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Medicaid Coverage as a Critical Component in Care Coordination and Continuity in Health Care Access During Reentry for Justice-Involved Individuals in Maryland

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This is to certify that the doctoral dissertation by

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has been found to be complete and satisfactory in all respects,
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by

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Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

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Abstract

Incarcerated individuals in the United States have a high disease burden. Moreover, most of them are released from incarceration without health coverage. The problem is that most incarcerated people in Maryland return to the community from incarceration without health coverage and cannot access health care. The purpose of this qualitative study was to understand how Medicaid enrollment staff and managers of the Medicaid program perceive the experiences and challenges of justice-involved individuals in navigating the Medicaid system in Maryland. The study was grounded in the behavioral model for vulnerable populations. The main research question aimed at understanding how the enrollment staff and managers of the Medicaid program perceive the experiences and challenges of justice-involved individuals in navigating the Medicaid system in Maryland. This study used semi structured interviews to collect data from 11 enrollment staff and managers. Data were coded and analyzed following a 4-step thematic analysis process. Findings in the study included having Medicaid enrollment as a component of discharge planning and the need to streamline Medicaid eligibility and expand coverage. A major limitation in the study was the small sample size that limited generalizability. Justice-involved individuals should be educated about Medicaid during Intake orientation to facilitate enrollment. The study results point to the importance of Medicaid as a source of access to health services when justice-involved-individuals leave incarceration. Providing health care access to returning justice-involved individuals can produce positive social change through structural change that reduces health inequities in the U.S.

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Dedication

I am making a two-pronged dedication for this dissertation. Firstly, I wish to dedicate the attainment of this academic milestone to my mother, now of blessed memory, mamma Theresia Mentongake. She toiled and moiled to ensure her children could get a better life than the one she endured. She had no formal education herself but had a sharp vision of the benefits of a good education. Her sacrifice and unflinching support during my post elementary school years helped to spark my ambition, from a spark into a glow. She would have been celebrating this achievement with pomp and style, if she were alive today.

I am also dedicating this dissertation to my wife, children, and grandchildren, who have all wondered why I undertook this ordeal in my later years. We surely missed plenty of family time together, but as you can see, it was worth the while. I thank my wife Elizabeth for taking care of the onerous house chores when I did not have the time to spare. I look forward to a more relaxed schedule for both of us as this endeavor reaches its apogee. I also want to thank my son Albert for providing the technical support that I needed during the entire process. I can only tell you all, we will soon be celebrating.

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I wish to extend my gratitude to my Dissertation Committee Chair, Dr. Rabeh Hijazi, and my committee member, Dr. Christopher Miller, for providing guidance, support, and your expertise throughout this dissertation process. You both showed patience with me, for a process that waxed and waned, when I could not have the appropriate data as planned. I thank you immensely for bearing with me during the uncertain research process that was unfolding.

I also thank a wonderful family friend, Alex, who together with my son, Albert, provided technical help during odd hours to set up interviews through Zoom and organize the interview transcripts.

My heartfelt appreciation goes to all the interview participants who willingly found the time during their workdays to sit through the interviews with me. Your involvement made this dissertation become reality. The gatekeepers in the various organizations provided enormous support by considering my request to conduct this research study and also giving it publicity. For that, I am profoundly grateful.

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Chapter 1: Introduction to the Study

Introduction

The purpose of this generic qualitative study was to understand how Medicaid enrollment staff and the managers of the Maryland Medicaid program perceive the experiences and challenges of justice-involved individuals in navigating the Medicaid system in Maryland. Medicaid is the largest public insurance program in the United States and the passage of the Affordable Care Act (ACA) in 2010 expanded Medicaid eligibility to low-income individuals by relaxing eligibility requirements (Bandara et al., 2015; Ejike-King 2014; Vogler, 2020). In the same vein, the Second Chance Act (SCA) was enacted to facilitate the process of acquiring health coverage for former inmates (Cuellar & Cheema, 2012). Even though a vast majority of incarcerated people have incomes that are below 138% of the federal poverty level, they still encounter numerous challenges to enroll in Medicaid. In this study, Medicaid enrollment is defined as the process of obtaining public health insurance after meeting eligibility requirements. Not having health coverage causes disruptions in health care access following the release of former inmates into the community.

Available literature has attributed enrollment challenges to the controversial Medicaid Inmate Exclusion Policy and the myriad of barriers that include minimal health literacy, misunderstanding the eligibility requirements, limited access to internet, not having required documentation, cost, and not having enough information or guidance (An et al., 2022). The Medicaid Inmate Exclusion Policy causes gaps in coverage by

suspending or terminating coverage following incarceration (Albertson et al., 2022). This study was conducted to understand the perceptions of the enrollment staff and Medicaid program managers about the experiences and challenges of justice-involved individuals as they engaged in the enrollment process for this vulnerable population. Findings from this study can help guide recommendations for policy improvements and strategies to improve the process.

This study adds to the current literature on health coverage for justice-involved people and contributes to positive social change by outlining the benefits for continued coverage that include continued access to health care and seamless reintegration of ex-offenders into the community. This first chapter introduces the topic of study and a background that includes the literature and gap to serve as a prelude to the study. The chapter also discusses the problem to be addressed in the study, the purpose for the study and the research questions. Other aspects of study that are dictated for the first chapter in a research study are included: conceptual framework, nature of the study, definitions, assumptions, scope/delimitations, limitations, and significance. The chapter ends by highlighting its major points in a summary that provides transition to Chapter 2.

Background

There is extensive research that indicates that returning ex-offenders face high levels of poverty, homelessness, and unemployment (Davis, 2022; Farrell & Gottlieb, 2020; Hu et al., 2020; Jennings et al., 2021; Khatri & Winkelman, 2022). Health insurance is a condition sine qua non for accessing health care, and the lack of insurance

or some other form of health coverage poses a major barrier to accessing health care after release (Hu et al., 2020). Lack of insurance, loss of insurance after losing employment, or loss of Medicaid, combined with inadequate discharge planning cause major disruptions in the continuity of care during reentry (Albertson et al., 2020).

The Medicaid Inmate Exclusion Policy that was enacted in the Social Security Amendments of 1965 prohibits the use of Medicaid to finance ambulatory health care provided during incarceration; this includes care for individuals still in pretrial (Khatri & Winkelman, 2022). The Medicaid Inmate Exclusion Policy results in the termination or suspension of Medicaid following incarceration, leading to gaps in Medicaid coverage at the time of release (Albertson et al., 2020). Termination requires reenrollment of the beneficiaries, whereas suspension requires a simple process of reinstatement. Recently incarcerated people come from low-income backgrounds, with an overrepresentation of racial and ethnic minorities that include African Americans, Latinos, American Indians, and Alaska Natives (Albertson et al., 2020; Ejike-King & Dorsey, 2014). The Medicaid program plays a cardinal role in ensuring access to care for this population.

It is imperative to address problems related to health insurance access for justice-involved people as they return to the community because of their high rates of chronic conditions, infectious diseases, disability, mental illness, and substance use disorder (SUDs) (Cuellar & Cheema, 2012; Jennings et al., 2021). Grodensky et al (2018) argued that possible benefits of health insurance coverage and appropriate care utilization for former offenders include supporting their own health, decreasing the use of the

emergency department, minimizing medical debt, and lowering the risk of infectious disease transmission. Not only does health insurance ensure continuity of care after release, it has been shown through research that it may be associated with lower rates of rearrests and drug use (Freudenberg et al., 2005, as cited in Cuellar & Cheema, 2012). Health insurance access for former inmates is therefore an issue that is relevant to both the health system and the criminal justice system.

The right to reasonable access to health care for justice-involved individuals was established in the landmark Supreme Court case of *Estelle v. Gamble*, which stipulated inter alia, that the health care for justice-involved populations must meet minimal standards of adequacy (Albertson, 2020; Flanagan, 2004). The principle of equivalence requires that jail and prison facilities should provide health care at a level that matches that which is available to the population outside of prison (Heidari et al., 2017). Despite the foregoing provision of the law, the current Inmate Exclusion Policy attempts to create barriers to care following imprisonment by causing Medicaid suspension or termination. Concern for health care access for incarcerated populations has been shown at the global level as well. Naravage et al. (2020) postulated that there are about 11 million people in prison worldwide, and all of them need access to quality health care. While advocating for inclusion of prison health care in current international development frameworks such as the 2030 Sustainable Development Goals (SDGs), they argue that prisoners face a high risk of being in a group that does not meet the international pledge “to leave no one behind” (Naravage et al., 2020).

Despite having varied and specific needs, addressing the health needs of youth, women, and elderly cycling in and out of jails and prisons requires coordination between community and correctional health care providers (Jennings et al., 2021). Discharge planning, which entails preparing prisoners for release, starts inside the prison or jail and needs to be continued after release, without interruption of health care and social support. A multicountry (Belgium, France, Germany, and Portugal) study to explore drug users' perceptions of drug use and risk behavior upon prison release found that 50% of all drug-related deaths occur within 12 weeks after release from incarceration (Jamin et al., 2021). In the same vein, research by Binswanger et al. (2007, as cited in Li-Rodenborn et al., 2020) found that the risk of fatal overdose among inmates with opioid addiction peaks during the first 2-week period after they are released from prison. Such avoidable deaths can be prevented through collaboration between health and social services in prison and community and eliminating gaps in Medicaid coverage for former offenders so as to ensure continuity of care.

Medicaid is the largest public insurance program in the United States and prior to the passage of the ACA in 2010, the policy on eligibility requirements has been categorical restrictions that limit coverage to the infirmed, the elderly, pregnant women, children, and members of families with dependent children (Grodensky et al., 2018; Vogler, 2020). The ACA provisions expanded Medicaid eligibility and created the Health Insurance Marketplace, and as of June 2018, 32 states and the District of Columbia had expanded Medicaid to all adults whose incomes fall below 138% of the federal poverty

level (Guyer et al. 2019; Vogler, 2020). In states that have expanded Medicaid eligibility, the stringent categorical restrictions no longer apply, and eligibility is now based on income only (Vogler, 2020). Based on ACA provisions, individuals who are not eligible for Medicaid may qualify for subsidies (federal tax credits) to assist them to purchase health insurance from state health exchanges (Cuellar & Cheema, 2012; Ejike-King & Dorsey, 2014). The state of Maryland, in which this study was conducted, chose to expand Medicaid (see Guyer et al., 2019; Milligan, 2012; Vogler 2020;).

Research published in the New England Journal of Medicine showed that expansion in Medicaid coverage for low-income adults produces a 6.1% decrease in mortality (Milligan, 2012). In states that did not expand Medicaid, eligibility criteria are restricted, and despite the importance of Medicaid's role in providing health care access to justice-involved people who qualify, there is a gap in the literature about this population's experience in the Medicaid enrollment process (Grodensky et al., 2018).

Two other pieces of legislation, though lesser known, also impact the reintegration of returning offenders and their acquisition of health coverage. These are the SCA of 2007 and the Mental Health Parity and Addiction Equity Act of 2008 (Cuellar & Cheema, 2012). Under the SCA, the federal government doled out U.S. $100 million in 2010 to state, local, and community organizations to, among other things, facilitate the reintegration of former inmates into the community after release from jail or prison (Cuellar & Cheema, 2012). In addition, these funds gave an opportunity to the states to examine possible barriers -- statutory, regulatory, or practical -- in the delivery of health

care to former offenders (Cuellar & Cheema, 2012). The focus of the latter Act was to address the coverage of mental health and substance abuse benefits in large group health insurance plans. In the last 2 decades, several federal and state policies were promulgated that have impacted health coverage for justice-involved people and their care during reentry (Blackburn et al., 2020). Despite these legislative efforts, problems of Medicaid enrollment and connecting to health care in the community continue to be a threat to the health and well-being of former offenders.

This study was aimed at understanding the approaches for improving Medicaid enrollment for ex-offenders in the state of Maryland. The study could help managers of the Maryland Medicaid program in the Department of Health and Mental Hygiene (DHMH), the Department of Human Resources (DHR), the Department of Public Safety and Correctional Services (DPSCS), the Department of Social Services (DSS), as well as the enrollment staff (navigators, in-person assisters, and community health workers) to have a better understanding of the enrollment process. Streamlining the Medicaid enrollment process for former inmates returning to the community from prison or jail would ensure that this marginalized population continues to have access to quality care. Health coverage can help reduce the use of emergency rooms for nonurgent conditions and facilitate linkage to primary care and transitioning (Somers et al., 2014, as cited in Blackburn et al., 2020).

Problem Statement

The prison population in the United States grew geometrically in the 3 decades between 1980 to 2010, from 330,000 to 1.5 million, while another 760,000 inmates are incarcerated in local jails at any given time (Cuellar & Cheema, 2012). Research has shown that the prison population started leveling off in 2008 following the years of rapid increases and steady growth (Cuellar & Cheema, 2012; Ejike-King & Dorsey, 2014; Farrell & Gottlieb, 2020). Despite this decline, the prison population in the United States remains the highest in the world (Farrell & Gottlieb, 2020). Almost all of these individuals will return to the community following their incarceration. Farrell and Gottlieb (2020) postulated that returning inmates constitute a vulnerable population with a high disease burden from increased rates of chronic medical conditions that include, hypertension, asthma, arthritis, diabetes, infectious diseases such as HIV, hepatitis B/C, TB, and mental health conditions and SUDs.

Following the provisions of the ACA, low-income, and nonelderly individuals without children who reside in Medicaid expansions states can qualify for Medicaid coverage if their income is below 138% of the federal poverty level (Albertson, 2020; Ejike-King & Dorsey, 2014). A large number of former inmates meet this criterion but cannot get enrolled because of the Medicaid Inmate Exclusion Policy. This prohibition was established at the inception of Medicaid and prevents coverage for services provided to people while they are in prison, jail, detention center, or other penal facility unless an inmate is treated in a medical facility outside the prison or jail for 24 hours or more

(Albertson, 2020). This means that Medicaid is typically suspended or terminated following incarceration, thereby creating gaps in coverage. The consequence of either measure is that people leave jail or prison without Medicaid eligibility and must reapply.

Some studies have pointed to the numerous challenges involved in Medicaid enrollment and retaining eligible populations. The gamut of Medicaid enrollment barriers also includes misunderstanding the eligibility requirements, minimal health insurance literacy, limited access to internet, not having required documentation, cost, and not having enough information or guidance (An et al., 2022). Several U.S. states, including Indiana, have addressed health coverage needs for justice-involved people by implementing policies to facilitate Medicaid enrollment for incarcerated people. Indiana implemented Medicaid eligibility expansion through a Section 1115 Medicaid Waiver which permits the Indiana Department of Corrections to submit applications for coverage on behalf of individuals prior to release and allowing for coverage to be suspended rather than terminated during incarceration (Balio et al., 2021).

The state of Maryland expanded Medicaid coverage under the ACA, and in addition had a CMS-approved Inmate Presumptive Eligibility Program beginning 2016 (Li-Rodenborn et al., 2020). Presumptive eligibility (PE) prevents lapses in coverage immediately after release by presuming that an inmate is eligible prior to processing the application, so that upon release, there can be implementation of full coverage for the inmate's health care (Li-Rodenborn, 2020; Bandara et al., 2015). Despite the key role of PE in ensuring continuity of care, correctional facilities in Maryland have not been able

to enroll a single individual in PE (Li-Rodenborn et al., 2020). The problem is that the majority of incarcerated people in Maryland return to the community from prison or jail without health care coverage and cannot access health services. Though there is extensive literature on Medicaid gaps and strategies on enrolling justice-involved populations in Medicaid in several other states, there is a paucity of current research that is focused on strategies for enrolling former offenders in Medicaid in Maryland and establishing connections to health care for these populations. It is important to understand how Medicaid enrollment staff and the managers of the Maryland Medicaid program perceive the experiences and challenges of justice-involved individuals in navigating the Medicaid system in Maryland, as well as the efficacy of the current process.

Purpose of the Study

The purpose of this generic qualitative study was to understand how Medicaid enrollment staff and managers of Maryland Medicaid program perceive the experiences and challenges of justice-involved individuals in navigating the Medicaid system in Maryland. At this stage in the research, Medicaid enrollment is generally defined as the process of obtaining public health insurance after meeting eligibility requirements.

Research Questions

This research was guided by a main question and two sub questions.

Research question (RQ): How do Medicaid enrollment staff and managers of Maryland Medicaid program perceive the experiences and challenges of justice-involved individuals in navigating the Medicaid system in Maryland?

Sub question (SQ)1: What are the experiences of the enrollment staff and the managers of the Maryland Medicaid program in the Medicaid enrollment of justice-involved individuals?

SQ2: What are the implications of the Medicaid staff and managers of the Medicaid program for enrolling justice-involved individuals in Maryland Medicaid?

Conceptual Framework for the Study

The behavioral model for vulnerable populations by Gelberg et al. (2000) grounded this qualitative inquiry. This model was conceptually designed to address the domains relevant to understanding the health and health care seeking of populations such as formerly incarcerated individuals (Gelberg et al., 2000). The behavioral model for vulnerable populations provided a structure that helped to explain the progression of the phenomenon of Medicaid enrollment that was the focus of the study (Osanloo & Grant, 2016). The model focuses on three core components to explain healthcare utilization: predisposin*g* factors, such as age, education and socio-economic status; enabling factors, such as personal or family income, and community resources; and need factors, such as health status of the population(s) (Lederle et al., 2021).

Applying this model of health services utilization to formerly incarcerated people is helpful in identifying the challenges they face in obtaining needed services and provides insight on improving their health status. The model has been used as a framework to understand factors that affect pre-incarceration, Medicaid enrollment for former inmates, and the likelihood that they will enroll in Medicaid post incarceration

(Grodensky et al., 2018). The constructs in the model can be used to explain the use of health services for justice-involved populations. Research has shown that predisposing factors of age, race, and victimization are associated with the extent to which health services are utilized (Ejike-King & Dorsey, 2014; Isbell et al., 2018). These studies have revealed that ethnic and racial minorities are disproportionately represented in the justice system. Having health coverage as an enabling factor in the model has been associated with greater access to and use of health services. Medicaid enrollment to obtain public insurance is an enabling factor and was the focus of this study. The need characteristics focus on the actual health problems of this population. The high burden of disease for justice-involved individuals is identified as health needs in the model, which, according to the model, can only be adequately addressed following health coverage. The three core factors in the behavioral model for vulnerable populations are explored in more detail in Chapter 2.

A conceptual framework similar to the behavioral model for vulnerable populations has also been used to provide more knowledge on the current prison to community transition health care planning. The vulnerable populations conceptual model proposed by Flaskerud and Winslow (1998) also has three components – resource availability, relative risk, and health status. This conceptual framework proposes that resource availability, relative risk, and health status are related, and that increased resource availability may decrease health risks and improve health status (Flaskerud & Winslow, 1998). A detailed examination of both models indicates that Medicaid is the

cardinal component in discharge planning that ensures continuity of care for former offenders. This study was guided by the behavioral model for vulnerable populations and its various determinants of health services utilization.

Nature of the Study

This generic qualitative inquiry approach used open-ended interview questions to provide answers to the RQs to better understand (a) how Medicaid enrollment staff and mangers of Maryland Medicaid program perceive the experiences and challenges of justice-involved individuals in navigating the Medicaid system in Maryland, (b) the experiences of the enrollment staff and the managers of Maryland Medicaid program in the Medicaid enrollment of justice-involved individuals, and (c) the implications of the Medicaid staff and mangers of Maryland Medicaid for enrolling justice-involved individuals in Maryland Medicaid. Generic qualitative inquiry is not formally embedded within any of the epistemological or philosophical traditions but was used to ask open-ended questions about the people involved, the Medicaid program itself, and the Medicaid enrollment process (see Patton, 2015). Recruitment of participants was through purposeful sampling, and this included enrollment personnel (navigators and in-person assisters) and management team members from the DHMH, DSS, DPSCS, and DHR. The study had prior IRB approval from Walden University and four partner organizations. Issues of confidentiality, consent, and other ethical concerns that protect the welfare of participants were addressed before initiating the study (see Kostere & Kostere, 2021).

Definitions

Given the variations in meanings and the connotations in the use of terms, this study provided definitions to constructs and terms that are found in the study.

Community health workers (CHWs): Or peer support specialists refers to people with a history of incarceration who connect and build relationships with potential patients and serve as supporters, advocates, and mentors (Waters, 2019).

In-person assisters (IPAs): Individuals who perform similar duties as navigators but are only authorized to enroll or renew clients into Medicaid (CMS, 2015, as cited in Richardson et al., 2021).

Jails: Country or city institutions that house individuals awaiting trial (detainees) and individuals convicted of misdemeanors (inmates) who are serving short sentences, generally less than 1 year (Camhi et al., 2020).

Justice-involved: An individual or population of individuals who come into direct contact with the U.S. criminal justice system (Camhi et al., 2020).

Medicaid enrollment: The process of obtaining public health insurance after meeting eligibility requirements (An et al., 2022).

Navigators: Individuals trained to assist consumers and employers with finding qualified healthcare plans through the marketplace (CMS, 2015, as cited in Richardson et al., 2021).

Prisons: State or federal facilities that usually incarcerate convicted felons (frequently referred to as inmates or prisoners) serving sentences longer than 1 year (Camhi et al., 2020).

Recidivism: The phenomenon in which an individual who was detained or incarcerated ends up back in a correctional facility (Camhi et al., 2020).

Reentry: The transition period between custody in jail or prison and the community (Camhi et al., 2020).

Assumptions

In conducting this study two assumptions were made. First, I assumed that the enrollment staff and Medicaid program managers had sufficient knowledge about the eligibility requirements for enrolling justice-involved individuals in Medicaid and that they fully understood the provisions of the ACA and SCA that expanded and facilitated Medicaid enrollment (see Cuellar & Cheema, 2012). This meant that respondents would be providing accurate and truthful answers to interview questions using such knowledge and experience. Inaccurate answers could diminish the trustworthiness of the findings (see Toma, 2011). Second, I assumed that the interview questions and interview protocols would be designed to fully explore the perspectives of Medicaid enrollment staff and the Medicaid management team members to elicit responses that can address the RQs. It was based on these assumptions that purposeful sampling was used to recruit participants who would have the required experience being studied and were willing to describe their experience (see Kostere & Kostere, 2021).

Scope and Delimitations

Medicaid is the largest publicly funded health insurance program in the United States for low-income families and individuals (Vogler, 2020), and the passage of the ACA in 2010 expanded eligibility to those who had incomes below 138% of the federal poverty level (Ejike-King, 2014; Farrell & Gottlieb, 2020). The focus of this study was on the perceptions of the Medicaid enrollment staff and the managers of the Maryland Medicaid program about the experiences and challenges of justice-involved populations in navigating the Maryland Medicaid system. Justice-involved individuals are a vulnerable population because of their high-risk behaviors, lack of knowledge about health promotion and disease prevention (Flanagan, 2004). People categorized as vulnerable include the poor; persons subjected to discrimination, intolerance, subordination and stigma; and those who are marginalized, disenfranchised and denied human rights (Carlisle et al., 1996, as cited in Flaskerud & Winslow, 1998).

Medicaid enrollment for incarcerated people is confronted with enormous challenges, the most crippling being the inmate exclusion policy. Under this policy, Medicaid is prohibited from financing the health care of anyone committed to jail, prison, detention center or other correctional facility, except the individual is treated in a medical facility outside of prison or jail for a 24-hour period or more (Albertson, 2020). Other challenges are related to low health literacy, lacking required documentation, limited internet access, difficulty getting information and guidance, and the general lack of life skills needed to complete application forms (An et al., 2022; Flanagan, 2004). Many of

the states that expanded Medicaid are realizing that majority of incarcerated people are eligible for Medicaid and putting strategies in place that establish connections to health care for former offenders. While there are many qualitative studies that deal with Medicaid enrollment in other U.S. states, there is, however, only very sketchy information about measures being taken in Maryland to eliminate gaps in Medicaid coverage for ex-offenders during reentry after incarceration. It is necessary to have some understanding about Medicaid enrollment in Maryland for justice-involved people.

Limitations

Research studies, irrespective of design, have limitations. A potential limitation in this study was the use of purposeful sampling strategy in recruiting participants. Purposeful sampling aims to capture the heterogeneity in the population, and I used this strategy to seek information-rich cases by recruiting participants with the characteristics and knowledge that could allow them to answer the RQs (see Maxwell, 2009). Since the selection of participants was based on my judgment, it raised issues of researcher bias. An additional limitation to this study was the sample size, which in this generic qualitative study was determined by saturation. Saturation has been explained to be the point at which the gathering of new data by the researcher does not reveal or add any added information (Creswell & Creswell, 2018). Given the possibility of having a small sample size in the study, the generalizability of the study's findings to a broader population was limited. Findings are deemed to be generalizable (transferable) when they extend to certain individuals and settings other than those studied (Toma, 2011). This

study did not include the voices and perspectives of justice-involved people. This made it difficult to know if their experiences and challenges in Medicaid enrollment and barriers to continuity of care could corroborate or refute those of the enrollment staff and members of the Maryland Medicaid program management team.

At the point of starting this study, which focused on Medicaid enrollment for justice-involved individuals, I had worked for more than 8 years in a correctional facility as a health care provider. Even though the research study did not take place in the facility where I work, there was the possibility of researcher bias because I was the principal research instrument in data collection. Given my familiarity with the carceral system, I certainly had my own experiences, values, beliefs, thoughts, opinions, and assumptions. In order to create transparency in the research process, I engaged in self-reflexivity through keeping and using a reflective journal. The research journal helped me to be introspective, assess my own biases and motivations, and make them known to the reader of my study, so that some of the decisions and choices made in the research process were understood (see Ortlipp, 2008).

Significance

This study can help to heighten awareness on the need to eliminate gaps in Medicaid coverage for justice-involved individuals. Justice-involved people are considered a vulnerable population with a high disease burden and in need of education in basic health, medications, self-care, hygiene, nutrition, dental care, health promotion and disease

prevention. The National Commission on Correctional Health Care (NCCHC) recommends continuation of support services and medications during reentry for former inmates (Flanagan, 2004). Transitional health care (discharge) planning ought to begin while an offender is still in prison or jail and continue in the community after release.

The experiences of participants in this study could help reveal that former inmates still face enormous policy barriers as well as challenges in trying to fulfil eligibility requirements for Medicaid enrollment. Even though the provisions of the ACA expanded Medicaid eligibility to vulnerable populations, the Medicaid Inmate Exclusion Policy prohibits coverage for services provided to incarcerated people (Albertson, 2020). Medicaid enrollment applications continue to be complex and require a large amount of documentation. These hurdles all combine to create discontinuities in care for Medicaid beneficiaries as they cycle in and out of prisons or jails. The study could add to existing literature concerning health coverage for formerly incarcerated people in Maryland. The findings could improve understanding of the Medicaid enrollment process and provide insights to streamline the enrollment process and make recommendations for improving policy in the Medicaid program.

Improving Medicaid enrollment strategies could eliminate gaps in Medicaid coverage and ensure continuity of care during reentry. The ACA had provisions to simplify enrollment in Medicaid such as no longer requiring an asset test for Medicaid eligibility for newly eligible adults (Cuellar & Cheema, 2012). The ACA also had provisions that promote new models of care delivery such as patient-centered medical

homes and health homes for individuals with chronic health conditions. Several states have maintained continuous Medicaid coverage for current and former inmates by suspending instead of terminating coverage. Continuing coverage increases the chances of successful integration into the community.

This study contributes to positive social change by ensuring that ex-offenders can be healthy upon release and make positive contributions to society in various settings. For example, many formerly incarcerated people can work as community health workers (CHWs) for the Formerly Incarcerated Transition program, which helps other individuals coming out of prison or jail to get access to health and social services (Waters, 2019). CHWs help formerly incarcerated people overcome the natural distrust of the health care system and fill the role of connecting and building rapport with potential patients and serving as supporters, advocates, and mentors (Waters, 2019). CHWs continue to have positive impact that improves the reintegration of former inmates into the community.

Summary

This generic qualitative study addressed the problem of Medicaid gaps and lack of insurance coverage for majority of incarcerated people in Maryland as they return to the community from prison or jail. It did so by attempting to understand the Medicaid enrollment strategies as well as the barriers and challenges that the enrollment process entails. Inmates as a vulnerable population, suffer from many chronic medical conditions such as hypertension, cancer, diabetes, arthritis, asthma/COPD, and mental health conditions, as well as infectious diseases that include HIV/AIDS, Hepatitis B/C (Farrell

& Gottlieb, 2020). Despite the health challenges that they face, most of them are released from prison or jail without any form of health coverage, causing a downward spiral in their health and well-being.

This chapter examined some of the Medicaid enrollment challenges that are related to minimal health literacy, misunderstanding of required documentation for Medicaid enrollment, cost, limited internet access, and lack of information. There is also the Medicaid Inmate Exclusion Policy that prohibits coverage for services provided to people in jails and prisons. Even after the ACA provisions expanded eligibility to low-income people with incomes below 138% of the federal poverty level, former inmates continue to face difficulties with enrollment despite meeting the criterion. Strategies to expedite Medicaid coverage should be part of discharge planning and some states such as Florida, Ohio and New Mexico are using their Medicaid managed care contracts to require plans to carry out "in-rich" into jails or prisons to connect people with comprehensive primary care. Despite the available literature on Medicaid enrollment in other states there is a dearth of such information on such efforts by the Maryland Medicaid program.

This chapter introduced the behavioral model for vulnerable populations by Gelberg et al. (2000), which guided the study. The model uses three core factors to explain health care utilization in vulnerable populations. Details of the model are presented in Chapter 2. The study design for this generic qualitative inquiry used interviewing as the data collecting instrument and the interview participants were

recruited through purposeful sampling. Pertinent limitations in the study were presented. This study adds to the existing literature on Medicaid enrollment to provide health care access to former offenders and contributes to positive social change through advocating for health coverage for justice-involved individuals so that they could have uninterrupted access to care after incarceration.

The next chapter examines the literature review that was conducted for the study. It begins with the search strategy and key terms used to identify sources, the conceptual framework, review of the literature that is relevant to the key components of the study, and a chapter summary.

Chapter 2: Literature Review

Introduction

Incarcerated individuals are usually low-income people who depend on Medicaid to be able to access and use health services. The Medicaid Inmate Exclusion Policy prohibits coverage for health services delivered to incarcerated populations, except for inpatient hospital stays outside of correctional institutions (Albertson et al., 2020). Termination of Medicaid coverage through this policy creates gaps in coverage as well as discontinuities in care for Medicaid beneficiaries as they cycle in and out of jail, prison, or detention. Ex-offenders are then faced with the challenge of reapplying for insurance coverage as they get released back into the community. There is a paucity of information on the perceptions of the enrollment staff and managers of Maryland Medicaid about the experiences and challenges of justice-involved individuals in navigating the Maryland Medicaid system.

The passage of several legislative acts such as the ACA, SCA, and the Mental Health Parity and Addiction Equity Act expanded Medicaid eligibility for justice-involved populations and helped to remove some barriers to Medicaid enrollment (Albertson et al., 2020; Cuellar & Cheema, 2012; Ejike-King & Dorsey 2014). Many expansion states developed strategies that incorporate Medicaid enrollment in discharge planning such as suspension instead of termination of Medicaid benefits following incarceration, PE, enrollment during incarceration, and accepting different forms of identification during enrollment.

This chapter addresses the conceptual framework that guided the study, its application to past studies, and the current one. This literature review covers gaps in Medicaid coverage and the lack of insurance coverage for justice-involved populations during the transition from jail or prison to the community. The literature review covers the following topics: prison population, lack of insurance for incarcerated populations, healthcare access challenges, legislative landscape and Medicaid expansion, and current strategies to enroll justice-involved populations in Medicaid.

Literature Search Strategy

I used the following databases to review recent literature relevant to the study: ProQuest Central, ProQuest Health & Medical Collection, CINAHL Plus, Google Scholar, PubMed, and Dissertations and Theses at Walden University. For all searches, the following key search terms were used in different combinations: *ex-offenders, criminals, ex-felons, justice-involved, jail, prison, prisoners, health, healthcare, healthcare access, health services accessibility, Medicaid, health coverage, health insurance, Affordable Care Act, Second Chance Act, Medicaid enrollment, reentry,* and *reintegration.*

Some useful articles that were found had exceeded the 5-year limit, but I included them in the literature review because they contained useful information that I could not find in the other recent sources. Ulrich's Periodicals Directory was used to verify if the articles from Google Scholar were peer-reviewed. Most of the available sources indicate that federal and state policies have a major impact on Medicaid enrollment as a source of

health coverage for justice-involved people. These sources are usually not peer-reviewed or recent and are written as briefs found in the publications of Urban Institute and The Commonwealth Fund.

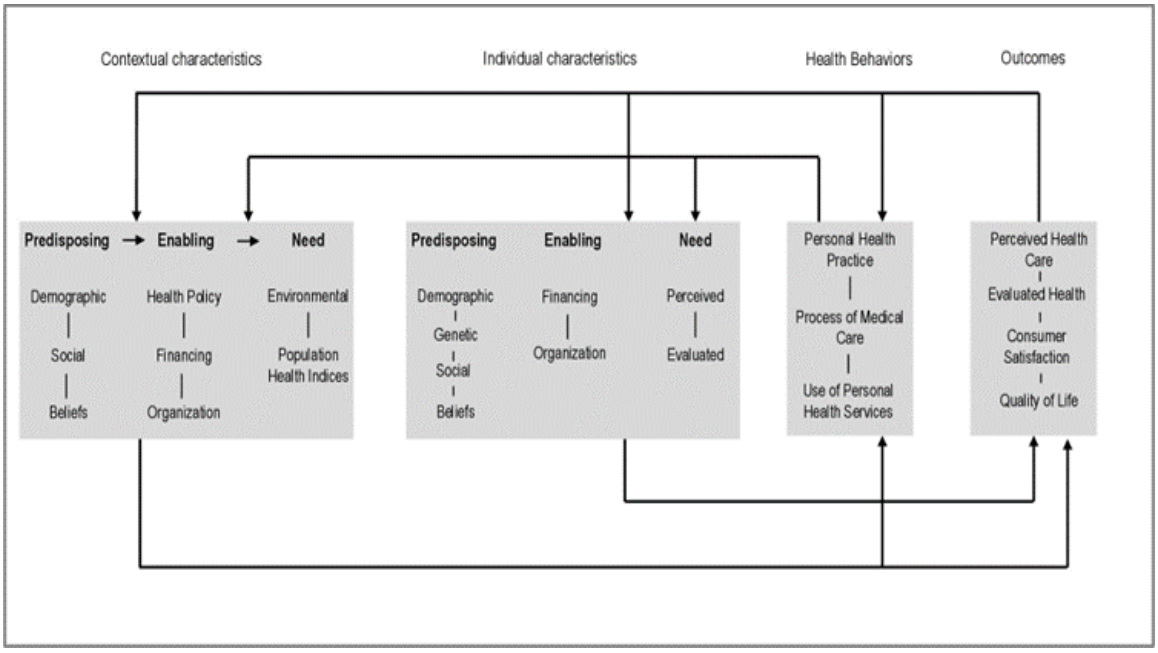
Conceptual Framework

This study explored the problem of Medicaid gaps and lack of health coverage for majority of justice-involved people in Maryland who return to the community from prison or jail without health care coverage and cannot access health services. Osanloo and Grant (2016) believed that a conceptual framework is the researcher's understanding of how the research problem will be adequately explored, the direction it will take, and the relationship between the variables in the study. The conceptual framework that guided this study was the behavioral model for vulnerable populations by Gelberg et al. (2000). It is a leading model often used to explain the use of health services and was designed to include domains that are mostly relevant to understanding the health and health seeking behavior of vulnerable populations (Gelberg et al., 2000). The model is an extension of the original behavioral model that was developed by Andersen and Newman and evolved because of Aday's framework aimed at addressing the needs of vulnerable populations (Aday, 1994, cited in Oser et al., 2016). The behavioral model for vulnerable populations helps in the identification of determinants that lead an individual to use health services (Oser et al., 2016). The application of this model of health services utilization to justice-involved populations helps in identifying the challenges they encounter in obtaining needed services and in providing insights into maintaining access to health care.

According to the authors of the model, it can be divided into traditional and vulnerable domains. The model uses three domains as determinants of health behaviors, including use of health services: predisposing factors, enabling factors, and needs factors (Lederle et al., 2020); see Figure 1.

Figure 1

The Behavioral Model for Vulnerable Populations



Note. Andersen's behavioral model of health services use. "From Application of Andersen's behavioural model of health services use: a scoping review with a focus on qualitative health services research," by Lederle, M., Tempes, J., & Bitzer, E. M., 2021, *BMJ open*, *11*(5), p. 2 e045018. https://doi.org/10.1136/bmjopen-2020-045018. Copyright 2021 by Lederle et al.

The predisposing traditional domain includes demographic characteristics such as age, gender, and marital status; health beliefs; and social structure (Gelberg et al., 2000).

Social structure characteristics are stated as ethnicity, education, employment, and family size. Other social structure characteristics are living conditions, criminal behavior and prison history; victimization; and mental illness. Prior research has indicated that the predisposing factors of age, race/ethnicity, incarceration history, mental illness, and victimization are associated with the extent to which health services are utilized (Gelberg et al., 2000). Scholars have postulated that a high proportion of incarcerated individuals are from low-income backgrounds and suffer from several chronic conditions and infectious diseases (Albertson et al., 2020). Farrell and Gottlieb (2020) pointed out that returning ex-offenders during reentry face challenges of poverty, homeless, and unemployment while Ejike-King and Dorsey (2014) stated that racial and ethnic minorities are disproportionately represented in the criminal justice system. An application of the predisposing factors in this model to ex-offenders reveals their inability to have routine access to care and resort to using emergency rooms for non-urgent conditions.

The enabling traditional domain includes personal/family resources that include regular source of care, insurance status, and income. Community resources include residence; region and health services resources; availability and use of information sources (Gelberg et al., 2000). Medicaid is public insurance, provided by the Center for Medicare and Medicaid Services. It is an enabling factor in the behavioral model for vulnerable populations and plays a vital role in determining access to and using health services. A combination of personal and community resources should help provide the

needed access to health services. Most justice-involved individuals are poor and have to rely on Medicaid as public insurance in order to access care. Community resources that enable and facilitate the health insurance process will be the staff of a public health department, social service agency; staff of a community-based or other nonprofit organization; corrections staff assisting in the corrections setting; navigators, in-person assisters and CHWs in the State Health Insurance Marketplace (Bandara, 2015). Some challenges that mitigate against the enabling domain are the existence of Medicaid Inmate Exclusion Policy that prohibits payment for health services for incarcerated people, shortage of enrollment staff, low health literacy, lack of information, and the need for many documents in the Medicaid enrollment process (An et al., 2022).

The need traditional domain includes self-perceptions (perceived need) and objective evaluations (evaluated need) of the general population health conditions. Needs of particular attention are tuberculosis, sexually transmitted diseases, premature and low-birthweight infants, and HIV/AIDS (Gelberg et al., 2000). When applied to the behavioral model for vulnerable populations, it is likely that medical problems, mental health and substance use disorders are correlates of higher utilization of health services. Research has shown that people in jails or prisons have higher risk than the general population for having chronic and infectious diseases such as hypertension, asthma, COPD, diabetes, arthritis, cancer, HIV/AIDS, and Hepatitis B/C (Bandara et al., 2015; Ejike-King, 2014). Other studies have indicated that the U.S. opioid crisis disproportionately affects the incarcerated population and that about two-thirds of the

incarcerated population in the country struggle with SUDs (Maryland Department of Health, 2018, cited in Li-Rodenborn, 2020).

The behavioral model for vulnerable populations specifies that vulnerable populations include minorities, undocumented immigrants, children and adolescents, mentally ill, chronically ill and disabled persons, the elderly, and impoverished and homeless persons (Aday & Awe ,1997, cited in Gelberg et al., 2000). The model has been modified for specific settings such as complementary and alternative medicine (Fouladbakhsh & Stommel, 2007, as cited in Lederle et al., 2021) and for specific target groups such as the behavioral model for vulnerable populations for homeless people (Gelberg et al., 2000). Many versions of the model for different settings or target groups are currently available and applied in health services research.

The application of the behavioral model for vulnerable populations in this study helped in understanding the factors that facilitate or hinder heath care access for justice-involved people as a vulnerable population. Incarcerated people are often poor and have low socioeconomic status. They have serious health problems but often lack health coverage to access health care. The use of the three domains in the model clearly explains the research problem in the study, which is the persistent gaps in Medicaid coverage and lack of insurance to provide care access for inmates during reentry.

Major Topics

Prison Population

The prison population in the United States grew geometrically in the 3 decades between 1980 to 2010 from 330,000 to 1.5 million while another 760,000 inmates are incarcerated in local jails at any given time (Cuellar & Cheema, 2012). Research has shown that the prison population started levelling off in 2008 following the years of rapid increases (Cuellar & Cheema, 2012; Ejike-King & Dorsey, 2014; Farrell & Gottlieb, 2020). Despite this decline, the prison population in the United States remains the highest in the world (Farrell & Gottlieb, 2020). The term correctional facilities include prisons, which are operated by state or federal government and usually incarcerate people who have a sentence of a year or greater (Bandara et al., 2015); jails are mostly operated at the county level and incarcerate people who have still to go to trial and those with sentences of one year or less; and community corrections settings such as probation and parole systems. The Sentencing Project 2021 clarified that probation is a court-ordered period of supervision in the community granted as an alternative to incarceration, and parole is a period of conditional supervised release into the community after the individual has served part of the jail term in state or federal prison (The Sentencing Project, 2021, cited in Hawks et al., 2022). Incarcerated is a generic term referring to a person confined to a jail, prison, or other institution (Davis, 2022).

Lack of Insurance for Incarcerated Population

Almost all incarcerated individuals will return to the community following their time in jail, prison, or detention. Farrell and Gottlieb (2020) posited that returning inmates constitute a vulnerable population with a high disease burden from increased rates of chronic medical conditions that include, hypertension, asthma, COPD, arthritis, diabetes, infectious diseases such as HIV/AIDS, hepatitis B/C, TB, and mental health conditions and SUDs (Farrell & Gottlieb, 2020). In 2015, available national data indicated that 24% of state prisoners reported substance dependence, 15% reported a mental health condition, while 42% reported both mental health and SUDs. The transition from incarceration into the community becomes complicated due to poor access to health services, especially for people with mental health illness or SUDs (Blackburn, 2020). Research has suggested that the first 2-week period following release is an acutely vulnerable period for ex-offenders. Binswanger et al. (2007, cited in Li-Rodenborn et al., 2020) found that in the 2 weeks following release, the mortality rate among ex-offenders was up 12.7 times the rate among the general population and that the leading cause of death during the period was drug overdose (cited in Bandara et al., 2015).

A major contributing factor to diminished health status among justice-involved populations is a lack of health insurance. In 2010, an estimated 50 million people in the United States did not have health insurance (Vogler, 2020), while about 80% of justice-involved people either lacked insurance coverage or the financial resources to pay for medical care prior to 2014 (Bandara et al., 2015). This lack of health insurance and

medical treatment is considered to be the most reported health need at reentry. In most states, those receiving Medicaid benefits prior to incarceration have their coverage terminated or suspended because of being in jail or prison. Measures to terminate or suspend Medicaid result from the Medicaid Inmate Exclusion Policy, which creates gaps in coverage, thereby disrupting the continuity of care to which they are entitled. The right to reasonable access to health care by justice-involved individuals was established in the Supreme Court case of *Estelle v. Gamble,* which also stipulated that the health care for justice-involved populations must meet minimal standards of adequacy (Albertson et al., 2020; Flanagan, 2004). An examination of the behavioral model for vulnerable populations confirmed that a myriad of health problems, low socioeconomic status, and lack of insurance all combine to diminish health services utilization by justice-involved people.

Healthcare Access Challenges

Transitional healthcare planning for ex-offenders often varies by jurisdiction and is usually about 1 month or 6 months prior to release. Inmates get released with no more than a 30-day supply of medications, and this makes it difficult for them to manage their health problems (Bandara et al, 2015; Li-Rodenborn et al., 2020). The Medicaid Inmate Exclusion Policy enacted in the Social Security Amendments of 1965 continues to prohibit the use of Medicaid to finance ambulatory health care provided during incarceration; this includes care for individuals still in pretrial (Khatri & Winkelman, 2022). The exclusion policy results in the termination or suspension of Medicaid

following incarceration, leading to gaps in Medicaid coverage at the time of release (Albertson et al., 2020). Termination requires re-enrollment of the beneficiaries while suspension requires a simple process of reinstatement. States have always had some level of autonomy in determining program generosity in the various states but categorical restrictions that limit coverage to the disabled, the elderly, children, pregnant women, and members of families with dependent children are the uniform policy (Vogler, 2020).

Current literature points to enormous challenges in Medicaid enrollment in eligible populations. The common barriers mentioned include limited health insurance literacy, lack of the required documentation, limited access to the internet, cost, and difficulty obtaining information. (An et al., 2022). It has been suggested that Medicaid enrollment for eligible people can be increased by providing user-friendly technology, self-service tools, and improving readability of enrollment materials (An et al., 2022). While a number of qualitative studies have examined the causes of barriers to accessing health services by ex-offenders, there is limited research about Medicaid gaps and the lack of Medicaid coverage for former offenders in the state of Maryland. There was, therefore, a need in this generic qualitative study to understand perceptions of the enrollment staff and managers of Maryland Medicaid about the experiences and challenges of justice-involved individuals in navigating the Maryland Medicaid system. Incarcerated populations face social and structural barriers including racial discrimination and stigma. Stigmatization is pervasive in TennCare and has been described by some social justice-oriented scholars to be the offshoot of deficit thinking, a social construct

that claims, “the poor and people of color caused their own social, economic, and educational problems” (Valencia, 1997, cited in Isbell et al., 2018). TennCare is the Medicaid Program for the state of Tennessee, and Isbell et al. (2018) conducted their research with the goal of educating government leaders, policymakers, and service providers to listen and provide care, instead of blaming recipients of government-sponsored healthcare as degenerate and lazy. Future research should aim to foster courage in marginalized groups who rely on government services to resist and even confront stereotyping so that we can have structural change to reduce health inequities in the U.S.

Legislative Landscape and Medicaid Expansion

The passage of three federal laws in recent years has helped to alleviate some of the insurance coverage challenges that justice-involved populations face during reintegration into the community. The ACA of 2010, promotes accessible, quality, and affordable health care for Americans by expanding Medicaid eligibility to low-income individuals and adults without children with incomes below 138%of the federal poverty level in states that opted to expand their Medicaid program (Ejike-King & Dorsey, 2014; Vogler, 2020). The ACA provisions indicate that people who are not eligible for Medicaid may qualify for subsidies to help pay for insurance premiums for private health plans that they purchase in the Marketplace. The ACA helped immensely to expand Medicaid coverage to ex-offenders who meet the income criterion (Albertson et al., 2020; Bandara et al., 2015; Blackburn et al., 2020; Cuellar & Cheema, 2012; Ejike-King &

Dorsey, 2014). Following passage of the SCA, the federal government gave state, local, and tribal authorities $100 million in 2010 to facilitate the transition of inmates into the community (Cuellar & Cheema, 2012). The funds provided an opportunity for the states to examine barriers to the delivery of health care to ex-offenders, including the lack of insurance (Cuellar & Cheema, 2012). The Mental Health Parity and Addiction Equity Act passed in 2008 was aimed at addressing the mental health and substance abuse benefits in large-group health insurance plans, but the law does not require plans to offer mental health benefits (Cuellar & Cheema, 2012).

The most recent piece of legislation is the Medicaid Re-entry Act that was passed by the U.S. House of representatives in November 2021 and is still under consideration in the Senate. Under this Act Medicaid would be allowed to pay for health care services for eligible individuals who are incarcerated starting up to 30 days before their release from jail or prison (Khatri & Winkelman, 2022). From the legislative standpoint, it is obvious some effort is being made by the federal government to improve access to health care for justice-involved individuals. However, as hitherto stated, individual states maintain a great deal of autonomy in determining the extent of the generosity afforded by the state's Medicaid program. And as of 2018, 32 states and the District of Columbia have expanded their Medicaid programs, following the passage of the ACA (Vogler, 2020).

Current Strategies to Enroll Justice-Involved Populations in Medicaid

The expansion of Medicaid by the ACA gave the expansion states the opportunity to enroll criminal justice-involved populations in health insurance, particularly Medicaid.

Many state and county corrections departments have launched programs that include Medicaid enrollment in discharge planning (Bandara et al., 2015). These enrollment strategies are only found in the Medicaid expansion states that include the state of Maryland. Four practices have so far facilitated the Medicaid enrollment process: suspending instead of terminating Medicaid benefits upon incarceration, presuming that an individual is eligible for Medicaid before the process is completed (PE), allowing enrollment during incarceration, and accepting alternative form of identification (Bandara et al., 2015).

Suspension Versus Termination

Some states have policies that suspend Medicaid benefits for people upon arrival at a correctional facility instead of terminating them. Prior to 2007, New York terminated inmates' benefits upon incarceration, and they waited several months after being released for their Medicaid reapplication to be processed (Bandara et al., 2015). In 2007, a new state law made it possible to suspend an inmate's benefits and reinstate them immediately following the inmate's release (Bandara et al., 2015).

PE

This practice assumes that an individual is eligible for Medicaid before they have completed the enrollment process, and allows providers to deliver services without waiting until the Medicaid application is processed (Bandara et al., 2015). The practice is mostly used in states to allow qualified entities (hospitals mostly) to provide temporarily Medicaid eligibility and immediate medical services to specific populations such as

pregnant women and children (Bandara et al., 2015). Connecticut serves as an example that has used this strategy for individuals released from the state prison system.

Enrollment During Incarceration

Many programs give people the opportunity to begin the enrollment process during incarceration when release is imminent and this ensures that inmates leave the corrections facility with Medicaid enrollment already approved (Bandara et al., 2015). The Washington State Health Care Authority (HCA) has released regulatory procedures that allow for enrollment up to 30 days if a correctional or county office has a Memorandum of understanding already in place with the HCA (Bandara et al., 2015).

Alternative Forms of Identification

Most inmates seeking Medicaid benefits do not have specific documents such as a driver's license or birth certificate (Bandara et al., 2015). Some programs have developed systems that allow enrollees to use alternative documents as proof of income and identification. Rhode Island allows the use of corrections identification (Bandara et al., 2015). Navigators and IPAs have used the Health Exchange portal to confirm the individual's identity through the use of a credit reporting company (Richardson et al., 2021).

The foregoing strategies to enroll justice-involved people in Medicaid are ongoing in several states but there is little or no information on enrollment strategies in Maryland. It was necessary to know what programs have been put in place to improve Medicaid enrollment for ex-offenders in Maryland. Future research should aim to assess whether

the various innovative practices to enroll former offenders in Medicaid decrease the probability of gaps in medication or care immediately following their release from incarceration.

Summary and Conclusions

Medicaid coverage is the single most important avenue for health care access for incarcerated populations. This public insurance is suspended or terminated when an individual is incarcerated, creating gaps in Medicaid coverage. The passage of the ACA and the SCA provided the opportunity for expansion states to develop programs to expedite Medicaid enrollment to ensure continuity of care as they transition back into the community. Discharge planning needs to incorporate Medicaid enrollment to ensure continuity of care after release from incarceration. The conceptual model for vulnerable populations provided guidance for this study and was applied to emphasize the importance of insurance as an enabling factor in health services utilization.

The literature review provided information on the impact of incarceration on Medicaid enrollment for inmates despite their high disease burden. It made clear some of the origins of gaps in Medicaid such the Medicaid Inmate Exclusion Policy. It covered important topics relevant to this study such as the burgeoning but marginalized incarcerated population, their lack of insurance, healthcare access challenges, legislative landscape and Medicaid expansion, and current strategies to enroll justice-involved populations in Medicaid. Chapter 3 will cover the methodology and strategies used in the research design.

Chapter 3: Research Method

Introduction

This generic qualitative study used the qualitative stance to understand how the Medicaid enrollment staff and managers of Maryland Medicaid program perceive the experiences and challenges of justice-involved individuals in navigating the Medicaid system in Maryland. Qualitative research is used to explore and understand the meaning that individuals ascribe to a social or human problem (Creswell & Creswell, 2018). This study focused on the problem of majority of incarcerated people in Maryland returning to the community from prison or jail without health care coverage and not being able to access health services. In order to address this health access problem, I sought answers to the following questions: (a) How do Medicaid enrollment staff and managers of Maryland Medicaid program perceive the experiences and challenges of justice-involved individuals in navigating the Medicaid system in Maryland? (b) What are the experiences of the enrollment staff and the managers of the Maryland Medicaid program in the Medicaid enrollment of justice-involved individuals? (c) What are the implications of the Medicaid staff and managers of the Medicaid program for enrolling justice-involved individuals in Maryland Medicaid?

The questions sought to elicit subtleties and nuances in the experiences of the enrollment staff and the managers of the Maryland Medicaid program and justified the need for a qualitative research approach. This chapter presents the methodology and justification for the qualitative approach, the role of the researcher, ethical issues,

sampling strategy and participant selection, instrumentation and data collection, data analysis, and trustworthiness.

Research Design and Rationale

Qualitative Approach

This study used qualitative methodology to understand the problem of lack of health coverage for majority of former offenders in Maryland as they return to the community. This understanding could only be achieved by meeting and talking directly with participants in their natural environment or places of work and allowing them to relate their experiences (see Creswell & Creswell, 2018; Creswell & Poth, 2018). The experiences in this inquiry came from the voices of the enrollment staff and the managers of the Maryland Medicaid program as they engaged in the Medicaid enrollment process for justice-involved individuals in Maryland. Qualitative research gathers several forms of data such as interviews, observations, documents, and audiovisual information and does not rely on a single data source (Creswell & Creswell, 2018). Every research starts with assumptions and the use of theoretical or conceptual frameworks to form the basis of the study of a research problem (Creswell & Poth, 2018). Creswell and Creswell (2018) referred to these philosophical assumptions as worldviews or paradigms. They adopted Guba's meaning of the term *worldview* as "a basic set of beliefs that guide action" (Guba 1990, p. 17, as cited in Creswell & Creswell, 2018). Researchers bring different worldviews or epistemological beliefs to inquiry and two of the best known are positivist worldview and constructivist worldview. Positivists hold the view that reality is fixed,

directly measurable through experiments, and that there is just one truth based on objectivity (Rubin & Rubin, 2012). The knowledge that develops through a positivist paradigm lens belongs to the numbers-based quantitative research (Tracy, 2010).

My study was guided by constructivism or naturalistic inquiry which assumes that reality constantly changes and that individuals develop subjective meanings of their experiences (see Creswell & Creswell, 2018; Creswell & Poth, 2018; Guba & Lincoln, 1989, as cited in Patton, 2015; Rubin & Rubin, 2012). The constructivist worldview relishes multiple realities in qualitative research, and this allowed me as researcher to be the main research instrument in this study (Patton, 2015). This means that the researcher is not objective in a qualitative study. Creswell and Poth (2018) and Creswell and Creswell (2018) outlined the following common characteristics of qualitative research: natural setting, researcher as key instrument, multiple methods, inductive and deductive data analysis, participants' multiple perspectives and meanings, emergent design, reflexivity, and holistic account. These characteristics and the constructivist worldview made my study amenable to the qualitative approach.

Design

A design is a plan that sets direction and gets the researcher moving into the field (Patton, 2015). In qualitative research, a design is not iron-clad but flexible and emergent. Some or all phases of the research process may be altered as the researcher is in the field and begins to collect data (Creswell & Creswell, 2018). Scholars have identified five approaches to qualitative inquiry that are popular across the social and health sciences:

narrative, phenomenology, case study, grounded theory, and ethnography (Creswell & Poth, 2018; Creswell & Creswell, 2018; Holloway & Brown, 2016). My research was based on generic qualitative inquiry, which is not among the established methodologies mentioned above. Generic qualitative inquiry is not formally embedded within any of the epistemological or philosophical traditions but was used to ask open-ended questions about the people involved, the Medicaid program, and the Medicaid enrollment process in Maryland (see Patton, 2015). Merriam (2009, as cited in Kahlke, 2014) postulated that the generic qualitative approach, which is also called basic qualitative or interpretive, can stand alone as a researcher's articulated approach. This methodology is aimed at understanding human experience by taking a qualitative stance and using qualitative procedures (Kostere & Kostere, 2021). Maxwell (2009) argued that qualitative research needs a broader and less restrictive concept of "design" than current popular approaches. Maxwell postulated that a good design in which the components work harmoniously together, promotes efficient and successful functioning of the research process; but cautions that a flawed design leads to poor operation or failure.

Rationale

I chose the generic qualitative inquiry approach because this approach provided structure or methodological congruence for my study and ensured that the purposes, questions, and methods are harmonious and interconnected (see Creswell & Poth, 2018). As a qualitative approach, generic qualitative inquiry has the basic characteristics of qualitative research as stated above. The generic qualitative approach fits the purpose of

my study, which sought to understand how Medicaid enrollment staff and managers of Maryland Medicaid perceived the experiences and challenges of justice-involved individuals in navigating the Medicaid system in Maryland. These perceptions of the research participants would help to provide answers to the RQ and provide tentative solutions and inform policy. The first contribution of qualitative inquiry, according to Patton (2015), is illuminating meanings and how humans make sense of the world. This qualitative design allows for multiple sources of data, but I used open-ended qualitative interviews as the most common data collection procedure (Kostere & Kostere, 2021; Seidman, 2012). Qualitative inquiry also gets the researcher deeply immersed in the research process as the principal instrument of inquiry (Creswell & Creswell, 2018; Creswell & Poth, 2018; Kostere & Kostere, 2021; Patton, 2015). The credibility of the qualitative methods depended on the skills, competence, and rigor that I brought to the field work as a research student. A central tenet of qualitative research is that the qualitative stance allows individuals to construct reality in their interaction with their social worlds (Merriam, 2009, cited in Kostere & Kostere, 2021). The quest for multiple perspectives and multiple realities demanded that I use reflexivity to prevent my background, values, and beliefs from interfering with the research process.

Role of the Researcher

Qualitative research texts point to the person conducting the interviews and engaging in observations in the field as the research instrument (Creswell & Creswell, 2018; Creswell & Poth, 2018; Holloway & Brown, 2016). Qualitative research is

interpretive research and I expected to have prolonged and intensive engagement with the participants (Creswell & Creswell, 2018). This extensive contact with study participants raised a number of strategic, ethical and personal issues during the research process. I had to consciously identify my biases, values, beliefs, interests, and personal background that shaped my interpretation of the data for the study. I used my research subjectivity to understand the participants and the meaning they gave to their various experiences as members of the Medicaid enrollment staff or as managers of the Maryland Medicaid management team. In order not to be unduly influenced by my subjectivity, I incorporated reflexive thinking into the study by keeping and using a reflective journal, field notes, diary, and writing memos (see American Psychological Association, 2020; Ortlipp, 2008). The research journal helped me to be introspective, assess my own biases and motivations, and shaped the development of codes and themes (see Creswell & Creswell, 2018).

At the time of collecting the data for this study I had worked as a healthcare provider (nurse practitioner) in a Maryland state prison for about 8 years. In this role, I did not get involved in discharge planning and had no prior knowledge of Medicaid enrollment. My study was not a “backyard” study (see Creswell & Creswell, 2018), and I anticipated that participants for the study would come from the Maryland Department of Human Resources (DHR), the network of local Department of Social Services (DSS), the Maryland Department of Health (MDH), and the Department of Public Safety and Correctional Services (DPSCS). I had no prior contact with any of the prospective

participants. This study began after getting approval from the Walden University Institutional Review Board (IRB). This was followed by contacting authority figures (gatekeepers) in the partner organizations to gain access to the study sites. I used an Interview Guide with open-ended questions to conduct responsive interviews with participants who met the inclusion criteria for this study. Trustworthiness in the findings of the study was achieved through triangulation and prolonged engagement (see Toma, 2011). Triangulation demonstrated that the findings were transferable, credible, dependable, and confirmable.

Methodology

This study used the generic qualitative approach to understand how Medicaid enrollment staff and the managers of Maryland Medicaid program perceive the experiences and challenges of justice-involved individuals in navigating the Medicaid system in Maryland. Qualitative research is guided by the philosophical assumption of the possibility of multiple realities, and that reality is based on the interpretations of people and changes constantly (Rubin & Rubin, 2012). Individuals therefore develop subjective meanings of their experiences. Qualitative methods such as in-depth open-ended interviews, direct observations, audiovisual information, and documents are used to explore and understand these subjective meanings (Patton, 2015). For this study, I used in-depth qualitative interviewing as the method of data collection. It was possible that some documents related to Medicaid enrollment in Maryland could surface when I was in the field, and I would certainly incorporate them among the research data.

Interviewing is described as a basic mode of inquiry and is rooted in an interest in understanding the experiences of other people and what these experiences mean to them (Seidman, 2012). As a primary tool of research, in-depth qualitative interviewing is either semi structured or unstructured (Rubin & Rubin, 2012). Both interviewing styles are scheduled and involve extended conversation between the researcher and the interviewee. In the semi structured interview, the researcher has a specific topic of inquiry, and uses an Interview Guide to prepare a limited number of questions in advance, and plans to ask follow-up and probing questions (Jacob & Furgerson, 2012; Patton, 2015). For the unstructured interview, there is an identified topic for the interview, but many of the questions are formulated as the interview proceeds (Rubin & Rubin, 2012).

I used an Interview Guide to conduct semi structured interviews with my research participants. The interview questions were based on the extensive literature review that I had carried out and the selected conceptual framework. These interview questions were grounded in the literature and helped address the RQs (see Turner, 2010). There were two sets of questions (see Appendices A and B) because of the differences in the experience between the two groups of participants: Medicaid enrollment staff and the managers of the Maryland Medicaid program. I used a script to guide the process from the beginning to the end of each interview session. Questions were open-ended and the interviews began with “tour” questions or icebreakers that helped establish trust and rapport between the interviewee and me (see Jacob & Furgerson, 2012; Patton, 2015; Rubin & Rubin, 2012). During each interview, I obtained permission from the interviewee to record the

interview electronically and only took brief notes during each interview. This interview technique allowed me to maintain eye contact with the interviewee. Purposeful sampling was used to recruit participants who had the required experience being studied and were willing to describe their experience (see Kostere & Kostere, 2021). Purposeful sampling can be used to adequately capture the heterogeneity in the population, thereby achieving the representativeness of the settings, individuals, and activities (Maxwell, 2009)

Data interpretation went concurrently with other parts of developing the qualitative study and followed Saldaña's (2016) descriptive and In Vivo coding processes, with first and second cycle coding. Codes were categorized, which means synthesizing the codes into consolidated meaning. Categories were further consolidated into themes that displayed multiple perspectives of study participants and formed the major findings in the study (see Creswell & Creswell, 2018). A qualitative computer analysis program (MAXQDA) was used to assist in analyzing the data.

Participant Selection Logic

Recruitment for this generic qualitative inquiry was guided by the purpose for the study which was to understand how Medicaid enrollment staff and the managers of the Maryland Medicaid program perceive the experiences and challenges of justice-involved individuals in navigating the Medicaid system in Maryland. The population of a study refers to all persons that could participate in the study (Kostere & Kostere, 2021). Because the study was focused on the standard criterion of experiencing the phenomenon of Medicaid enrollment in Maryland, the sampling strategy was criterion-based and

purposeful. Prospective participants in the study were presumed to have enrollment experience and be willing to describe their experience. Maxwell (2009) emphatically described purposeful sampling as the deliberate selection of particular settings, individuals, or events because of the important information they can provide that cannot be obtained anywhere else. Such purposeful sampling helped me as the researcher to understand the problem and the RQs in the study from people that were directly involved in the enrollment process. For this inquiry, the population of study was limited to Medicaid enrollment staff (navigators and in-person assisters) and management team members from the MDH, DHR, DPSCS, and DSS. Inclusion criteria for enrollment personnel include having a minimum of 1 year of experience as an application assistor and currently working as a Medicaid or Medicaid agency staff or community-based enroller. Prospective participants from management had direct involvement in Medicaid enrollment rules, regulation, and policy. Justice-involved individuals were excluded from the study because of the ethical hurdles of involving a protected population in a research study.

After getting IRB approval for the study, I sent out invitation letters to gatekeepers in the partner organizations via email to have access to the research sites and initiate the recruitment process. In the letter, I introduced myself, stated the purpose of the study and possible benefits accruing from the study. I emphasized the voluntary nature of the study and the measures that I had taken to protect the participants' privacy and confidentiality. Prospective participants were made aware that there were no risks

involved in participating and that each participant was free to withdraw from the study at any time during the research process. An Informed Consent statement was enclosed in the letter so that those willing to participate in the study could do so by indicating "I consent." Consent was actually obtained through audio-recording before beginning the interview. I sent follow-up emails as reminders to concretize interview arrangements.

In qualitative research, concepts of sample size and saturation continue to engender a lot of debate in academia, but I aimed for a sample size of 8 to 15 participants for the individual interviews (see Kostere & Kostere, 2021). I finally had 11 participants. Nine were enrollment staff and two were from Medicaid management. Saturation is a concept found in grounded theory and intimates that the researcher stops collecting additional data when gathering fresh data does not bring new insights or reveal new properties (Creswell & Creswell, 2018). Samples for qualitative studies are generally much smaller than those for quantitative studies and this is because qualitative inquiry is concerned with meaning and not necessarily making generalizations (Mason, 2010). I attained saturation after nine interviews when I realized that subsequent interviews did not reveal any new information. I continued with two more interviews before stopping.

Instrumentation and Data Collection

I was the research instrument for this generic qualitative study (see Creswell & Creswell, 2018; Creswell & Poth, 2018; Holloway & Brown, 2016), and data were collected using in-depth, semi structured interviews. As a basic mode of inquiry, I used responsive interviewing to understand the experiences of various participants in Medicaid

enrollment for justice-involved-individuals in Maryland and what these experiences mean to them (see Seidman, 2012). The interview process followed a script or Interview Guide that I developed in advance. The Interview Guide ensured that I shared the same information with each interviewee (see Myers & Newman, 2007; Jacob & Furgerson, 2012).

Face-to-face interviews had been the preferred interview technique because this allows synchronous communication in time and space and provides the advantage of observing social cues such as voice, tone, and body language (Opdenakker, 2006). These social cues can be useful during data interpretation. I used Zoom interviews instead because the participants were hard to reach due to their work schedules or extensive travel time to the agreed interview sites. I started each interview by going through the consent procedures and asking for permission from the participant to have the interview recorded electronically. During each interview, there were follow-up and probing questions to obtain clarification or more information from the interviewee. Each interview ended by me thanking the interviewee for cooperation and asking them if there were any further remarks that may be relevant to the topic or interview process. I then provided my contact information for possible additional follow-up or questions. The interview recordings were transcribed verbatim and analyzed using coding techniques and later stored on my password protected computer.

Procedures for Recruitment and Participation

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for quantitative studies and this is because qualitative inquiry is concerned with meaning and not necessarily making generalizations (Mason, 2010). I attained saturation after nine interviews when I realized that subsequent interviews did not reveal any new information. I continued with two more interviews before stopping.

Data Analysis Plan

I used Zoom One Pro to do a verbatim transcription of each audio recording and later read each text while listening to the recording. This early step gave me the opportunity to correct spelling or other errors and anonymize the transcripts so that the participant or site could not be identified. Data analysis followed Saldaña's (2016) descriptive coding and In Vivo coding processes, with first and second cycle coding. I proceeded with a combination of hand coding on a hard copy of the transcript and also used a computer-assisted qualitative data analysis software (CAQDAS) to assist in analyzing the data. My chosen software program for data analysis was MAXQDA, and I learned how to use this program for data analysis. I did the analysis as the researcher, but MAXQDA facilitated data storage, coding, retrieval, comparing, and linking (see Patton, 2015). Coding in qualitative inquiry is the use of a word or short phrase to identify topics, issues, similarities, and differences that appear in the participants' responses and interpreted by the researcher (Sutton & Austin, 2015). For this study, I used field notes as a complementary source of information to facilitate the coding process.

I did thematic analysis by pulling together codes from one or more transcripts to present the findings of the study in a coherent and meaningful way. Themes emerged

after I consolidated categories, and they showed the relationships between two or more concepts (see Rubin & Rubin, 2012). The selected themes were relevant to the RQs and appeared as the major findings in the study (see Creswell & Creswell 2018).

Issues of Trustworthiness

In quantitative research, rigor in the inquiry can be easily established using the four criteria of validity, reliability, generalizability, and objectivity, so long as the researcher can draw meaningful inferences from instruments that measure what they intend to measure (Sutton & Austin, 2015; Toma, 2011). On the contrary, qualitative research is interpretive, descriptive, inductive, and in natural settings (empirical) with the researcher as the main instrument of research (Toma, 2011). This makes establishing rigor in qualitative inquiry more challenging for the researcher. Coding involves subjectivity in qualitative data analysis and raises issues of the credibility of the coding process. The differences in the philosophical assumptions used in quantitative and qualitative approaches on questions of ontology, epistemology, and methodology led Lincoln and Guba (1985), as cited in Toma (2011), to suggest that qualitative researchers should establish the trustworthiness of their research findings by demonstrating that they meet the criteria of credibility, transferability, dependability, and confirmability.

During the research process, I took steps to ensure that the findings met the standards of qualitative validity and qualitative reliability to enhance trustworthiness. Qualitative validity is aimed at establishing the extent of accuracy of the findings in the eyes of the researcher, the participant, or the readers of the study (Creswell & Miller,

2000, as cited in Creswell & Creswell, 2018), whereas qualitative reliability is an indication that the researcher's approach is consistent across different researchers and among different projects (Gibbs, 2007, as cited in Creswell & Creswell, 2018). I used the following validity procedures to check the accuracy of procedures: triangulation, transcript checking, reflexivity, prolonged engagement in the field, and audit trail.

I pursued the triangulation strategy by conducting interviews with two separate groups of participants, Medicaid enrollment staff and some of the managers of the Medicaid program in Maryland, to enhance the quality of the data from a different source (Anney, 2014). In addition, triangulation was used when participants were recruited from four different organizations (see Appendix C). Transcript checking was done to include the voices of interviewees in the data analysis and interpretation by sending out the final transcripts to participants for their review and comments. Many of them responded and indicated they were satisfied with the verbatim transcriptions. Reflexivity was another validity procedure that I used to assess my biases as a researcher by stating how my background, personal beliefs, values, male gender, history, and African-American ethnicity helped to shape the interpretation of the findings (see Tracey, 2010). Reflexivity was achieved by me keeping and using a reflective journal, field notes, diary, and writing memos (see Ortlipp, 2008). My prolonged engagement in the field gave me the opportunity to understand the Medicaid enrollment process in Maryland. I was immersed in the participants' world, thereby increasing the accuracy of the findings. During this research process I received constant scholarly guidance from my dissertation committee

members and their feedback surely strengthened the trustworthiness of my study. Field work for this study only started after it had been approved by the Walden University IRB.

I used an audit trail to check on the qualitative reliability of the approach that I used for this study. I accomplished this by documenting the various steps used for the study and keeping raw data and interview notes collected from the field for future audit trail (see Anney, 2014; Creswell & Creswell, 2018).

Ethical Procedures

Ethics issues permeate any qualitative research process from the point of writing the proposal to the point of publishing the findings in the study. In this qualitative research, it was not possible to foresee all the possible ethical problems and dilemmas before the study began (see Holloway & Brown, 2016). Ethics concerns autonomy, rights, safety, and the well-being of participants. I applied to the Walden University IRB to ensure that my study was in compliance with the ethical requirements of the university (see Creswell & Creswell, 2018). The IRB of the university is responsible for ensuring that all Walden University research complies with the university's ethical standards as well as U.S. federal regulations (Walden University, n.d.). The ethics review and approval by the IRB is required for all Walden-affiliated studies before participant recruitment, data collection, or dataset access can occur (Walden University, n.d.). I received approval from the Walden University Institutional Review Board, and the number was 10-30-23-0752763.

After obtaining IRB approval for the study, I proceeded to write letters to gatekeepers in the partner organizations to obtain their permission to have access to the sites and study participants (see Creswell & Creswell, 2018). The invitation letter to prospective participants in the study clearly stated the purpose of the study and the need for consent to participate in the study. Prospective participants were informed that their participation was voluntary and that anyone could withdraw at any time from the study and without repercussion. Participants were educated to understand that consent may not be one-time, and that consent may be obtained any time there are changes in the research process (see Holloway & Brown, 2016). I deployed strategies to reassure participants of their privacy, anonymity, and confidentiality by using a combination of letters and numbers to avoid identification of study participants. For this study, enrollees were identified by the upper-case letter N, followed by a number (N1, N2, N3) and managers were designated with the upper-case letter M, followed by a number (M1; see Appendix C). I had to abide by the ethical principles of nonmaleficence and beneficence to ensure no harm occurred to any study participants and if possible, the study should produce some benefit for the individual or the community (see Holloway & Brown, 2016). At the end of the study, I assured participants that the data collected would be stored in a password-protected computer for a minimum of 5 years.

Summary

Chapter 3 identified the qualitative approach as the chosen method of inquiry for this study. The constructivist paradigm and the eight most known characteristics of

qualitative research were presented. The selected design for this study was the generic qualitative inquiry, which is also known as basic qualitative or interpretive. This methodology does not belong to the established methodological traditions. However, it has the common characteristics found in qualitative research and uses the constructivist worldview of multiple realities, multiple perspectives, and the researcher as instrument to understand human experience by using qualitative procedures (Kostere & Kostere, 2021). My study was aimed at understanding the perceptions of Medicaid enrollment staff and managers in the Maryland Medicaid program about the experiences and challenges of justice-involved individuals in navigating the Medicaid system in Maryland. The need to understand these perceptions made the generic qualitative inquiry methodology a proper fit for the study.

The prominent role of the researcher in this qualitative study raised the question of researcher bias. Reflexivity was highlighted to underscore the impact that my background and values as the research instrument could have on the findings. I mentioned the ethical concerns that are inherent in a qualitative research process and addressed these concerns through the need for consent to participate in the research, clarity in the research purpose, providing confidentiality and privacy for participants, and obtaining Walden University IRB approval for the study. I used in-depth qualitative interviews as the methodology to explore and understand the subjective meanings of the experiences of participants in the study (see Patton, 2015). Purposeful sampling was used to select individuals that had the required experience of being involved in the Medicaid

enrollment process in Maryland to participate in the study. Responsive interviewing was my primary data collection method, and I used an interview guide to conduct the interviews. All interviews were recorded electronically and transcribed verbatim.

I analyzed data following the descriptive coding and In Vivo coding processes with first and second cycle coding (see Saldaña, 2016). MAXQDA was used as a computer-assisted qualitative data analysis software to assist with the hand coding that I did on a hard copy of the transcript. Thematic analysis was used to develop the themes that became the findings in the study. Trustworthiness was ensured by pursuing strategies to meet the standards of qualitative validity and qualitative reliability. Meeting these standards established trustworthiness in the research findings and portrayed that the findings met the qualitative criteria of credibility, transferability dependability, and confirmability. Chapter 4 will present the findings of the study.

Chapter 4: Results

Introduction

The purpose of this generic qualitative study was to understand how Medicaid enrollment staff and managers of the Maryland Medicaid program perceive the experiences and challenges of justice-involved individuals in navigating the Medicaid system in Maryland. The study focused on understanding the experiences and challenges of justice-involved people during Medicaid enrollment while still incarcerated or after release from incarceration. I interviewed eleven participants from four Medicaid enrollment organizations in the study. This study was guided by a main question and two sub questions.

RQ: How do Medicaid enrollment staff and managers of Maryland Medicaid program perceive the experiences and challenges of justice-involved individuals in navigating the Medicaid System in Maryland?

SQ1: What are the experiences of the enrollment staff and managers of Maryland Medicaid program in the Medicaid enrollment of justice-involved individuals?

SQ2: What are the implications of the Medicaid staff and managers of the Medicaid program for enrolling justice-involved individuals in Maryland Medicaid?

This chapter covers the setting, demographics, data collection, individual participants, data analysis, trustworthiness, and results for the study.

Setting

I used emails to contact gatekeepers of some of the Medicaid enrollment programs in Maryland as well as a contact person in the Maryland Department of Health. I stated the purpose of the research interview in the emails and forwarded the Invitation Letter and Consent Form. Several email exchanges occurred when clarification was requested about the purpose of the study or setting up the interview times. The Partner Organization Agreement for the community-based organization that showed interest in participating in the study was signed within a short time. The site agreements from the incarceration facilities took much longer. Eleven participants from four different organizations participated in the data collection (see Appendix C).

My initial plan was to conduct face-to-face interviews, but I switched to using Zoom when I realized that Zoom was a possible means of interviewing participants on sites with closed access. I used an Interview Guide for the interview process, and this ensured that I shared the same information with each interviewee. I introduced myself at the beginning of each interview and then stated the purpose of the research study. The voluntary nature of the study, the risks and benefits, informed consent, and issues of anonymity and confidentiality were explained before the interview began. I made it clear to each interviewee that he or she was free to withdraw from participating at any time. Consent to participate in the study was obtained through audio-recording before I started the interview.

Demographics

Purposeful sampling was used to select participants for this study. Participant demographics and characteristics were not relevant to the study. Participants met the inclusion criteria for enrollment personnel or managers of Maryland Medicaid program. There were 11 participants in the study. There were nine females and two males. All four participants from one of the participating organizations turned off their video cameras and I could hear only their voices.

Data Collection

I conducted 11 interviews with participants from four organizations using Zoom and all interviews were audio-recorded for transcription purposes. I introduced myself at the beginning of each interview and clearly stated the purpose of the research. This was followed by me informing participants about the voluntary nature of the study and the ethical obligation of maintaining each participant's privacy. I obtained verbal consent through audio-recording before beginning each interview. Although the original transcripts bore the names of participants, these names were deleted in the prepared transcripts. Pseudonyms were used in the final transcripts to anonymize the participants and their organizations, using letters and numbers. For example, one of the organizations was given the pseudonym PGC, and the participants were M1PGC, N1PGC, N2PGC, N3PGC (See Appendix C).

Each interview was audio-recorded, with the shortest one lasting for 19 minutes and 41 seconds, and the longest lasting 40 minutes and 42 seconds. One interview had to

stop when the participant said she had to leave to attend a meeting. I used two separate Interview Guides to ask open-ended interviews questions that were aimed at answering the RQs in the study. There was an Interview Guide for enrollment staff (see Appendix A) and another for managers in the Maryland Medicaid program (see Appendix B). I asked follow-up questions and used probes when I needed clarifications about the interviewees' responses. I took hand-written notes on main points during the interviews. I ended the interviews by asking the participant if there was anything he or she would like to ask that I had not already asked about. Two responses to this question stood out. One participant asked me if I could restate the purpose of the study, which I did. The other participant said he would be interested in seeing a study that focused on how justice-involved individuals keep up with Medicaid coverage after they leave incarceration.

The interviewing process went on for a little more than 3 months. The first interview was conducted on January 19, 2024, and the last on April 26, 2024. After conducting interviews with participants from the first two organizations, I realized that the responses did not adequately address the RQs in the study. I went on to make a Request for Change in Procedures from the Walden University IRB. This allowed me to make other contacts with organizations that carried out Medicaid enrollment within correctional facilities. The site approvals from the carceral system delayed because of the need to have senior management of the prison health contractor understand the purpose of the study.

Data Analysis

All the interviews were conducted using Zoom One Pro. This software did audio-recording and automatic transcription as well. I listened to the recordings carefully and repeatedly and verified that the final transcripts accurately reflected the participants' words. Each transcript was reviewed to make sure that it was complete and accurate. The names of participants were deleted, and they were all given pseudonyms to preserve their privacy. One hundred and eighteen pages of transcripts were converted into Word documents and imported into MAXQDA for coding and thematic analysis (see Saldaña, 2016).

The data imported into MAXQDA were coded using Descriptive Coding and In Vivo Coding. According to Saldaña, (2016), "Descriptive Coding summarizes in a word or short phrase – most often a noun – the basic topic of a passage of qualitative data" (p. 102). In Vivo Coding uses a word or short phrase from the actual language used in the qualitative data (Saldaña, 2016). According to Saldaña, (2016), "A code in qualitative inquiry is most often a word or short phrase that symbolically assigns a summative, salient, essence-capturing, and/or evocative attribute for a portion of language-based or visual data (p. 4). Saldaña further stated, "I advocate that qualitative codes are essence-capturing and essential elements of the research story that when clustered together according to similarity and regularity (a pattern), they actively facilitate the development of categories and thus analysis of their connections" (p. 9).

The quotations from Saldaña (2016) indicate how codes are grouped to make it easier to form categories, and further synthesize categories into themes. Unlike a code or category, a theme is a word or phrase that describes what a piece of data is about (Saldaña, 2016). Rubin and Rubin (2012) postulated that themes "offer explanations of why something happened, what something means, or how the interviewee feels about the matter" (p. 194). The data analysis was inductive analysis and driven by the collected data and did not attempt to fit the data into any preexisting categories (see Kostere & Kostere, 2021). In this study, I did the first cycle coding and second cycle coding of imported data using MAXQDA. This QDA software made organizing, retrieval, and systematic analysis of the data possible. During the first cycle coding, I worked through all interview transcripts and coded them, line by line, section by section to assign codes to text passages (see Appendix D). In the second cycle coding, I merged some of the codes and developed the category system (see Appendix E).

The goal of thematic analysis in this study was to develop themes that analyzed the data through the lens of the RQs in the study. Following Saldaña's (2016) guiding principles, I followed a 4-step process to analyze the data in the study to answer the RQs of the study.

- Step1: Identifying codes in the data. This step involved using descriptive coding and In Vivo coding to assign labels to sections of the data to capture and highlight important ideas and concepts in the data. A total of 137 codes

were developed and merged into a code table in a Word document (see Appendix D).

- Step 2: Creating categories of codes and developing high-level categories. In this step, I linked the codes together based on some shared characteristics to create categories. These were organized in a table created in a Word document (see Appendix E). Commonalities between the categories of codes were identified and they were related to form high-level categories in the data analysis process towards some consolidated meaning.
- Step 3: Reviewing high-level categories and synthesizing them to generate themes through analytic memoing. During this step, I established relationships between the high-level categories to look for themes. Saldaña (2016) explained that qualitive inquiry involves deep reflection by the researcher and recommended analytic memoing in this step. In the data analysis process, I wrote many code memos, document group memos, document memos, and in-document memos. These memos helped me to be immersed in the data and to recognize and capture essential meaning in the data.
- Step 4: Applying emerged themes to the RQs of the study. In this step I reflected on the themes developed in Step 3 and their relevance to answering the three RQs in the study. As illustrated in Table 1, the six themes that emerged from the thematic data analysis supported the RQs of the study.

Theme 1: Understanding the Medicaid Enrollment Process and the Purpose for Medicaid

This theme focused on how the enrollment staff perceived the experiences and challenges of incarcerated individuals during Medicaid enrollment. The secondary themes that emerged included enrollment process, enrollment assistance, and enrollment sites.

Theme 2: Medicaid Eligibility in Maryland

This theme highlighted the Medicaid eligibility requirements in Maryland. The enrollment staff and managers of the Medicaid program were unanimous about the eligibility requirements; The two secondary themes that emerged were U.S. citizenship and Maryland residence.

Table 1

Research Questions with Related Themes

Research questions	Themes
How do Medicaid enrollment staff and managers of Maryland Medicaid program perceive the experiences and challenges of justice-involved individuals in navigating the Medicaid system in Maryland?	Understanding the Medicaid enrollment process and the purpose for Medicaid Medicaid eligibility in Maryland
What are the experiences of the enrollment staff and managers of the Maryland Medicaid program in the Medicaid enrollment of justice-involved individuals?	Medicaid enrollment gets challenging after release from incarceration Medicaid enrollment as part of discharge planning
What are the implications of the Medicaid staff and managers of the Medicaid program for enrolling justice-involved individuals in Maryland Medicaid?	Ensuring health care coverage after release from incarceration Streamlining Medicaid eligibility and expanding coverage

Theme 3: Medicaid Enrollment Gets Challenging After Release from Incarceration

This theme was developed from the experiences of a small number of justice-involved involved seeking Medicaid enrollment in the community. This may occur because they missed enrollment prior to release or refused to be enrolled during incarceration. Others under community supervision such as parole or probation may want to be enrolled in Medicaid. This theme was related to the perceptions of the enrollment staff in the community regarding the Medicaid enrollment experiences and challenges faced by justice-involved individuals. The secondary themes were incarceration and community enrollment.

Theme 4: Medicaid Enrollment as Part of Discharge Planning

Perceptions about enrolling incarcerated individuals in Medicaid as part of discharge planning were captured by the enrollment staff in correctional facilities and managers of the Medicaid program. The secondary themes that emerged included proactive enrollment, discharge planning, and incarceration.

Theme 5: Ensuring Health Care Coverage After Release from Incarceration

The perceptions of the enrollment staff and managers of the Medicaid program underscored the need for completing the enrollment process to establish health coverage for justice-involved people. The enrollment process is finalized when the individual is assigned to a Managed Care Organization (MCO). The two secondary themes that emerged were the impact of Medicaid and Medicaid suspension and termination.

Theme 6: Streamlining Medicaid Eligibility and Expanding Medicaid Coverage

This theme was developed from the perceptions of managers of the Medicaid program and two of the enrollment staff participants. The three secondary themes that emerged included CMS Demonstration Waiver; expanding coverage; and innovation and improvement. The themes are described in Table 2.

Table 2

Summary of Themes

Theme	Description
Understanding the Medicaid enrollment process and the purpose for Medicaid	Having knowledge of eligibility requirements, the documents needed, and access to care
Medicaid eligibility in Maryland	Being a US citizen and a Maryland resident
Medicaid enrollment gets challenging after release from incarceration	The challenges of proof of income, more documentation, and non-incarceration
Medicaid enrollment as part of discharge planning	Medicaid enrollment is part of the release package that ensures access to services
Ensuring health care coverage after release from incarceration	Complete enrollment requires being assigned to an MCO and setting up medical appointments
Streamlining Medicaid eligibility and expanding coverage	Improving enrollment and coverage through data sharing, collaboration, and innovation.

Evidence of Trustworthiness

Lincoln and Guba (1985, as cited in Toma, 2011) suggested that rigor and trustworthiness of research findings in qualitative inquiry should be established by demonstrating that they meet the criteria of credibility, transferability, dependability, and confirmability. As stated in Chapter 3, I used the following validity procedures to ensure these criteria were met in the data analysis process:

Triangulation

The triangulation of data from two sets of participants drawn from four different organizations increased credibility in the findings (see Anney, 2014). The multiple sources of data corroborated data from the different organizations and enhanced the trustworthiness of findings.

Transcript Checking.

I did not do member-checking because of the time constraint. However, I sent a final copy of the interview transcript to each study participant to verify that the transcripts reflected their responses. Participants were told to review the transcripts and to suggest any necessary changes. Among those that replied, one made corrections to some acronyms, and the other participants confirmed the accuracy of their transcripts. Confirming the accuracy of participants' transcripts served as a strategy to establish trustworthiness in the study.

Prolonged Engagement

My data collection took 3 months and 1 week to be completed. I became immersed in the participants' world, and this gave me the opportunity to have a better understanding of the Medicaid enrollment process in Maryland. Such extensive fieldwork and information gathering increased the accuracy of my findings. I did not find any discrepant cases.

Reflexivity

I assessed my biases as a current employee of a health care contractor for Maryland DPSCS by keeping and using a reflective journal. I wrote notes and memos in this journal from the moment I started the research process. I used reflexivity to state how my background, personal beliefs, and values helped shape the interpretation of the finding.

Audit Trail

I have demonstrated trustworthiness in the study by documenting the various steps I used for the study and keeping the raw data, interview transcripts, and notes that were collected for this study for future audit trail.

Results

This section presents the results of the data analysis of data collected through individual interviews through Zoom. Participants from four different organizations were given pseudonyms and the organizations were identified in all study documentation as PGC, MDH, HCAM and YC to protect privacy. The presentation of results of the data

analysis is organized through the lens of the RQs and the related themes that emerged from the data (see Table 1). The analysis of the data in this study revealed the various perceptions of Medicaid enrollment staff and those of managers of the Medicaid program in Maryland about the experiences and challenges of justice-involved individuals as they navigate the Medicaid system in Maryland. These perceptions were mostly related to enrollment experiences and challenges during incarceration but some occurred during community enrollment.

The purpose of this generic qualitative study was to understand how Medicaid enrollment staff and managers of Maryland Medicaid program perceived the experiences and challenges of justice-involved individuals in navigating the Medicaid system in Maryland. To achieve the stated purpose of this study it was necessary to provide answers to the following RQs: (a) How do Medicaid staff and managers of Maryland Medicaid program perceive the experiences and challenges of justice-involved individuals in navigating the Medicaid system in Maryland? (b) What are the experiences of the enrollment staff and managers of the Maryland Medicaid program in the enrollment of justice-involved individuals? (c) What are the implications of the Medicaid staff and managers of Medicaid program for enrolling justice-involved individuals in Maryland Medicaid?

Main RQ

The main RQ for this generic qualitative study was as follows: How do Medicaid staff and managers of the Maryland Medicaid program perceive the experiences and

challenges of justice-involved individuals in navigating the Medicaid system in Maryland? Incarcerated persons are considered a vulnerable and protected population (Neher et al., 2020). The prohibition of interviewing them directly dictated that their experiences and challenges during Medicaid enrollment be ascertained only through the perceptions of those that are involved in their Medicaid enrollment. Participants' responses during the Zoom interview revealed two themes that were related to this question: (a) understanding the Medicaid enrollment process and (b) Medicaid eligibility in Maryland.

Theme 1: Understanding the Medicaid Enrollment Process

This theme referred to the extent to which incarcerated individuals understood the information in the Medicaid application as well as its purpose. In situations where enrollment took place in the community, the theme also pertained to how the enrollees used the various enrollment methods such as online, in-person, and the telephone. Though the perceptions of participants varied, most of them thought the low literacy level made it difficult for some enrollees to understand the process and there were occasional language barriers as well. M1PGC noted, "Some consumers know what Medicaid is, and they know and they're trying to enroll, and others do not know how Medicaid works, and so we have to explain it to them." In the same vein, another participant's perception was that the inability to read or write was a challenge for some enrollees. N3PGC stated:

> I think if it comes down to the level of learning of that person, if they really are not fluent with English, or know how to read and write, then I think that they'll have a difficult time applying by themselves.

Some participants had the perception that the Medicaid application was longer than a regular application and somehow confusing. N2HCAM noted:

> I think our application is a little bit condensed than the normal application. But some of it can still be a little bit confusing. So, they sign a (…), it's like the penalty of perjury, which is like the first thing they sign after filling out the front page of all their basic information. And towards the bottom of the paragraph, it says something about… something along the lines of like, "I am not incarcerated, and I know that if I am incarcerated, I can't fill out this application". But then, a couple of pages later, they fill out something that lets the system know they're incarcerated.

N1YC reflected on the lengthy nature of the application by noting:

> I would say it's simplified, but it's lengthy; it's simplified, but it's lengthy in a sense that the application itself, all you need mostly is the address, the Social, the birth date. But you got so many pieces of papers that you're filling this across. And so, it's not (…) and then having somebody to assist along with them. I haven't seen where anybody has truly struggled with the application process, and because you're right there working with them through the way. So, it's mostly just your address, your phone number, your Social Security number, your email

> address, and what kind of benefits you you're looking for. And then it's like maybe, another 10 more pages that are asking for the same thing. I think that's sometimes gets a little frustrating.

In response to the question about how simplified the application was, an enrollment staff member in the community, N2PGC noted:

> So, I think that the application is pretty clear, straightforward. If I were to give advice, I would just say, take your time and read the prompt because it could be easy if you just are patient with the process, because everything is all laid out for you. So, when it's asking for your contact information, put your contact information, when it's asking for your income, put your income, input in correctly. Otherwise, there's a top issues and complications.

A manager in the Medicaid program, M1MDH, had this reflection on the same topic:

> The Medicaid application, and the health connections website is pretty straightforward and without comparing it to other states. I'm not sure how much simpler it could be or understand the specific question from eligibility standpoint. But it comes across as very user friendly.

Some justice-involved individuals do not trust Medicaid as a government program, and N3PGC shared this experience:

> They think that also they don't have an immigration status here that is active, that they can't apply for their children, even though the children are born here. So, it's

> a lot of trust issues happening as well because they think that we're going to leak out their information. And therefore, that's why they don't seek out help.

N2YC had similar a perception about how some justice-involved individuals respond when called up for Medicaid enrollment by stating:

> But in those cases where they just don't trust us, they'll just say, "I just don't want it". I would you know, try to impress upon them how important it is to have it and if they still decline, ultimately it is their choice; So, I'll put it down as a refusal.

The responses of participants in the study revealed experiences and challenges that were mostly related to low literacy level, lack of knowledge about Medicaid, and distrust about Medicaid as government-funded program that they erroneously thought could put them in trouble instead of providing access to health care.

Theme 2: Medicaid Eligibility in Maryland

This theme emerged based on the Medicaid eligibility requirements established in the state of Maryland. Medicaid enrollment in Maryland requires that the individual should be resident in Maryland and be a U.S. citizen. Participants' responses indicated perceptions that some justice-involved individuals were not eligible for Medicaid enrollment due to lack of proof of legal status in the United States and/or not being Maryland residents. A review of the participants' responses reflects the importance of U.S. citizenship as an eligibility requirement. To this effect, N1YC indicated, "So, citizenship plays a big role. And I think if you don't have citizenship in the United States, then you cannot apply for Medicaid."

Even after meeting the income criterion, the enrollee still has to meet the citizenship requirement. This was made clear in the response by N2YC, who said, “So, if you have no income, you qualify for Medicaid, though you also have to be a US citizen.” M1HCAM also mentioned the importance of US citizenship in the enrollment process by pointing out, “So, the required criteria are citizenship, income, and household sizes.”

In addition to having legal status in the United States, the individual applying for Medicaid in the Maryland should also have residence in Maryland. The need to fulfill this requirement of a Maryland address is seen in the response by N2HCAM:

> I think that's probably driven how we see people. I can't tell you for sure that it has, but I feel like, from my understanding of it, it has, because that's kind of the angle we take; that everyone here is eligible until you know, they say that they're not a Maryland resident, or they're not a US Citizen. But otherwise, if they do meet those criteria, they're also eligible and will get Medicaid, because most of the time that is how it works.

In another part of the response, N2HCAM continued by saying, “So, what we focus on is being a Maryland resident and being a U.S. citizen.” The response from M1HCAM also indicted the importance of Maryland residence to qualify for Medicaid in the state, “Well, in the State of Maryland, considering it is a Maryland-based insurance.”

Main RQ Conclusion

Understanding the Medicaid enrollment process and the purpose for Medicaid were to two themes that emerged after careful analysis of the data to address the main

RQ: How do Medicaid enrollment staff and Managers of Maryland Medicaid program perceive the experiences and challenges of justice-involved people in navigating the Medicaid system in Maryland? The various responses indicated participants' perceptions that justice-involved individuals needed education and assistance from enrollment staff to successfully enroll in Medicaid. The Code Matrix Browser in Figure 2 illustrates these perceptions, in which coded texts from all the four participating groups were coded with enrollment assistance and Medicaid education during enrollment. Some of the individuals have low literacy levels and some refuse to sign up due to their lack of knowledge. Not having legal status in the United States and/or not having a Maryland residence will disqualify the justice-involved individual from enrolling in Maryland Medicaid.

Figure 2

Code Matrix Browser

SQ1

SQ1 of this study was as follows: What are the experiences of the enrollment staff and managers of Maryland Medicaid program in the Medicaid enrollment of justice-involved individuals? This was a SQ prepared to support the main RQ. This question was designed to explore participants' experiences related to Medicaid enrollment of justice-involved individuals in Maryland Medicaid. These experiences varied depending on

whether enrollment was done in the community or in a correctional facility. Data gathered through the interviews revealed two major themes that addressed the RQ. The two themes were (a) Medicaid enrollment gets challenging after release from incarceration and (b) Medicaid enrollment as part of discharge planning.

Theme 1: Medicaid Enrollment Gets Challenging After Release from Incarceration

The inmates that are released from incarceration without Medicaid find it more challenging to enroll in the community because they will be treated the same as all other enrollees in the community. Ex-offenders will have to show proof of income and other documentation that will not otherwise be required if enrollment is done during incarceration. Except, possibly for people on parole, active incarceration excludes anybody from enrolling in Medicaid in the community. M1PGC mentioned this in her response by saying, “I think, if you're under parole, I believe you can apply for Medicaid; once you're in in a penal institution, you cannot. That goes through a different agency.” M1PGC explained further:

> If they are not working, of course, and they're American citizens, they'll qualify for Medicaid, but they have to be returning citizens. We cannot assist someone that is incarcerated. We don't do outreach in the penal institutions only outside the community. I mean, with people that are community, that are free.

Participants indicated that individuals recently released from incarceration will be required to furnish the same documents as all other civilians applying for Medicaid. This point was emphasized by N2PGC:

> On a typical day, not usually enrolling a majority population of justice-involved individuals, but when I have and have assisted individuals that have been incarcerated, it's like a regular involvement. Really, I just get their information, even if it's limited to their ID and Social Security number. We just create the account and move forward. We don't treat them any different than a regular civilian, I mean.

After release from incarceration, the newly released individuals face the challenge of proof of income when applying for Medicaid. Participant N1PGC stated, "If employed, pay stubs or W2 wages, and tax statement." This income requirement in the community contrasts with the income requirement experience when enrollment occurs during incarceration when N2YC indicated, "They have to be below 138% percent of the federal poverty level, which the persons I'm dealing with are way below that; they have no income."

Participants who did Medicaid enrollment in correctional settings stated that incarceration status bestows PE for Medicaid on the justice-involved people. N1YC noted:

> And they just qualify. It's very, very helpful because, even on my behalf as a discharge planner. I'm confident in that, okay, this person is maybe like 80 percent, as long as the immigration status is okay, that person is almost like in the 90 percent that they will get an MA Number. Then I can also assist in getting a medical appointment outside in the community for them. So, it is very helpful for

> them and myself in, you know, knowing confidently that there's a high chance that they are eligible to get insurance, or the Medicaid.

Participants' responses indicated that justice-involved individuals, when released from incarceration without Medicaid, usually face some challenges to navigate the Medicate system. They are required to provide more documents than are required for enrollment while still incarcerated. People under community supervision such as probation are not eligible for Medicaid enrollment in the community.

Theme 2: Medicaid Enrollment as Part of Discharge Planning

This theme was developed from participants' views that Medicaid enrollment usually occurred in preparation for the release of incarcerated individuals back to the community. Participants mostly indicated that the integration of Medicaid enrollment into discharge planning ensures that inmates will have continuity of care during reentry. The significance of having Medicaid as part of discharge planning was noted in this response by N1YC:

> So, Medicaid, Oh, my goodness! I feel like is the core of even what I do because I teach them about how to take care of themselves once they get in the community. But if they don't have insurance then that doesn't go very far; then it's difficult to continue care for them. Because a lot of them are leaving the facilities without any funds: they starting a new life: they go into half-way houses. So, it's a lot of things that they are going to or get set up with. And if we have Medicaid and they enroll in Medicaid; that's at least one portion of the issues solved because they

> have insurance, and therefore they can at least continue with their health regiments or healthcare that they were receiving within the walls.

This importance of Medicaid enrollment for justice-involved individuals occurring even when the release is at short notice was seen in the response of participant N2HCAM when she stated:

> So, we're mostly part of the discharge planning. For me, I am a part of the discharge, so I see them within 60 days of them leaving. Sometimes there's unscheduled releases. So, that becomes like within a week. We can see them up to 24 hours before they leave. But most of the time I'm seeing them 60 days out.

Inmates sometimes came up with other concerns during Medicaid enrollment as part of discharge planning. Participants shared some of their experiences as to how these concerns were addressed. M1HCAM noted:

> If there's, if we meet with the incarcerated individual, and they are stating that they need housing or assistance, once they are released, we refer them to one of the other programs that can assist with those issues. Social work tends to help with like IDs and housing.

Proactive enrollment is encouraged so that incarcerated individuals receive orientation about Medicaid during intake and at prerelease. This ensures that justice-involved-individuals get enrolled in Medicaid at their time of release. This benefit of being proactive in Medicaid enrollment was noted by M1MDH:

> The idea is to prevent the situation where someone walks out of jail, and then says, “Oh, my gosh! I now have to fill all of this stuff out, and I need to set up this online account and that account, remember this password and put in an address; and I have no idea whether this address is going to be mine for a month, or whether it's going to be mine for a few weeks; be able to get to the judge so I can get out; but really, I don't think or expect to live there long term” Like all of those things, the idea is that we’re providing the assistance beforehand.

A lot of interagency collaboration and data sharing is needed to provide early notification about releases so that the enrollment staff gets to enroll everyone that is scheduled to leave incarceration. The essence of inter-agency collaboration to facilitate Medicaid enrollment prior to discharge was noted by M2MDH:

> Information is shared from DPSCS to Medicaid on indicating when someone's incarcerated and their release date so that they are able to code the individual if they're enrolled in Medicaid already. Code their Medicaid account, if accordingly, it was suspended. Meaning that, you know, it's there, and then they can with the current information (…), so that if Medicaid has the release date, they can then release the code of suspension upon their release of the information about the release date.

Participants noted that Medicaid enrollment is a two-step process. Filling the application is the first step, and choosing a Managed Care Organization constitutes the next step. Participant N3PGC explained the process this way:

> Medicaid is usually a two-part, so it's a Medicaid and then there's the Managed Care Organization part. The Managed Care Organization part is basically the provider that's in charge of the clinics and spots that you can go get checked.

This information was corroborated by M2MDH who said:

> And they still need to, you know, sign up for an MCO after their release. But then to be able to, you know, have the coverage to be able to reach out to PCP and have, you know, the care that they need.

SQ1 Conclusion

The purpose of this SQ1 was to firstly, explore the experiences of the enrollment staff and mangers of Maryland Medicaid program during Medicaid enrollment of justice individuals in the community. Secondly the question sought to investigate the experiences of participants in discharge planning. Participants' responses revealed that justice-involved individuals were either ineligible to enroll in Medicaid in the community or experienced difficulties in the enrollment process, when attempting to do so in a community setting.

Participants also described the vital role of Medicaid enrollment in discharge planning. Some participants explained that Medicaid provided highly needed access to health care during reentry and mentioned the need for enrollees to be assigned to a Managed Care Organization to complete the enrollment process.

SQ2

SQ2 of this study was as follows: What are the implications of the Medicaid staff and managers of the Medicaid program for enrolling justice-involved individuals in Maryland Medicaid? This SQ gave support to the main RQ. The RQ was designed to elicit participants' views on the impact that Medicaid had on justice-involved individuals and possible avenues for improving the state Medicaid program. After a review and analysis of the data gathered from the Zoom interviews, two themes emerged. The two themes were (a) ensuring health care coverage after release from incarceration, and (b) streamlining Medicaid eligibility and expanding coverage.

Theme 1: Ensuring Health Care Coverage After Release from Incarceration

This theme related to participants' views that Medicaid is the main source of access to health care services after they are released from incarceration. Participants pointed out that the health care received during incarceration would stop when justice-involved individuals are released. A lot of these individuals are released into the community with chronic health conditions, mental health conditions, and substance use disorders. They all need to have health coverage to continue to have access to care after release. N1YC provided this explanation:

> I teach them about how to take care of themselves once they get in the community. But if they don't have insurance then that doesn't go very far; then it's difficult to continue care for them. Because a lot of them are leaving the facilities without any funds: they're starting a new life: they go into half-way houses. So, it

> it's a lot of things that they are going to or get set up with. And if we have Medicaid and they enroll in Medicaid; that's at least one portion of the issues solved because they have insurance, and therefore they can at least continue with their health regiments or healthcare that they were receiving within the walls.

Involving the enrollment staff and managers of the program in the enrollment of justice-involved individuals has far-reaching implications. Inmates receive a lot of education and assistance in the enrollment process while still incarcerated and their incarceration status gives them de facto eligibility for Medicaid. Participant N1YC noted:

> I think that has been very helpful because when I do help with the application, there is a portion that almost immediately qualifies you, and one of them is "Are you an incarcerated individual?"; and if you check that box, then we don't have to do other things like income and verify a lot of other things, because that automatically helps them qualify. So, I think if anything that makes the whole application process so much easier.

Inmates needed education and assistance to understand the enrollment process, the eligibility requirements, and the required documents. M1PGC noted:

> So, the navigators, we break it down to them and community workers. We break down what Medicaid is, that it's a government agency through the State of Maryland. And we tell them what the eligibilities are. You must be legal in the country. You must have either a Social Security number or tax ID for certain

> immigrants. And it's also income-based and family size-based. So, all of those things, we break it down and explain it to them.

The need for education was also stated by N2YC:

> They don't understand how it works. They don't understand if they have to make a payment, or if they have to pay someone. There's also a lot of mistrust. And the government - they think that you know, someone thinks that if they give you their information, they'll be targeted somehow or spied on, or they just…. A lot of them don't have a good understanding of how any of it works, really.

It is a relief for incarcerated individuals when they get assistance in the various correctional facilities to obtain Medicaid before release. They are aware that they do not have income despite having health conditions that need follow up after release. A participant in a managemnt role noted, ”They have that support and not have that stress".

Medicaid, as a public insurance, provides access to health care for people with low income. Most of the incarcerated people are in this low-income group and understand that active Medicaid provides access to health services in the community after release from incarceration. Participants shared their views about Medicaid providing access to care for justice-involved people. M1HCAM said:

> I would say it's been very helpful. Like I stated, once they go back in the community, they're able to get their first examination. There is another program that works with the inmates 60 days when they're going back to the community

> helping them adjust. So, they're making sure that they're getting all of their wellness checks; that they're able to see the doctors.

N2HCAM also shared her views about inmates being enrolled in Medicaid at reentry:

> I work with the discharge nurse who has to make appointments for chronic care; like individuals who have chronic care, or who have had chronic care. So, I know that they have doctors' appointments when they get out, and you know we can only hope that they go to them, and that just means that they have the coverage they need when they're going to those appointments to make sure they can keep getting the medicines they have been taking. But they really need things like that.

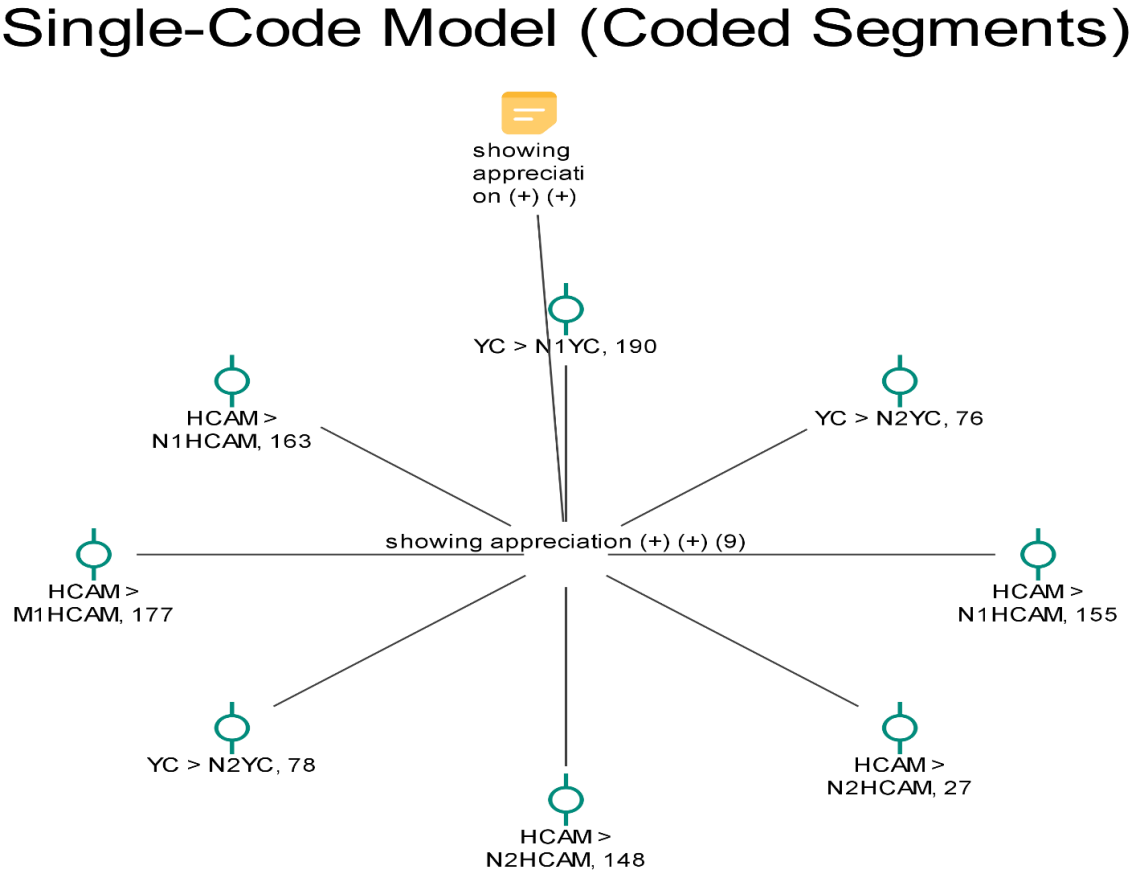
Another participant, M1PGC stated:

> I would say, and this is, I'm switching the answer a little bit. Returning citizens, the impact it has, some of them when they come out of imprisonment, and they're returning citizens; they might have certain health issues, such as mental health, such as they haven't had a proper physical in some time, and we'll make sure that their Medicaid is covered, is active to enable them to get the care that they need. Maybe they have medications that need to be picked up from a pharmacy, but they don't have health insurance to pay for it. We make sure that their Medicaid is active.

Incarcerated individuals have shown appreciation for being enrolled in Medicaid prior to leaving incarceration. Such appreciation was perceived by five participants who did Medicaid enrollment, as shown in the concept map in Figure 3.

Figure 3

Concept Map for the Code Showing Appreciation



Those with chronic health conditions have appreciated the opportunity to continue to have health care in the community as well as fill prescriptions from the pharmacy. N2YC noted:

> I would say, I mean, they're very pleased. They've been very excited. I get a lot of guys who just tell me, especially the older ones. You know, if they're in their twenties, “It's not really that big a deal”, but if they're over 35, they do express great gratitude like, ‘Oh, I don't know. You know, I wasn't sure how I was going to be able to manage’. A lot of them ask if they're going be able to get their teeth fixed because of, you know, needing to get things done.

Medicaid enrollment provided continued access to health care and justice-involved individuals get connected to community resources as a result. Participant, N1HCAM responded thus:

> I think we're probably at 80% of individuals that are being released that have some sort of health insurance before they leave; and they are given resources at that point as well: to have a doctor, know where the pharmacies are, to have medications. I know here in KYZ, anybody that is on a chronic (…), has a chronic condition, receives 30 days’ worth of medications and also receives a doctor's appointment within 2 weeks of them leaving so that they can get their refills once they're out.

N1YC also shared this view:

> I think that has helped tremendously because once you know that at least I have insurance, and I can go and get help. It is knowing that you are able to get help without having to come out of pocket and pay has helped these individuals a lot.

Participants indicated in their responses that having access to care in the community has kept former offenders healthy and well, and possibly reduced the possibility of re-offending to get incarcerated. N1HCAM noted:

> So, I do believe it's helped with them not coming back to prison. Because now they have mental health choices. They can go to, you know, therapists and stuff like that, and they can get their medications now. So, I really think the recidivism is down.

On this same topic, M1HCAM noted:

> However, we were told that having active Medicaid allows them to not have to repeat the same offense again, so that they have to go back and rely on the state of Maryland to cover their bills. Now they have Medicaid that will help them in the outside community.

Maryland is one of the states that expanded the Medicaid program, and in response to a question on the impact of incarceration on Medicaid, M1MDH noted, “In Maryland, the way that it works, if someone is incarcerated, is that their Medicaid eligibility is suspended except for specific, right now, except for specific services, which is inpatient hospitalization.” Another participant responded to the same question by saying, “If they are enrolled in Medicaid, they will be suspended.”

Theme 2: Streamlining Medicaid Eligibility and Expanding Coverage

This theme related to strategies that help to speed up the enrollment process and ensure no one leaves jail without enrolling in Medicaid, if they wanted to. Unfortunate situations occur where some incarcerated individuals are abruptly released from incarceration following court orders. This does not provide enough time for the enrollment staff to enroll such individuals. Data gathered from the interviews showed participants' responses indicating that data sharing and coordination ensures that individuals are enrolled in Medicaid in a timely manner. Given the limited coverage that Medicaid provides to enrollees, participants from management pointed out that some improvements are needed in the state Medicaid program to expand coverage and make enrollment a seamless process. N1YC made this remark about the limited nature of Medicaid: "So, that's probably the only challenge that I've heard expressed, is they cannot go to particular providers because of it's limited. The Medicaid insurance has its limits."

The discrepancy in coverage, with chronic conditions covered by Medicaid while excluding coverage for substance use disorders was pointed by M2MDH who stated:

> The people with chronic conditions are still receiving care; but, for example, someone with substance use disorder, not receiving the treatment necessarily within incarceration. So, I think that there's definitely, I mean, where have you looked at (unclear), there's this substance use crisis.

Given the limitations in Medicaid and some existing flaws, participants in management gave responses that acknowledged these flaws and the need for

improvement. Participant M1MDH introduced a topical marker that the state is working on to improve coverage, “We're working on beginning to asking CMS for approval of an 1115 Demonstration Waiver." This participant explained the purpose for the section 1115 Demonstration Waiver as:

> To provide Medicaid eligibility for certain populations of people who are incarcerated, and 90 days prior to the release from incarceration. We're hoping to provide case management, Medication-assisted treatment, and counseling as well as 30 days of medication upon release for specific populations.

Another participant from the Medicaid program stated her views about the current Medicated system as follows:

> We have older systems a lot of times with data which is not unique to any particular things. But you're working with many different departments. You're working with many different systems. So, we want to make sure you improve communication and data sharing. And we want to make sure that you are, when the program is implemented (…), you want to make sure the people are receiving the benefit and track the success or evaluate the program.

The involvement of managers in this study had the implication of such participants sharing their views on how the current system is performing and where changes could be made. M2MDH stated:

> Working on identifying ways to streamline the eligibility processes, the data, the data sharing processes so that we, as Medicaid can receive information that a

> particular person is going to be released through regular course of business, at least 120 days before release, so that 90 days pre-release they would be able to receive services. So, the teams have been working to try and streamline the data sharing process a little bit.

The targeted beneficiaries for expansion were mentioned by participant M1MDH as, "Folks who have been identified to have a substance use disorder, and people who have been identified to have severe mental illness."

SQ2 Conclusion

The purpose of SQ2 was to understand the implications of the Medicaid staff and managers of Medicaid program for enrolling justice-involved individuals in Maryland Medicaid. Two major themes, ensuring health coverage after release from incarceration, and streamlining Medicaid eligibility and expanding coverage, emerged after thorough review and analysis of interview data. To address the first theme, ensuring health coverage after release from incarceration, participants provided responses concerning their involvement in the Medicaid enrollment of incarcerated individuals. Such involvement had several implications. The inmates were able to get enrolled in Medicaid through participants' assistance in the process. Access to care was mentioned as the greatest impact derived from Medicaid enrollment. Participants thought that having Medicaid helped to reduce recidivism. The inmates also appreciated having access to health services at reentry.

Streamlining Medicaid eligibility and expanding coverage was the second major theme related to this RQ. This theme was aimed at eliciting the views of participants from management. Management implications in the Medicaid process, as contained in the responses, were noted as being able to identify some of the problems in the Medicaid system and finding ways to address them. Efforts are being made to improve coordination and data sharing and a CMS 1115 Demonstration Waiver is in process to expand coverage to individuals with mental illness and substance use disorders.

Summary

The purpose of this generic qualitative inquiry was to understand how Medicaid enrollment staff and managers of Maryland Medicaid program perceive the experiences and challenges of justice-involved individuals in navigating the Medicaid system in Maryland. Chapter 4 reported on the study findings, using the interview data that was collected. Thematic analysis as outlined by Saldaña (2016) was used to guide the data analysis in the study. The thematic analysis was inductive thematic analysis, and I followed the 4-step process in analyzing the data. In Step 1, I identified codes using descriptive coding and In Vivo coding to summarize passages of interview transcripts. Step 2 involved grouping codes with common characteristics to form more meaningful categories and also developing high-level categories. Step 3 involved reviewing the high-level categories and synthesizing them into themes. In Step 4, I reflected on how the themes that emerged were relevant to answering the RQs in the study.

Thematic analysis of data in the study yielded six major themes, that conveyed meaning in the data that could be used to address the RQs. The main RQ was as follows: How do Medicaid staff and managers of the Maryland Medicaid program perceive the experiences and challenges of justice-involved individuals in navigating the Medicaid system in Maryland? Through analysis of the interview data, two themes were developed to answer the RQ. The first theme was understanding the Medicaid enrollment process and the purpose of Medicaid. The second theme was Medicaid eligibility in Maryland. These themes were used to elicit participants' perceptions about the experiences and challenges of justice-involved individuals as they navigate the Medicaid system in Maryland.

The second RQ was the first of two sub questions of the main RQ: What are the experiences of the enrollment staff and managers of Maryland Medicaid program in the Medicaid enrollment of justice-involved individuals? After analyzing the data collected for the study, two major themes emerged that were used to address this RQ. The first theme was Medicaid enrollment gets challenging after release from incarceration. The second theme was Medicaid enrollment as part of discharge planning. These themes captured participants' perspectives and experiences in the Medicaid enrollment of justice-involved individuals.

The third RQ was the second of two sub questions of the main RQ: What are the implications of the Medicaid staff and managers of Medicaid program for enrolling justice-involved individuals in Maryland Medicaid? Through thoughtful analysis of the

data collected in the study, two themes emerged which were used to address this RQ. The first major theme was, ensuring health care coverage after release from incarceration. The second major theme was streamlining Medicaid eligibility and expanding coverage. These themes captured participants' perspectives on the implications of the Medicaid staff and managers of the medicaid program for enrolling justice-involved individuals in Medicaid.

This generic qualitative study was aimed at understanding how Medicaid enrollment staff and managers of Maryland Medicaid program perceive the experiences and challenges of justice-involved individuals in navigating the Medicaid system in Maryland. These perceptions were explored through the voices of participants in the enrollment staff and Medicaid management. Trustworthiness was established in this study using validity procedures such as triangulation, transcript checking, prolonged engagement, reflexivity, and audit trail. Reflexivity was used to address researcher bias and I kept a journal throughout the research process. Ethical procedures were followed to protect the privacy and identities of participants and their organizations. The data collected through Zoom interviews were coded and analyzed with the assistance of MAXQDA, a qualitative data analysis software.

In Chapter 5, I will present the interpretation of the findings, limitations of the study, recommendations for further research, and potential impact for positive social change. I will also relate the study findings to the literature review and the conceptual framework that guided this study.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

The purpose of this generic qualitative study was to understand how Medicaid enrollment staff and managers of Maryland Medicaid perceive the experiences and challenges of justice-involved individuals in navigating the Medicaid system in Maryland. The study was based on the gap identified in the literature review. The gap was related to the dearth of information on the measures that the Maryland Medicaid program has taken to ensure the uninterrupted enrollment of justice-involved individuals in Medicaid. I formulated three RQs to address this gap: (a) How do Medicaid enrollment staff and managers of Maryland Medicaid perceive the experiences and challenges of justice-involved individuals in navigating the Medicaid system in Maryland? (b) What are the experiences of the enrollment staff and the managers of the Maryland Medicaid program in the Medicaid enrollment of justice-involved individuals? (c) What are the implications of the Medicaid staff and managers of the Medicaid program for enrolling justice-involved individuals in Maryland Medicaid?

Farrell and Gottlieb (2020) postulated that incarcerated individuals are a vulnerable population with a high burden of disease from increased rates of chronic medical conditions, mental health conditions, and substance use disorders. Despite a plethora of legislation such as the ACA and SCA to facilitate Medicaid enrollment, the majority of incarcerated people in Maryland return to the community from prison or jail without health coverage and cannot access health services. This qualitative study sought

to understand the experiences and challenges that inmates express in the enrollment process. This understanding was obtained through the perceptions of study participants who participated in Medicaid enrollment.

Eleven interview participants from four different organizations shared their perceptions about the experiences and challenges of justice-involved individuals in navigating the Maryland Medicaid system. I collected the data, then coded and analyzed them, using thematic analysis. Six themes emerged from the data analysis and were relevant to addressing the RQs. The themes appear as the major findings in the study (see Creswell & Creswell, 2018). The themes are (a) understanding the Medicaid enrolment process and the purpose for Medicaid, (b) Medicaid eligibility in Maryland, (c) Medicaid enrollment gets challenging after release from incarceration, (d) Medicaid enrollment as part of discharge planning, (e) ensuring health care coverage after release from incarceration, and (f) streamlining eligibility and expanding coverage.

Participants in the study were from two groups. The first group, enrollment staff, voiced their perceptions about the experiences and challenges of justice-involved individuals in navigating the Medicaid system in Maryland. These perceptions came from being directly involved in the enrollment process. The second group were managers in Maryland Medicaid. Participants from management showed familiarity with matters of policy and indicated that there were flaws that called for innovation in the Medicaid program.

Interpretation of the Findings

The findings showed congruence with the literature review, the conceptual framework, the research design, and the RQs. The literature review indicated that incarcerated individuals have a high disease burden but return to the community without access to care. This is due to the controversial Medicaid Inmate Exclusion Policy which prohibits active enrollment during incarceration. Responses from participants indicated that this exclusion policy continued to be anathema to Medicaid enrollment for justice-involved individuals. Medicaid is terminated or suspended during incarceration, depending on state policy (Albertson, 2020).

The behavioral model for vulnerable populations by Gelberg et al. (2000) provided a structure that guided this study. The model has three core components to explain health care utilization: predisposing factors such as age and education; enabling factors such as personal or family income, and community resources; and needs factors such as health status of the population(s) (Lederle et al., 2021). The application of this model to this study was based on the enabling factors. Having health insurance or Medicaid as an enabling factor in the model has been associated with greater access to and use of health services. Responses from all participants indicated the pivotal role of Medicaid in providing access to health care for this low-income population. The qualitative design of the study provided for extensive discourse on Medicaid enrollment by participants. The responses indicated the challenges exist. While Medicaid suspension was related to policy, the justice-involved-individuals had challenges related to limited

health insurance literacy, lack of the required documentation, limited access to internet, difficulty obtaining information, language proficiency, language barriers, and need to improve readability of enrollment material (An et al., 2021).

Themes

After coding and conducting a four-step thematic analysis of the interview data, six themes emerged and were relevant to addressing the RQs.

Theme 1: Understanding the Medicaid Enrollment Process and the Purpose for Medicaid

The perception by the enrollment staff was that most justice-involved individuals have low literacy levels and needed assistance and guidance to understand the application information. There were instances where individuals refused to enroll in Medicaid due to mistrust or not having proper knowledge of its purpose. Those that did not enroll in Medicaid while incarcerated showed up in community centers for Medicaid enrollment after release. It was often challenging for them to enroll in the community. Active incarceration provides de facto eligibility because all inmates meet the income requirement of having income below 138% of the federal poverty level (Vogler, 2020). In addition, less documentation is needed for enrollment while incarcerated because identification in formation during incarceration is available in government databases such as Offender Case Management System and Medicaid Management Information System.

Theme 2: Medicaid Eligibility in Maryland.

The states have a great deal of autonomy in determining their Medicaid program generosity (Vogler, 2020). It was clear from participants' responses that only Maryland residents are eligible for Medicaid enrollment in the state. Those applying for Medicaid in Maryland must also be U.S. citizens. Justice-involved individuals that did not show proof of residence in Maryland were deemed ineligible for enrollment.

Theme 3*:* Medicaid Enrollment Gets Challenging After Release from Incarceration

Participants gave reasons for some inmates leaving incarceration into the community without Medicaid. A major reason was ineligibility due to not being Maryland residents and/or not having legal residence in the United States. Other reasons were either deliberately refusing to enroll or missing enrollment if the release was unforeseen and therefore not scheduled. When enrollment occurred in the community setting, the former offenders were required to meet the same eligibility requirements for state Medicaid and present the same documents as those enrolling from the community. These documents included a Social Security number, a birth certificate, a regular ID, and proof of income. These were often challenging requirements for newly released former inmates. The participants had the perception that former inmates were treated the same as the rest of the civilian population and there was no indication of stigmatization.

Theme 4: Medicaid Enrollment as Part of Discharge Planning.

Participants' perceptions were that most inmates are enrolled in Medicaid before they exit the carceral system and that Medicaid is a major component of discharge

planning. The NCCHC recommends continuation of support services and medications during reentry for former inmates (Flanagan, 2004). Such health coverage can help reduce the use of emergency rooms for nonurgent conditions and facilitate linkage to primary care and transitioning (Somers et al., 2014, as cited in Blackburn et al., 2020). This finding was a major development in facilitating Medicaid enrollment in the state during reentry.

Theme 5: Ensuring Health Care Coverage After Release from Incarceration

This finding put emphasis on making inmates understand they needed to continue to have access to health services after they leave incarceration. The perception from participants was that some inmates had become extremely comfortable with the health they received during incarceration and did not understand how to continue with health access after release. Participants pointed out how Medicaid enrollment has a two-step process. Initial enrollment in the jail is the first step and linking to a Managed Care Organization is the second and last step. It was important for participants to provide detailed information on the second step to complete the enrollment process after release.

Theme 6: Streamlining Medicaid Eligibility and Expanding Coverage

Medicaid is the largest public insurance program in the United States and serves mostly disadvantaged and low-income people (Grodensky et al., 2018; Vogler 2020). It has its limits as well. This finding emerged from responses of participants who were familiar with Medicaid policy. Two of the participants had the perception the Maryland Medicaid program had old systems that needed revamping and that there was need to

expand coverage to mostly people with mental health problems. A participant mentioned the use of Section 1115 Waiver to target expansion of Medicaid eligibility and services to individuals with mental illness and substance use disorders. This effort to streamline Medicaid eligibility aligned with one of the strategies that Medicaid expansion states are using to facilitate Medicaid enrollment.

Limitations of the Study

This was a qualitative study in which I used purposeful sampling strategy in recruiting participants. This was necessary to recruit participants that met the inclusion criteria for the study. The small sample size in the study ($N = 11$) limited the generalizability of the study's findings to a larger population. The sampling strategy that was based on my judgement raised issues of researcher bias, and this created a limitation in the study. The findings in the study were based on the perceptions of participants about the experiences and challenges of justice-involved people as they navigate the Medicaid system in Maryland. This meant that the study did not include the voices and perspectives of justice-involved people themselves. It was therefore not possible to determine if the perspectives of justice-involved people would refute or corroborate the perceptions that study participants rendered. Another limitation of the study was not having demographic data. Such data were, however, not relevant to the study.

Recommendations

The findings in this study were based on the perceptions of participants about the experiences and challenges of justice-involved people in navigating the Maryland

Medicaid system. It would be more compelling for future research to include justice-involved individuals directly, to understand their experiences and challenges. Carceral systems have closed access for obvious reasons, but I still recommend that additional research should be with incarcerated individuals themselves, despite their protected population status. Such research can provide a first-hand account of their experiences and challenges in Medicaid enrollment. This study revealed the inmates' knowledge deficit concerning Medicaid. My next recommendation is that incarcerated individuals receive very simplified orientation about Medicaid at Intake and have written information that they can keep with them. This may help allay their suspicions and apprehensions about Medicaid when the time comes for them to enroll.

I also recommend that the justice-involved individuals have adequate information about how to connect to an MCO as they exit from incarceration. The jail or prison staff should make them understand that they do not get access to care, until they are enrolled by system in an MCO. It is this link with the MCO that completes the enrollment process. It would be better if the MCO selection be with the help of the staff in the jail or prison before inmates' release. I recommend that managers of the Maryland Medicaid program do some networking with other states that are more advanced with managing the Medicaid enrollment challenges for justice-involved individuals. This can be an opportunity for them to learn from other programs and use such information to make improvements in Maryland.

My observation is that the Medicaid Inmate Exclusion policy creates gaps in Medicaid coverage for incarcerated populations through suspension of coverage. I recommend that federal government should abolish this policy. Those who serve shorter sentences in jails face the biggest challenges because of this exclusion policy, which causes the need to reinstate their Medicaid after being in jail for less than 1 year. My last recommendation is for future research to investigate the extent of health care utilization in the community by justice-involved individuals after enrolling in Medicaid. It is also necessary to have research focused on possible engagement in risky health behaviors that are related to having health coverage. Such research could reveal possible moral hazards by former offenders.

Implications

This study adds to the existing literature on Medicaid enrollment in Maryland. It also heightens awareness of the need to ensure that justice-involved individuals have continuous access to health care as they return to the community from incarceration. This research revealed the need for Medicaid enrollment to be a major component of discharge planning in correction facilities. This awareness demands that regular communication and data sharing between the Medicaid agency and the Department of Public Safety and Correctional Services should exist to provide enough time for enrolling individuals in Medicaid when their release is imminent.

Prior to 2014, about 80% of justice-involved people either lacked insurance coverage or the financial resources to pay for medical care (Bandara et al., 2015). A high

proportion of incarcerated people have low-income income backgrounds and have an elevated level of chronic health conditions (Albertson et al., 2020). These vulnerable individuals must rely on Medicaid as public insurance to access care. In the behavioral model for vulnerable populations, Medicaid is the enabling factor when I applied the model to this study. Grodensky et al. (2018) argued that benefits of health insurance coverage and appropriate care utilization for former offenders include, supporting their own health, decreasing the use of the emergency department, reducing medical debt, and lowering the risk of disease transmission. Research has shown that health insurance may be associated with lower rates of recidivism and drug use (Freudenberg et al., 2005, cited in Cuellar & Cheema, 2012). This study contributes to positive social change by ensuring that ex-offenders can be healthy upon release and make positive contributions to society in various settings. Providing health care access to returning justice-involved individuals can help introduce structural change to reduce health inequities in the U.S. society.

Conclusion

The purpose of this qualitative study was to understand how those who participate in enrolling justice-involved individuals in Maryland Medicaid perceive the experiences and challenges of these individuals as they navigate the Medicaid system. I collected the data through Zoom interviews and later did coding and data analysis with the assistance of MAXQDA. A four-step thematic analysis yielded six themes that constituted the findings of the study. The themes were (a) understanding the Medicaid enrollment process and the purpose for Medicaid, (b) Medicaid eligibility in Maryland, (c) Medicaid

enrollment gets challenging after release from incarceration, (d) Medicaid enrollment as part of discharge planning, (e) ensuring health care coverage after release from incarceration, and (f) streamlining eligibility and expanding coverage.

The results point to the importance of Medicaid as a source of access to health services when justice-involved individuals leave incarceration. Incarcerated individuals are a vulnerable population and are usually poor, homeless, and unemployed. They also have a high burden of chronic diseases, mental health problems, and substance abuse disorders. After months or years of receiving health care services in various prisons and jails, they must rely on Medicaid as public insurance to continue to access care after release. The findings revealed the challenges that they face during Medicaid enrollment, as they depend on help from enrollment staff to complete the process. The perception from participants in the study was that the application was unnecessarily lengthy and repetitive, warranting revision to what the program requires to enroll. The state Medicaid itself needs revamping, as mentioned by interviewees. Innovation should aim at improving data sharing and collaboration between various agencies to ensure that enrollment staff gets every individual enrolled in Medicaid at the time of release.

Reponses from participants indicated the Medicaid program has made improvements in the enrollment process. It was remarkable to see how proactive enrollment has taken root in correctional facilities. One participant mentioned that PE has become redundant due to the speedy enrollment process currently in place. Inmates understood the importance of Medicaid and showed their appreciation after completing

the enrollment process. Medicaid provides access to health care for this vulnerable population and reduces health inequities in the state.

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Appendix A: Interview Questions for Enrollment Staff

1. Tell me about a typical day for you as you go out to enroll justice-involved people in Medicaid.

2. When you have to enroll a justice-involved individual, what eligibility requirements should he or she have to qualify for Medicaid?

3. What mechanisms are in place in corrections and state Medicaid agencies to communicate with each other about a person's incarceration and Medicaid coverage status?

4. What documentation is needed to facilitate the Medicaid enrollment process in Maryland?

5. Given that most justice-involved individuals seeking Medicaid benefits do not have specific documents such as a driver's license or birth certificate, what alternative documents are used as proof of income and identification?

6. Tell me about the locations at which you assist in Medicaid enrollment for justice-involved people.

7. What are your concerns, if any, about going into these settings to assist incarcerated people in Medicaid enrollment?

8. How have these concerns been addressed?

9. How simplified is the information on the Medicaid application?

10. What languages are currently used for the Maryland Medicaid application?

11.The state of Maryland had a CMS-approved Inmate Presumptive Eligibility Program in 2016. Presumptive eligibility practice assumes that an individual is eligible for Medicaid before he or she has completed the enrollment process. How has presumptive eligibility facilitated the enrollment of justice-involved populations in Medicaid?

12. Federal regulations require state Medicaid agencies to administratively renew coverage of beneficiaries, using available federal and state data, not excepting incarcerated people. How well have these federal regulations served justice-involved people in Medicaid enrollment?

13. Proactive enrollment is encouraged as a routine component of either orientation at intake or discharge planning prior to release. Please explain at what point you are mostly involved in enrolling incarcerated individuals.

14, What lessons, if any, has the Maryland Medicaid program learned from programs in other states that could help in improving Medicaid enrollment for justice-involved people in Maryland?

15. What impact has Medicaid enrollment of justice-involved individuals had on their ability to access health care services?

16. What impact has Medicaid enrollment of justice-involved individuals had on possible re-incarceration?

17. Is there anything else that you would like to ask that I have not already asked you about?

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Appendix B: Interview Questions for Management

1. What has been your experience in your role as a manger in the Maryland Medicaid program?

2. Given the many Medicaid and health care system policies and processes as well as justice processes, what inter-agency collaboration strategies are in place to provide the information and documents that are typically required to verify Medicaid eligibility for justice-involved individuals?

3. Is there any federal statute, regulation, or policy that prevents individuals from applying for, being enrolled, or being renewed for Medicaid while incarcerated?

4. Please tell me what percentage of Maryland's adult population that is newly eligible for Medicaid could be justice-involved.

5. What initiatives are in place to connect justice involved people to Medicaid in Maryland?

6. What, if any, challenges confront the Medicaid agency in leveraging the existing enrollment staff – including community-based navigators, application assisters, and eligibility workers to conduct outreach and enrollment for justice-involved people?

7. Tell me in what locations the enrollment staff are usually deployed to carry out enrollment activities.

8. What measures have state and local authorities taken to address potential concerns of enrollment staff to work with justice-involved populations and more so, in a jail or prison setting?

9.Tell me about any efforts that have been made to involve incarcerated individuals as trained peer assisters who could provide general education about Medicaid and help their peers to complete parts of the Medicaid application.

10. Describe the budgetary issues that the Maryland Medicaid program encounters in the Medicaid enrollment effort.

11. In the state of Maryland, what is the consequence on Medicaid eligibility when an individual becomes incarcerated?

12. Following incarceration, a person's Medicaid eligibility is either terminated or suspended. Please tell me what is needed to regain coverage in each of these situations.

13. Proactive enrollment has the advantage of establishing Medicaid eligibility at pre-release but requires a justice agency to define prioritization criteria for targeted enrollment assistance. Please explain how proactive enrollment has been working so far in Maryland.

14. The state of Maryland had a CMS-approved Inmate Presumptive Eligibility Program in 2016. Presumptive eligibility practice assumes that an individual is eligible for Medicaid before he or she has completed the enrollment process. Please explain how Presumptive Eligibility has been implemented in Maryland.

15. What lessons, if any, has the Maryland Medicaid program learned from programs in other states that could help in improving Medicaid enrollment for justice-involved people in Maryland?

16. What impact has Medicaid enrollment of justice-involved individuals had on their ability to access health care services?

17. What impact has Medicaid enrollment of justice-involve individuals had on possible re-incarceration?

18. Is there anything else that you would like to ask that I have not already asked you about?

Appendix C: Participant Log

Pseudonym	Organization	Role	Date of Interview
M1PGC	PGC Health Connect	Management	01/19/24
N1PGC	PGC Health Connect	Navigator	01/19/24
N2PGC	PGC Health Connect	Navigator	01/19/24
N3PGC	PGC Health Connect	Navigator	01/19/24
M1MDH	MDH	Management	01/22/24
M2MDH	MDH	Management	01/22/24
M1HCAM	HCAM	Management	04/15/24
N1HCAM	HCAM	Navigator	04/15/24
N2HCAM	HCAM	Counselor	04/16/24
N1YC	YC	Navigator	04/26/24
N2YC	YC	Navigator	04/26/24

Appendix D: List of Codes

Step 1: List of Codes

Partial enrollment at prerelease

Unscheduled releases

Presumptive Eligibility

Medicaid coverage during reentry

Enrollment issues

Conditions of eligibility

Most important eligibility requirements

Ward of the state

Medicaid enrollment during prerelease

Declining Medicaid enrollment

Being dismissive

Release without enrollment

Prolonging incarceration

Uninsured inmates

Younger people

Turnaround time

Presumption of eligibility

Verification and authentication

Knowledge

Enrollment assistance

Medicaid budget

Validity period for Medicaid

Education

Simplified application

User-friendly application

Phone and in-person assistance

Seamless process

Customer Service

Service preference

Literacy level

Bilingual navigator

In-person support

In-person enrollment

Language barrier complex

Mistrust

Language hotline

Medicaid staff

Non-involvement of peers

Addressing language barriers

Medicaid application is lengthy and repetitive

Translation help

Application language

Online enrollment

Medicaid education

Suspicion and apprehension

The vital role of Medicaid

Active Medicaid provides access to health services

Problem solving and assistance

Access to mental services and medications

Primary Care Physician (PCP)

No connection

Positive impact

Uniqueness of Medicaid programs

Limited coverage

Medicaid support decreases recidivism

Showing appreciation

Targeted beneficiaries

Support and relief

Enrollment locations

Enrollment inside the facilities

Safety concerns

Open communication

Unsafe situation

Immigration status

Non-Us citizen

Citizenship documents

Asylees

Legal resident

Proof of citizenship

We have to deem them ineligible

Refugees

Inmates' concerns during enrollment

Personal documents

Facilitating discharge planning

Community Organizations

Structure

Separate and independent administrations

Data sharing

Proactive enrollment

Enrollment flexibilities

Inter-agency collaboration

Internal collaboration

Application limited to individual

Effective proactive enrollment

Enough time for enrollment

Enrollment timing

Complete enrollment

Fee-for-service

Choosing the MCO

Signing the Medicaid application ends further contact

Temporary Medicaid insurance

Medicaid card assistance

CMA 1115 Demonstration Waiver

Reentry pilot

Expanding coverage

Lack of knowledge

Reentry Waiver

Innovation and improvement

Understanding and addressing health needs

Need for change

Guidance from programs in other states

Improving the eligibility process

Medicaid suspension

New application

Reinstating suspended Medicaid

Medicaid suspension effect

Inpatient hospitalization

Incarceration block

Maryland residence

State and federal data

Frustration of the enrollment staff

Home address

Population outreach

Workers' Authorization

Social Security

I-10 Workers' Authorization

Income criteria

Enrollment challenges

Freedom

Non-involvement in enrollment of incarcerated people

Enrollment in Medicaid or health plan

Photo ID

Birth certificate

Current address

Proof of income

Required documents

Equal treatment

Recently released from incarceration

Similar documents for health insurance

Free health services

Stopgap

Clinic payments

Tax credit

Unhampered enrollment for recently released

Private insurance

Enrollment limitation

Different door

Incarceration precludes enrollment

Appendix E: Categories and Related Codes

Step 2: Categories and Related Codes

Categories	Related codes
Active incarceration	Partial enrollment at pre-release; Unscheduled releases; Presumptive Eligibility is redundant; Medicaid coverage during reentry; Enrollment issues; Conditions for eligibility; Most important eligibility requirements; Ward of the state; Medicaid enrollment during prerelease; Declining Medicaid enrollment; Being dismissive; Release without enrollment; prolonging incarceration; Uninsured inmates; Younger people; Turnaround time; Presumption of eligibility; Verification and authentication.
Enrollment process	Knowledge; Enrollment assistance; Medicaid budget; Validity period for Medicaid; Education; Simplified application; User-friendly application;

Categories	Related codes
	Phone and in-person assistance; Seamless process; Customer service; Service preference; Literacy level; Bilingual navigator; In-person support; In-person enrollment; Language barrier complex; Mistrust; Language hotline; Medicaid staff; Non-involvement of peers; Addressing language barriers; Medicaid application is lengthy and repetitive; Translation help; Application language; Online enrollment; Medicaid education; Suspicion and apprehension.
Impact of Medicaid	Active Medicaid provides access to health services; Problem solving and assistance; Access to mental services and medications; Primary Care Physicians (PCP); No connection; Positive impact; Uniqueness of Medicaid programs; Limited Coverage; Medicaid support deceases recidivism; Showing

Categories	Related codes
	appreciation; Targeted beneficiaries; Support and relief; The vital role of Medicaid.
Enrollment sites	Enrollment locations; Enrollment inside the facilities; Safety concerns; Unsafe situation.
Citizenship	Immigration status; NonUS citizen; Citizenship documents; Asylees; Legal resident; Proof of citizenship; Green card holder; Visas; Citizenship; we have to deem them ineligible; refugees.
Discharge planning	Inmates' concerns during enrollment; Personal documents; Facilitating discharge planning; community organizations.
Proactive enrollment	Structure; Separate and independent administrations; Data sharing; proactive enrollment; Enrollment flexibilities; Inter-agency collaboration; Internal collaboration; Application limited to individual; Effective proactive enrollment;

Categories	Related codes
	Enough time for enrollment; Enrollment timing.
Enrollment assistance during reentry	Complete enrollment; Fee-for-service; Choosing the MCO; Signing the Medicaid application ends further contact; Temporary Medicaid insurance; Medicaid card assistance.
Streamlining eligibility process	CMS 1115 Demonstration Waiver; Reentry pilot; Expanding coverage; Lack of knowledge; Reentry Waiver; Innovation and improvement; understanding and addressing health needs; Need for change; Guidance from programs in other states; Improving the eligibility process.
Medicaid suspension and termination	Medicaid suspension; New application; Reinstating suspended Medicaid; Medicaid suspension effect; Inpatient hospitalization; Incarceration block.

Categories	Related codes
Maryland residence	Maryland residence; State and federal data; Frustration of the enrollment staff; Home address.
Community enrollment	Population outreach; Workers' Authorization; Social Security; I-10 Workers' Authorization; Income criteria; Enrollment challenges; Freedom; Non-involvement in enrollment of incarcerated peers; Enrollment in Medicaid or health plan; Photo ID; Birth certificate; Current address; Proof of income; Required documents; Equal treatment; Recently released from incarceration; Similar documents for health insurance; Free health services; Stopgap; Clinic payments; Tax credit, Unhampered enrollment for recently released; Private insurance.
Incarceration	Enrollment limitation, Different door; Incarceration precludes enrollment; Cause for exclusion.