. Paraprofessionals do not hold professional degrees; instead, they draw on their personal experience and knowledge of a particular community to inform their interactions with clients. Typically, they work to improve the health and health care of low-income populations, racial and ethnic minorities, and other populations that historically have experienced disparities in access to health care and in health outcomes.

Improving health for populations that have experienced health disparities may require going beyond the conventional boundaries of health care to address social factors that affect health, including housing, employment, and criminal justice involvement. Thus, services provided by paraprofessionals may be wide-ranging. For example, peer support providers may counsel and motivate clients, advocate for them, serve as role models, teach daily living skills, navigate the health system, and help clients overcome other barriers to recovery.¹

The unique combination of experience and flexibility that paraprofessional health workers possess makes them ideally suited to serve justice-involved populations. This report describes how paraprofessional health workers can help justice-involved populations and discusses opportunities to fund paraprofessional services for the justice-involved through Medicaid. Where possible, it offers real-life examples of how such arrangements are working or could work and describes the pros and cons of these options.

Potential Impacts of Paraprofessional Services

A growing body of research has found that paraprofessional peer support providers can help improve clinical outcomes and lower costs. Studies have found that, in many cases, peer support providers can:

- Equal or surpass the effectiveness of professional providers;
- Contribute to increased overall health, wellness, and feelings of self-efficacy;
- Reduce inpatient hospitalizations and crisis service utilization;
- Improve social functioning;
- Reduce substance use; and
- Enhance outcomes when working as part of a care team with professional providers.²

There's the potential too, that helping people navigate the criminal justice system successfully, as HOPE's peer services providers do, will lead to reductions in recidivism and reincarceration. Keeping court dates, for example, is important. Failure to appear in court and other pretrial supervision violations often result in further criminal charges, revocations from the community to jail, and more severe sentencing. Research has shown that two-year recidivism rates rise as the number of days spent in jail pretrial increases³ and that people held in jail pretrial are more likely to receive harsher sentences.⁴

Peer support providers who focus on behavioral health issues aren't the only paraprofessionals working in communities, or with the justice-involved. A more general category of workers known as community health workers (CHWs)—sometimes called community health advocates, community health educators, or, in Hispanic communities, *promotores* or *promotoras de salud*—have become increasingly prominent in the health care system as well. Like peer service providers, CHWs may deliver a variety of services, including chronic disease management, health system navigation, and counseling.⁵

Research supports the effectiveness of CHW services. For example, CHW services that help patients manage chronic diseases like asthma and diabetes have been shown to improve “health outcomes, health behaviors, and patient satisfaction.”⁶ One study in New Mexico tracked patients with a history of high service utilization who received CHW services. Compared to a control group, patients receiving CHW services showed decreased utilization of emergency rooms, inpatient services, prescription drugs, and outpatient care.⁷

Justice-involved Individuals, Service Needs, and Paraprofessionals

In addition to the re-entry challenges they face after leaving jail, members of the justice-involved population have high rates of serious health problems, including mental illness and substance use disorders. Paraprofessionals such as peer support providers and CHWs, with their personal experience, knowledge, and flexible service options, are uniquely suited to serving the needs of justice-involved individuals—helping them re-enter their communities successfully while improving and maintaining their health.

At the end of 2012, approximately seven million adults in the United States were under some form of correctional supervision, including jail, prison, or community supervision.⁸

Jails process approximately 11.7 million admissions a year, including a number of people who cycle back and forth between jail and their communities.⁹ Approximately 96% return directly to the community from jail.¹⁰ This large population of justice-involved individuals has disproportionate rates of chronic and infectious diseases compared to the general population, including higher prevalence of hypertension, hepatitis, and HIV (Figures 1, 2, and 3).¹¹

FIGURE 1. Hypertension by Age, Jail and Prison Inmates and the General Population

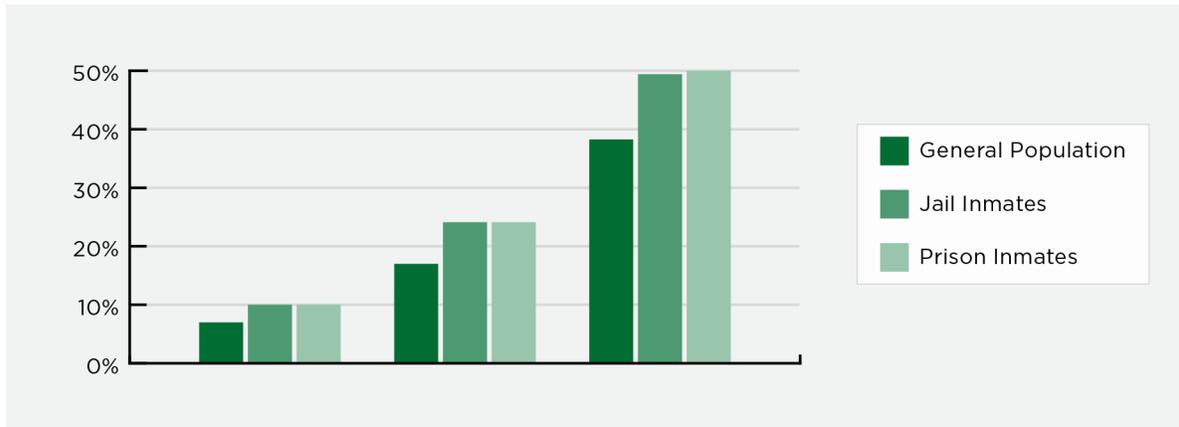


FIGURE 2. Hepatitis by Age, Jail and Prison Inmates and the General Population

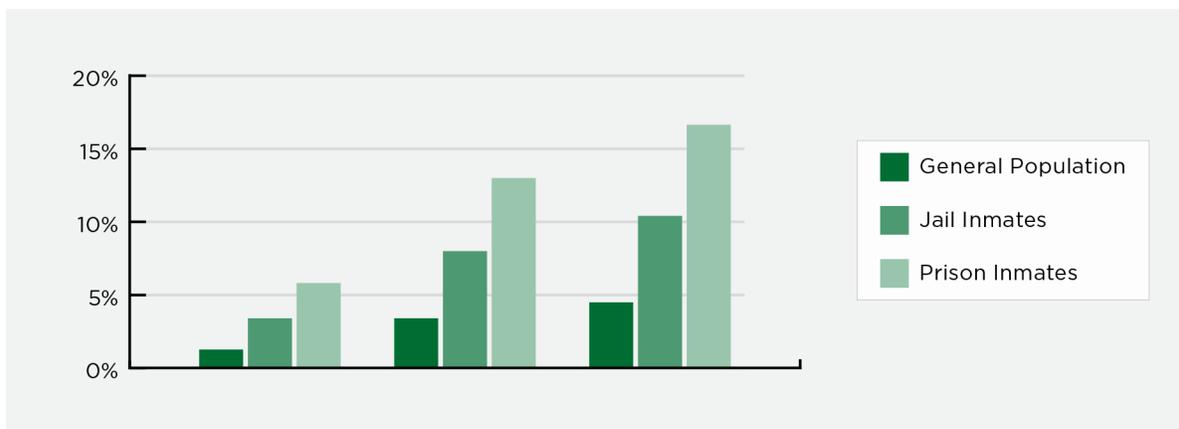
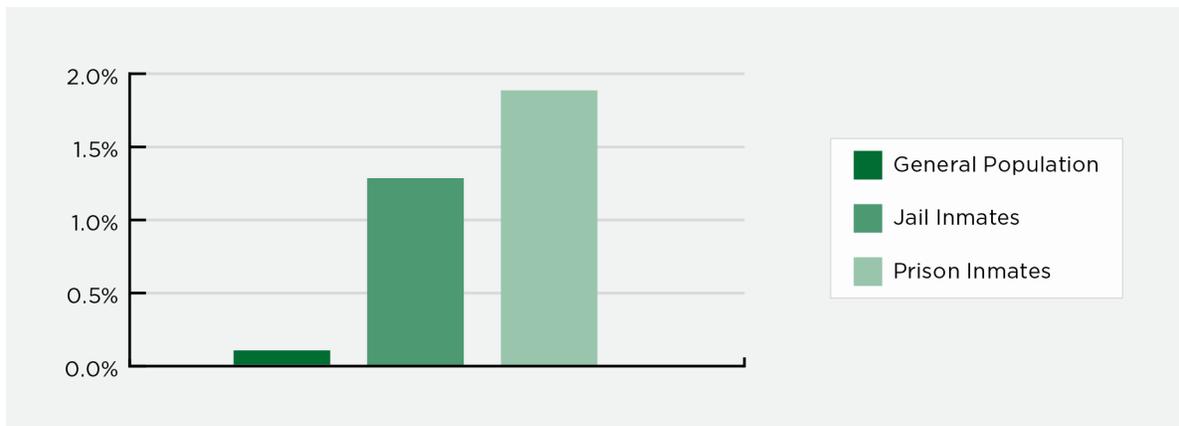


FIGURE 3. HIV, Jail and Prison Inmates and the General Population



Justice-involved individuals also have markedly higher levels of behavioral health disorders than the general population. Approximately 67% of people in jail meet the diagnostic criteria for substance dependence or abuse.¹² Fifteen percent of men and 31% of women in jail have been diagnosed with a serious mental illness (Figures 4 and 5).¹³

FIGURE 4. Substance Dependence or Abuse, Jail Inmates and the General Population

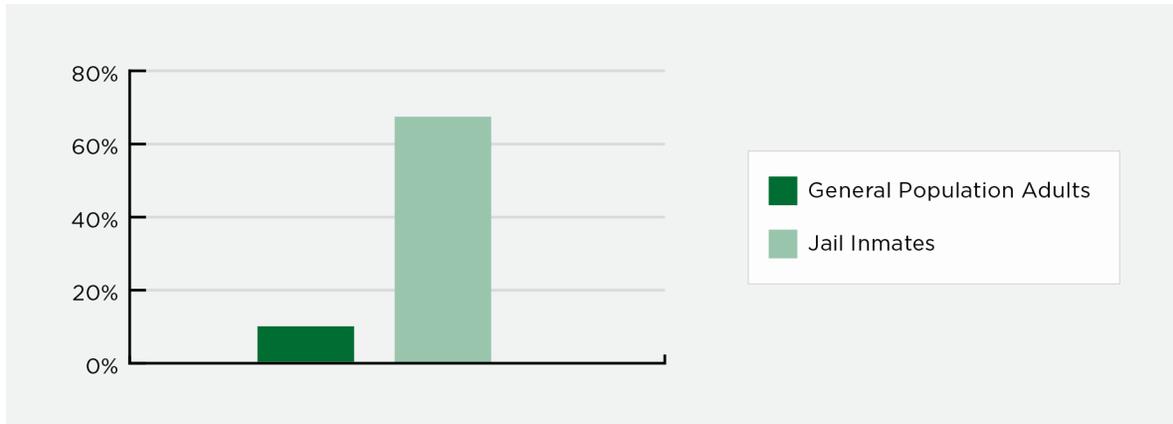
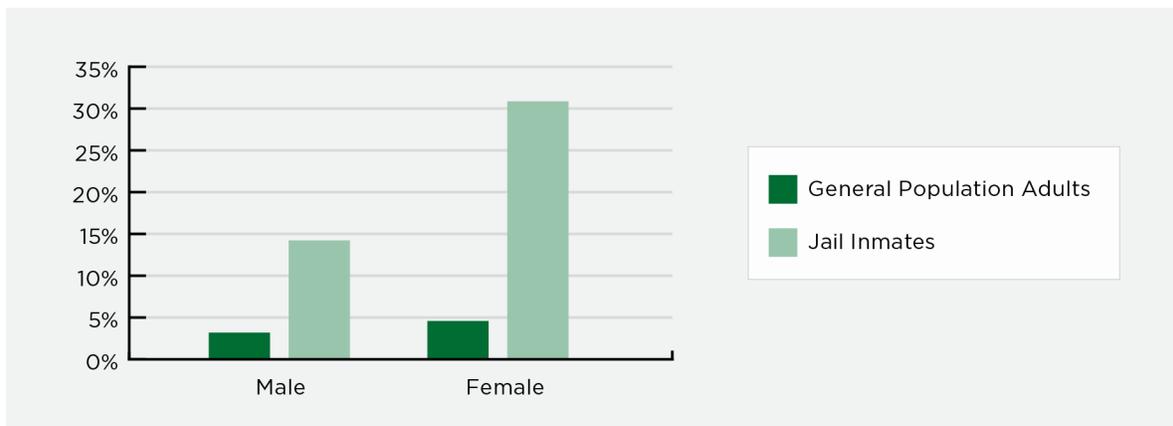


FIGURE 5. Serious Mental Illness, Jail Inmates and the General Population



Historically, justice-involved individuals have had limited access to health care in the community. The vast majority has been uninsured, with one study showing that 90% of people released from jail in San Francisco had no health insurance.¹⁴ As a result, many justice-involved individuals either have sought care in emergency rooms or forgone community-based care entirely. For example, one study reported that 80% of inmates with chronic diseases in Hampden County, Mass., had not received care in the community in the year prior to incarceration.¹⁵

Because the Affordable Care Act (ACA) gave states the option to expand Medicaid eligibility to childless adults with income up to 138% of the federal poverty level, it is likely that many justice-involved individuals are newly eligible for Medicaid. However, that does not ensure that they will seek out health insurance on their own. After Massachusetts’s 2006 health reform initiative, one study found that while only 2.6% of the state’s general population was uninsured, 22% of people

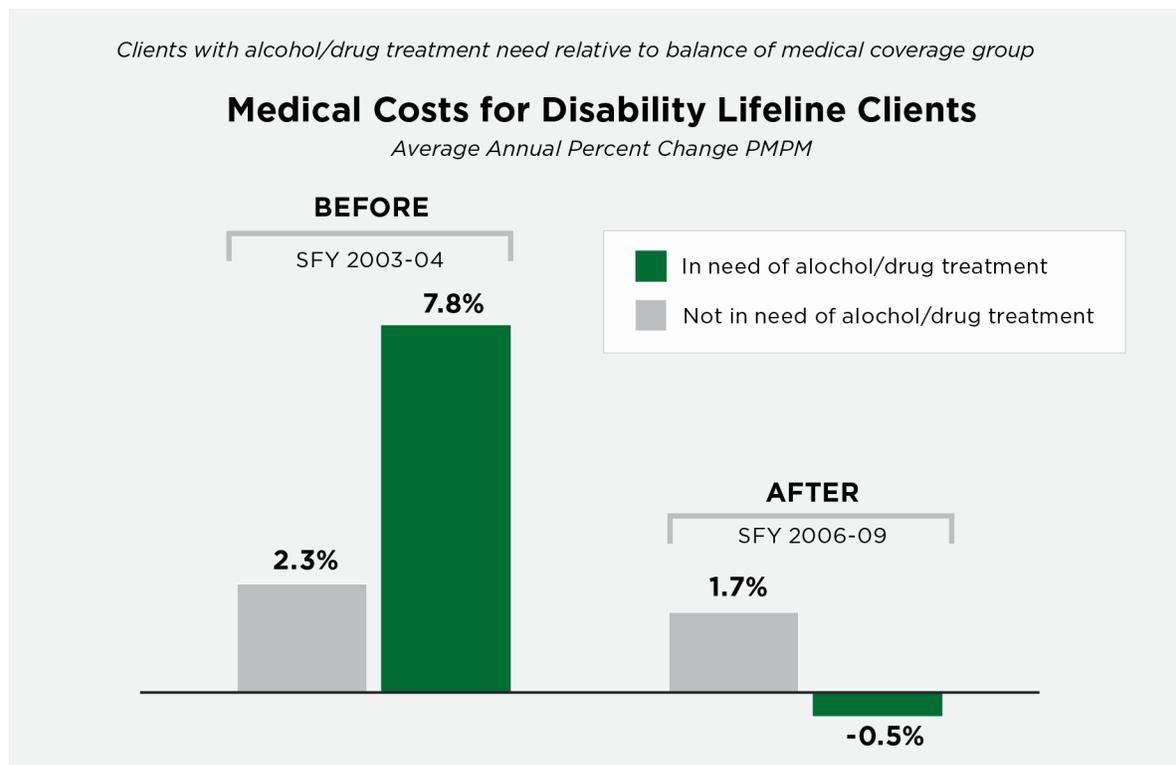
admitted for public substance use disorder treatment were uninsured. The uninsured population was disproportionately represented by low-income adults and Black and Hispanic people, all of whom are also disproportionately represented in the criminal justice system.¹⁶

Evidence suggests that improving access to care—especially to services such as substance use disorder treatment—for justice-involved populations could produce benefits for individuals and society alike.

In Washington State, health economist David Mancuso studied the impact of expanded substance use disorder treatment to low-income individuals, including many with histories of justice system involvement. In the 12 months following treatment, arrests declined by up to 33% compared to control groups that needed treatment but did not receive it. Additionally, the treatment resulted in up to \$1.16 in savings to the criminal justice system for every dollar spent on treatment, and \$2.83 in savings for every dollar after factoring in savings to crime victims.¹⁷

The potential savings may be even greater. Substance use puts people at risk for catastrophic injuries, infectious diseases, and chronic disease progression, all of which contribute to high medical costs. Mancuso found that growth in medical expenditures for low-income individuals with substance use treatment needs decreased relative to those without substance use needs in the years after the state expanded access to substance use treatment (Figure 6).¹⁸ Linking justice-involved individuals with appropriate behavioral health services could help eliminate health disparities and reduce recidivism, criminal justice costs, and health care costs.

FIGURE 6. Medical Cost Growth after Washington State’s Substance Use Disorder Treatment Expansion



Source: Washington State Department of Social and Health Services

Justice-involved individuals often face a variety of challenges as a result of their criminal records, such as prohibitions or restrictions related to food stamps and cash assistance, public housing, getting a driver's license, and obtaining student loans.¹⁹ These barriers, in turn, may make it more difficult for people to manage their health issues. Having stable housing, for example, has been shown to improve overall health status, improve outcomes for people living with HIV/AIDS, improve mental health, and reduce substance use.²⁰ In addition, inability to deal with these challenges may lead individuals to re-offend and be re-incarcerated.

Paraprofessional health workers with shared health, cultural, socioeconomic, linguistic, and even criminal justice backgrounds could bring justice-involved individuals into the mainstream health care system and deliver services that traditional providers are neither trained nor reimbursed to provide, including services that address clinical needs and non-clinical needs that affect health. By connecting justice-involved individuals to appropriate community health services and helping them overcome justice-related challenges, paraprofessional health workers can support client recovery and health while reducing recidivism and costs associated with health care and the criminal justice system.

Medicaid Funding for Peer Support Providers

States have many options for providing Medicaid-funded peer support services to justice-involved populations.

In 1999, Georgia became the first state to cover peer support services as a Medicaid benefit, and other states soon followed suit.²¹ Recognizing the growing interest in peer support services, the Centers for Medicare & Medicaid Services (CMS, the federal agency that administers Medicaid) issued a 2007 guidance letter to state Medicaid directors confirming that peer support services could be a Medicaid-reimbursable service and outlining the steps necessary to pursue the option.

In the letter, CMS affirmed that peer support services for individuals recovering from mental health and substance use disorders are an evidence-based model of care that may include aspects of both counseling and support services. CMS likewise affirmed its commitment to state flexibility and innovation, while recognizing that one of the strengths of the peer support approach is the ability to tailor services to meet clients' individual needs.

The letter declared that states may deliver peer support services through several Medicaid funding authorities in the Social Security Act, including three authorities that states had already used to fund peer support services:

- **Section 1905(a)(13)**, also known as the "rehab option," is commonly used by states to provide Medicaid behavioral health services. States may add new services under the rehab option through amendments to Medicaid State Plans, which are the Medicaid program contracts between the state and the federal government. State Plan Amendments (SPAs) have two significant advantages: 1) they do not have to be budget-neutral; and 2) although they must be approved by the federal government, the review process is less stringent than for the waiver authorities discussed below.

- **The 1915(b) Waiver Authority** is a primary mechanism for developing Medicaid managed care systems and/or behavioral health systems. Medicaid managed care organizations (MCOs) receive fixed or “capitated” payments from states in order to pay for some or all of a designated group of beneficiaries’ Medicaid services. Unlike SPAs, 1915(b) waivers must be budget-neutral and must pass through a comparatively more stringent federal approval process.
- **The 1915(c) Waiver Authority** is an option for states to deliver Home and Community Based Services (HCBS), including behavioral health services, for clients who otherwise would be at risk of institutionalization. Like 1915(b) waivers, 1915(c) waivers must be budget-neutral and pass through a more stringent federal review process.²²

States may also authorize peer support services through the Section 1115 waiver authority, which allows states to waive federal Medicaid requirements in order to pursue research and demonstration projects or comprehensive changes to their Medicaid programs. Although the CMS letter did not state that peer support services may be delivered through a 1115 waiver, the flexibility that 1115 waivers afford states in making changes to their Medicaid programs suggests that this is an option. Like the waivers discussed above, 1115 waivers must be budget-neutral and pass through a more stringent review process than that for SPAs.

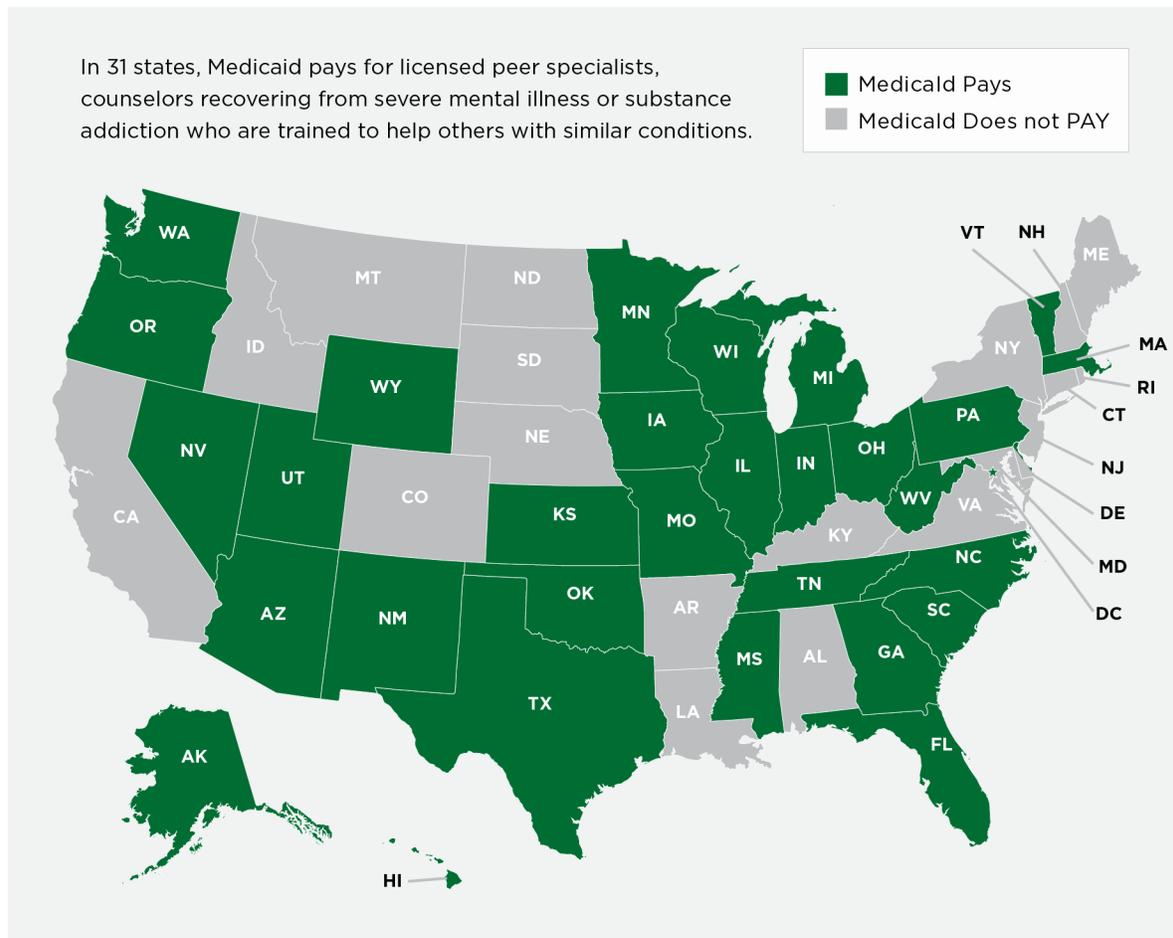
The rehab option and 1915(b) and (c) waiver authorities are the primary vehicles that states have used to deliver Medicaid behavioral health services. States’ decisions regarding which authority to use for peer support services would likely depend on the authority they use for behavioral health services in general. However, there is nothing precluding states from using other funding authorities for peer support services.

The CMS letter also outlines three broad requirements for states looking to adopt peer support services:

- Peer support providers must be supervised by a competent mental health professional as defined by the state.
- Peer support services must be coordinated within the context of a client’s individualized care plan.
- Peer support providers must complete training and certification as defined by the state.²³

CMS’ broad guidelines for funding and administration of peer support services point to the federal government’s support for state flexibility in developing and delivering peer support services for individuals with behavioral health disorders. As of September 2013, 31 states had adopted Medicaid-funded peer support services (Figure 7).²⁴

FIGURE 7. Mental Health Peer Specialists: States Where Medicaid Pays for Them



Source: OptumHealth and Appalachian Consulting Group

Under the ACA, mental health services, substance use disorder services, and rehabilitation services are now essential health benefits that all private health plans and Medicaid programs must provide. Because states have the flexibility to define Medicaid essential health benefits, this may be an opportune time for those states that do not currently offer peer support services to consider adding them to their Medicaid programs and tailoring them to the needs of justice-involved individuals.

The high prevalence of behavioral health disorders among justice-involved populations, combined with the flexibility that states have in funding and delivering peer support services, should encourage states to explore providing Medicaid-funded peer support services to justice-involved individuals. If addressing challenges related to the criminal justice system is part of a person’s recovery plan, then peer support services that address justice-related needs in the context of overall recovery could be Medicaid-reimbursable.

Following are three case studies of a state that has adopted peer support services using one of the funding mechanisms described above. Each case study discusses the relationship between the funding mechanism and the services provided, as well as the implications for using peer support services to meet the unique needs of justice-involved individuals.

Peer Support Services under the Rehab Option: Arizona

Unlike most Medicaid services, services provided through the rehab option may be delivered in a variety of locations (including clients' homes or other appropriate locations), and providers are not required to hold professional degrees or licenses. Similarly, services do not need to be clinical in nature and may include training in social and life skills. States define the scope, duration, and limitations of services, as well as medical necessity and provider certification criteria, in their Medicaid State Plans.

There are certain federal restrictions to services provided under the rehab option. For example, room and board, education, and vocational services cannot be reimbursed through the rehab option (although supported employment can). Also, in order to qualify for behavioral health services provided through the rehab option, clients must have a diagnosed behavioral health disorder, and the services must "involve the treatment or remediation of a condition that results in an individual's loss of functioning," which may be a behavioral health disorder.²⁵

Arizona used a SPA to add recovery-oriented services, including peer support services, to its Medicaid program under the rehab option. Arizona's State Plan defines peer support services as:

Services provided by persons who have been consumers of the behavioral health system and who are at least 18 years old. Peer support may involve assistance with more effectively utilizing the service delivery system such as assisting with developing plans of care, accessing supports, partnering with professionals, overcoming service barriers or assisting the member to understand and cope with the member's disability, behavior coaching, role modeling and mentoring.²⁶

This description is the authority under which HOPE bills Medicaid for the peer support services it provides. Not every HOPE client re-entering the community from jail is eligible for Medicaid, and not every Medicaid-eligible client has a behavioral health disorder. Moreover, services that HOPE provides inside the jail cannot be billed to Medicaid because federal Medicaid funding cannot cover services provided in jail. To account for the funding gaps, HOPE receives supplemental funding through other sources.

However, Arizona's State Plan description of peer support services is sufficiently broad to tailor recovery-oriented supports to Medicaid-eligible, justice-involved individuals with behavioral health disorders. This could include providing encouragement and assistance in complying with court obligations, overcoming stigma and other challenges created by criminal justice involvement, and other measures necessary to help individuals achieve recovery and live independently in the community.

The State Plan rehab option could afford states the flexibility to tailor recovery-oriented peer support services to justice-involved individuals. States that do not offer Medicaid peer support services may be able to add them through the SPA process.

Peer Support Services under a 1915(b) Waiver: Colorado

It is not clear whether states using the 1915(b) waiver authority have tailored peer support services to justice-involved individuals, but the potential exists. Section 1915(b) waivers allow states to waive certain federal Medicaid requirements. States primarily use 1915(b) waivers to: 1) create Medicaid managed care programs; or 2) to create certain programs, usually for mental health and/or substance use disorder treatment, that are “carved out” of the rest of a state’s Medicaid financing and delivery system.²⁷ Unlike SPAs, 1915(b) waivers must be budget-neutral, meaning that they cannot increase overall Medicaid costs compared to the projected cost without a waiver.

Colorado’s Medicaid behavioral health system (encompassing mental health and substance use disorder services) is carved out under a 1915(b) waiver, and includes recovery services provided by peer support specialists as a covered benefit.²⁸ Similar to Arizona, Colorado wrote a waiver describing a broad and flexible array of services that peer support specialists are able to provide. According to the waiver:

Recovery-oriented services promote self-management of psychiatric symptoms, relapse prevention, treatment choices, mutual support, enrichment, and rights protection. They also provide social supports and a lifeline for individuals who have difficulties developing and maintaining relationships. These services can be provided at schools, churches or other community locations. Recovery services are peer counseling and support services, peer-run drop-in centers, peer-run employment services, peer mentoring for children and adolescents, Bipolar Education and Skills Training (BEST) courses, NAMI courses, Wellness Recovery Action Planning (WRAP) groups, consumer and family support groups, warm lines and advocacy services.

Although it is not clear whether Medicaid-funded peer support services in Colorado have been tailored to justice-involved populations, it appears possible to do so in a manner similar to what Arizona has done. Likewise, other states that supply peer support services through a 1915(b) waiver—either through a comprehensive managed care system or, like Colorado, through a behavioral health carve-out—may be able to tailor peer support services to justice-involved individuals as well. In states that use 1915(b) waivers for behavioral health benefits without peer support services, advocates could work with state partners to seek Medicaid-funded peer support services through a waiver amendment.

Although 1915(b) waivers provide states with significant flexibility to design benefits, they must be budget-neutral, which makes obtaining federal approval more difficult. Additionally, waivers and waiver amendments tend to be more difficult to obtain than SPAs, due to increased scrutiny by CMS. Advocates of peer support services should consider their states’ existing behavioral health system as well as the respective benefits and drawbacks of the various Medicaid funding authorities when exploring the potential for peer support services.

Peer Support Services under a 1915(c) Waiver: Wisconsin

Medicaid Home and Community Base Services (HCBS) are designed to allow people who have been institutionalized or who are at risk of becoming institutionalized in health care facilities (jails are not considered eligible institutions) to live in non-institutional settings. States can use Section 1915(c) waivers to fund HCBS for individuals who currently require an institutional level of care. Like 1915(b) waivers, 1915(c) waivers must be budget-neutral.

In 2007, Wisconsin received approval for a 1915(c) waiver to provide HCBS for people with both a physical disability and a persistent mental illness who are transitioning out of nursing homes, and peer support services are included in the waiver as a covered service. However, given the narrow scope of eligibility for HCBS under the waiver, it is unlikely that many justice-involved individuals would be eligible for peer support services.²⁹

Because eligible individuals must require an institutional level of care, 1915(c) HCBS are likely not well suited as a means of providing peer support services to justice-involved individuals.

Peer Support Services using the 1915(i) State Plan Option: Untapped Potential

Similar to but more flexible than the 1915(c) waiver, the 1915(i) State Plan option could be an effective funding authority for states seeking to provide peer support services

The Deficit Reduction Act of 2005 added section 1915(i) to the Social Security Act, creating an option for states to amend their State Plans in order to provide HCBS for individuals who do not yet require institutional levels of care, but who are at risk of becoming institutionalized, as defined by the state. States have flexibility in designating eligible populations and tailoring services to meet their needs. Individuals with mental health disorders and/or substance use disorders can be eligible for 1915(i) HCBS even if they do not have other health disorders, which could allow states to provide HCBS to many justice-involved individuals. States have considered developing various criteria for 1915(i) services for individuals with behavioral health disorders, including individuals who:

- Have had more than one episode of care in a more intensive setting than outpatient treatment;
- Have been persistently unemployed or underemployed;
- Are unable to maintain a social support system;
- Lack basic living skills; or
- Demonstrate inappropriate social behavior.³⁰

Any service available through a 1915(c) waiver is also available through the 1915(i) State Plan option, including peer support services. In addition to peer support services, states may provide many other services known as “habilitative services” through the 1915(i) option, designed to

help individuals acquire and retain skills necessary for living in the community. States have flexibility to define Medicaid habilitative services (an essential health benefit under the ACA), which, among other services, may include transportation, supported education, and recreational services.³¹

The flexible eligibility criteria and service mix available through the 1915(i) State Plan option could make it a robust vehicle for providing services to justice-involved individuals that could promote safe, healthy, and independent living in the community.

It is unclear whether any state has used the 1915(i) State Plan option to deliver peer support services to individuals with behavioral health disorders. However, depending on a state's definition of eligibility for 1915(i) services, it appears that individuals with histories of justice involvement could meet the eligibility requirements. Moreover, because 1915(i) services are provided through a SPA, budget neutrality is not required. This could make adoption of 1915(i) services an easier route to providing peer support services compared to the options provided by section 1915(b) or (c) waivers.

Managed Care and the Flexibility of Capitation

In many states, managed care has become the main vehicle for delivering Medicaid services. The number of Medicaid beneficiaries receiving some or all of their benefits through MCOs has grown since states began implementing managed care systems in the 1980s. In 2012, the Kaiser Family Foundation estimated that approximately 66% of all Medicaid beneficiaries were enrolled in MCOs. That proportion could soon be much higher, as the vast majority of people in the ACA's Medicaid expansion population, including justice-involved individuals who newly gain eligibility, are expected to receive care through MCOs.³²

The increasing reliance on managed care in the Medicaid program has implications for the delivery of peer support services and for services delivered to justice-involved populations. As long as MCOs meet federal and state service requirements, they have discretion to pay for goods and services that are not covered by Medicaid. It is possible that Medicaid will pay for peer support services that help individuals overcome challenges related to justice system involvement. In addition, MCOs may have the flexibility to fund services above and beyond what is reimbursable in order to assist justice-involved populations in addressing various non-clinical factors that affect health.

For example, MCOs could employ or contract with organizations that employ peer support providers in order to deliver recovery services to justice-involved individuals. If peer support services are a Medicaid benefit in the MCO's state, Medicaid may reimburse those services as part of the MCO's capitated payment. However, in the event that a justice-involved plan enrollee needs services that are not eligible for Medicaid reimbursement—for example, direct transportation to a court appearance—the MCO could still pay the peer support provider, or the organization employing the peer support provider, for those services.

Such arrangements could make economic sense for MCOs. When a Medicaid beneficiary becomes an inmate of a jail or prison, that individual's Medicaid enrollment is either suspended

or terminated. In either case, the state's capitated payment for that beneficiary would likewise be suspended or terminated. MCOs may be able to help justice-involved individuals with behavioral health disorders avoid unnecessary incarceration resulting from direct manifestations of their behavioral health disorders (for example, drug possession charges or failed drug tests) or other avoidable technical violations (for example, missed court dates). This could improve beneficiaries' overall health and wellness, and, by maintaining members' enrollment, improve MCOs' bottom lines. The opportunities for improving health and reducing both costs and recidivism could grow as more justice-involved individuals become enrolled in Medicaid MCOs.

Medicaid Funding for Community Health Workers

Community health workers (CHWs) may perform a broad scope of potential duties, including helping patients adopt healthy behaviors, conducting outreach, providing resource navigation, and providing some routine clinical services (such as blood pressure screenings). Although their specific jobs and duties may vary, all CHWs share cultural, linguistic, socioeconomic, and/or racial and ethnic ties to the communities they serve.³³

A recent initiative called the Transitions Clinic Network recognized that CHWs with histories of incarceration could draw from their personal experiences to positively impact justice-involved individuals. The Transitions Clinic model uses formerly incarcerated individuals as CHWs to help recently released prison inmates who have chronic diseases. These CHWs work in care teams at Federally Qualified Health Centers (FQHCs) with physicians who have experience with justice-involved populations. The goal is to improve patient health, decrease costs, decrease reliance on emergency rooms and inpatient hospitalizations, and to improve access to primary care.³⁴ According to an early evaluation of the Transitions Clinic model published in the *American Journal of Public Health*, the CHWs provide:

(1) case management support, including referrals to community-based housing, education, and employment support; (2) medical and social service navigation, including accompanying patients to pharmacies, social services, and medical or behavioral health appointments; and (3) chronic disease self-management support, including home visits for health education and medication adherence support.

The evaluation found evidence that the Transitions Clinic approach is working. The number of Transitions Clinic patients who had any emergency room visits was 15% lower than that of a control group. Perhaps more strikingly, Transitions Clinic patients had an overall reduction in emergency room visits of 51% compared to the control group.³⁵

The CHW services provided in the Transitions Clinic model are not Medicaid-covered services.³⁶ Instead, the intervention is funded by a grant from CMS's Center for Medicare and Medicaid Innovation (CMMI), a program created under the ACA. The CMMI award demonstrates the federal government's recognition that services provided by CHWs that are tailored to meet the needs of the justice-involved could have profound impacts on health and on health care system costs. This kind of support, combined with further research demonstrating the efficacy of CHWs, could pave the way for more sustainable financing of CHW and other services tailored to meet the needs of justice-involved populations.

Despite the evidence of their effectiveness, funding for CHW services historically has been difficult to sustain. Organizations providing CHW services have relied mostly on short-term grants from private philanthropies and government agencies, as is the case with the Transitions Clinic Network. One reason for this lack of funding is that, unlike peer support providers, CMS has not recognized CHW services as Medicaid-reimbursable. Nevertheless, there are opportunities to fund CHW services through Medicaid, including:

- Through MCOs that either directly employ or contract with organizations that employ CHWs and
- Through Section 1115 Waivers.

The following case studies illustrate the opportunities to fund CHW services through MCOs and 1115 waivers and discuss the implications for justice-involved individuals.

Community Health Worker Services under Medicaid Managed Care: New York

Medicaid MCOs have broad flexibility to use their capitated funding once minimum federal and state service requirements have been satisfied. As discussed earlier in the context of peer support services, MCOs may use their resources to employ or contract with organizations that employ CHWs even though the services are not directly billable to Medicaid.

One Medicaid MCO that has pursued this option is Health Plus in New York City, which directly employs CHWs as “community health education associates.” Some CHWs provide “community education services,” including “health risk assessments, case management referrals, appointment scheduling, targeted clinical interventions,” and home visits. CHWs employed by Health Plus help the MCO meet certain New York State Medicaid requirements, such as providing health education services. However, the services that the CHWs provide go beyond what is required by the state.³⁷

Although it is not clear whether any Medicaid MCOs employ CHWs to tailor services to justice-involved individuals, the flexibility they have through capitated funding likely would allow them to do so. With the vast majority of justice-involved individuals who are newly eligible for Medicaid likely to enroll in MCOs, the option of tailoring CHW services to their needs could help improve health outcomes, reduce costs, and reduce recidivism. As discussed, helping people maintain their benefits in the community could be a sensible business proposition for MCOs. If the early data from the Transitions Clinic model of care are any indication, CHWs with histories of incarceration could be valuable and uniquely qualified members of the health care team.

Community Health Worker Services Under the 1115 Waiver Authority: California

In 1999, California received approval for a 1115 waiver demonstration program to expand family planning services to low-income women and adolescents. The demonstration, known as the Planning, Access, Care, and Treatment (PACT) program, allows certain services provided by CHWs, including the administration of pregnancy tests and counseling, to be billed to Medicaid.³⁸

Because they can provide states with broad flexibility to cover new services and populations, it is likely that states could use 1115 waivers to fund CHW services tailored to justice-involved populations. However, like all Medicaid waivers, 1115 waivers must be budget-neutral and must pass through the federal review process.

Medicaid Administrative Claiming: Filling the Gaps

Federal law prohibits federal Medicaid funds from being used to pay for services provided in jails and prisons. This preclusion of Medicaid spending, known as the inmate exception, would prevent Medicaid from reimbursing peer support or CHW services provided to inmates, potentially limiting efforts to begin care prior to release. However, certain administrative activities relevant to preparing inmates for re-entry are potentially eligible for federal reimbursement.

Most federal Medicaid spending is for services provided to beneficiaries. However, federal reimbursement is also available for administrative activities that support the “proper and efficient administration” of the Medicaid State Plan. States may receive this federal support for administrative activities through Medicaid Administrative Claiming (MAC). State governments, local governments, and community-based organizations can participate in MAC by coordinating with the state’s Medicaid Single State Agency, which administers the Medicaid State Plan and submits administrative claims to the federal government. Most MAC-eligible activities can receive reimbursements at 50% of total costs. Before receiving MAC reimbursements, an entity would need to either become a claiming unit, as designated by the Single State Agency, or subcontract with an existing claiming unit.³⁹

Certain activities that help enroll inmates in Medicaid may be reimbursed. For example, California received approval from CMS to seek MAC reimbursement for providing “eligibility intake administrative activities to an inmate to facilitate their enrollment into Medi-Cal” (California’s Medicaid program) within 30 days of the inmate’s release.⁴⁰ Eligibility intake activities could include Medicaid outreach and Medicaid application assistance. In California’s MAC plan, no other activities related to jail or prison inmates are eligible for reimbursement.

California’s experience suggests that MAC reimbursement is available for peer support or CHW services that involve Medicaid outreach or application assistance for justice-involved individuals, if such services are provided within 30 days prior to an inmate’s release or any time after release. After release, other potentially MAC-reimbursable activities for justice-involved individuals include non-emergency transportation to Medicaid-covered services and referrals, coordination, and monitoring of Medicaid-covered services.

Paraprofessional initiatives tailored to justice-involved individuals may be able to use MAC reimbursements to help fund their services and to perform certain activities while clients are still incarcerated. Peer support and CHW programs could use MAC to help pay for activities they are already performing or take on new activities with the knowledge that they could be MAC-reimbursable. Either way, programs looking to pursue MAC reimbursements would need to coordinate with their Single State Agency and, potentially, with local government agencies

in order to obtain designation as a claiming unit or subcontract with an existing claiming unit. If successful, paraprofessional interventions for justice-involved individuals could use MAC funding to complement other Medicaid service funding streams.

Paraprofessional Services, Justice-involved Individuals, and Population Health

One of the ACA's goals is the improvement of population health, including the elimination of health disparities. This goal cannot be achieved without addressing the needs of justice-involved individuals, a population with major health disparities and other challenges that impact health.

Through Medicaid expansion, the ACA has created an opportunity for many justice-involved individuals to gain health insurance for the first time. However, eligibility does not guarantee that justice-involved individuals will enroll, have access to health care, or find health care in the community that addresses their unique needs.

Peer support providers and CHWs could play an important role in bringing justice-involved individuals into the health care system, delivering culturally competent services, and drawing on shared experiences to help clients overcome their often interrelated barriers to health and community re-entry. Paraprofessional health workers have the knowledge and flexibility to address non-clinical challenges to health that justice-involved individuals face—including barriers to housing, employment, community integration, and independent living—and that traditional health care providers are less prepared to address.

With their lived experiences and flexible reimbursement options, peer support providers and CHWs are ideally positioned to provide services to justice-involved individuals. Criminal justice and health care systems that collaborate to deliver paraprofessional services to justice-involved populations are likely to see improved health outcomes, reduced costs, and reduced recidivism. These results benefit everyone.

Notes

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