Unmanaged Care:
The Role of Massachusetts Behavioral Health Partnership in Prisoner Reentry

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“Unmanaged Care” explores the responsibility of a Medicaid behavioral health carve-out in prisoner re-entry planning and care. Utilizing the Massachusetts Behavioral Health Partnership (MBHP) as an example, the following policy brief describes the practical, clinical and economic rationales for an expanded and explicit role. Through an exploration of context, a framework is presented upon which three policy options are offered. The concluding recommendation calls for the implementation of all three options, to allow MBHP’s resources to match the variety of clinical needs of returning prisoners.

The Revolving Door Between the Streets and the Cellblock

According to the Executive Office of Public Safety and Security (EOPSS), approximately 20,000 inmates return to communities in Massachusetts each year ill-prepared to overcome the medical, behavioral health and social barriers that face them (2009). Within three years, at least 63 percent are re-incarcerated (EOPSS, 2009). The high rate of recidivism is connected to the lack of investment in coordinated reentry planning, treatment services and rehabilitative programs (EOPSS, 2009; CSG, 2002). The revolving door between the “street and the cell block” adversely impacts public safety and public health; and the rising costs of incarceration consume scarce state resources. With no single agency or entity responsible for reentry planning, efforts to ensure continuity of care are inadequate (Roberts et al., 2002). The demographics of the incarcerated population; their high rates of mental health, substance abuse and/or medical conditions; and their status as offenders, marginalize them from care when they transition home (Roberts et al., 2002; MPHA, 2003; Williams, 2005; Hammett et al., 2002). Taken in concert, these issues speak to the need of managing the care of returning prisoners.
The prison population in Massachusetts tripled between 1980 and 2002, a trend that is not Massachusetts’ alone, but part of a national rush to incarcerate, putting 1 in 100 people in the United States behind bars (Brooks et al., 2005; Pew, 2008). Correctional institutions currently serve as de facto public health facilities, in part as a result of the deterioration and deinstitutionalization of public health systems, as well as the criminalization of mental illness, substance abuse and homelessness. The largest mental health institutions in the United States are urban jails, and twice as many seriously mentally ill people receive services in jails and prisons than in public psychiatric hospitals (Wilper et al., 2009; Weisman, 2005). Mental health and substance abuse problems are ubiquitous within correctional facilities across the nation, including Massachusetts (Magaletta and Verdeyen, 2005).

Massachusetts has a dual system of corrections, with a state-run Department of Correction (DOC) and thirteen county-run Houses of Corrections (HOC). The Massachusetts DOC houses 11,100 individuals annually: prisoners serving more than two-and-a-half years, female inmates unable to be housed in county facilities, and people civilly committed for detoxification and substance abuse treatment (Marshall, 2008). County HOCs house an estimated 16,500 inmates annually, accounting for 92 percent of Massachusetts’ incarcerated population (MSC, 2004; MA DOC, 2009). On average, HOC inmates serve 8.5 months, with no inmate serving more than 36 months (MA DOC, 2009). The overwhelming majority of the 16,500 county inmates return to communities in Massachusetts each year (although annual release numbers are not currently tracked for county facilities) and, in 2007, the DOC released 3,140 inmates “to the streets” (MA DOC, 2008; CJPG, 2005). Within the DOC population, 90 percent of inmates have substance abuse issues and 25 percent have an open mental health case (Marshall, 2008). The rates of substance abuse and mental illness amongst the county inmate population are unknown, but assumed to be similar to those of the DOC population (CJPG, 2005).

Healthcare for Offenders

The Massachusetts Behavioral Health Partnership (MBHP), as the behavioral health carve-out for the typical MassHealth coverage returning prisoners receive, plays a major role in providing services and care for a population disproportionately affected by mental
illness and substance abuse issues. Although MBHP manages high-risk populations, the specific and special needs of ex-offenders place an additional burden on MBHP within an environment of competing mandates and dwindling resources. The task is not MBHP’s alone, but requires buy-in from state legislators, the Department of Correction (DOC), county Houses of Corrections (HOC), Medicaid officials, health care practitioners, advocates and the returning prisoners themselves. With carefully crafted and implemented policies focused on the variety of behavioral health needs of the ex-offender population, MBHP can reduce costs, improve outcomes and maintain its reputation for quality care, all while filling a service gap for returning prisoners, their families and their communities.

Currently, Massachusetts policymakers do not know how many inmates across Massachusetts receive any kind of behavioral health treatment during their incarceration. Nationally, only one-quarter to one-third of inmates with recognized mental health conditions receive treatment while in prison. Among inmates with severe psychiatric illnesses, only half receive services while incarcerated (Beck and Maruschak, 2001; Morgan et al., 2007). Massachusetts also lacks data on how many inmates have a mental and/or substance use disorder but remain undiagnosed while incarcerated. The question is not esoteric, but fundamental in terms of MBHP’s ability to plan, both financially and organizationally, for the behavioral health needs of the ex-offender population.

Screening and Assessment

Under Federal guidelines, inmates recognized by correctional staff as needing psychological or psychiatric treatment, either based upon a classifications screen or during their incarceration, receive planning and coordination for such services upon discharge from the facility. As reported by the Department of Justice, an independently administered test of a national sample of inmates found that 63 percent had acute mental illness symptoms that were missed by routine screening performed by corrections staff (DOJ, 2007). Classification screens are intended to identify inmates at acute psychiatric risk and/or inmates in need of medical withdrawal from alcohol and/or narcotics. Screens also rely heavily upon past use of behavioral health services; for the incarcerated population, this is an ill-fitting diagnostic tool (Williams, 2005; Fellner, 2007). Corrections staff are poorly trained to recognize mental disorders in
the milieu, and often misinterpret clinically significant behaviors as being attempts at manipulation (Kupers, 1999). The rule in corrections is that you don’t diagnose what you don’t have the resources to treat (Kupers, 1999).

If a significant number of inmates in Massachusetts have undiagnosed mental illness, then those individuals return home without the care they may desperately need. Without a link to community-based services, ex-offenders may misuse emergency room care to treat psychological issues and their resultant problematic behavior, or they may further decompensate, requiring higher levels of care than may have been needed had the right supports been in place. Overall, it can be argued that rates of mental illness and substance use disorders within the Massachusetts’ incarcerated population are drastically underestimated. That said, even those who are identified and are most at risk go without comprehensive reentry planning and care coordination. For example, despite the overwhelming behavioral health issues of the DOC population, 2,562 inmates were released to the community in 2006 with only one mental health coordinator responsible for planning their reentry care (Marshall, 2008). HOCs are limited in their ability to provide such planning for the majority of returning prisoners, with Hampden County being the sole exception.

The Transition Home: Reentry Research and Practice

The main forces behind the push towards informed and coordinated reentry planning are the goal of reducing recidivism and issues related to public health. Reducing recidivism is the gold standard for any offender intervention, whether inside correctional facilities or outside in communities. Not only is incarceration costly, averaging approximately $40,000 per inmate per year, but there are social and emotional costs for individuals, families and communities (CJPG, 2005; Rose and Clear, 2001; Williams 2006). The cycle in and out of prison, especially from and to disadvantaged neighborhoods, decreases public safety, increases violence and places unfair demands on overburdened systems of care within such communities (Williams, 2005; Williams, 2006; Rose and Clear, 2001, Sullivan, 20089; Brooks et al., 2005). However, focusing on reduced recidivism as the sole rationale for outpatient
behavioral health services in reentry care is dangerous given the weak causal links found in the research (Lovell et al., 2002; Magaletta et al., 2007, Sullivan et al., 2007).

Issues of public health arise from the fact that inmates are disproportionately infected with communicable diseases and affected by chronic diseases (Williams, 2005). Research shows that returning prisoners are linked to increased rates of HIV/AIDS, especially among African-American women, and increased rates of other infectious diseases like Hepatitis C (Williams, 2005; Miller 2007; Adimor et al., 2006; Hammett et al., 2002). The relationship between inmate behavioral health and public health is primarily experiential, although studies show public health benefits associated with intensive substance abuse treatment (Chandler et al., 2004; Melnick and Taxman, 2007). Across the board, the research is clear on the need for coordinated physical, mental and behavioral health reentry planning and care, in conjunction with support services around issues of housing and employment (Lynch and Sabol, 2001; Bazelton, 2002; Travis, 2000; Travis et. al., 2001).

Research on recidivism and Medicaid coverage for seriously mentally ill detainees (people held but not incarcerated) showed benefits for both the criminal justice and mental health systems, the report warned against generalizing the findings to the inmate population (CSG, 2007). However, as stated by the Massachusetts Public Health Association “without health care coverage, access to community programs, and assistance and support with reintegration, the criminal justice population’s illnesses will worsen, posing an increased health and safety threat to the communities to which they return (2003, p. 5).” The timing of health insurance coverage for returning prisoners is critical. Although county HOC inmates - who have on average of a fifth grade reading level – submit a MassHealth application once released, this disconnect and delay is counterintuitive to good health practice and to Massachusetts' commitment to outreach and access (CJPG, 2005). Timing is also important in terms of reducing recidivism. The first year after release is a critical period during which former prisoners are susceptible to reoffending (Brooks et al., 2005). For returning prisoners with mental illness and/or substance use disorders, insurance coverage at the time of release is vital to obtaining psychological/psychiatric services in the community. Without access to services, ex-offenders with mental illness and/or substance use disorders are left with limited options,
and are more at risk for recidivism than ex-offenders who do not have mental disorders (Bazelton, 2002; CSG, 2005; Travis, 2000).

**Eligible but Uncovered**

Currently the Division of Health Care Finance and Policy (DHCFP) mandates that a correctional facility may not be used as an address when applying for MassHealth and that benefits be cut after an inmate serves thirty days. Through a pilot program between the DHCFP and the DOC, a waiver allows the majority of eligible DOC inmates to have MassHealth Essential coverage (and a card in hand) at the time of release. The DOC and the DHCFP made great strides in improving access to MassHealth coverage for all DOC inmates and was nominated by the Council of State Governments for an Innovations Award because of their combined efforts (Marshall, 2008). The waiver, however, does not cover the majority of returning prisoners – those in county HOCs, and cannot ensure coverage even for DOC eligible inmates. For example, in 2006 the DOC submitted 2,656 MassHealth applications, 1,273 inmates were covered at the time of their release, and 1,383 inmates were placed on a waiting list for coverage (MBHP, 2006). Even if the DHCFP waiver were extended to include county HOCs, there is an enrollment cap for MassHealth Essential coverage. In 2006, CMS approved an increase from 44,000 to 60,000 enrollees; however 10,800 eligible applicants were placed on a waitlist that same year (MBHP, 2006).

MassHealth Essential covers adults without dependent children who meet income eligibility guidelines and automatically enrolls those covered into MassHealth’s Primary Care Clinic (PCC) plan, with MBHP as the behavioral health carve-out. Unlike MassHealth Standard, in which enrollees can choose among a few managed care plans with differing behavioral health coverage schemes, enrollees in MassHealth Essential cannot change their plan. Therefore, many ex-offenders have no choice regarding their insurance plan, and MBHP is solely charged with managing their mental health needs. The challenge is then twofold: including county HOCs in the waiver and closing the enrollment gap for MassHealth Essential.

Insurance coverage for this population is fundamental, but is not within itself enough to bring about the positive outcomes associated with comprehensive reentry planning and care.
A Rational Role for MBHP

Little is known nationally about the role of a Medicaid behavioral health carve-out in reentry planning and care, despite the research around the importance of coverage and access to substance abuse and/or mental health services (Morrissey, 2004; Lynch and Sabol, 2001; Lovell, 2008; CSG, 2005). MBHP can continue to demonstrate its progressive approach to caring for vulnerable populations by becoming the leader in this arena. Given the “skill set” of MBHP in providing clinically appropriate care to high-risk populations, a specialized focus on returning prisoners is a natural extension of what MBHP already knows how to do, and for which it is well regarded. In fact, MBHP is already serving returning prisoners, both intentionally and by default. With regard to the former, in 2005 MBHP completed a performance incentive project for health care service providers involving returning prisoners. MBHP set up a system linking MassHealth eligible prisoners with Community Support Persons (CSPs) and outpatient services. The health care service provider agencies operating CSP programs and local reentry centers are now independently running the program after MBHP established the connection through the incentive project. Given that the incentive project was not, and is not, a part of MBHP’s contract requirements with MassHealth, the project signals MBHP’s awareness of the service needs of returning prisoners, as well as the potential benefits of such service (Stelk, 2009). To that end, expanding MBHP’s role in reentry planning and care is practically viable, given that it has already invested financial resources in such initiatives.

MBHP also provided enhanced service provision to returning prisoners by default through a medical care management program. Known as EssentialCare, the program was available to members enrolled in MassHealth Essential and was created in response to the high utilization rates and undertreated conditions endemic in many Essential plan members. The program is no longer part of MBHP’s case management services, but consisted of twelve dedicated field-based licensed case managers that served 500 members by providing integrated care coordination and outreach (MBHP, 2006). The characteristics of the referred members included: frequent utilization of services, misuse of emergency room services, a history of noncompliance with treatment, high rates of poverty, a
chronic disease burden and predicted high medical costs (MBHP, 2006).

Although ex-offender status was not a part of the data collected for the EssentialCare program - making it difficult to know the number of involved members with a history of incarceration - many returning prisoners share these characteristics (Watson, 2000). It is conceivable that MBHP was already providing intensive care coordination to returning prisoners through the EssentialCare program without its explicit knowledge. The performance incentive project and the EssentialCare program, combined with the unknown ex-offender beneficiaries of MBHP’s other care management programs, suggests that MBHP should take a decisive role for in reentry planning and care. In other words, MBHP is aware of the specialized need for care management for ex-offenders and can build off of existing practices and programs.

If the repeated legislative effort to require that all eligible returning prisoners have MassHealth at the time of discharge passes (an issue addressed later within this brief), MBHP will see a dramatic increase in its members. It is a fundamental benefit for any managed care organization to be able to plan for how many members will enroll, when, and with what kind of utilization rates and needs. MBHP will also face an influx of members who experience higher rates of medical, mental health and substance abuse issues than the general population, as well as significant barriers in regard to housing, public assistance and employment. MBHP will benefit from proactively planning for the enrollment of returning prisoners by putting in place utilization management strategies and effective care management programs to offset the risk and burden associated with this population. Moreover, given its commitment to quality care and best practices, several clinical rationales exist for MBHP to proactively coordinate and attentively manage the behavioral health needs of ex-offenders.

Decrease in Corrections Supervision

First, increasing numbers of prisoners are being “released to the streets” without the benefits of probation/parole, an issue highlighted by the Governor’s Commission on Criminal Justice Intervention (EOPSS, 2009). The proportion of prisoners released from DOC facilities under supervision decreased from 80 percent in 1980 to 33 percent in 2002 (Brooks et al., 2005). The function of
probation/parole departments in requiring, referring and/or tracking behavioral health treatment for ex-offenders is lost when prisoners are released without supervision. The concern for MBHP is that this function provided some form of a safety net for high-risk ex-offenders by creating de facto case management. The conceivable negative consequences of the loss of this benefit include: delays in accessing treatment, lower retention rates in treatment and declines in mental health status and functioning. For MBHP to mitigate these consequences, it needs to fill the case management gap created by the waning role of parole/probation departments across the state.

Challenges of Reentry Environment

Second, the majority of prisoners return to disenfranchised, disadvantaged and under-resourced communities. A 2005 research report by the Urban Institute on prisoner reentry in Massachusetts found that the highest number of released prisoners return to Suffolk County, and are heavily concentrated in neighborhoods in Boston with the highest rates of poverty and unemployment in the state (Brooks et al., 2005). Worcester County is home to the second largest number of returning prisoners, with Worcester and Suffolk counties accounting for more than one third of Massachusetts’ ex-offender population (Brooks et al., 2005; CJPG, 2005). The issue for MBHP is that health care service providers, organizations and agencies within these communities are ill-equipped to meet the exceptional needs of ex-offenders given the overwhelming demand and need for services within these communities as a whole. The ability to proactively plan for the treatment needs of returning prisoners not only improves their clinical outcomes, but may also result in collateral benefits for the communities in which they live.

Health Effects of Incarceration

The third rationale encompasses research related to the beneficial and harmful health effects of incarceration itself. A report on correctional health by the Massachusetts Public Health Association (MPHA) found that the majority of inmates across the state do not receive regular medical or mental health care prior to incarceration. Studies found that the health status of many inmates improved as a result of the medical care received while incarcerated, gains that are lost when inmates are released without coordinated reentry planning (Wilper et al., 2009). For example, a
study using self-reported data by the Hampden County Jail found that general health and emotional functioning improved from the time of intake to shortly after release (Lincoln and Conklin, 2002). However, it is important to note that Hampden County employs a public health model of correctional care that is exceptional and is not replicated in any other state or county facility. If incarceration is a period of intervention that improves physical and mental health status for many inmates, then it is in-line with best practices to ensure continued services in the community to support and strengthen such gains.

Research also shows that incarceration negatively impacts the physical and behavioral health of inmates (Wilper et al., 2009; Massoglia, 2008). A study exploring the association between incarceration and health found that a single episode in prison had a much larger relationship with poor health than current drug use (Schnittker and John, 2006). Dr. Kupers, author of Prison Madness: The Mental Health Crisis Behind Bars (1999), writes of the decline in mental health functioning for inmates as a result of the harshness and brutality of correctional facilities themselves. Moreover, Dr. Kupers (1999) notes that the inability and/or unwillingness of correctional staff to recognize signs of emotional distress and decline in inmates (those who may or may not have had a previously diagnosable disorder), leads to inmates being released with untreated acute mental illness. For a population already disproportionately affected, the heightened prevalence and severity of behavioral health issues caused by incarceration is justification for intensified and coordinated care upon release.

The transition process from prison, a very controlled and regulated environment, to the community has implications for mental health functioning. “Gate fever,” a syndrome defined by anxiety and irritability, is widely recognized by those working with returning prisoners. The limited research on this syndrome found that it is not ultimately debilitating, but when coupled with the documented ineffective and destructive coping mechanisms of released offenders, can adversely impact mental health status and functioning (Travis et al., 2001; Zamble and Porporino, 1997). By providing assistance at the moment of release, an opportunity is created to build a bridge to the kinds of health and social services that can support healthy and effective coping mechanisms while reducing symptoms of anxiety.
The moment of release is also a critical time to ensure that inmates with substance abuse issues, who may have experienced a significant period of abstinence during their incarceration, receive the support and services needed to sustain recovery. In the absence of treatment, rates of relapse following release from prison are strikingly high. It is estimated that two-thirds of untreated heroin abusers resume their patterns of use and criminal behavior within three months of release (Wexler et al., 1998). The clinical and social consequences of substance abuse are well documented, and with 90 percent of Massachusetts’ returning prisoners reporting a substance abuse issue, the need for coordinated care at the time of release is essential (Marshall, 2008; MA DOC, 2009).

Although the specific clinical benefits of coordinated services for returning prisoners in Massachusetts is yet to be studied, an evaluation of the EssentialCare program provided some evidence. As previously discussed, the EssentialCare program provides enhanced care management to MBHP members with characteristics and demographics similar to those of ex-offenders. The Center for Health Policy Research at the University of Massachusetts Medical School evaluated the program in 2005 and found improved outcomes across all domains. Regarding clinical outcomes, EssentialCare members were more compliant with treatment, had improved scores on a standardized measure of mental health functioning and fewer acute and emergency care services. A hybrid care management model like EssentialCare could result in similar positive outcomes for returning prisoners.

Racial Disparities and Quality of Care

The final clinical rationale is MBHP’s commitment to quality care as it relates to racial and ethnic health disparities. While only 14 percent of Massachusetts’ general population is identified as being “non-white,” 57 percent of inmates in DOC facilities, 92 percent of whom are male, are identified similarly (Marshall, 2008). The reality of Disproportionate Minority Confinement (DMC) means that “correctional facilities, as social institutions, will continue to be important in shaping the life-course and health trajectories of Black and Latino men, as well as their families and communities” (London and Myers, 2006, p. 165). By providing enhanced behavioral health services through planning and care coordination to returning prisoners across the state, Massachusetts can work to rectify the racial/ethnic health disparities endured by
prisoners in the past, and counteract the same disparities they face when they return home.

Effective Use of Resources

For any behavioral health carve-out, clinical goals related to prevention, intervention and coordination are also associated with the managing of costs and the efficient use of resources. The same holds for MBHP, as many improvements in clinical outcomes result in financial savings. The risk-pool of MBPH behavioral health members is already highly skewed. Eligible returning prisoners who are able to access and retain coverage are already included amongst MBHP’s members, although efforts to expand coverage at the time of release may increase the financial risk of MBHP under its current contract with the Massachusetts’ Medicaid program. The difficulty in detailing the economic implications and rationales lies in what is unknown about the utilization patterns of ex-offenders in Massachusetts. Concrete conclusions cannot be drawn; however, inferences are possible through the application of research conducted on similar populations.

The only available information regarding health services utilization by ex-offenders in Massachusetts is a survey of inmates at the Hampden County Correctional Center (HCCC). The survey found that 80 percent of chronically ill inmates did not receive regular health care prior to incarceration and many used local hospital emergency rooms as their primary care practitioner (MBHA, 2003). The Massachusetts Public Health Association (MBHA) cited this survey during testimony before the Massachusetts’ Senate in support of insurance coverage at the time of release. According to the MPHA, insurance coverage, access to primary care and care coordination after release, will result in “cost savings of fewer emergency room visits requiring expensive medical intervention from advanced and untreated illness” (MBHA, 2003, p. 3). The inappropriate use of expensive health services pre and post incarceration can be legitimately generalized to a significant share of Massachusetts’ returning prisoner population.

A study of male drug-abusing inmates in Kentucky was conducted to investigate the impact on the U.S. health care system and health care costs associated with the increasing numbers of prisoners returning to communities (Leukefeld et al., 2006). Within a year after release, many of the ex-offenders frequently
utilized emergency rooms and hospitals. The strongest predictor of use of these high-cost health services was health status, which includes substance use disorders and mental disorders (Leukefeld et al., 2006). Based upon these findings, the researchers recommend that with “targeted community reentry services, which include learning how to control personal health problems, it is possible that costly health services could be reduced” (Leukefeld et al., 2006, p. 83).

The financial implication is that returning prisoners commonly access and misuse costly services that are not clinically indicated. By ensuring that ex-offenders receive the appropriate level of care at the time of release, MBHP can decrease costs by diverting returning prisoners from utilizing unnecessary emergency care services. The evaluation of the EssentialCare program supports this statement, while also offering evidence related to decreased psychiatric hospitalizations and rates of office visits (MBHP, 2006). Again, the EssentialCare program did not specifically target ex-offenders, but served characteristics. As seen in Table 1, EssentialCare demonstrates statistically significant reductions in inpatient hospitalizations, emergency room visits, and office visits when comparing pre- and post-data.

The changes in utilization resulted in a 19 percent reduction in per member-per month (PMPM) claims, a savings of $150 per member per month (MBHP, 2006). Comparable efforts to manage the health needs of ex-offenders could offset projected costs associated with enhanced service delivery. To fully understand the financial risks and financial benefits associated with reentry planning and care coordination by any managed behavioral health care company, additional research is needed. However, the information available suggests that proactive planning through appropriate service referrals, and care coordination, can result in savings.

Counter Arguments

The rationales presented are not conclusive. For example, practical rationales also exist for MBHP to continue to rely upon current mechanisms that identify members with acute behavioral health needs. Case workers and reentry coordinators within correctional facilities are charged with making the necessary referrals for inmates with severe mental disorders, significant
substance abuse problems and/or chronic medical conditions to support the inmate upon release. Health care service providers can then refer the individual to MBHP’s care management programs without any specialized system recognizing the ex-offender status of the member. Those returning prisoners with the most acute needs can be served by the system as it already exists, especially if the member is a “frequent flier” as MBHP uses software to identify and target such members.

Behavioral health care, especially substance abuse treatment, is not the purview of MBHP alone; nor are referrals and connections to social service providers. The Department of Public Health (DPH) and the Department of Mental Health (DMH) can provide case management and treatment services to returning prisoners. Regional reentry centers (RRCs) and designated non-profit organizations are designed to respond to the complex needs of ex-offenders and may be more capable of working with this population and understanding the systems that most affect this population. Returning prisoners who want behavioral health treatment can seek treatment on their own, ensuring that those receiving treatment are the ones who value the service and will benefit from the service.

The EssentialCare evaluation used to argue for improved clinical and financial outcomes should not be overstated in its generalizability to the returning prisoner population – who are indeed not one entity, but a mix of people with differing risks, needs and strengths. The evaluation design was limited in regard to its inability to control for non-program related changes resulting in

<table>
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<th>Service</th>
<th>Pre-enrollment visits/year</th>
<th>Post-enrollment visits/year</th>
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</tr>
<tr>
<td>Office Visits</td>
<td>1.7</td>
<td>0.5</td>
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*Note: From Massachusetts Behavioral Health Partnership (2006).*
observed outcomes being inaccurately attributed to the program (Posavac and Carey, 2006). The reported cost savings in terms of service utilization do not take into account the costs of the program; therefore the savings may not be savings at all. The reduction in service utilization is assumed to be beneficial; however the evaluation was unable to determine whether or not these reductions were clinically appropriate. Finally, the interaction between care managers and members was not discussed. The style and clinical approach of the care managers, and their therapeutic relationships with members, may be the driving force behind the reported clinical outcomes, resulting in overstatement of the impact of the design and components of the program.

The arguments against a proactive, informed and decisive role for MBHP in prisoner reentry are cogent and need to be considered. However, the rationales supporting such a role are overwhelming. If MBHP is to consistently apply its mission across the membership it serves, a mission that speaks to meeting needs as defined by members; effectively and efficiently managing state resources; facilitating linkages, consensus building and collaboration among state agencies, consumers and other public policy makers; consumer involvement in service delivery and design; strengthening links between psychological and medical services; and attending to behavioral health in terms of all health behaviors and increasing health care innovations and best practices, then prisoner reentry planning and care coordination needs to be fully integrated into the policies and practices of MBHP.

**Clinical Care Management**

Reentry planning and care needs to be: a team effort, with true consumer involvement; a managed transition from services “inside the walls” to the community; a connection to clinically and culturally appropriate services; coordinated and monitored (Miller, 2005; Travis, 2000). In other words, clinical care managers are essential (Watson, 2000). MBHP either operates itself, or funds through health care service provider agencies, several models of clinical care management. Given MBHP’s commitment to best practices, and its status as a for-profit company, these models signal MBHP’s confidence in clinical case management as a means of improving outcomes for members and as a source of cost savings.
Moreover, the Massachusetts Medicaid Policy Institute reported that care management was a way to manage MassHealth’s spending trends under Massachusetts’ reform (MMPI, 2007). The proposed policy options for MBHP’s role in prisoner reentry and care are based upon its models of clinical care management, which is supported both by research on effective reentry services and by research regarding the effectiveness of clinical care management.

No matter its name - clinical care management, case management, Assertive Community Treatment, etc – the proactive functions of this kind of service for adults with serious behavioral health issues are supported theoretically and empirically (Mueser et al., 1998; Rapp and Goscha, 2004; Bedell et al., 2000). Clinical care management is found to significantly improve consumers’ functional status and quality of life, while also reducing the cost of care and the amount of time spent in jail (Gorey et al., 1998; Ziguras and Stuart, 2000). The need for clinical care management is also supported by research, which found that few ex-offenders received clinically meaningful levels of outpatient care after their release, and decreased recidivism and improved mental health status require enhanced services like those offered by “case managers” and services accessed for ex-offenders by “case managers” (Lovell et al., 2002).

**Technicalities of Proposed Policy Options**

The Assessment Unit at MBHP reviews referrals by health care practitioners for care coordination services and determines the level of care needed for the member based on clinical, social and medical indicators. The care coordination programs are CSPs and Intensive Case Managers (ICMs) - and formerly, EssentialCare - and comprise the three policy options offered in this article. For each alternative MBHP needs to work with the Reentry Services Division at the DOC and its counterparts in the county HOCs. The responsible personnel at the correctional facilities identify MassHealth eligible inmates in need of care coordination well before discharge. Until MassHealth is guaranteed for all returning prisoners, county HOCs will need to submit a MassHealth application for the inmate, which will be denied, but can be activated upon release.² Referrals to the Assessment Unit (which are available on-line) are made by the reentry/discharge
coordinator(s) on behalf of the identified inmate, who should, in keeping with good practice, be aware of the referral.

MBHP will need to develop a specialized system for processing referrals from correctional facilities due to issues around timeliness of insurance coverage. For returning prisoners, MBHP could identify one of its care management programs to serve all referred inmates or choose amongst them. The following details some of the augmentations to the CSP, ICM and EssentialCare programs that may be necessary to serve the particular needs of returning prisoners.

**Policy Options**

1. *Enhance Use of Community Service Providers*

   MBHP has already identified CSPs as a beneficial service for returning prisoners through its aforementioned performance incentive initiative. However, MBHP is not actively involved in the initiative and could reinstate itself in a meaningful way. First, MBHP can reinstate the incentives for CSPs to work with ex-offenders. Second, contracts with higher rates can be offered to provider agencies running CSP programs that invest in clinical trainings focused on ex-offenders, and who dedicate CSP “slots” for referred returning prisoners. Third, MBHP can hold conferences for CSPs working with returning prisoners to highlight best practices and support information sharing across the medical and psychological spectrum, particularly with respect to behavioral factors impacting health outcomes. Fourth, authorizations for CSPs serving ex-offenders can begin shortly before the inmate is discharged to improve planning and continuity of care.¹

2. *Creation of Specialized Intensive Care Managers*

   ICMs are Master’s level employees of MBHP and work out of MBHP’s regional areas. The purpose of the ICM program is to coordinate care for referred members, typically those with high utilization rates of intensive and costly services. ICMs develop and monitor treatment plans, can authorize all levels of care covered by MassHealth, and can act as gatekeepers to higher levels of care to prevent the misuse of inpatient hospitalizations. The outreach component of ICMs is limited, although they do communicate directly with the member and the member’s treatment team, while
also hosting or attending treatment conferences. A MBHP member can have an ICM in conjunction with other care management services, which is often the case.

ICMs in each regional office can be identified as exclusively serving ex-offenders and be provided with the appropriate clinical training on an on-going basis. Before an inmate is discharged, the ICM can be assigned, allowing them to team with reentry/discharge coordinator(s) and treating professionals at the facility to ensure that the appropriate service referrals are in place before the inmate is released. Specialized ICMs can develop a robust knowledge of the community services available to returning prisoners, as well as tactics to manage the specific health services barriers ex-offenders face (Iguchi et al., 2005). Finally, specialized ICMs can serve as a source of assistance to providers unfamiliar with treating returning prisoners.

3. Reinstall the EssentialCare Program

The EssentialCare program can be reinstated and explicitly serve returning prisoners. Care managers can work with the inmate prior to discharge and collaborate with correctional staff so the inmate is released with the necessary services in place. The timing of behavioral health and medical appointments is critical, as delays often lead to decompensation and re-incarceration (NIC, 2007). MBHP can also replicate the EssentialCare model and create a separate program that solely serves ex-offenders, allowing the program to operate in the same manner as EssentialCare but with a dedicated focus.

Implementation Concerns

All of the proposed options involve three essential components that can impact the feasibility and viability of the programs as described. First, the availability of clinical training on treatment and other issues related to ex-offenders is almost non-existent. However, there are provider groups and organizations across the state that specialize in serving this population. The University of Massachusetts Medical School maintains the contract with the DOC to provide medical and behavioral health services and the University’s Commonwealth Medicine is a leading research and advocacy institute for best practices in correctional care. MBHP, in
conjunction with the DOC and the University of Massachusetts, can promote and sponsor trainings initiatives, conferences and forums to enhance and inform the delivery of services to returning prisoners.

Second, the policy options offered herein insist upon the clinical care coordinator working with reentry/discharge planning coordinator(s) prior to a referred inmate’s discharge. Correctional facilities may not be open to outside health practitioners, and correctional staff may have little time to dedicate to collaboration. Clinical care coordinators may be intimidated by the facility itself and may have a different perspective than correctional staff. For example, the main focus in correctional facilities is public safety, which can be in direct opposition to a clinical care coordinator’s focus on treatment. MBHP will need to provide outreach to correctional facilities so that the responsible personnel are aware of the referral process to the Assessment Unit and know what to expect in working with clinical care coordinators. Correctional facilities will need to introduce clinical care coordinators to the culture and practices of the facility. Through an on-going process of relationship building, such obstacles can be overcome.

Third, prisoners will need to understand the services available to them through MBHP, and actively engage in the care provided. Prisoners may be reluctant given their past history with behavioral health providers and treatment, a belief that they need to manage their own problems, or out of fear of stigma, before and after release (Morgan et al., 2007). The challenge for MBHP and correctional facilities alike is educating soon-to-be-discharged prisoners about the benefits of reentry planning and care.

The barriers to implementation make the task for MBHP complicated, but not impossible. An opportunity exists for MBHP and the State to begin an overt effort to understand the behavioral health, medical and social needs of returning prisoners, their impact on the Massachusetts health care system and the effectiveness of clinical care management programs for this population. However, MBHP operates in a context with multiple barriers to such an initiative. MBHP cannot act alone and key stakeholders may be unwilling or unable to provide the requisite support. The complicating and complementary political, health literacy, economic, organizational and social factors must be analyzed before any policy solutions are designed - not only to
ensure for the feasibility of the solutions, but also in recognition that decisions are not made in a vacuum.

Barriers and Advantages of Context

As the effects, impacts and consequences of Massachusetts Health Reform continue to unfold, MBHP operates in a context that is constant only in its changing. Beyond the aftershocks of the individual mandate - tremors felt by MBHP and its network providers - other state initiatives require a shift in resources and service delivery across the behavioral health field. The transforming field is the landscape upon which MBHP must meet its contractual obligations and performance incentives, while the recession creates financial shortfalls across sectors. Undertaking any new initiative within this climate is challenging, if not impossible. Even if the case is made for a strong and present role for MBHP in prisoner reentry and care, proposed policy solutions are feasible only if the barriers of context are taken into consideration.

Political Environment

Strong partnerships are needed to overcome silos in the state system and the competing interests among key stakeholders. Political will, in the area of prisoner reentry, is fundamental to opening the door to strong partnerships. The Second Chance Act, federal legislation that passed with overwhelming bipartisan support and was signed into law by President Bush in April 2008, authorized $165 million for states, local governments and community partners to improve coordination of reentry services (Reentry Roundtable, 2009). The American Recovery and Investment Act of 2009 allocated $133 million for prisoner reentry initiatives and programs (Reentry Council, 2009). Taken in concert, these federal acts signal a concern from both sides of the aisle regarding issues of prisoner reentry, and a willingness to take action.

Political will in Massachusetts’ state government is evident in key commissions, executive office initiatives and legislative attempts. The Governor’s Commission on Criminal Justice Innovation and the Governor’s Commission on Corrections Reform produced “reports highlighting the need to reform strategies for
transitioning offenders back into the community, starting with the moment they are incarcerated” (EOPSS, 2009). In response to the recommendations in each report, the EOPSS and the DOC created Regional Reentry Centers (RRCs). Key Massachusetts legislators, including Senator Richard Moore, the Chairman of the Committee on Health Care Financing, continue to propose bills regarding prisoner reentry. Most recently Senator Moore proposed a bill that would allow all eligible returning prisoners to obtain MassHealth coverage upon discharge from a correctional facility, a bill that has been before the legislature for the past six years. In the 2007-2008 legislative session the bill died in the Senate Ethics and Rules committee; however it is unclear why the bill continues not to pass (MA Leg, 2009). A possible reason is that, no matter the increased political palpability of issues regarding reentry, prisoners are not a priority and remain marginalized in the political system.

**Massachusetts Healthcare Reform**

Another possible reason the proposed bill has yet to pass is that, if signed into law, the bill would impact the enrollment cap on MassHealth Essential. To comply with the law, the DHCFP would need to request an amendment to the 1115 demonstration waiver between Massachusetts and the Center for Medicare and Medicaid Services (CMS). The state cannot guarantee CMS’ approval, making the enrollment cap a significant barrier to an initiative by MBHP to provide cohesive behavioral health services. MBHP cannot coordinate care for ex-offenders on a waiting list, and no current mechanism exists between the DHCFP and the DOC to identify which of the 52 percent of eligible returning prisoners on the waitlist are most in need of coverage at the time of release (Marshall, 2008). The only option for MBHP is to advocate for the expansion of the enrollment cap, which the state may be unwilling to request given the unpredicted costs of health insurance reform.

The individual mandate was projected to decrease the need for the Uncompensated Care Pool (UCP) and result in substantial savings. Although spending on the UCP decreased over the past two years, the anticipated savings have yet to come to fruition (DHCFP, 2009). According to the Massachusetts Medicaid Policy Institute (MMPI), reductions in UCP spending are critical to the renewal of health insurance reform (2007). It is possible that a proportion of individuals accessing services paid by the UCP are ex-offenders (Leukefeld et al., 2006). By including obligations and
incentives regarding prisoner reentry in its contract with MBHP, the state could shift a share of the costs of treating ex-offenders under the UCP, and through other state funded systems, to Medicaid, which is subject to a 50 percent match in funding by the federal government.

**Competing Priorities**

Even if a prisoner reentry initiative by MBHP results in cost savings for the state and MBHP, both are under financial pressure related to the Children's Behavioral Health Initiative (CBHI). In 2005, a class action lawsuit (*Rosie D. v. Romney*) was brought against the state for failure to comply with the Early Periodic Screening Diagnosis and Treatment (EPSDT) provision of the Medicaid Act (CPR, 2006). The court-ordered remediation plan, known as the CBHI, mandates that the DHCFP and DMH provide enhanced community based services and care for MassHealth children; the majority of whom are MBHP members. As the state begins the process of dramatically altering its behavioral health service delivery model, the financial burden of CBHI is unknown – but it is projected to have drastic effects on state agencies and MBHP alike (Kenny, 2007). Financial and organizational resources must be directed to the CBHI given that they are court ordered, meaning that other initiatives by the DHCFP, DMH and MBHP may need to take a backseat.

**Practitioner Concerns**

The CBHI also impacts health care practitioners, raising concerns about practitioner capacity in general, as well as concerns regarding the additional administrative burdens placed on network providers as a result of the CBHI (Kenny, 2007). However, there are benefits to the changes under the CBHI that include: augmentation of clinical outreach services, like the CSP program, potential decreased workloads for MBHP’s ICMs, and an overall focus on care coordination for Medicaid members. The issue of practitioner capacity is endemic across the state, and intensified for the returning prisoner population. First, few practitioners specialize in working with ex-offenders, in part due to the lack of training in graduate and doctoral clinical programs (Magaletta and Verdeyen, 2005). Second, a case study by the National Institute of Corrections and the Criminal Justice/Mental Health Consensus Project found that many providers and community mental health
clinics (CMHCs) are reluctant to serve ex-offenders (CSG, 2007). The reasons cited included provider and CMHCs “worry about safety, liability and reliability of some segments of the ex-offender population” (CSG, 2007, p. 11).

Overcoming the challenges of the lack of practitioner skill and comfort in treating returning prisoners, the lack of providers in general (which results in lengthy waitlists across the network), and the reluctance (and sometimes resistance) of providers to serve ex-offenders will be difficult. However, MBHP’s performance incentive program referenced earlier in this brief was an attempt to encourage CSP to work with this population. Additional actions by MBHP in this area will be discussed in conjunction with the proposed policy options. The issues are not solely MBHP’s to solve, but require that academic clinical programs incorporate training in behavioral health treatment and the needs of ex-offenders, and that ongoing training in this area is available to clinicians and practitioners in the field.

Beyond the clinical and capacity concerns of the practitioner network, practitioner agencies are experiencing drastic cuts in their budgets due to the recession and diminished (or dismantled) funding from the state. Practitioner agencies across the state are cutting programs and staff making it difficult for them to serve their current clientele, let alone taking on the challenge of treating a disproportionately ill population. The Governor’s budget cuts to agencies under the Executive Office of Health and Human Services (EOHHS) impacts services for returning prisoners and shifts a share of the costs onto MBHP.

**Funding Within State Agencies**

The loss of funding for staff and programs at EOHHS agencies like the DMH, Department of Public Health (DPH) and Department of Mental Retardation (DMR) means that those returning prisoners who would have been eligible for services through these agencies in the past may be denied services due to increasing restrictions on eligibility. These returning prisoners will go without the benefits of the case management, outreach and residential services of the agencies. Ex-offenders who manage to pass the eligibility determination phase will find that their caseworker is overwhelmed, and that there is limited funding for community-based outreach services and almost no funding for residential
and/or inpatient treatment facilities. MBHP and safety net health care service providers are left to care for returning prisoners in relative isolation or must fill in the gaps left by the diminished resources of EOHHS agencies. Advocacy groups and consumers across the spectrum are reeling, pushing back against the state to save their specific programs and support their specific populations. Ex-offenders are always low on the list in an environment of zero-sum thinking. However, such thinking is counterproductive to improving the health and well-being of all residents across the state, and this time of crisis should be a time of consensus building for those dedicated to serving the needs of vulnerable populations.

**Stakeholder Relationships**

An initiative involving prisoner reentry ultimately involves reaching consensus across multiple stakeholders with differing ideologies, resources, mandates, agendas and politics. MBHP already formed connections with DMH, DPH, DOC, RRCs and non-profit agencies in regard to reentry services and care. The largest disconnect is between MBHP and county HOCs. For MBHP to take on an initiative regarding prisoner reentry, they must build relationships with county HOCs, since the majority of returning prisoners in the state are released from county HOCs. However, the relationship is more complex than that of MBHP and DOC, in which MBHP coordinates with one entity – the reentry services division. Thirteen county HOCs involve thirteen different discharge-planning units, with varying levels of resources. The multitude of players, and the lack of uniformity, makes coordination difficult, but not impossible.

MBHP highlights its role in serving as “the coordinating entity for numerous state departments and agencies,” and through these relationships “built programs that offer easy access, a minimum of bureaucratic barriers, and the highest standards of care” (MBHP, 2009; para. 3). MBHP can expand this role to include county HOCs. Each county may be willing, but unable. Lack of personnel, overwhelming caseloads, other priorities and organizational impediments may interfere with a county HOC engaging in a coordinated effort with MBHP. Examples of overcoming these barriers exist in multiple counties. Dr. Thomas Conklin, the creator of the award winning public health model at the HCCC, and Sheriff Ashe of Hampden County, are two strong advocates for county correctional reform (Montalto, 2006). Sheriff Cabral of Suffolk
County currently supports an initiative linking discharged inmates to a specialized program of integrated care at a CHC in Boston (Sullivan, 2008; SCSD, 2008). Initiatives and structures for coordinated reentry care are in place in many county HOCs, allowing MBHP to enter into the conversations and systems already in effect.

MBHP Role and Constraints. Certain systemic barriers are outside MBHP’s control, although its resounding voice will amplify attention to such barriers. MBHP can’t improve the diagnosis and recognition of behavioral health issues of inmates during their incarceration. MBHP can’t authorize MassHealth coverage for every eligible prisoner at the time of release or his or her placement on a waitlist for Essential coverage. MBHP can’t change the financial forecast or the competing demands on all behavioral health systems. What MBHP can do is build off its existing care coordination programs, with the expressed purposes of supporting the transition home for Massachusetts’ prisoners, and providing the appropriate treatment opportunities to help keep them there.

**Recommendations and Conclusion**

Returning prisoners are a population with a range of medical and behavioral health issues. The Assessment Unit at MBHP is capable of determining the level of care required for members, and can continue to do so within an informed system dedicated to processing and evaluating referrals from correctional facilities. The investment of financial, organizational and staffing resources will pay for itself over time. Given the sheer numbers of returning prisoners, MBHP can begin by implementing the program with the DOC, with whom it already has a working relationship, and running pilot programs in Hampden County, Suffolk County and Worcester County. Hampden County is committed to improving correctional and reentry services, can easily adopt the initiative, and is capable of supporting MBHP in data collection and evaluation of a pilot program. Worcester and Suffolk counties have the highest number of returning prisoners and are most in need of enhanced partnerships and reentry programs.

In response to MBHP’s proactive and enhanced role in prisoner reentry, DHCFP should incorporate the functions of this role into MBHP’s contract with MassHealth, while also seeking CMS
approval for increasing the enrollment cap for Essential coverage. Continued advocacy is needed to support legislative attempts to cover all MassHealth eligible inmates at the time of release and until this is realized, DHCFP can extend the waiver with the DOC to cover county HOCs. Vested stakeholders need to come together to translate the importance of prisoner reentry to the public. Massachusetts needs evaluation of MBHP’s reentry programs and research on returning prisoners. The Center for Health Policy and Research at the University of Massachusetts Medical School conducted the evaluation of the EssentialCare program and MBHP can build off of this working relationship, while also tapping into the multitude of health policy institutes and researchers across the state.

The recommendations of this brief take the best of what is currently practiced, and addresses the issues of access, inclusion, equity and connection for returning prisoners. MBHP has a great responsibility for ensuring that the incarcerated population is indeed counted and cared for, and a great opportunity to effect change. With the precedent set by Massachusetts in having the first and largest Medicaid behavioral health carve-out contract, MBHP can set its own precedent in proactively managing the behavioral health needs of returning prisoners (Sabin and Daniels, 1999).

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Notes

1. A public health model of correctional care takes a comprehensive approach to the health care needs of inmates and the community and includes a spectrum
of high-quality health and behavioral health services. The core values of the model include: wellness, treatment of disease, prevention of illness, collaboration and access to care during and after incarceration (Conklin, 2004).

2. County HOCs can follow the model of the HCCC, which has an on-going understanding with MassHealth. During the discharge planning process, MassHealth applications are submitted and then denied. Once the inmate is discharged, the inmate has a standing appointment at a community health clinic that resubmits the application for approval. Once approved, coverage is retroactive to the date of original submission, thereby covering services immediately upon release.

3. MassHealth allows for services to be billed back to the date of the original application, even if the activation of coverage is delayed.

References


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