2017

Attitudes of Women Offenders towards Medicaid Enrollment and Coverage under the Affordable Care Act

Morrisa Barbara Rice
Walden University

Walden University

College of Health Sciences

This is to certify that the doctoral dissertation by

Morrisa Rice

has been found to be complete and satisfactory in all respects,
and that any and all revisions required by
the review committee have been made.

Review Committee
Dr. Michael Furukawa, Committee Chairperson, Health Services Faculty
Dr. Magdeline Aagard, Committee Member, Health Services Faculty
Dr. Patrick Tschida, University Reviewer, Health Services Faculty

Chief Academic Officer
Eric Riedel, Ph.D.

Walden University
2017

Abstract

Attitudes of Women Offenders towards Medicaid Enrollment and Coverage under the Affordable Care Act

by

Morrisa Barbara Rice

MHA, Hofstra University, 1999

BS, Spelman College, 1995

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Health Services

Walden University

April 2017

Abstract

Although women offenders face barriers to successful reentry into their communities, as yet, no research has explored their experiences in accessing health care reentry services. Medicaid enrollment, the process of applying for Medicaid coverage, can be offered as a health care reentry service. Women offenders in jails have shorter sentencing times compared to those in prison, which presents Medicaid enrollment opportunities before release. The Second Chance Act provides the opportunity for reentry services, and the Affordable Care Act provides the opportunity for Medicaid coverage for women offenders. This phenomenological study explored the attitudes of women offenders about Medicaid enrollment and coverage. The conceptual framework for this study was the Andersen's behavioral model. Interviews were conducted with 11 women offenders who were randomly recruited, spoke English, had a minimum of a 6th grade education, and were not on restriction based on jail policy. Data were collected and coded to develop themes for analysis and interpretation. Most participants had an adequate understanding of the purpose of Medicaid coverage and had favorable perceptions of Medicaid enrollment. Barriers to Medicaid enrollment were identified: a lack of language proficiency, denial of coverage, poor health literacy, and a lack of understanding of health information. Facilitators to Medicaid enrollment were identified: providing a translator, being treated with respect as a person to reduce stigma, and assistance with enrollment forms. These findings can contribute to positive social change. Jails have the chance to address these barriers and incorporate the facilitators to make it simpler for women offenders to enroll in Medicaid before released from jail.

Attitudes of Women Offenders towards Medicaid Enrollment and Coverage under the Affordable Care Act

by

Morrisa Barbara Rice

MA, Hofstra University, 1999

BS, Spelman College, 1995

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Health Services

Walden University

April 2017

Dedication

This dissertation is dedicated to women offenders across the country who will reenter society at some point in time. It is my hope that the findings and recommendations of this study will highlight opportunities to improve policies and programming related to their health care reentry needs.

Acknowledgments

I would like to thank God for giving me the strength to pursue this degree despite being a mother, wife, and career woman. I thank my parents Gwendolyn Armstead and the late Nathaniel Armstead for providing the foundation that has positively impacted my personal, professional, and education journey. I also thank my mother for always motivating me when life got hard and personal challenges stood in my way. I thank my husband George (GE) because unbeknownst to him, he is the reason I decided to step out on faith and moved forward to pursue a PhD. He continually encouraged me (his Diez) to cross the finish line by saying "you are closer than you have ever been before." I would also like to thank my children Taylor (Sis) and George (CJ) for being patient with me during this challenging journey. You motivated me because when I saw school getting hard for you, I shared my challenges and successes in my coursework and continued to lead by example so we could all work hard together. You both make me a better person and I am proud to be your mother. Thank you to my many friends and family members who have been my biggest cheerleaders by providing moral support, encouragement, and love. I thank my classmates in my dissertation cohort because we continued to encourage each other to "keeping the lantern on." I also want to thank Robert Green, Kendra Jochum, and the rest of the Montgomery County Department of Correction and Rehabilitation staff for the opportunity to conduct my study at the jail. Finally, thank you to my committee, Dr. Michael Furukawa (Chair and Content Expert) and Dr. Magdeline Aagard (Methods Expert), for your valuable guidance and unwavering support throughout this dissertation journey. We cooperated so I could graduate and we are done!

Table of Contents

List of Tables

List of Figures

Chapter 1: Introduction to the Study

Introduction

The purpose of this study was to understand the lived experiences of women offenders with Medicaid enrollment and their attitudes towards Medicaid coverage under the Affordable Care Act (ACA). Medicaid enrollment is the process of applying for Medicaid coverage while in jail. The goal was to inform future policy decisions and practices. While some studies in criminal justice settings have addressed the various barriers to reentry, no prior research has examined women offenders' health care reentry needs during the reentry process, such as enrolling in Medicaid and getting coverage (Phillips, 2010; Herrschaft, Veysey, Tubman-Carbone, & Christian, 2009). The location of this study was the Montgomery County Department of Correction and Rehabilitation (MCDOCR) in the state of Maryland.

The study was conducted in order to understand the implications of Medicaid enrollment as a health care reentry service for women offenders to obtain Medicaid coverage. To address this gap, a qualitative approach was used, including interviews. The implications for social change was to identify the barriers and facilitators to Medicaid enrollment prior to release from incarceration and provide recommendations to correctional facilities and policymakers on what may be needed to provide access to health care for women offenders after release from jail

This chapter will discuss the topic of this study, why this study needed to be conducted including the research literature related to the study topic, and the gap in the literature that needed to be addressed. The problem statement and the significance and

relevance to health care policy will be highlighted. The purpose of this study will be described in further detail as well as the research questions. The conceptual framework and the nature of this study including a summarization of the methodology that was used to conduct this study will be identified. Definitions, assumptions, scope and boundaries, limitations, and significance of this study are provided in this chapter. Lastly, a summary of the major points will conclude this chapter to provide a transition to Chapter 2.

Background

Several studies have indicated a lack of coordination among the United States' correctional system and community health organizations (e.g., transitional community health clinics and health departments) in providing comprehensive health care in addressing the needs for all offenders (Bechelli et al., 2014; Boutwell & Freedman, 2014; Cuellar & Cheema, 2012; Iglehart, 2014; Marks & Turner, 2014; Patel & et al., 2014; Regenstein & Rosenbaum, 2014; Rich et al., 2013; Somers et al., 2014). However, no research was found on the experiences of women offenders with health care reentry services, such as Medicaid enrollment to obtain Medicaid coverage.

Binswanger et al. (2011) suggested that social policies related to the physical and mental health of offenders do not provide sufficient reentry planning so that offenders can have a successful transition from incarceration to the community. Discharge planning and the connection with health care services in the community are critical for reentry because of the various health care needs (physical and mental health) that can be exacerbated if services and medications are not rendered to offenders after release from incarceration (Ejike-King & Dorsey, 2014; Malave, 2014). Iglehart (2014) suggested that

jail-involved populations that have high rates of communicable diseases as well as mental health conditions, substance abuse disorders, or chronic conditions, often reenter their communities without health care coverage. Collaboration between community health organizations and correctional agencies could provide the opportunity for offenders to be enrolled in Medicaid and thus have access to health care (Iglehart, 2014).

The ACA has been timely and offers the opportunity to provide enrollment for jail-involved individuals in health care coverage, especially for those individuals whose coverage is suspended or terminated for Medicaid (Bandara et al., 2015). As a result of the ACA, correctional facilities and community health organizations have the opportunity to develop policies and procedures (such as patient navigators), to identify jail-involved individuals and to help them regain coverage that was suspended or terminated or else to enroll them in health care coverage. Correctional facilities may lack the capacity to provide enrollment services (Regenstein & Rosenbaum, 2014). However, patient navigators are an option. They have been used in jail settings for individuals impacted by HIV and drug use to assist them gain access to medical and social services. Navigators have been able to establish connections and to help clients with appointments. This navigator model could be a vehicle to help women offenders enroll in Medicaid and to gain access to health care upon release (Koester et al., 2014). Wright, Van Voorhis, Salisbury, and Bauman (2012) suggested that there are gender-responsive factors (understanding the physical, behavioral, social and cultural differences between female and male offenders) that impact women in correctional facilities, and staff could be trained to provide better services for women. More research is needed to understand the

impact of public health policy, such as the ACA and Medicaid coverage, on the health care reentry needs of women offenders.

Cuellar and Cheema (2012) suggested that additional research be conducted that could impact policy so that this vulnerable population could take advantage of Medicaid expansion under the ACA. Reentry programming staff could help with Medicaid outreach and enrollment (Cuellar & Cheema, 2012). Salem, Nyamathi, Idemundia, Slaughter, and Ames (2013) conducted a study to identify the gaps needed for homeless women ex-offenders related to successful reentry. The focus was on barriers to health care access, including treatment for mental health and substance abuse, to understand the role played by these barriers in recidivism). Scott and Dennis (2012) examined a program "Recovery Management Checkups" and the impact of substance abuse treatment and abstinence on HIV risk behaviors and recidivism. Women ex-offenders who participated in the program were compared to women ex-offenders who did not participate in the program. Their findings indicated that women ex-offenders who participated in the program (and had support to avoid substance abuse) were more likely to return to treatment compared to those women offenders who did not participate in the program or receive support (Scott & Dennis, 2012).

The studies mentioned above could be replicated in other settings such as jails to provide further insight into women's access to health care services and successful gender-responsive reentry programming that reduces recidivism for women offenders due to timely federal legislation including the SCA and ACA.

This study addressed three gaps in the literature: What are the health care reentry needs of women offenders? What efforts are underway to meet those needs? What are the attitudes of women offenders towards Medicaid enrollment including health literacy, stigma, and access and Medicaid coverage? This study was needed to better understand the experiences of women offenders and the implications of coordinating health care reentry services during incarceration to prepare the offenders for reentry into their communities.

Problem Statement

Little is known about the implications of the ACA and Medicaid expansion (e.g., enrollment) on women offenders before their reentry into their communities. The impact of public health policy on women's health is an important issue of long-standing debate. The War on Drugs legislation has contributed to the increase in women's incarceration in the last couple of decades (Lenox, 2011). Women are often offenders of nonviolent crimes and serve shorter sentencing times than men, typically up to 1 year in a jail setting (Lenox, 2011). Women offenders being released from jail will often reenter their communities with more limited resources compared to their male counterparts. If women offenders do not have access to reentry services such as housing, transportation, employment, and health care services, the lack of access to these services could lead to recidivism (Scroggins & Malley, 2010; Brooks, 2014).

Although women offenders comprise only 7% of the incarcerated population, they have higher rates of HIV and sexually transmitted infections (STIs) compared to men offenders. Because women are often incarcerated for drug-related and sex offenses, this

puts them at further risk for HIV and other STIs (Maruschak, Berzosky, & Unangst, 2015). Furthermore, women offenders in jail are more likely than men offenders to report ever having a chronic condition—68% and 48%, respectively—as well as having an infectious disease 20% and 13% respectively (Malave, 2014; Springer, 2010). Jail-involved women tend to be uninsured due to gaps in health insurance coverage, instability in the workforce, and or at some point was were a dependent through a spouse's health plan (Fitzgerald, Cohen, Hyams, Sullivan, & Johnson, 2014). The only consistent health care they may have received was during while they were incarcerated. However, upon release, they often do not seek continued health care that could be related to the lack of coordination between the jail and community health organizations. Without receiving adequate treatment after release, women offenders could have unmet health care needs (as mentioned earlier) and cycle in and out of jail (Malave, 2014; Marks & Turner, 2014).

Most women offenders who have children under the age of 18 are eligible for Medicaid benefits; however, a greater number of women not in this category are uninsured and also eligible for Medicaid benefits (Rich, Cortina, Uvin, & Dumont, 2013). Women offenders in jail meet Medicaid's eligibility requirements, but Medicaid will not cover them if considered incarcerated such as being booked into jail (Cardwell, 2012). With the risk of Medicaid and Medicare being revoked upon arrest and incarceration due to the "inmate exception" rule, women offenders have to reapply for Medicaid, and the enrollment process can take up to 3 months (Cardwell, 2012; Springer, 2010). The 'inmate exception" rule allows those who are incarcerated to be covered by Medicaid

only if they are in a medical facility (e.g., hospital, nursing facility, intermediate care facility) for a 24-hour period or longer. The limited access to health care, such as Medicaid enrollment, can be linked to women offenders' lower rates of high school graduation. Women offenders often require significant assistance in obtaining health care services upon reentry due to lower health literacy rates. Another health care service that a majority of women offenders need is behavioral health care, despite health care reform and the expansion of coverage (Rich et al., 2013). Upon release to the community, women offenders tend to have issues such as social instability and homelessness; often they lack insurance. Without adequate insurance, they can not get routine medical care, important screening tests nor treatment of chronic diseases (Springer, 2010).

The ACA offers an important opportunity for expanding Medicaid eligibility and enrollment that can be coordinated in jail settings by using navigators as part of reentry services (Fitzgerald et al., 2014). Medicaid expansion affords women offenders access to health care services and reduces the financial barrier to health care (Rich et al., 2013). Many women offenders often lack health care insurance before incarceration. However, women offenders who had Medicaid coverage before incarceration may experience a loss of this benefit, which is due in, part to Medicaid either being suspended or terminated while considered incarcerated (Mark & Turner, 2014). One of the greatest transitional service needs reported by women offenders during a pre-release interview was public health insurance (Garcia & Ritter, 2012). Jails can work with state Medicaid offices to provide patient navigators to help women offenders with enrollment as a reentry service (Rich et al., 2013). Economic disparities and access to equitable health care are ongoing

issues for all incarcerated individuals. Access to government-subsidized health care coverage can result in (a) improved health outcomes for all offenders and (b) assist in providing healthier communities (McDonnell, Brooks, & Lurigio, 2014). Thus, more research is needed to understand the impact of the ACA on the health care reentry needs of women offenders.

Women offenders face a myriad of issues when reentering society, for example, access to health care, mental health, and substance abuse services (Cobbina & Bender, 2012; Scroggins & Malley, 2010). She will often have co-occurring needs related to substance abuse, physical abuse, and mental health and may need additional support and health care services to transitioning back into the community (Garcia & Ritter, 2012).

Women offenders need gender-responsive reentry programming to address their diverse needs. Current legislation, such as the Second Chance Act (SCA) and the ACA, should be evaluated for effectiveness in meeting the health care needs of women offenders in Washington, DC, and surrounding areas (Kellett & Willging, 2011). This qualitative study examined the perspective of women offenders with respect to Medicaid enrollment during the reentry process. This study addressed the implications of the ACA and Medicaid expansion on Medicaid enrollment for women offenders. This study also highlighted the experience of women offenders with Medicaid enrollment (process of meeting with someone to being enrolled), including the issues of health literacy, stigma, and access.

Purpose of the Study

The purpose of this study was to examine the lived experiences of women offenders with Medicaid enrollment and their attitudes toward Medicaid coverage at the MCDOCR in the state of Maryland. Previous studies on this topic have addressed the barriers to reentry from a policy perspective; however, no prior studies were found that examined this topic in a jail setting. To address this gap, participants were interviewed to develop an understanding of their experience during reentry, that is, from the jail setting into their communities.

Research Questions

Three research questions were developed to help understand the lived experiences of women offenders in a jail setting with Medicaid under the ACA.

1. What are the attitudes of women offenders in jail settings toward Medicaid coverage under the ACA?
2. What are the experiences of women offenders in jail settings with Medicaid enrollment under the ACA?
3. What are the implications for women offenders in jail settings of Medicaid coverage under the ACA?

Conceptual Framework for the Study

This study was based on Andersen's widely known behavioral model, which has been used to examine both the individual and contextual determinants of health service usage. The model has three major components: predisposing factors, enabling factors, and need factors (Babitsch, Gohl, & von Lengerke, 2012). This study focused on the

enabling factors, including the conditions that foster service utilization, such as health insurance, and the influence of health policies on access to health care. Both will be described in greater detail in Chapter 2.

The predisposing factors include demographics such as age, sex, and gender; social factors such as education, ethnicity, and relationships with others; and mental health factors such as attitudes, and beliefs. The enabling factors include the conditions that foster service use, such as income, health insurance, cost-sharing, access to transportation, wait times for health care, and the influence of health policies on access to health care. The need factors occur at the individual level, for example, a person's perceived need for health services and viewpoint of their health, including physical and mental health needs (Babitsch, Gohl, & von Lengerke, 2012).

Other theories, such as feminist and rational choice theory, have been used in studies similar to this one, were explored with respect to the previously mentioned issues faced by women offenders. Details about the Andersen behavioral model and its application to this study appear in Chapter 2. The open-ended interview questions were linked to Andersen's behavioral model and focus on enabling factors (Babitsch, Gohl, & Von Lengerke, 2012).

Nature of the Study

I used a phenomenological design to understand (a) the experiences of women offenders with Medicaid enrollment, and (b) the implications of the ACA in providing access to Medicaid enrollment for women offenders and the impact of federal legislation.

Phenomenology allowed the women to share their experiences by responding to open-ended questions based on the research problem (Creswell, 2009).

The study site did not have an Institutional Review Board (IRB) requirement, but the contact person provided valuable input for developing the IRB application required by Walden University. The point of contact provided me with a letter of cooperation and staff helped me with recruitment strategies, such as the best way to introduce and describe the study, confidentiality, informed consent, and any address any other concerns. However, I was responsible for recruiting and signing up the participants and thus reducing the potential for perceived coercion.

Definitions

This study provided definitions of the concepts of this study as some of the terms may have different meanings to various readers of this study.

Incarcerated population refers to the inmates of a prison, jail, halfway house, boot camp, and other facilities in which individuals are locked up overnight or during weekend programs (Bureau of Justice Statistics [BJS], n.d.).

Sentenced prisoners refer to prisoners under the jurisdiction of state and federal correctional authorities who have been given a sentence of more than 1 year (BJS, n.d.).

Jail-involved offenders or jail inmates refer to offenders confined in short-term facilities that are usually administered by a local law enforcement agency and that are intended for adults, but sometimes hold juveniles before or after adjudication. Jail inmates usually have a sentence of less than one year or are being held pending a trial, awaiting sentencing, or awaiting transfer to other facilities after a conviction (BJS, n.d.).

Recidivism refers to a person's relapse into criminal behavior, often after the person receives sanctions or undergoes intervention for a previous crime. Recidivism is measured by criminal acts that resulted in rearrests, reconviction or return to prison with or without a new sentence during a three-year period following the prisoner's release (National Institutes of Justice, n.d.-b).

Reentry or offender reentry is the transition from life in jail or prison to life in the community. Reentry specifically involves using programs that promote the effective reintegration of ex-offenders into communities when they are released from prison and jail (NIJ, n.d.-a).

Assumptions

In this study, my assumption was that the jail was aware of the ACA and SCA and has used various strategies to provide Medicaid enrollment through reentry program and services. This assumption was made because the SCA was signed into law on April 9, 2008, and the ACA was signed into law on March 23, 2010. The SCA provides opportunities for correctional facilities to engage in programming to allow for the successful transition of ex-offenders back into their communities. The ACA provides the opportunity for incarcerated populations to be eligible for Medicaid and coverage upon reentry back into their communities. The jail has utilized a health care insurance enrollment specialist and patient navigators to assist with Medicaid enrollment. The reentry program manager is responsible for the coordination of the reentry program services and providing all offenders, including women, with information about these

services. Women offenders should have been aware of these services and had access to reentry services including Medicaid enrollment to address their health care reentry needs.

Scope and Delimitations

The implication of Medicaid enrollment among women offenders in the jail setting was selected as the focus of this study. Due to the passage of the longstanding SCA, enacted in 2008, and ACA, enacted in 2010, women offenders have access to Medicaid coverage regardless of being pregnant or a mother. Women offenders often have more challenges than men offenders, such as a higher rate of chronic conditions, mental health needs, reproductive health issues, and the lack or nonexistence of health care coverage before and after incarceration. No prior research was found that examined the experiences of women offenders with this opportunity. Many commentaries have been published regarding the implications of the ACA on justice-involved individuals; but there have been no empirical studies on the experiences of justice-involved individuals, primarily women offenders in jail. The SCA and reentry programs have been evaluated but the focus was on non-health care reentry programs, such as housing, employment, and transportation. Both ACA and SCA are timely and could have important implications for justice-involved individuals and health outcomes.

There are barriers to Medicaid enrollment and health care coverage after release for incarcerated individuals including the lack of coordination between the correction facilities and community health organizations (Kellett & Willging, 2011; Brooks, 2014). Stigma, the lack of health literacy, and the cumbersome process of Medicaid enrollment

have also contributed to the current barriers to Medicaid enrollment and thus to coverage Marks & Turner, 2014.

This study has transferability to other situations. Although this is a qualitative study and results may not be generalized, correctional facilities and policymakers can use its findings to understand the implications of providing Medicaid enrollment coverage during reentry in jail settings and best practices and gaps with the enrollment process from the perspective of women offenders. The study findings can inform additional research that may be beyond the scope of this study.

Limitations

As with any study, there are limitations related to the methodology; in this case, they include transferability and dependability. This study used a qualitative approach and conducting interviews with women offenders provided the perspective and views of the study participants. Although the jail's leadership, along with the reentry staff who implement the policies and programs, could have been study participants, it was important to explore the perspective of the women offenders. This study did not include interviews with leadership and the reentry staff, therefore, limiting their perspective. The perspectives of the correctional facility leadership and reentry staff members could provide additional insight on the implications of Medicaid enrollment for women offenders during the reentry process. Again, this study aimed to give a voice to the recipients of the services rather than the facilitators of the services. This study focused on experiences with Medicaid enrollment for women offenders and not the impact of Medicaid enrollment on health care coverage after release. However, this study highlights

the opportunities for improvement in the Medicaid enrollment process as reported by the women offenders. The information collected from this study is based on the experiences of a small subset of women offenders in Montgomery County in the state of Maryland where the ACA was implemented, and Medicaid expansion has taken place. Therefore, the study findings may not be transferable to other states that did not implement the ACA and Medicaid expansion. Other states that have implemented the ACA and Medicaid expansion, but have not incorporated Medicaid enrollment opportunities during reentry, can use the study findings to understand the barriers and facilitators of Medicaid enrollment from the perspective of women offenders.

Lastly, there was potential for bias in this study. I am a female and am sensitive towards the needs of women offenders, as I have worked in the field of women's health for over 11 years at the Federal level. In addition, I had prior experience working with women offenders on sensitive issues related to partner notification, testing, and counseling services for HIV/AIDS and syphilis. My role as the instrument and developing the interview guide could have influenced the interpretation of the responses to the interview questions, therefore presenting the potential for bias. To limit the risk of researcher bias, I received feedback from the committee to develop the final interview questions. I also asked for clarification as needed regarding the responses received from the participants in the study.

Significance

The SCA authorized funding to state, local, and community organizations for reentry programs and funding to examine barriers to the delivery of health care, including

lack of health care insurance. It gives organizations the authority to provide reentry services, such as assistance with Medicaid enrollment. The ACA authorized access to affordable health care insurance for low-income populations (Cuellar & Cheema, 2012). In order to assist women offenders with access to Medicaid services after release from incarceration, Medicaid enrollment opportunities while in jail are important

Offering these services is critical in addressing behavioral health and other healthcare needs as well as in reducing recidivism among this population (Rich et al., 2013). Enhanced Medicaid enrollment opportunities by using patient navigators and jail reentry programs could improve health outcomes for women offenders, including a reduction in health care coverage volatility, access to affordable health care insurance and comprehensive health care after release (Fitzgerald et al., 2014). Rosen et al. (2014) suggested that future research should focus on the success of Medicaid enrollment that could be conducted in jail settings during the reentry process (Rosen et al., 2014).

Gender-responsive reentry programming can improve the reentry experience of women offenders into their communities and reduce recidivism (Brooks, 2014; Mallicoat, 2011). For women, access to healthcare and social services are critical aspects of the reentry process (Cobbina, 2010). It is critical to understand the lived experiences of women offenders in the community reintegration process and their ability to access health care services (e.g., Medicaid enrollment) including mental health (Doherty, Forrester, Brazil, & Matheson, 2014). Allowing the women offenders to describe their experiences with Medicaid enrollment provided a deeper understanding of what was working well and what was not working well with the current enrollment process. The experiences of

women offenders are valuable in understanding the practices and overall services provided to foster social change and address the diverse needs of women offenders (Mallicoat, 2011).

Summary

This study focused on three research questions that are expected to contribute to the literature on the implications of the ACA and Medicaid enrollment for women offenders during the reentry process. Specifically, the study examined the lived experiences of women offenders with Medicaid enrollment practices in jails and the implications for improvements in Medicaid enrollment opportunities [of what exactly?] for leadership and reentry staff members at various correctional facilities. Little is known about the experiences of offenders, primarily women offenders with the current Medicaid enrollment practices in the jail setting. This study addressed the gap, health care reentry needs (Medicaid enrollment), in the literature and can inform correctional facilities and other decision-makers in program planning and policy development with respect to the experiences of women offenders with Medicaid enrollment practices in the jail setting. Based on the interviews with the women offenders, this study could inform and impact the practices of the reentry program at MCDOCR where the study was conducted.

Although the state of Maryland has implemented the ACA and Medicaid expansion, there are perceived barriers to Medicaid enrollment for incarcerated individuals, including low health literacy, stigma, and Medicaid's cumbersome process. To further understand these barriers, women offenders were provided a voice to describe their experiences with the process of Medicaid enrollment in jail during the reentry

process. Understanding their experiences with Medicaid enrollment can provide additional insight and potential solutions to these barriers.

Most qualitative studies on incarcerated individuals have focused on reentry needs such as housing, employment, and transportation. This study focused on health care reentry needs, a gap in literature. A phenomenological method of inquiry provided the opportunity to ask structured open-ended questions that allowed women offenders the opportunity to describe their experiences with Medicaid enrollment during the reentry process while in jail. Conducting these interviews allowed me to collect data, synthesize data, identify common themes, and produce findings highlighting the experiences of women offenders with this phenomenon. Existing barriers and facilitators were identified. A phenomenological study can highlight findings to address gaps in the current literature and opportunities for further research that have not been addressed in previous research studies related to the ACA and Medicaid expansion Medicaid enrollment in a jail setting during the reentry process. Therefore, my use of phenomenology was most effective in addressing the three research questions in this study.

The following chapter will focus on the literature review conducted for this study. This includes the literature search strategy, the conceptual framework, rationale for the theory choice, literature review related to the key concepts of the study, and a summary of the chapter.

Add previews of the remaining chapters.

Chapter 2: Literature Review

Introduction

Jail-involved women tend to be uninsured due to gaps in health insurance coverage such as termination or suspension upon incarceration, instability in the workforce, and at some point may have been a dependent through a spouse's health plan (Fitzgerald, Cohen, Hyams, Sullivan, & Johnson, 2014). The only consistent health care they may have received was while they were incarcerated. However, upon release, they often do not seek additional health care due to the lack of health care coverage and coordination between the jail and community health settings. Little is known about the experiences of women offenders with Medicaid enrollment; however, without adequate treatment and coverage after release, they could have unmet health care needs and cycle in and out of jail (Malave, 2014; Marks & Turner, 2014). This study sought to understand the lived experiences of women offenders with the ACA and Medicaid enrollment.

It is clear from the literature that Medicaid enrollment has increased, but little is known about the lived experiences or attitudes and beliefs of women offenders in getting enrolled in Medicaid (Bandara et al., 2015). The ACA has changed Medicaid coverage for women offenders who were not previously eligible or who lost coverage. The ACA has expanded Medicaid eligibility and enrollment that can be coordinated in jail settings as a part of its health care reentry services (Fitzgerald et al., 2014).

This chapter will discuss the study's conceptual framework and how it has been applied to previous research and how it is applied to this study. The exhaustive review of the current literature will cover the following topics: War on Drugs; gender-responsive

health care reentry needs; Second Chance Act; Affordable Care Act; Medicaid expansion under the ACA; barriers to Medicaid enrollment; barriers to addressing health care reentry needs; and opportunities for future research.

Literature Search Strategy

To identify relevant literature, I used the following databases: Google Scholar, SocINDEX, EBSCOhost, ProQuest, ProQuest Dissertations, ProQuest Criminal Justice, PsycINFO, and Criminal Justice Periodicals. The following keywords searchers were used in a variety of combinations: *incarcerated, women, woman, women, female, offenders, Medicaid, enrollment, coverage, expansion, reentry programs, justice-involved, gender-responsive, Affordable Care Act,* and *Second Chance Act*. The primary combination of keywords that informed the study included women offenders, reentry programs, ACA, Medicaid enrollment, Medicaid coverage, and Medicaid expansion. The keyword combinations produced many study results; however, few studies were directly related to Medicaid enrollment and women offenders.

I used the results that identified the health care reentry challenges and needs of women offenders, as well as opportunities to meet the health care reentry needs of women offenders. The results included providing access to Medicaid enrollment through the ACA and enhanced linkages between the correctional system and community-based health care organizations.

I did an extensive search to obtain historical information on the laws that could impact the health care reentry needs of women offenders, including the SCA and the ACA. Lastly, the literature review provides a justification and rationale for the need of

this study as well as ways in which this study can contribute to the literature and ongoing research.

Conceptual Framework

The phenomenon studied was the lived experience of women offenders with Medicaid enrollment under the ACA. Theory is a set of concepts and ideas and examining the relationships among these categories. Theory is a story or a statement related to what is happening and why in relationship to a phenomenon. It can provide new insight and understanding of a phenomenon and shed light on a relationship that could potentially be unnoticed or misunderstood (Maxwell, 2013). The conceptual framework for this study was based on a widely known model, Andersen's behavioral model of health services use, which was developed over 25 years ago and has been used to examine both the individual and contextual determinants of health service usage (see Figure 1 below).

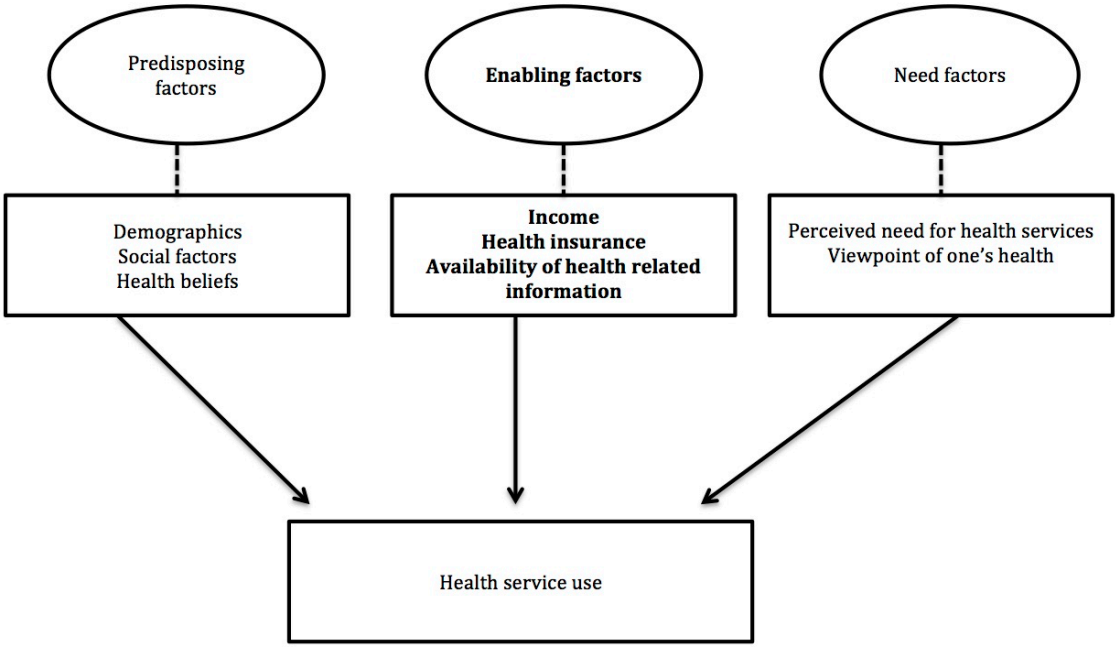

Figure 1. Andersen behavioral model of health services use. Adapted from "Re-visiting Andersen's Behavioral Model of Health Services Use: A Systematic Review of Studies from 1998-2011," by B. Babitsch, D. Gohl and T von Lengerke, 2012, *GMS Pyschosoc Med*, 9, p. 9. Copyright 2012 by Babitsch et al.

Many health economists, as well as psychologists, have effectively applied this model in research. It was initially used to understand the reasons why families use health services, define and measure access to care, and assist in policy development to promote equal access to care. Although not the first of its kind related to conceptual models, it

integrated many of the questions of "why and how" related to the use of health services (Andersen, 1995).

This model has three major components that are: predisposing factors; need factors; and enabling factors (Babitsch, Gohl, & von Lengerke, 2012). *Predisposing factors* include demographic characteristics such as age and sex, social factors including education, and mental health as they relate to health beliefs. *Need factors* include a focus on differentiating the perceived need for health services and how people view and experience their health and illness and evaluate need. This study focused on the *enabling factors* component including the conditions that foster service utilization such as health insurance coverage (e.g., Medicaid) and the influence of health policies on access to health care. These enabling factors include the ability of an individual to pay for health care services and cost-sharing requirements determined by the individual's health insurance status. At the organizational level, this includes outreach and education programs in addition to health policies (Babitsch, Gohl, & von Lengerke, 2012).

Andersen (1995) suggested that community and personal enabling resources should be present including health personnel and facilities availability. If these enabling factors are available, then individuals have the means to access the services and utilize the services. Examples provided included income, health insurance, and a regular source of care. One issue about enabling services is that organizational factors are not taken into consideration and have received little attention (Andersen, 1995).

Barriers to health enrollment exist not only due to the lack of Medicaid knowledge, stigma, and health literacy of offenders, but also the lack of continuity of care

between the jail and the community related to discharge planning and termination or suspension of Medicaid benefits while in jail. Many jails do not have the capacity and resources to participate in enrollment or re-enrollment activities, and many offenders lack the documentation to determine eligibility for Medicaid (Marks & Turner, 2014). However, providing access to health care insurance through Medicaid enrollment for women offenders in jail is an enabling factor because jails can serve as an enrollment site for those eligible for health care coverage during discharge planning and reentry. Lastly, developing policy and procedures to determine eligibility and provide enrollment through the reentry staff members and navigators have been identified as an enabling factor and could be achievable (Regenstein & Rosenbaum, 2014).

The behavioral model of health services use has been adapted for vulnerable populations recognizing the health care needs of this population. According to Gelberg, Andersen & Leake (2000), the behavioral model for vulnerable populations was designed to understand the health and health-seeking behaviors of vulnerable populations. Homeless individuals faced more health care challenges and revised the original model for this vulnerable population. I focused on the impact of utilization of services and the enabling domain to include insurance status, receipt of public benefits, and availability and use of information sources (Gelberg, Andersen, & Leake, 2000).

This study benefitted from the inclusion of the behavioral model for health care services and the adaptation of the behavioral model for vulnerable populations. These models apply to women offenders, who have been characterized as a vulnerable population due to incarceration, and this study sought to examine their experiences with

Medicaid coverage and the enabling factors related to access and utilization of health care services. Gelberg, Andersen & Leake (2000) utilized a qualitative approach to study the targeted population using a structured protocol. This study used a qualitative approach and structured interview protocol.

Key Variables and Concepts

War on Drugs

The impact of public health policy on women's health is an issue of long-standing debate and importance. The War on Drugs legislation has contributed to the increase of women's incarceration in the United States in the last decade (Lenox, 2011). Women are often offenders of nonviolent crimes and serve shorter sentencing times than men typically up to one year in a jail setting (Lenox, 2011). Women offenders released from jail will often reenter their communities with limited resources, and if they do not have access to reentry services such as housing, transportation, employment, and health care services, this could lead to recidivism (Scroggins & Malley, 2010; Brooks, 2014).

Gender-Responsive Health Care-Related Reentry Issues

Reentry issues, in general, have been a focus of correctional experts; however, issues facing women offenders continue to lag behind. Women offenders have often lacked the services needed to foster community reentry (Herrschaft, Veysey, Tubman-Carbone, & Christian, 2009). Gender-responsive programs and services are essential to a female ex-offender's ability to reintegrate back into their regular routine and their community (Brooks: 2014; Mallicoat, 2011). There have been several studies that focus on the role of support systems, transportation, and employment; however few studies

have focused on the correlation between access to health care and recidivism. Although women offenders comprise only 7% of incarcerated individuals, they have higher rates of HIV and STIs compared to men offenders (Maruschak, Berzosky, & Unangst, 2015). Furthermore, women offenders in jail are more likely than men offenders to report ever having had a chronic condition, (68% and 48%, respectively) as well as having an infectious disease (20% and 13% respectively) (Malave, 2014; Springer, 2010). Jail-involved women tend to be uninsured due to gaps in health insurance coverage, instability in the workforce, and at some point was a dependent through a spouse's health plan (Fitzgerald, Cohen, Hyams, Sullivan, & Johnson, 2014). The only consistent health care they may have received was while they were incarcerated. However, upon release, they often do not seek additional health care due to the lack of health care coverage and coordination between the jail and community health settings. Without adequate treatment, they will have unmet health care needs and cycle in and out of jail (Malave, 2014; Marks & Turner, 2014). Upon release to the community, women offenders tend to have issues such as social instability, homelessness, and lack of insurance. Without adequate insurance, they cannot access routine medical appointments and gain access to important screening tests and treatment of chronic diseases (Springer, 2010).

Cobinna (2010) suggested gender-responsive reentry services and access to health care and insurance are critical in the successful reentry of women offenders because of their unique health care needs. For example, women offenders experience greater rates of mental health challenges and addictions compared to their male counterparts and can benefit from access to behavioral health care (Cobbina, 2010; Malave, 2014).

The correlation between better health outcomes and recidivism has often been overlooked. Female ex-offenders have unique and different needs (e.g., reproductive health care) compared to male ex-offenders that should be considered in reentry program planning (Cobbina, 2010). It is important to understand the experiences of female ex-offenders as it relates to their health care and behavioral needs for community reintegration (Doherty, Forrester, Brazil & Matheson, 2014). Access to health care improves not only their health outcomes but also their ability to find stable employment and support their families (Spjeldnes & Goodkind, 2009).

Second Chance Act

The Second Chance Act of 2007 (SCA) authorized funding to state, local, and community organizations for reentry programs and to examine barriers to the delivery of health care including the lack of health care insurance. However, the question remains regarding if the needs of women offenders are being met. The rates of women offenders have risen over the past few years, and gender-responsive programming is critical to their successful reentry into society and to reduce recidivism (The Sentencing Project, 2012). The SCA provides the authority for organizations to provide reentry services such as Medicaid enrollment.

Affordable Care Act

The ACA is timely for fostering collaborative processes to screen jail-involved individuals for coverage eligibility, maintaining coverage as available, especially for those individuals whose coverage is suspended, and ensuring linkages take place upon their release (Regenstein & Rosenbaum, 2014). As a result of the ACA, correctional

facilities and community health organizations have the opportunity to understand the experiences of women offenders and Medicaid coverage. These experiences can be valuable in the development of policies and procedures to identify the needs and enroll female offenders in Medicaid for the first time or to restore coverage that may have been suspended or terminated. The ACA offers an exciting opportunity for the expansion of Medicaid eligibility and enrollment that can be coordinated in jail settings as a part of health care reentry services (Fitzgerald et al., 2014). The ACA authorized access to affordable health care insurance to low-income populations (Cuellar & Cheema, 2012). Both the SCA and the ACA authorities are important and timely. The ACA is timely as it can fill the gap of promoting positive reintegration and health care services for women offenders through Medicaid expansion and enrollment upon release from incarceration (Kellett and Willging, 2011). However, in the past, reentry programs focused on the needs of incarcerated men being released from correctional facilities and did not take into account the specific needs of women (Flores & Pellico, 2011; Guthrie, 2011).

Medicaid Expansion under the ACA

A great number of women offenders are uninsured and could be eligible for Medicaid benefits (Rich, Cortina, Uvin, & Dumont, 2013). Women offenders in jails may meet Medicaid's eligibility requirements, however will considered incarcerated may lose Medicaid coverage (Cardwell, 2012). Often times the enrollment process could take at minimum three months for women offenders who previously had Medicaid coverage or are seeking coverage (Cardwell, 2012; Springer, 2010). Women tend to have lower rates of graduating from high school and require significant assistance in enrolling in Medicaid

due to lower health literacy rates. Other issues include the need for behavioral health care (Rich et al., 2013). Upon release to the community, women offenders tend to have issues such as social instability, homelessness, and lack of insurance. Without adequate insurance, they cannot access routine medical appointments and gain access to important screening tests and treatment of chronic diseases that Medicaid expansion could address (Springer, 2010).

Medicaid expansion affords women offenders the opportunity to have access to health care services and reduces the financial barrier to health care (Rich et al., 2013). One of the greatest transitional service needs reported by women offenders during a pre-release interview was public health insurance (Garcia & Ritter, 2012). Jails are afforded the opportunity to work with State Medicaid offices to provide patient navigators to assist women offenders with enrollment as a reentry service before release (Rich et al., 2013). Economic disparities and access to equitable health care is an ongoing issue for incarcerated populations. However, access to government-subsidized health care coverage can result in improved health outcomes for women offenders and safer and healthier communities (McDonnell, Brooks, & Lurigio, 2014). Thus, more research is needed to understand the implications of the ACA and Medicaid coverage for health care reentry needs of women offenders.

Barriers to Medicaid Enrollment

Although little is known about the barriers that women offenders face related to Medicaid enrollment, there have been some studies that have examined the factors and perceived Medicaid enrollment barriers for other populations. Stuber and Bradley (2005)

interviewed women primarily at several community health centers during clinic visits to assess if education, reported health problems, misinformation about Medicaid and the enrollment process served as a barrier to Medicaid enrollment. The study findings indicated that the Medicaid application process was cumbersome, having a physical health problem (including mental health needs), and a lack of education presented Medicaid enrollment barriers. Those respondents with prior experience related to the Medicaid program reported fewer barriers to enrollment. Those respondents who resided in States with a simplified process (including outreach and enrollment opportunities) reported being better informed about Medicaid enrollment (Stuber & Bradley, 2005).

Barriers to Addressing Health Care Reentry Needs

Several studies have indicated that there is a lack of coordination among the correctional system and community health systems to provide comprehensive health care in addressing the needs of all ex-offenders (Bechelli et al., 2014; Boutwell & Freedman, 2014; Cuellar & Cheema, 2012; Iglehart, 2014; Marks & Turner, 2014; Patel & et al., 2014; Regenstein & Rosenbaum, 2014; Rich et al., 2013; Somers et al., 2014). However, less research has focused on the needs of women offenders for health care reentry services, specifically Medicaid coverage.

Other researchers have found that policies need to be evaluated related to effectiveness for reentry programming and examining key aspects of the ACA such as Medicaid expansion may be an opportunity for reentry programs to assist with access to health care services (Binswanger et al, 2011; Cuellar & Cheema, 2012).

Salem et al. (2013) conducted a study to identify the gaps needed for homeless women ex-offenders related to successful reentry. The focus was on barriers to health care access including mental health and substance abuse to understand the roles played in recidivism that can be addressed by access to Medicaid coverage (Salem et al. 2013).

Opportunities for Further Research

Binswanger et al. (2011) suggested policies related to the physical and mental health of offenders does not provide sufficient reentry planning for the successful transition from incarceration to the community. Discharge planning and the connection with health care services and coverage in the community is critical for reentry because of the various health care needs that can be exacerbated if services and medications are not rendered to offenders (Ejike-King & Dorsey, 2014; Malave, 2014).

Cuellar and Cheema (2012) suggested additional research be conducted to impact policy about the opportunity for this vulnerable population to take advantage of the Medicaid expansion. Reentry programming staff can assist in Medicaid outreach and enrollment (Cuellar & Cheema, 2012).

Iglehart (2014) suggested jail-involved populations who have high rates of communicable diseases such as mental health conditions, substance abuse disorders, or chronic conditions, often reenter their communities without health care coverage. Collaborations between community health organizations and correctional agencies provide the opportunity for Medicaid enrollment and access to health care (Iglehart, 2014). Understanding the experiences of women offenders can provide further insight into the needs of this vulnerable population.

Regenstein and Rosenbaum (2014) suggested that correctional facilities might lack the capacity to provide enrollment services. Patient navigators have been used in jail settings for individuals impacted by HIV and drug use to assist in access to medical and social services. The patient navigators have been able to established connections and assist clients with appointments. Adapting this model could be used to assist women offenders enroll in Medicaid and have access to health care during reentry (Koester et al., 2014). States could target funding towards outreach and enrollment related to Medicaid in correctional facilities, especially jail settings. Also, simplifying the Medicaid enrollment process could eliminate this as a barrier (Stuber & Bradley, 2005). More research is needed to understand the impacts of public health policy, such as the ACA, on health care reentry needs of women offenders, specifically Medicaid coverage.

It is known that ACA provides the opportunity for Medicaid coverage to women offenders and several opportunities exist for correctional facilities, policy decision-makers, and community health care providers to provide comprehensive health. We also know that some women experience stigma against Medicaid coverage, lack access to care, have low health literacy with understanding Medicaid. However, what is unknown are the experiences of women offenders toward the Medicaid enrollment process during reentry while in jail. Also, there have been variations in the process of Medicaid enrollment such as the use of patient navigators, Medicaid enrollment specialist, and reentry staff members.

Summary and Conclusions

Currently, Medicaid enrollment under the ACA offers a great opportunity for women offenders to have access to Medicaid enrollment opportunities and coverage. Women offenders may have their Medicaid benefits suspended or in most cases terminated upon incarceration, however during the reentry process before release from jail, can be enrolled in Medicaid. The ACA policy impacts all incarcerated individuals. However, this study contributed to the literature and addressed some of these gaps such as what are jails doing, what are the health care reentry needs of women offenders, and their experiences with Medicaid addressing their health care needs. As a result, jails can be in a better position to target their Medicaid enrollment based on the experiences and needs of women offenders. This study also can impact social change as correctional facilities, policy decision-makers, and community health organizations begin to understand the issues women offenders face related to addressing their health care needs and health care coverage before release from incarceration. Also, the opportunity exists at this study site to educate women offenders on Medicaid coverage, ways to maintain their health, and accessing services and using their coverage upon release into the community. In this chapter, the current literature related to women offender health care related issues, the policies impacting these issues, and the need to understand their experiences with Medicaid coverage has been highlighted.

Chapter 3 provides a discussion of the methodology, study participant selection, data collection and procedures, validity, and ethical considerations used to address the gap in the literature related to this study.

Chapter 3: Research Method

Introduction

The purpose of this study was to understand the lived experiences of women offenders with Medicaid enrollment under the ACA to inform future policy decisions and practices. Previous literature in other studies related to criminal justice settings has addressed the various barriers to reentry, but few have examined the perspective of the women offenders during the reentry process related to health-care reentry needs such as Medicaid enrollment (Phillips, 2010; Herrschaft, Veysey, Tubman-Carbone, & Christian, 2009). This study was very timely and builds upon others studies to examine the successes and challenges of coordinating the health care reentry services (Binswanger et al., 2011; Fitzgerald et al., 2014).

This chapter will detail the research design and purpose, study participant selection, the role of me as the primary researcher, protections of the study participants, ethical considerations, informed consent and confidentiality, data collection, data management and analysis, and validity and reliability. Also, this study provided additional insight into a study population and topical area that has received little attention in the past.

Research Design and Rationale

The goal of the study was to understand the lived experiences of women offenders in a jail setting with Medicaid enrollment and obtaining coverage under the ACA. This study also addressed the following three research questions:

1. What are the attitudes of women offenders in jail settings toward Medicaid coverage under the ACA?
2. What are the experiences of women offenders in jail settings with Medicaid enrollment under the ACA?
3. What are the implications for women offenders in jail settings of Medicaid coverage under the ACA?

Correctional facilities have an excellent opportunity to intervene before the release of women offenders back into the community. Many of these women face challenges such as medical and psychological issues due to the lack of access to care before and after incarceration. Hammett, Roberts, & Kennedy (2001) suggested that providing interventions related to the health care reentry needs of offenders such as discharge planning, community linkages, and the consideration of the continuity of care offer opportunities to improve health outcomes. The central concept of this study was to understand the lived experiences and phenomenon of Medicaid coverage among women offenders utilizing a qualitative approach that can be useful in exploring social and real issues.

The two primary research methodologies used in the field of social research are quantitative and qualitative. For this study, the qualitative methodology was more appropriate. It allowed me to gain a better understand the participant's experience with Medicaid enrollment while in jail and attitudes toward Medicaid coverage. Fieldwork is a way in which I can place myself in the environment and examine individuals in the natural course of their daily activities and lives (Frankfort-Nachmias & Nachmias, 2008).

Phenomenology is useful in exploring social and human problems through the use of open-ended questions allowing study participants to detail their lived experiences (Creswell. 2007). Phenomenology focuses on the life history of a person, and through transcribed recordings of discussions, I studied the experience of the study participants (McNabb, 2013; Starks & Trinidad, 2007). For example, I chose phenomenology to obtain the personal narrative stories of women offenders related to the experience of Medicaid enrollment, which allowed me to understand the experiences in real everyday life settings (McNabb, 2013). The feedback received from women offenders may be valuable in understanding the implications of Medicaid coverage for health care reentry needs.

Role of the Researcher

My role in this study was to recruit study participants and understand their experiences utilizing interviews (Janesick, 2011; Phillips, 2010;). I interviewed women offenders to gain additional insight of the lived experiences with Medicaid coverage under the ACA (Patton, 2002a).

Understanding the policies of correctional facilities and having ongoing communication with the reentry program manager before the data collection period was proven to be beneficial. I served as the primary data collector for this study and building a rapport with the reentry program manager was important. I did not have any professional relationships with the study participants and, therefore, did not have any power over the study participants. The relationship with the reentry program manager was also strictly professional. The only interaction that I had with the study participants

was to describe the purpose of this study and recruit and interview study participants. Therefore, I did not have any influence on participation and responses received during the interviews (Miles, Huberman, & Saldana, 2014).

Most critical will be building a positive relationship with the women offenders (Patton, 2002a). Past experiences gained in interviewing incarcerated populations, related to sexual partner notification and counseling, was valuable in reaching the women offenders in this study. As a public health professional, I had previous experience designing a qualitative study with the assistance of a research team.

As mentioned before, my relationship with the reentry program manager, reentry staff, and women offenders, was strictly professional and did not present any issues. However, with any study, there is always the potential for researcher bias. My experience with a particular problem or population may present some sensitivity, and my interpretation of the study results could be biased. I provided full disclosure of any biases at the beginning of this study as a means of addressing any issues that would impact this study (Miles et al., 2014; Creswell, 2007). I managed biases by making my intentions clear for the study participants regarding why I was conducting this study, how the data would be collected, and what will happen to the data upon completion of this study. I set aside her experiences or biases, to the extent possible, to have a fresh viewpoint of the phenomenon also know as bracketing (Creswell, 2007). Also, I firmly adhered to the research questions as the guiding principle when conducting this study (Miles, Huberman & Saldana, 2014).

There are no other ethical issues, as I did not conduct this study within my work environment. Because the study population includes incarcerated individuals, financial incentives were not allowed. However, the reentry program manager informed me that non-financial approved and inspected incentives are permitted. I decided not to offer an incentive to reduce the perception of coercion.

Methodology

Participation Selection Logic

I interviewed women offenders at a jail in the state of Maryland. I held one in-person meeting at the proposed study site with the reentry staff team and conducted several conference calls with the reentry program manager to build rapport and maximize access to the study participants. This study was described in great detail to the reentry program manager and staff including any changes to this study. Before the selection of this site, there were two sites under consideration for this study. Site visits to both facilities were conducted to determine the feasibility of the site. After several discussions, it was decided that the jail would provide the best avenue to conduct a rich study due to the size of the female population and women-specific programs at the site.

This study focused on the experience of women offenders with Medicaid coverage; therefore, the sampling strategies for this study were homogeneous, criterion, and purposeful sampling. The study participants needed to women offenders in the jail that spoke English, as I am not bilingual. The study participants also needed to have a minimum of a 6^{th} grade education to be sure that they would be able to comprehend the informed consent form and interview questions for this study. They also could not be on

restriction according to jail policy. All study participants received the same interview questions to eliminate bias, and the data presents a more accurate account of the phenomenon since the study participants met specific criteria to detail the lived experience (Patton, 2002a).

Qualitative studies usually involve a small sample size so it was anticipated that a total of ten women offenders would be recruited and interviewed, but no more than 15 women offenders. As such, having a small sample size allows for saturation and gave me the ability to conduct in-depth interviews and collect data efficiently detailing the phenomenon (Creswell, 2007). I held a brief session no longer than 30 minutes with the women offenders to describe the study and seek the interest of the women offenders. If interested in participating, unique study identification numbers were utilized to keep track of the study participants. I met with the interested individuals to discuss what would be needed for participation, describe the informed consent process, and answer any additional questions. Of the qualified study participants, no less than ten but no more than 15 study participants would be selected randomly to reduce bias. Understanding the relationship that exists between saturation and sample size is necessary for qualitative research because conducting in-depth interviews of a small sample size allowed me to begin to gather data that support specific themes and categories to the point of saturation. Saturation occurs when no new information emerges from the in-depth interviews and no longer contributes to themes or categories (Creswell, 2007).

Instrumentation

There are several qualitative data collection methods. However, this study used standardized open-ended interviews. Several questions can be asked related to phenomenology such as what is the meaning of a person's experience and how do they cope with the phenomenon (McNabb, 2013). To establish sufficiency of data collection instruments, I examined peer-reviewed literature and published qualitative dissertation studies to develop a standardized open-ended interview protocol. The selection of these instruments provided a voice for women offenders to elaborate and share their experience and allowed me to answer the study research questions.

Interviewing allowed for open-ended questions as opposed to the use of surveys, which would have involved closed-ended questions (Creswell, 2007). Four different types of interviews are available when using qualitative methods that include informal conversations, an interview guided approach, closed and fixed responses, and standardized open-ended interviews. All methods allow for opened ended questioning; however, there are differences. The informal conversations do not utilize an interview protocol to guide specific questions so there may be variation in the study participant responses as they answer questions that are not predetermined (Patton, 2002b). An interview-guided approach allows me to develop specific questions and asks study participants the same questions. The interview guided approach limits flexibility in the study participant's response compared to the informal conversations. The closed and fixed response interview is limited because questions are predetermined, and categories are already determined. The data can easily be analyzed. However, themes are often consistent only if the responses fit into the predetermined categories (Creswell, 2007).

The standardized open-ended interview is somewhat structured, and the questions are asked the same and in the same sequence for each study participant. However, the questions are broader and allow the study participants to elaborate beyond the specific question as needed. This approach can reduce interviewer bias, and various themes may emerge depending upon the responses from the study participants. For this study, I identified three published dissertation studies that guided the development of standardized open-ended interview questions and the interview questions were the same and asked in the same sequence for all study participants. However, study participants were given the opportunity to elaborate and provide further details as needed with similar probing questions (Miles et al., 2014; Janesick, 2011; Patton, 2002a). Also, one-on-one interviews were beneficial for the women offenders because they were able to express themselves without the fear of having to disclose sensitive information in a group setting (Binswanger et al., 2011).

Researcher-Developed Instrument

Although research was limited in the particular focus of this study, I reviewed peer-reviewed literature and other dissertations that examined various aspects of the reentry experiences of women offenders to develop the study instrument (Binswanger et al.; Phillips, 2011; Herrschaft et al., 2009). Also, I was able to identify a peer-reviewed qualitative study examining the impressions of abortion costs and the availability of Medicaid coverage for low-income women. The guiding principles used in the development of the interview guide related to the knowledge of Medicaid policies on abortion, enrollment and remaining in health insurance, attitudes related to current

abortion laws, and experiences gaining and paying for abortion (Dennis, Manski, & Blanchard, 2014). Input in the development of this guide was received from the dissertation committee method expert and the reentry program manager to ensure readability for the study participants (Binswanger et al., 2011). Lastly, if more detail was needed for data analysis, I asked structured, probing questions (McNabb, 2013).

I linked the open-ended interview questions to the theoretical framework, Andersen's behavioral model, focusing on enabling factors that foster service utilization and the influence of health policies on access to health care (Babitsch, Gohl, & Von Lengerke, 2012). The following questions were asked of the women offenders during the standardized open-ended interviews conducted at the jail:

1. What does Medicaid coverage mean to you?
2. What is your attitude towards the opportunity to have access to Medicaid enrollment in jail before release?
3. What has been your experience with Medicaid coverage under the ACA while in jail? (Prompt questions: access to affordable services such as women wellness exams, substance abuse services, and mental health services.)
4. Access to health care insurance is important, so have you met with someone to discuss Medicaid enrollment upon reentry or release from incarceration? If so, tell me about this experience/process and the type of support you have received? (Prompts: Programs, access to patient navigator, healthcare enrollment specialist, women-specific programs).

5. What do you perceive to be the facilitators (or working well with) to Medicaid enrollment while in jail? (Prompts: A person who is dedicated to Medicaid enrollment, forms available, easy to understand)
6. What do you perceive to be the barriers (or not working well with) to Medicaid enrollment while in jail? (Prompts: Forms complicated, no ID, not interested in Medicaid enrollment, not organized or consistent)
7. How do you think these barriers/facilitators to Medicaid enrollment will influence your access to health care when released from incarceration?
8. Are there any health concerns that you feel can be addressed by having Medicaid coverage upon release from incarceration? If so, please identify these health concerns?
9. What is your level of comfort that you will be connected with the appropriate community health organizations to receive the services to meet your health care needs?
10. Is there anything else you would like for me to know that we have not already addressed in this interview?

These interview questions were instrumental in obtaining the information needed for this phenomenological study.

Taking into account for this qualitative study that I developed the instrument and the threat of researcher bias, content validity needed to be established. Therefore, I ensured that the member checking and peer debriefing occur before, through the data collection, and analysis phases of this study (Creswell, 2007). The quality and selection

of the data collection tool could be a potential for bias. However, I carefully selected the data collection tool in consultation with the dissertation committee and the site (Patton, 2002b). I also engaged in intensive interviews to collect rich data that was detailed and varied. Verbatim transcripts were used along with detailed field notes (Maxwell, 2013). Also, I remained current and reviewed any laws related to the ACA and Medicaid coverage that could impact Medicaid enrollment at the site that could impact the interview questions and this study.

As mentioned earlier, to establish sufficiency of data collection instruments, I examined peer-reviewed literature and published qualitative dissertation studies to develop the standardized open-ended interviews. This approach allowed for elaboration of the experience and provided a voice for women offenders to share their experiences and address the study research questions.

Procedures for Recruitment, Participation, and Data Collection

The data collection period took place shortly after IRB approval and for 1 month. The interviews were conducted in a private area of the jail that had minimal distractions and offered privacy. I discussed if there was a mandate for an officer present in the room with the reentry program manager and it was not required. However, an officer was present right outside of the room. I was also assured that staff members were responsible for maintaining the confidentiality of the women offenders at the jail at all times. I discussed with the reentry program manager what steps could be taken to ensure privacy during data collection to minimize the knowledge that eligible women offenders are participating in this study. The reentry program manager advised me that women

offenders have several individuals from the outside that come in for various reasons/appointments and it would not be odd for this type of visit related to this study. Since this study did not involve the collection of sensitive information such as sexual/emotional abuse or criminal history, psychological harm was minimized. I conducted interviews with the study participants that lasted no longer than 30 minutes. The data collection method was in-depth and semi-structured recorded interviews to allow for a rich collection of data. To record additional data captured during this study, I maintained a research journal. Journaling was accomplished before and after the interviews to capture my feelings and thoughts related to each interview. Journal entries were also useful for the coding process during data analysis (Janesick, 2011).

The interview protocol included two instruments: standardized open-ended interview questions and an informed consent form that was fully discussed with the study participants, and informed consent was reiterated at the conclusion of the interviews. Study participants were also given the opportunity to withdraw at any time from this study and were reminded of confidentiality through this study (Creswell, 2007). I served as the primary investigator, and the study participants serve as co-researchers as we explored the phenomenon.

All interviews utilized digital technology through audio recordings and the study participants were provided with a study number. This approach allowed me to accurately capture the data for playback and analysis (Creswell, 2007). Also, before the start of each interview, the equipment was tested for functionality (Janesick, 2011).

If too few study participants were recruited due to various dropout reasons, I agreed to work with the reentry staff manager promptly to identify additional eligible study participants. However, I was responsible for the recruitment of the study participants to reduce perceived coercion by reentry staff.

Upon completion of the interviews and once the recording stopped to conclude the interview and before exiting this study, the study participants were asked if they had any final questions or concerns related to this study. The study participants were debriefed about the purpose of this study and how the study results would be utilized. The study participants were informed of the ability to withdraw from this study at any time and assured of confidentiality (Creswell, 2007). There were no follow-up procedures established or follow-up interviews largely because I was not certain if all of the study participants would be available for follow-up interviews due to varying jail times and release from the jail.

Data Analysis Plan

The interview questions were written to elicit detailed responses from the participants that would help answer the three research questions in this study. The interview questions addressed the questions and are located in Table 1.

Table 1

Research Questions and Specific Interview Questions

Research question	Interview question
1. Attitudes towards Medicaid coverage under the ACA among women offenders in jail settings.	1, 2
2. Experiences with Medicaid enrollment under the ACA among women offenders in jail settings.	3, 4, 5, 6

3.	Implications of Medicaid coverage under the ACA for women offenders in jail settings.	7, 8, 9

I organized the data according to phrases and then developed them into a cluster of themes or categories. I used qualitative data software such as NVivo, to analyze the data through the use of coding and theme techniques. Also, I employed basic data analysis methods such as Post-It notes to hand code the data. Other computer software packages were used to include Microsoft Word that was password-protected (Creswell, 2007).

Data storage was password-protected on a portable drive, laptop, and voice recorder. The jail did not require me to provide access to the data and audio recordings of the interviews. The data will be stored at a minimum of 5 years following the research study.

I was aware that there might be discrepancies in the data collected and thoroughly examined the supporting and discrepant data before making a decision to exclude or modify any data. I sought feedback as needed from the dissertation committee to check for any issues in interpretations and methods. The other alternative was to report the discrepant data to the study participant for clarification, however, because there would be no follow-up in this study, this alternative was not utilized (Maxwell, 2013).

Phenomenological studies also employ themes translated into meaningful statements within the narrative, and several common themes emerged from this study related to the research questions based on the coding. The themes analyzed and coded are presented via narratives with quotations to support the data. Figures and tables were also

used. Through this qualitative data analysis technique, a final summary of the lived experiences of the study participants in this study related to the experiences of women offenders with Medicaid coverage and enrollment under the ACA emerged (Creswell, 2007).

Issues of Trustworthiness

It was imperative that I developed a relationship with the study participant and the study site. In return, the study participants felt comfortable providing honest and detailed responses to the research questions (Creswell, 2007). The reentry manager at the study site made arrangements for me to meet the study participants before the onset of the interviews. During this time, questions related to the study were answered and the study process was explained.

According to Trochim (2006), a qualitative researcher uses the following terms to address internal and external validity and issues of trustworthiness: credibility (internal validity); transferability (external validity); dependability (reliability); and confirmability (objectivity).

Credibility allowed me to ensure that there is congruity between the study participants experience and my interpretation. I used reflection to establish credibility by repeating the study participants' responses back for clarification and agreement as well as member checking during the interview (Trochim, 2006).

Transferability allows me the ability to generalize or apply the study findings in other situations and context beyond the scope of this study. I have described the research

and assumptions; however, researchers who want to generalize this study are responsible for making a judgment in the transferability of the study findings (Trochim, 2006).

Dependability allows others to replicate this study and refers to the consistency related to this study and inquiry process. I highlighted any changes made during this study so other researchers could replicate the study. To ensure dependability, I provided the details of how this study was conceptualized, data collection and analysis, and reporting of the results changes (Trochim, 2006).

Confirmability allows me the opportunity to confirm the results with others (Trochim, 2006). Also, I used data triangulation to compare and crosscheck the consistency of the data to include interview transcripts, researcher's notes, and observations to validate and support the research findings (Creswell, 2007).

Receiving outside feedback related to the interpretation of the study participant data is important. In certain environments, study participants can provide feedback related to the interpretation of the findings of the study increasing the trustworthiness of the data (Creswell, 2007). In the event, as was the case in this study, a study participant is unable for whatever reason to review the interview transcript, I sought the input and guidance from the dissertation committee to ensure that the methods and interpretations cross-referenced.

Ethical Procedures

E-mail exchanges, in person discussions, and verbal conversations took place granting me access to the study participants at this study site. The reentry manager

reviewed and sent forth a letter of cooperation to jail director and it was signed and granted me the ability to conduct this study at this site.

Women offenders are a vulnerable population, and I ensured personal risk was minimal. For example, because of past criminal activity, no questions about criminal activity or sentencing were asked. This study focused specifically on addressing the three research questions and answering the standardized open-ended interview questions unless the offender opts to provide additional information on her own. However, study participants were informed before the start of the interviews that if any information related to criminal activity was disclosed, I was mandated to report the information.

The women offenders reviewed a detailed overview about this study, confidentiality, and any potential risks. I gave study participants the opportunity to ask any clarifying questions, as needed. I ensured the autonomy of the study participants to protect their vulnerability and assure the study participants that the study data would be confidential. Study participants were also informed of their right to withdraw from this study at any time and their right to confidentiality (Creswell, 2007). Also, study participants were reminded of their right of refusal to answer any questions that make them feel uncomfortable. There was one informed consent form provided to the study participants for signature to participate in the research and to provide rights to me related to the use of audio recordings. The informed consent provided guidance on the best way study participants could reach me if there were any questions about the research. After receiving guidance from a research ethics support specialist at Walden, I was advised that I could remove the data collected and signed informed consent form by shredding and

deletion of the audio recordings, in the event that a study participant wants to withdraw from this study at any time and did not want any of the data collected to be used for analysis. However, if the study participant decided to withdraw from the study after some data was collected, I could ask the study participant if the data collected thus far could be used. If the study participant agreed to allow me to use the data collected then the data and the signed inform consents form would be retained for use in the study.

The Institutional Review Board (IRB) review is critical and ensures the protection of all subjects in this study. I received approval from the Walden Institutional Review Board, No. 09-27-16-0360485.

I was cognizant of potential ethical concerns and reviewed the Walden IRB resources related to working with vulnerable populations who require additional levels of protection. However, any undue influence was minimized to the greatest extend possible. I worked with the reentry program manager to minimize the breach of confidentiality, any potential coercive elements, and any psychological harm to the women offenders for this study (e.g., policies prohibiting the removal of data from this study site, listening to audio recordings, and reviewing written notes.). It was restated several times that at any time a study participant could refuse to participate in this study. If this happened, I would work with the reentry program manager to identify additional study participants who qualify for this study if more study participants are needed and I would do the recruitment. If a study participant had an adverse response during the data collection period for any reason that may be harmful to herself or me, the reentry program manager or designee would be immediately notified, and the interview would conclude. The

reentry program manager in consultation with me could determine if the study participant was eligible to return to this study.

There were no other ethical issues, as I did not conduct this study within my work environment. Because the study participants were offenders, financial incentives were not allowed. However, as mentioned earlier in Chapter 3, the reentry program manager informed me that non-financial approved and inspected incentives were appropriate and could be provided to the study participants. I decided against offering an incentive as described earlier in this chapter.

Summary

Chapter 3 provided an introduction and justification for this research study purpose, design, and rationale that was to understand the lived experiences of women offenders with Medicaid enrollment and attitudes towards Medicaid coverage. The chapter provided detail related to the research design, my role as the researcher, methodology including study participant selection, data collection instruments and management, and data analysis plan. This chapter also provided specific details related to the rationale and choice of a qualitative phenomenological approach including the interview development process. I chose phenomenology to explore the perceptions of the participants through open-ended interview questions in a jail setting. The interviews were audio recorded and later transcribed using NVivo. I have addressed the issue of ethical considerations and trustworthiness including receiving IRB approval and maintaining confidentiality with vulnerable populations.

Chapter 4 will detail further the data collection process and describe of the study findings.

Chapter 4: Results

Introduction

In this qualitative study, I focused on the Medicaid enrollment opportunities offered to women offenders at the MCDOCR. The purpose of this phenomenological study was to understand the lived experiences of 11 women offenders with Medicaid enrollment and attitudes towards Medicaid coverage to inform future policy decisions and practices. This study was guided by the following three research questions:

1. What are the attitudes of women offenders in jail settings toward Medicaid coverage under the ACA?
2. What are the experiences of women offenders in jail settings with Medicaid enrollment under the ACA?
3. What are the implications for women offenders in jail settings of Medicaid coverage under the ACA?

In this chapter, I present the setting, demographics, results of the data collection and data analysis for this study.

Setting

The study site was a jail. I initially presented the study to eight women offenders, in a group, in the women's unit before I began data collection for the one-month period. However, over the duration of the data collection period I was able to recruit more participants for the study, which will be discussed later in this chapter. I introduced myself, described the purpose and procedures of the study, its voluntary nature, the risks

and benefits, informed consent, and confidentiality. After the presentation, no questions were asked. I provided a Letter to Participants with further information about the study.

An interview room in the women's unit provided a private location for the interviews. An officer was present outside of the room at all times due to the jail policy; however, the officer could not hear the conversation. The reentry program manager in consultation with the women's unit manager determined it would be best to conduct the study on Friday afternoons when the women had more availability.

Demographics

For this study, I did not use a demographic study questionnaire, as this data collection tool was not relevant to the study questions and would not add any value to the study design. However, using homogenous and purposeful sampling methodology to recruit study participants, all study participants were women offenders and ages 18 and older. I used random selection and purposeful selection to ensure credibility for this study. Any woman offender interested in participating in the study who was not on confinement was eligible to participate.

Data Collection

I conducted this study using face-to face in-depth interviews with each of the 11 study participants in an interview room provided by the jail with the officer located outside of the interview room. The data collection period was for one month, however the study was introduced on a Wednesday before the interviews began. The interviews were conducted on Fridays between the hours of 1 p.m. and 4 p.m. based on my recruitment efforts, availability and interest of the women offenders, and their Friday schedule.

Before each interview began, I explained the inform consent form and obtained a signature before turning on the audio recording to capture the data. I also reminded each participant of her right of refusal at any time during data collection. Each participant was assigned a participant number (e.g., P1, P2, P3), which was recorded in the research notes, filename of the audio recording, and transcripts, to ensure confidentiality.

Each interview lasted no more than 30 minutes and was audio recorded with written consent from the participant. In addition to audio recordings, I took handwritten notes after each interview to capture things occurring outside of what was recorded in the transcript such as body language and gestures. There were no unusual encounters during the interviews, and all study participants were willing to share their perceptions and experiences in detail related to the research questions and ten interview questions. Some study participants provided their thoughts on questions that were not necessarily applicable to them, however, discussed what they heard others say in the jail that related to specific interview questions. I did have to use some prompt questions to receive complete answers and obtain clarification related to the responses. I initially thought many women would be interested in participating in the study, but that was not the case. However, after seeing me at the jail on Fridays and building rapport, other women offenders became interested and participated. Either because of word of mouth from other women offenders who participated and offered encouragement, out of curiosity, or me simply reminding them how valuable their thoughts and perceptions would be for this study. At the conclusion of each interview, I asked the study participant if there were any additional thoughts that they would like to share before I stopped the audio recording.

Data Analysis

I used the audio recordings and the detailed transcriptions to begin data analysis. I coded all 11 transcripts based on the responses received from the study participants. To maintain confidentiality, I used the term "P1, P2, P3, etc." when referring to each participant. I used a program called "Dragon Dictates" to help me transcribe the interviews to save time. The software was trained to recognize my voice, so as I listened to the audio recordings I would repeat the participant's words and the software transcribed my voice into text. I repeatedly reviewed the audio recordings to capture all words spoken by the study participants including slang, diction, and gestures (such as the sound of a laugh or frustration). I also reviewed the transcriptions on several occasions to ensure that I was familiar with the data before data analysis.

I used the three research questions in the dissertation proposal and one of the major components (enabling factors) of the Andersen's Behavioral Model of Health Services Use to guide the data analysis (Babitsch, Gohl, & von Lengerke, 2012). IQ1 and IQ2 addressed research RQ1, IQs 3, 4, 5, and 6 addressed RQ2, and IQs 7, 8, and 9 addressed RQ3. Data from the 11 interviews was initially coded and placed in tables using Microsoft Word that was later used to create nodes (parent and child nodes) in NVivo for further analysis. The process of hand-coding in Microsoft Word and coding through NVivo was useful in moving inductively from smaller coded units to larger categories and themes. The coding process is important to organize smaller coded units into categories and themes based on the participant's experiences and perceptions (Saldana, 2009).

The three primary themes identified from data collection were: (a) Purpose of Medicaid coverage; (b) Medicaid enrollment opportunities; and (c) Medicaid enrollment barriers and facilitators related to the experience. These themes are described in Table 2.

Table 2

Summary of Primary Themes

Primary Theme (Parent Node)	Description
Purpose of Medicaid coverage	Understanding of the purpose and benefits of Medicaid coverage
Medicaid enrollment opportunities	Perceptions of being offered enrollment opportunities or lack thereof
Medicaid enrollment barriers and facilitators	Perceptions of barriers and facilitators that exist or could exist related to the experience

Theme 1: Purpose of Medicaid coverage. IQ1 captured the perceptions related to this theme, and all 11 study participants provided their perceptions about the purpose and benefits of Medicaid coverage. Secondary themes that emerged included providing access to health care; coverage for hospital and surgeries; coverage for mothers and babies; and coverage for people with limited resources as indicated in Table 3.

Theme 2: Medicaid enrollment opportunities. IQ2 captured the perceptions related to Medicaid enrollment opportunities (*note that this is different than the experience which is captured in Theme 3*) and all 11 study participants responded. The secondary themes were coded at positive perceptions; negative perceptions; and neutral perceptions as indicated in Table 2. Nine of the 11 study participants had favorable attitudes towards Medicaid enrollment opportunities that included Medicaid enrollment

being a good program especially for those who need insurance to cover care and bridge the gap for incarcerated individuals. One of the 11 study participants felt knowledgeable about Medicaid and did not see Medicaid as positive or negative service, and one of the 11 study participants saw it as negative service and felt it was dumb and pointless.

Theme 3: Medicaid enrollment barriers and facilitators related to the experience. IQ4, 5, 6, and 7 captured the perceptions related to the barriers and facilitators that exist or could exist to Medicaid enrollment experiences while in jail during reentry. The secondary themes related to the barriers included language proficiency; denied coverage; poor health literacy and lack of understanding of health information; and the lack of identification (ID) as indicated in Table 3. The secondary themes related to the facilitators included assistance with enrollment forms; translators; how-to-videos, being treated with respect; and group settings as indicated in Table 3. In addressing IQ4, three of the 11 study participants had ever met with someone to discuss the opportunity to enroll in Medicaid. Seven study participants had not met with someone either because they were not offered the opportunity or had insurance and one study participant was offered the opportunity but declined because she felt she had the knowledge to enroll on her own when she was released. As mentioned earlier in Chapter 4, funding for an enrollment specialist was reduced at the jail and could have impacted the number of women who were offered the opportunity to discuss Medicaid enrollment.

In addressing IQ5, 8 of the 11 study participants provided their beliefs of what was working well or could work well (facilitators) with Medicaid enrollment while in jail. These facilitators included assistance with enrollment and forms, having a translator

to assist with literacy and language barriers, being treated with respect, and providing a group setting and how-to videos. One study participant said she had no comment, one study participant said she did not know, and one study participant said everyone should be eligible and able to enroll. I did not code this last response since it did not address this question. In addressing IQ6, 8 of the 11 study participants provided their beliefs of what was not working well or would not work well (barriers) with Medicaid enrollment while in jail, for example, language, being turned away, literacy, and lack of an ID. Three of the 11 study participants had no response to this question. However they also indicated that they had not met with an enrollment specialist while in jail. It is important to note that some study participants regardless if they met with an enrollment specialist or not, still provided their perception of what a facilitator or barrier would be with respect to the Medicaid enrollment experience while in jail. Their perceptions were based on what they had experienced or had heard from other women offenders in the jail. I included the data to inform future practices related to Medicaid enrollment experiences because this study focused on the perceptions of women offenders and Medicaid coverage and enrollment while in jail.

Table 3

Secondary Themes

Primary theme (parent node)	Secondary theme (child node)
Medicaid coverage purpose	Providing access to insurance for health Providing coverage for hospital visits and surgeries Providing coverage for mothers and babies Providing coverage for people with limited resources

Medicaid enrollment opportunities	Positive perceptions Negative perceptions Neutral perceptions
Medicaid enrollment barriers	Language proficiency Denied coverage Poor health literacy and lack of understanding of health information Lack of proper identification (ID)
Medicaid enrollment facilitators	Assistance with enrollment and forms Providing a translator "How-to videos" instruction Being treated with respect as a person to address stigma Group settings fore Medicaid enrollment assistance and instruction

Evidence of Trustworthiness

To ensure credibility, I used reflection and asked clarifying questions if I was not certain what was meant by the participant's response for agreement. To ensure the highest level of transferability, this study contained rich and detailed accounts of the participant's experiences and perceptions to generalize the study findings in other situations and context beyond the scope of the study. To ensure dependability, I highlighted in this chapter, any changes made or observed during this study, as well as provided details of the conceptualization, data collection and analysis, and reported any changes in the results. To ensure confirmability, I used data triangulation to compare and crosscheck the consistency of the data. I reviewed the audio recordings several times and compared it to the transcripts throughout data analysis. Due to the shorter time spent in jail, some of the study participants were released upon my return limiting the ability for

future interviews. Therefore, I did not factor in the study participants reviewing their transcripts after the interviews or before data analysis to ensure consistency and fairness. The member checks consisted of me reviewing the audio recordings several times, transcribing the participant's actual words to the best of my ability, and paraphrasing and summarizing the information for accuracy of the data collected. I also sought input and guidance from the dissertation committee to ensure methods and interpretations were cross-referenced.

Results

This qualitative phenomenological study describes the lived experiences of women offenders with Medicaid enrollment under the ACA while in jail as a reentry service. Through data collection and analysis, I asked 11 study participants to provide detailed responses to ten research questions (Appendix C) related to her perceptions and experiences with Medicaid coverage and enrollment while in jail during reentry. The study participants were very vocal and informative, and the overall perception is that Medicaid enrollment is needed and necessary for women offenders in jail as a health care related reentry service. This section describes the findings and is organized by the following five categories, which represent the ten interview questions that addressed the three research questions: (a) Purpose of Medicaid coverage; (b) Attitudes towards Medicaid enrollment opportunities while in jail; (c) Barriers and facilitators to Medicaid enrollment while in jail; (d) Health concerns that could be addressed by access to Medicaid coverage; and (e) Linkages to community health organizations upon release.

Purpose of Medicaid Coverage

It was important to understand if the study participants were familiar with the purpose of Medicaid coverage and the ACA. Nine of the 11 study participants were familiar with Medicaid coverage, and two of the 11 study participants indicated they did not know about Medicaid coverage. Three of the 11 study participants never heard of ACA. The overall perceptions for most study participants that emerged as secondary themes included the benefits of Medicaid such as providing access to insurance for health; coverage for hospitals visits and surgeries; coverage for moms and babies; and coverage for people with limited resources. Below is a sample of responses that addressed this category.

> P1**:** It helps people who cannot afford personal insurance or health coverage. It is a good program for mommies who cannot take their babies to the doctors.
>
> P2**:** Well insurance that's what I know. Meaning insurance for health, well to cover your medicines and things like that.
>
> P5**:** you have insurance for you for you to cover medical bills or anything while you at the hospital or injured in a car accident.
>
> P10: I used to have Medicaid coverage for surgeries, hospital bills, and emergency room visits and a lot of things.

Despite most of the study participants being familiar with Medicaid coverage, two of the 11 study participants felt that Medicaid coverage was not on the same level as private insurance and provided limited health care coverage.

> P3: It's subpar it is insurance but subpar to private insurance companies. I mean that it's not as inclusive, Medicaid or what I think or what my perception is that it

would not cover as many procedures, you might have less of a pool of doctors to choose from, and that is in particularly because Medicaid pays less to the doctors, and you probably will not be able to get top-notch physicians (*jail door slams on outside*) because it is a government run program.

P7: Poor people. That it's for poor people! And they just feel bad for us so they want to throw us some insurance… Private insurance is for people who have money you can pay for it. Medicaid is just something that I feel like the government wants to put out to try to make themselves look good.

Previous literature suggested that a lack of knowledge of health care insurance options might be a barrier to accessing care (Marks & Turner, 2014). , However, most of the study participants showed a willingness to share in detail what they knew about Medicaid coverage and demonstrated that they adequate knowledge of Medicaid and the ACA.

Attitude Towards Medicaid Enrollment Opportunities While in Jail

Most of the study participants were vocal about their attitudes towards Medicaid enrollment opportunities while in jail. The secondary themes that detailed their attitudes included: positive perceptions; negative perceptions; and neutral perceptions. Nine of the 11 study participants had positive perceptions towards Medicaid enrollment opportunities while in jail and the one study participant who felt "neutral" and did not need Medicaid enrollment assistance, thought others could benefit from the opportunity. One other participant thought that it was pointless and not needed at all. Three of the 11 study participants provided in-depth responses related to their positive perceptions (including

the study participant with a neutral response) that emphasized the importance of the opportunity, which is expressed below.

> P4: I think it is good because I do not know about Medicaid insurance and how to get it when I leave the jail. Insurance is important to me and my babies... Nobody talk to me about coverage and no experience with it.
>
> P8: It is awesome... For people who don't receive or have not previously dealt with doctors… A great reentry asset… Continue care… Bridge the gap.
>
> P10: Me personally, I didn't need any help, but there are some inmates who do need people to help them because they are not sure they don't know how to go about that or use their resources. People do not know where to go when released from jail.

Most of the study participants had positive attitudes and perceptions towards Medicaid enrollment opportunities and indicated that Medicaid was important to them. It is important to note that funding was reduced to support Medicaid enrollment assistance in the jail before the onset of data collection. Despite most study participants not having the experience of meeting with someone to assist with Medicaid enrollment (which I learned after asking this interview question), they still felt favorable towards the opportunity to be enrolled and encouraged it for all people who were eligible. The positive perceptions expressed by the study participants can be seen as a facilitator and could support the need for Medicaid enrollment opportunities, as there appeared to be minimal resistance to receiving this opportunity.

Medicaid Enrollment Experience While in Jail

Three of the 11 study participants indicated that they had met with an enrollment specialist and provided accounts of the experience.

> P5: I was happy; it was a good for me. I just seen things like what type of insurance group I was with, and me do I have a home to go to when I leave here and food stamps and stuff she was showing me her little paper with the options on it and stuff she was really organized and stuff and letting me know that she would help me and things. So yes I think on the lady out there. Ms. Joy she was talking to me about like if I need, what do I need help with on the outside like food stamps, and stuff, did I have insurance, did I have shoes, clothes and everything, and did I need help with the job and things like that.
>
> P8: I have had someone come talk to me but from my understanding, you have to be a resident in the state perhaps when you leave here. I talk to someone about it when I was here in early 2015 when I was waiting for … but I guess that's too much information (*then giggles*). I filled out a form and everything and I was covered when I left the jail but this time around I heard people say they had to have an address to send it to in in the county, so that's why I did not touch because I knew that I was not returning to county. It was a flyer up and it's actually an ongoing situation where you can put in a blue slip or a special form to talk with the Medicaid people and I just never like explored that option because in my mind I was told that you have to have a county address for them to send a card to so I kind of like chalked it up and said well I will just apply once I get out of

here. I am in a position to be able to fill it out the paperwork and if there are areas on the application that were difficult, it would be resourceful to help them out.

P9: I remember a few months ago somebody came here for insurance or insurance company, they signed up everybody's name that they knew didn't have any insurance. But my problem was that I didn't have any address outside so I asked them I need can you send it here but they said no you have to have an address outside, I didn't have access to an address, I told them one of my friends address but my friends said I didn't receive that. And yes the blue paper, so you need some… license or MVA, or some stuff like they gonna help you if you don't have ID…

One participant indicated that she met with the reentry worker but for other resources not related to health care. This participant indicated she was knowledgeable about Medicaid enrollment and the ease of getting enrolled on her own when released.

P10: There is someone, they've came to me and I have met with the reentry worker for other resources but not for health care because I know how to go about that. This past time when I was released I just went online and filled out the enrollment form and my information came in the mail the card everything for my son and myself. Nothing was difficult it was pretty easy it was pretty much self-explanatory, general questions.

The few study participants who met with an enrollment specialist expressed having a positive experience; but again, the reduced funding appears to have had an impact on the ability to offer this opportunity. The remaining study participants had not

met with an enrollment specialist. One study participant who had not had the opportunity to meet with enrollment specialist indicated her first time talking with anybody about Medicaid, since being in jail, was in the interview with me. Two other participants indicated that they were not offered Medicaid enrollment since they already had other insurance. One participant indicated she had not met with anyone and did not want to meet with anyone.

I was not able to ask about jail times to avoid disclosure of charges, therefore was unable to ascertain the length of time the study participants had been in jail. It appears that those who did not meet with an enrollment specialist entered the jail after funding for the enrollment specialist was reduced. Based on the responses related to the "opportunity for" and not "the experience" of Medicaid enrollment, many of the study participants were interested in meeting with an enrollment specialist. They felt it would have been beneficial if they had the opportunity to discuss and enroll in Medicaid because they really needed insurance upon release from incarceration.

Barriers and Facilitators to Medicaid Enrollment While in Jail

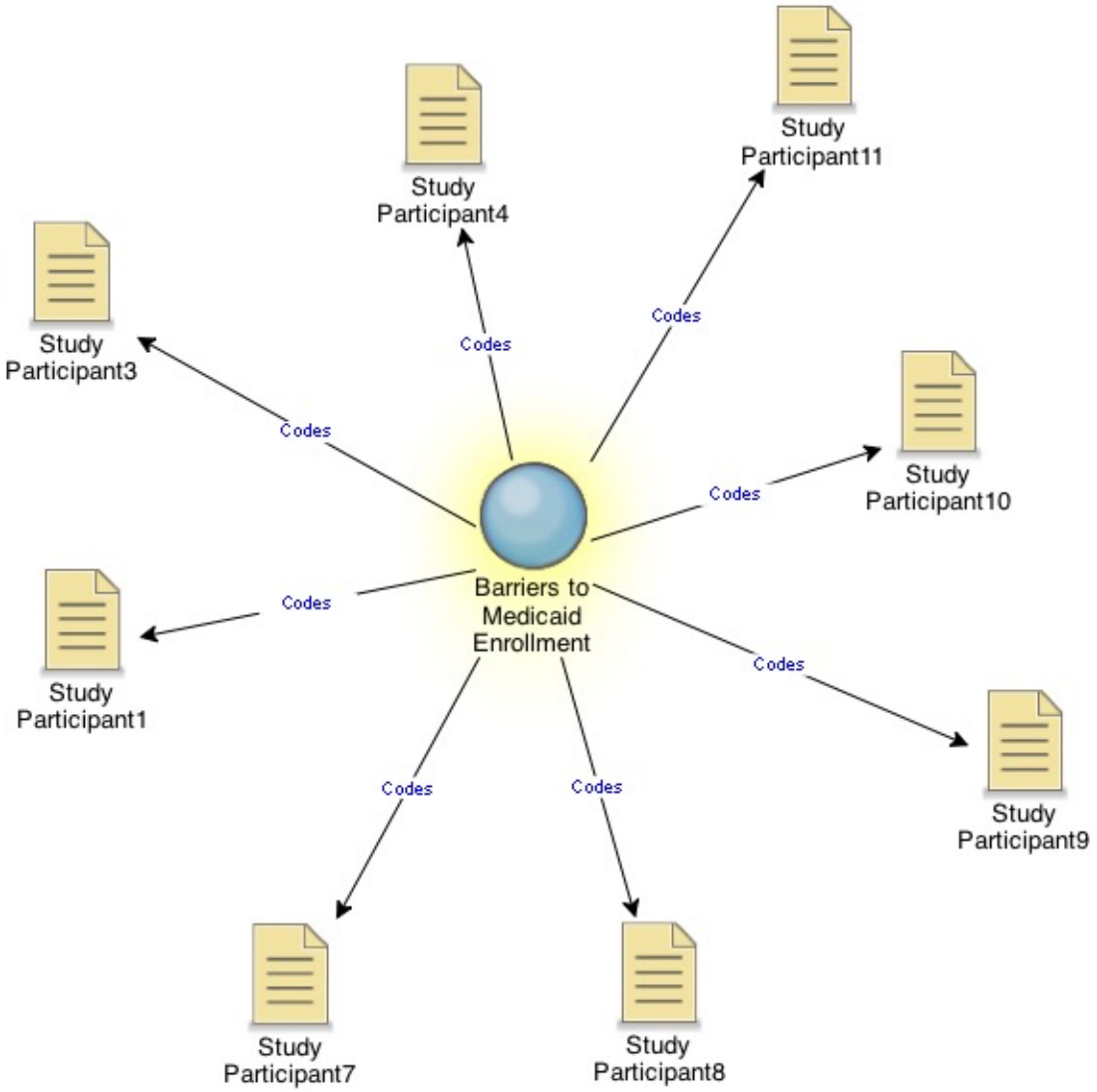

Figure 2. Node: Study participants who reported barriers to Medicaid enrollment.

Most of the study participants provided their beliefs of what was not working well or would not work well (barriers) with Medicaid enrollment while in jail as shown in Figure 2. Below are some of the responses:

P1: The struggle I see is many people get turned away very bad. I don't think nobody should be turned away like when them go for social services or apply for

Medicaid or whatever they need, they should not be turned away because they don't meet certain expectations of the people that's offering this program. So a lot of people come in here and they don't have identification. A lot of people weren't born in the state here like me I was born in Jamaica, come here when I was younger. But oh a lot of people have green cards or don't have green cards, they don't have ID, no home address, don't have a lot of things, but they need coverage. And then there are a lot of illiterate people that can't read nor write. So they are going to need help. A lot of people speak a foreign language and a lot of them would be too ashamed sometimes to reach out, but yeah in a situation like this, there should be one person of each nationality, and office like this one to translate for each person that, from different places like that so they can understand.

P4: Nobody come and talk to me about Medicaid insurance or coverage in jail and I have children.

P8**:** A lot of people come here and they don't have a home. They don't have a home to go to so, they don't have an address or they are here from another state and just got caught up. So they don't know if they can transfer it to another part when they go back to their original residence. A lot of people think that just because they have a felony, they are not eligible for Medicaid. So those are some of the barriers although some may be fabricated or some may be actual barriers.

P9: I didn't know that it was important because everybody forget about the people that are in the jail or they don't care about us. I'm a human being, because most of

them think we are animals, we are not animals we are human beings, we need everything. I was mad and I thought this government doesn't care about us, and nobody cares about us: the case manager or nobody, and you are here listening to us, but hopefully something good will happen in the future.

P10: It is a concern because some people do not have ID or an address. They are homeless or they don't have anywhere to go when they are released from jail or are on the outside. They do not even know that you can go online to apply for insurance.

The secondary themes related to Medicaid enrollment barriers are highlighted above in the responses to include**:** language proficiency; denied coverage; poor health literacy and lack of understanding of health information; and lack of proper ID. These findings are consistent with previous literature related to barriers that exist when considering Medicaid enrollment in correctional facilities.

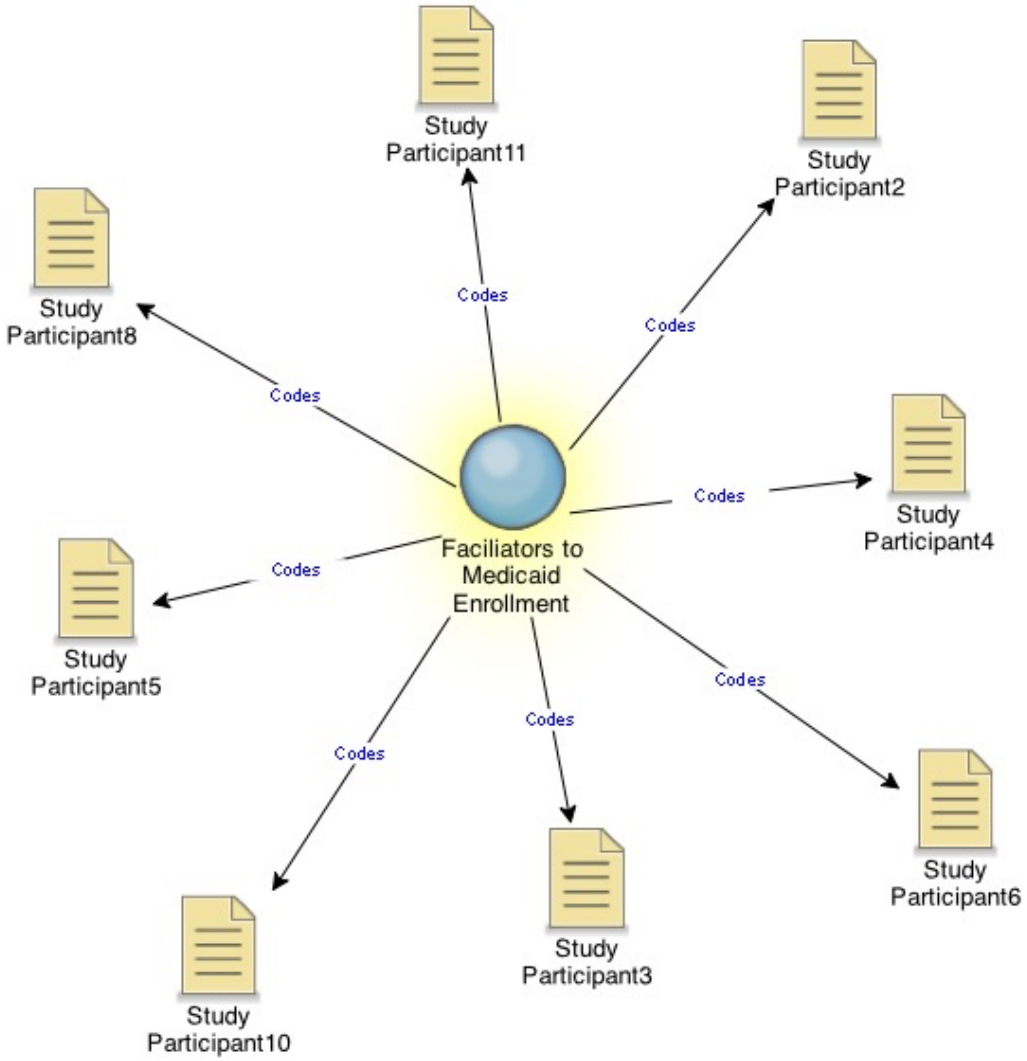

Figure 3. Node: Study participants who reported facilitators to Medicaid enrollment.

Most of the study participants also provided their beliefs of what was working well or could work well (facilitators) with Medicaid enrollment while in jail as represented in Figure 3. Below are some of the detailed responses:

P2: To be able to have help filling out the papers, the forms, because I know about Medicaid for my daughters and I had before for them but it is different because it is something separate from them so now I need more orientation about me. I

would need to know what the coverage is, where can I use the Medicaid, and what kind of medicine and who accepts Medicaid. I have a drivers license so getting and ID is not a problem for me. Because I had before with my kids I would want to know if they were going to give me the same ID number or something like that.

P10: Maybe bring in their laptop, sit down with that person or inmate, and show them how to apply. Maybe it should be someone who is directly dedicated to Medicaid, because they know more about it and reentry. They could say, “Here is how you get your GED,” and be more hands-on. Maybe have an application handy for me, maybe have examples of applications, a video on how to fill it out, because some people just don’t know.

P6: I would be able to understand the forms and not need assistance with that. However, having someone there at the jail to assist with enrollment would be beneficial.

P8: How soon would insurance be available? What are the different plans and PPOs, I mean HMOs that I could subscribe to? I guess how often do I need to re-certify and stuff like that? Also what does it cover? I would think just rather than having a flyer up, because sometimes some people don’t see a fly and it will skip their minds to go and apply and sign up for it just to have more so like an assembly where it’s I won’t say mandatory but it is more so in your face we are coming in to survey people you know to see if they want to sign up for health care you can sign up after we explained you know have a workshop where they are talking and engaging with you and allowing them to sign up after the conclusion

of the message or announcement versus outlier, you know I've seen a lot of flyers and I've signed up for a lot of things but they either, they never happen, or just didn't get scheduled, or it got pushed back, but instead of that I would say, an announcement like we have other assemblies in the main hall and have people sign up after.

P3: Well, probably because for some people you would have to have a Spanish-speaking specialist. So you need a translator, you need to read aloud because maybe some people don't read and say I will just pass on enrolling. I guess make it fun and important to the women. Explain that this is to benefit them and that they deserve it, they deserve to have good medical care.

The secondary themes related to Medicaid enrollment facilitators are highlighted above in the responses to include**:** assistance with enrollment and forms; access to a translator; providing how-to videos; being treated with respect as a person to address stigma; and providing group settings for enrollment assistance and instruction. Most of these findings are consistent with previous literature related to facilitators when considering Medicaid enrollment in correctional facilities. However, the study participants identified additional areas for consideration such as providing group settings for enrollment assistance and instruction, and using how-to videos to assist with Medicaid enrollment in the jail.

Health Concerns That Could Be Addressed by Access to Medicaid Coverage

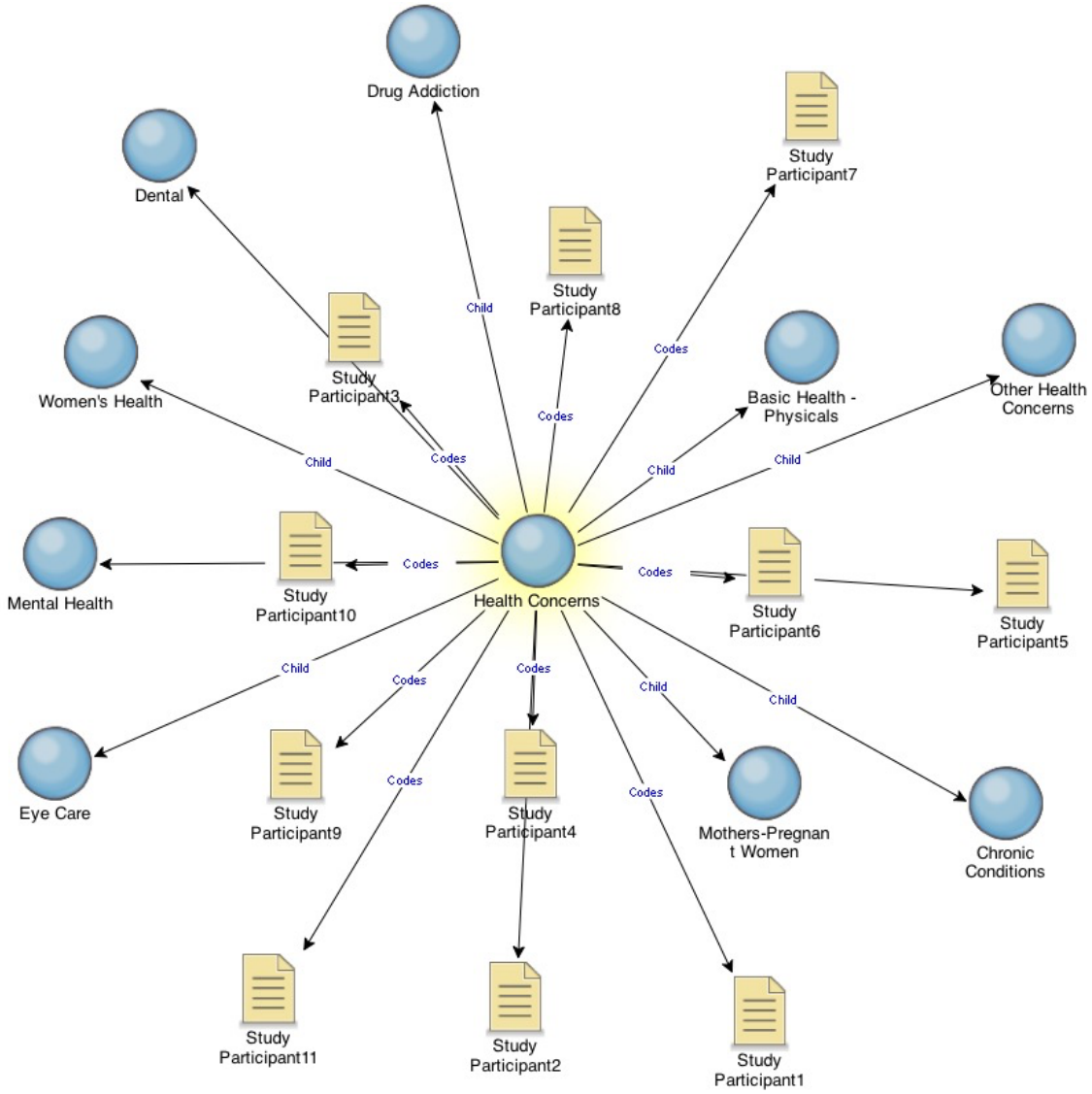

Figure 4. Node: Health concerns reported by study participants.

All of the study participants provided their perceptions related to health concerns that could be addressed by having Medicaid coverage upon release as represented in Figure 4. Although not shown in Figure 4, the primary child nodes that emerged were women's health (n=8), mental health (n=5), drug addition (n=5), and basic health – physicals (n=5). Women's health, mental health, and drug addiction have been reference

in previous studies, as being some of the greatest health care needs for women offenders. There were other child nodes identified by a few of the study participants, and one study participant indicated that maintain her dental work was important because she liked candy and everybody likes candy and has cavities. Another study participant indicated that eye care, and being able to get glasses, was important to her. Both study participants that talked about dental and eye care both felt that Medicaid did not cover these services but should. However, very few study participants mentioned mothers and pregnant women (n=3) as a health concern. When speaking of women health issues, most women referred to mammograms, well women visits, STIs, and gynecological care, but not related to pregnant women and mothers. This was an interesting finding especially since most of the women were knowledgeable about Medicaid providing insurance for mothers and babies. Lastly, "other health" conditions reported by a small number of study participants included needing specialized medical supplies for specific needs (e.g., dermatology, diabetes, and rheumatology). Very few study participants identified chronic disease such as heart disease, cancer, and diabetes, which has been known to be health challenges for women offenders.

Community Health Organizations Linkages Upon Release

Ten of the 11 study participants described their level of comfort to being linked with the appropriate community health organizations to receive services to meet their health care needs. Six study participants had negative perceptions, three study participants had neutral perceptions, and one study participant had a positive perception as represented in Figure 4. One of the study participants responded; however, the

response indicated a lack of understanding the question and therefore was excluded. Below are some of the thoughts and perceptions of the study participants.

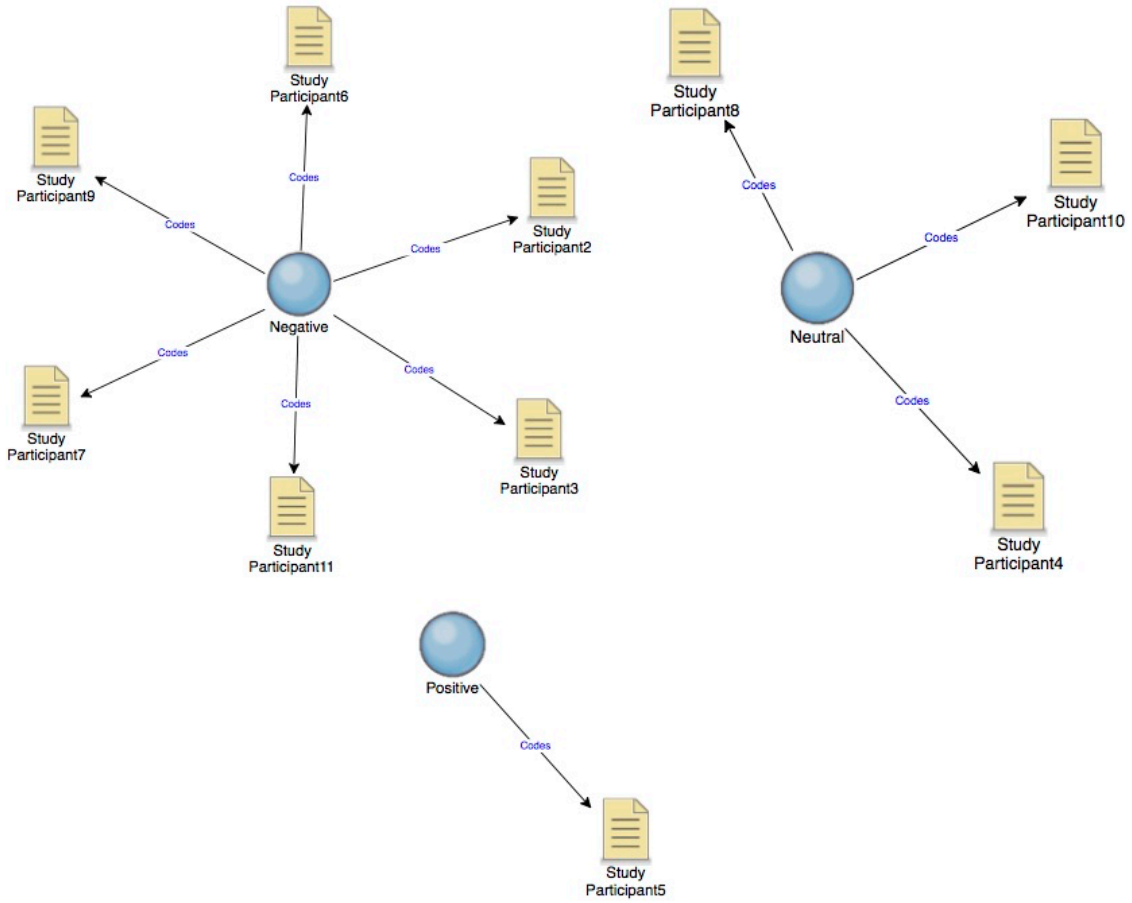

Figure 5. Node: Study participants' perceptions related to community health linkages.

P5: I would be linked with the appropriate community health organizations so that I could get the services that I need to take care of my health and be healthy with myself and then at the same time be able to take care of my mom.

P4: I really don't know.

P8: I would say both however, I have dealt with Medicaid on the outside or social services and also I'm going to be released through the reentry program so they actually liaison with me about a lot of benefit and community resources that I can use once I am outta here with the reentry cry then I can catch the bus. So I can get to those appointments.

P10: I wouldn't necessarily say they are doing a good job but I wouldn't say that they're doing a bad job either. They are just presenting the information and whether you go with it is upon you.

P2: Well now I am worried and thinking about I don't have insurance, if I received the help from Medicaid I would feel good. I would then have something that would help me then go to the doctor.

P3: I am skeptical that it would do very much because a lot of the perception here is that these people are just lost cause that it and the women feel it too… that they would care enough to make sure that when people you know when they are released, they have a basket full of tools that they can use in their comfortable with those tools, I am skeptical about that.

P6: I think they could do better

P7: I feel like it only applies to certain people… When I say that I feel like when they look at our files they be like oh I feel so bad for this person we're going to help them with all the resources that they need, you know, as some people they don't do as much for as they do for others, so I feel like it solely up to that like each person and what is it about their case in their file, etc. like me… I have

limited resources, but not too much seeing as if I don't plan to live here, so not really much I could do with it, but being as though somebody else would be interested, you are not offering it to them.

P9: That I don't think so is not that much information here they give us a little information but we need more information, for example myself and I go outside and I release from here, so my first concern is about my job, my place, my insurance, so I rather to have somebody help me from here to find out what can I do when I get release from here, and don't waste my time just find what I'm looking for, like I don't know where should I go what is the best place for me where is that I don't know, so I rather to have the information here, but nobody's here for telling us. Or give us information about this stuff.

P11: Not comfortable at all. Because they just do not keep up, if they are not caring for you when you come in it is no way they can help with resources on the outside. I am not even expecting them to.

It was an unexpected finding that 6 of the 11 study participants would have negative feelings about being linked to community health organizations upon reentry. The study participants highly stressed that they did not feel confident they would get the health care services they would need upon reentry into their communities. Previous literature suggests that a lack of coordination and linkages between reentry programs and community health organizations can be a barrier to positive health outcomes for incarcerated individuals. The responses received from the participants in my study support these findings.

Summary

Three emerging primary themes were identified based on the responses of 11 study participants: purpose of Medicaid coverage; Medicaid enrollment opportunities; and Medicaid enrollment barriers and facilitators related to the experience. Five categories were used to highlight the findings of this study: (a) Purpose of Medicaid coverage; (b) Attitudes towards Medicaid enrollment opportunities while in jail; (c) Barriers and facilitators to Medicaid enrollment while in jail; (d) Health concerns that could be addressed by access to Medicaid coverage; and (e) Linkages to community health organizations upon release.

Medicaid coverage was perceived by most of the women as important and needed. The 11 study participants had an adequate understanding of Medicaid coverage and all except one participant, expressed a favorable perception related to the value of Medicaid enrollment opportunities and that it was really needed especially for women offenders in jail. The secondary themes that emerged related to the purpose of Medicaid coverage included providing access to insurance for health, coverage for hospital visits and surgeries, coverage for mothers and babies, and coverage for people with limited resources. Many of the women had positive perceptions and adequate knowledge about the purpose of Medicaid coverage. However, two of the study participants expressed strong negative perceptions related to Medicaid. One study participant indicated that it was subpar to other types of insurance and did not cover quality health care and the other study participant indicated it was the type of insurance that the government just threw to poor people to make the government look good.

Most of the study participants had favorable perceptions towards Medicaid enrollment opportunities while in jail, despite only three women having the experience of meeting with an enrollment specialist while in jail. The other eight women, except for one, expressed that they would have liked to speak with someone about Medicaid enrollment. This was an unexpected finding that being able to meet with a Medicaid enrollment specialist was truly needed and desired by the study participants who had never had encounter with an enrollment specialist. Many of the women spoke about themselves as well as others, include male offenders, needing health care coverage and also indicated that the most consistent health care they received was while incarcerated. The ability to be enrolled in Medicaid while in jail seemed important for the study participants to maintain continuity of care received before, during, and after incarceration.

Medicaid enrollment barriers were identified as a primary theme and secondary themes included language proficiency; denied coverage; poor health literacy and the lack of understanding of health information; and the lack of proper ID. These perceived barriers support the literature that suggested that poor health literacy, the lack of documentation, and language proficiency are Medicaid enrollment opportunities. Medicaid enrollment facilitators were also identified as a primary theme and secondary themes. Study participants provided their perceptions of the facilitators to Medicaid enrollment such as assistance with enrollment and the forms; providing a translator; using how-to-videos; being treated with respect as a person to address stigma; and providing group settings for enrollment opportunities and instruction. Some of the study

participants felt that they should be treated with respect when being offered assistance with reentry services to include Medicaid. Although stigma was not mentioned directly, many of the study participants felt uncomfortable about asking about getting assistance for fear of not being treated like a respected person and that Medicaid was only for poor people or lacked resources. Previous literature indicated that stigma has often been seen as a barrier to seeking health care insurance as well as lack of understanding of the Medicaid enrollment process and forms.

Most of the participants reported several health concerns that could be addressed with access to Medicaid. Past studies have suggested that women offenders often experience substance abuse and mental health issues more than adult male offenders. It was not surprising that mental health and substance abuse was identified as primary health care concerns that could be addressed by Medicaid coverage. Most of the study participants felt that women's health was an important health care concern indicating that gender-responsive programming is still important and needed.

An unusual finding was that the study participants felt that basic health (e.g., physicals) was a priority health care concern. However, many did not identify mothers and pregnancy as a health concern. This could be that most of the study participants knew that Medicaid covers moms, pregnant women, and children, and other issues needed to be noted as important.

Six of the 11 study participants had negative feelings about linkages to community health organizations upon reentry and did not feel confident that they would get the health care services that they would need. This was an unexpected finding. One

participant even mentioned that she was not expecting them to provide linkages and she did not care. Previous literature suggests that a lack of coordination and linkages between reentry programs and community health organizations can be a barrier to positive health outcomes for incarcerated individuals and findings from this study suggests the same.

Lastly, when given the opportunity to indicate if they wanted to provide anything else or had any other concerns, another unexpected theme emerged related to health care received inside the jail. The study participants understood that this study was about the opportunity and experience of Medicaid enrollment but also expressed their perceptions of health care inside the jail. Several study participants expressed that they felt the care inside the jail was adequate and some even indicated it was the first time in a while that they had received health care services. However, many indicated that the care was often delayed and getting to sick call (e.g., emergency care) was often difficult.

In Chapter 5, I will present the interpretation of the findings, limitations of the study, recommendations for further studies, and implications for positive social change. I will also highlight the correlation of the study findings to previous literature and the conceptual framework used for this study.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

The purpose of this study was to understand a gap in the literature: the lived experiences of women offenders with Medicaid enrollment before being released from jail. Some studies have addressed different barriers to reentry in correctional facilities; but no research was found that examined the experiences of women offenders and their healthcare needs upon reentry, such as Medicaid enrollment (Phillips, 2010; Herrschaft, Veysey, Tubman-Carbone, & Christian, 2009). This study sought to provide additional insight for correctional facility leadership, community health organizations, and policymakers on the issues women offenders face when addressing their healthcare needs and healthcare coverage before release from incarceration.

Eleven study participants provided their perceptions about their experiences related to Medicaid enrollment and attitudes towards Medicaid coverage. Three research questions and ten interview questions guided the focus and findings of this study. The key findings of this study are organized by five categories: (a) Understanding the purpose of Medicaid coverage; (b) Attitudes towards Medicaid enrollment opportunities while in jail; (c) Barriers and facilitators to Medicaid enrollment while in jail; (d) Health concerns that could be addressed by access to Medicaid coverage; and (e) Linkages to community health organizations upon release.

Most of the study participants had an understanding of the purpose and benefits of Medicaid coverage and also had favorable perceptions of Medicaid enrollment opportunities. Despite only a small number of participants having experienced Medicaid

enrollment while in jail, most identified several barriers to Medicaid enrollment. However, the participants were able to (a) provide valuable insight into some of the facilitators that have fostered the Medicaid enrollment experience, (b) highlight key health concerns, and (c) recommend future practices. The findings overall suggested that Medicaid coverage and enrollment is important and it was desired by the participants at this jail.

Interpretation of the Findings

My interpretation of the study findings confirmed and extended what was found in the peer-reviewed literature. A qualitative study design allowed me to analyze the data into three primary themes: Purpose of Medicaid coverage; Medicaid enrollment opportunities; and Medicaid enrollment barriers and facilitators related to the experience. The findings related to the phenomenon and the research questions were presented in the five categories mentioned above, based on the perceptions of women offenders in a jail setting. I used NVivo to organize and code the data.

Marks & Tuner (2014) suggested that a lack of knowledge of health care insurance options could be a barrier to accessing care. However, all 11 of the participants demonstrated their knowledge and understanding of the purpose of Medicaid and the ACA. Secondary themes that related to the purpose of Medicaid included access to health insurance, coverage for hospital visits and surgeries, coverage for mothers and babies, and coverage for people with limited resources.

The ACA legislation has provided the opportunity for jail-involved individuals to be screened for coverage eligibility, maintain coverage, and be linked to community

health resources upon their release (Regenstein & Rosenbaum, 2014). Regenstein & Rosenbaum (2014) suggested that correctional facilities might lack the capacity to provide enrollment services. Nine of the 11 study participants had favorable attitudes toward Medicaid enrollment opportunities. However, only three study participants had the opportunity to actually meet with an enrollment specialist due to a reduction in funding before the start of the data collection period. This finding supports the literature that suggests one of the greatest transitional service needs reported by women offenders during pre-release interviews is public health insurance (Garcia & Ritter, 2012).

Eight of the 11 study participants reported barriers and facilitators to Medicaid enrollment while in jail and several secondary themes emerged. Riche et al. (2013) suggests that limitations to access to health care such as Medicaid enrollment can be linked to women offenders often requiring significant assistance in obtaining services upon reentry due to lower health literacy rates. Stuber and Bradley (2005) interviewed women primarily at several community health centers during clinic visits to assess if education, reported health problems, misinformation about Medicaid and the enrollment process served as barriers to Medicaid enrollment. Findings indicated that the Medicaid application process was cumbersome, having a physical health problem (including mental health needs), and a lack of education presented Medicaid enrollment barriers (Stuber & Bradley, 2005). Those respondents with prior experience related to the Medicaid program reported fewer barriers to enrollment. It was not surprising that the overall perceptions of participants in my study who did not have prior experience with Medicaid coverage supported the literature that barriers do exist related to Medicaid enrollment. Study

participants identified health literacy, language proficiency, being denied coverage, and the lack of proper identification as barriers to obtaining Medicaid coverage. However, to address some of these barriers, study participants identified assistance with enrollment and the forms, providing a translator, and being treated with respect as a person to address stigma as facilitators to obtaining Medicaid coverage.

The top health concern identified by the study participants was women's health. Cobinna (2010) suggested gender-responsive reentry services, access to health care and insurance are critical in the successful reentry of women offenders because of their unique health care needs. Female ex-offenders have unique and different needs (e.g., reproductive health care) compared to male ex-offenders that should be considered in reentry program planning (Cobbina, 2010). The study participants also identified mental health and drug addiction as important health care issues. However, without adequate insurance, they cannot access routine medical appointments and gain access to important screening tests and treatment of chronic diseases (Springer, 2010). This finding from my study also supports the literature that women offenders often experience greater rates of mental health challenges and addictions compared to their male counterparts and can benefit from access to behavioral health care through health care coverage (Cobbina, 2010; Malave, 2014).

Women offenders often lacked services needed to foster community reentry, and gender-responsive programs and services are needed for successful reintegration back into their communities (Brooks: 2014; Mallicoat, 2011; Herrschaft, Veysey, Tubman-Carbone, & Christian, 2009). Also, jail-involved women tend to be uninsured due to a

variety of reasons and the only consistent health care many receive may be while incarcerated (Fitzgerald, Cohen, Hyams, Sullivan, & Johnson, 2014; Malave, 2014; Marks & Turner, 2014). As a result, women offenders may have unmet health care needs and experience recidivism due to lack of health care coverage and coordination between the jail and community health settings (Malave, 2014; Marks & Turner, 2014). My study findings support the literature in that six of the 11 study participants did not feel confident that they would be linked to community health organizations. They also felt they would not have access to health care and unmet health care needs unless they received Medicaid enrollment assistance as a reentry service. Discharge planning and the connection with health care services and coverage in the community is critical for reentry and access to health care because of the various health care needs that can be exacerbated if services and medications are not rendered to offenders (Ejike-King & Dorsey, 2014; Malave, 2014).

The theoretical framework for this study was the Andersen's behavioral model and the adaptation of this model for vulnerable populations that has been used to examine both the individual and contextual determinants of health service usage. This model has three major components: predisposing factors; enabling factors; and need factors (Babitsch, Gohl, & von Lengerke, 2012). This study focused on the enabling factors component including the conditions that foster service utilization such as health insurance (e.g., Medicaid) and the influence of health policies on access to health care. Andersen (1995) suggested that community and personal enabling resources should be present

including health personnel and availability of facilities. If these enabling factors are available, then individuals have the means to access the services and utilize the services.

The perceptions of the participants in my study support this theory related to enabling factors and the impact on determinants of health service usage. As mentioned earlier, the funding for the enrollment specialist was reduced and 8 of the 11 of the study participants were not afforded the experience to meet with the individual, which could impact their access to health care. Those that had the experience with an enrollment specialist indicated that this enabling factor (access to the Medicaid enrollment experience and coverage) was a positive experience and did provide the opportunity to access services. Another enabling factor present was that most of the study participants had knowledge of Medicaid and the benefits of coverage. Other enabling factors that were seen as limited or a barrier through the lens of the study participants included their lack of confidence in discharge planning and linkages to community health organizations, limitation of Medicaid enrollment and assistance while in jail, and the lack of documentation (e.g., ID) to be eligible for Medicaid. Many jails, without proper funding, do not have the capacity and resources to participate in enrollment or re-enrollment activities and many offenders lack the documentation to determine eligibility for Medicaid (Marks & Turner, 2014). However, most of the study participants felt that access to Medicaid enrollment would be enhanced if enabling factors (facilitators) such as assistance with enrollment and the forms; having a translator; using how-to-videos; being treated with respect; and providing group settings for enrollment opportunities were available.

Limitations of Study

This study focused on the perceptions of women offenders using purposeful sampling of a specific population through qualitative interviews. As with any study that uses purposeful sampling, there will be bias and errors. I did not collect any demographic data for this study, and therefore the findings do not describe the demographics of the study participants. This study focused on experiences of the study participants with Medicaid enrollment and not on the impact of enrollment and health outcomes after release from incarceration. Also because the funding was reduced to support an enrollment specialist, only a small number of women in the study had the experience of meeting with enrollment specialist.

Recommendations

Ten of the study participants reported that having assistance with Medicaid enrollment opportunities and coverage is important and needed. Many of the study participants would have welcomed the opportunity to meet with an enrollment specialist but were not able to do so due to limited resources at the study site. Study participants identified several barriers that needed to be addressed and facilitators to address these barriers to Medicaid enrollment. Study participants recommended that resources be identified to have a dedicated person to coordinate Medicaid enrollment, assistance in filling out the paperwork and getting the proper documentation. Study participants felt that coordinating Medicaid enrollment in a group setting while treating the women offenders with respect could address stigma and offer peer support. They also described the need for assistance with health literacy and language barriers. Surprisingly, I learned

that the study participants also felt that men face similar challenges when accessing health care and men's needs should also be examined and explored in future studies.

My first recommendation is to interview reentry staff or staff involved in discharge planning to get their thoughts and perceptions about the benefits of Medicaid enrollment opportunities in the jails including the barriers and facilitators. This was a limitation of this study and exploring the perceptions of staff could identify best practices or challenges faced when trying to provide these services. My second recommendation is future research conducted on women ex-offenders who experienced Medicaid enrollment and the impact on health outcomes. There could be a correlation between women ex-offenders being enrollment in Medicaid while in jail and a positive impact on their health outcomes. My third recommendation is a comparison study between a correctional facility (e.g., jail) in a state that has expanded Medicaid to a state that has not implemented the ACA and expanded Medicaid. This could identify best practices and limitations to Medicaid enrollment during reentry.

Lastly, I asked all study participants in the final interview question, if there was anything else that they wanted to share that was not already addressed in the interview. All appreciated the opportunity to be heard and provide a voice, however, reiterated that everyone should have access to healthcare. One study participant recommended policymakers need to try harder to make this happen regardless if someone has been incarcerated or not. Some of the study participants indicated that access to health care while in jail could be better which was an unexpected recommendation. Several of the study participants felt that there although there is access to health care while in jail, it was

often significantly delayed and also described emergency care (sick call) as difficult to obtain. Therefore, recommended that additional research should be considered related to the experiences of women offenders with health care services within jail settings and implications for policy.

Implications

Cuellar and Cheema (2012) suggested additional research be conducted that can impact policy about the opportunity for this vulnerable population to take advantage of the Medicaid expansion. Reentry programming staff can be instrumental in Medicaid outreach and enrollment (Cuellar & Cheema, 2012). Policymakers could examine potential resources including funding that could assist reentry-programming staff or dedicated enrollment specialists in providing Medicaid enrollment to eligible women offenders through training and educational opportunities. Jails have the opportunity to serve as an enrollment site for those eligible for health care coverage during discharge planning and reentry however resources are needed (Regenstein & Rosenbaum, 2014). This study explored the barriers and facilitators and identified strengths and opportunities for improvement, as reported by the study participants related to the Medicaid enrollment process during reentry and implications for enhancing health care coverage. This study filled a gap by exploring the perceptions of women offenders interviewed at this study site related to Medicaid enrollment opportunities in a state that implemented the ACA and expanded Medicaid. Lastly, other states that have implemented the ACA and Medicaid expansion can utilize the study findings to incorporate or enhance Medicaid enrollment into their reentry program and process.

This study has the potential for positive social change at the organizational level and examination from policymakers related to the experiences of women offenders with Medicaid enrollment and attitudes towards Medicaid coverage. Correctional facilities, policy decision-makers, and community health organizations will be able to understand the issues women offenders identified in this study related to addressing health care coverage and needs before release from incarceration. Also, the opportunity exists to empower women offenders and provide education on Medicaid coverage and enrollment, accessing services, and foster linkages to community health organizations upon release back into their communities.

Conclusion

The ACA has been timely for providing enrollment for jail-involved individuals in Medicaid coverage. The SCA was instrumental in developing reentry programs that assist in reintegration of offenders back into their communities by providing various services including health-related reentry services. There were three major themes that emerged related to the lived experiences of the women offenders: Purpose of Medicaid coverage meaning; Medicaid enrollment opportunities; and Medicaid enrollment barriers and facilitators related to the experience. The findings were reported in five categories: (a) Purpose of Medicaid coverage; (b) Attitudes towards Medicaid enrollment opportunities while in jail; (c) Barriers and facilitators to Medicaid enrollment while in jail; (d) Health concerns that could be addressed by access to Medicaid coverage; and (e) Linkages to community health organizations upon release.

I was surprised that 9 of the 11 study participants understood the purpose and benefits of Medicaid coverage. I was also surprised that 8 of the 11 study participants were very vocal in describing several barriers to Medicaid enrollment and facilitators that support findings in previous literature stigma (e.g., being treated with respect as a person), health literacy, and the lack of access to health care. By exploring the lived experiences of women offenders, this study identified what knowledge and perceptions that women offenders have about Medicaid, the barriers and facilitators that exist to Medicaid enrollment, and the main health care issues identified as a priority. The study participants continued to emphasize that access to health care, assistance with Medicaid enrollment, and linkages to community health resources were very important and needed to address their health care concerns. Many of the study participants were worried that they would not have access to healthcare because they could not navigate through the enrollment process without assistance and would be ignored and overlooked because they were viewed as poor people who lacked resources.

The findings from this study support and contribute to previous research and literature related to the health care reentry needs of women offenders in a jail setting. These findings also suggest that correctional facilities and community health organizations should continue to examine policies and procedures to impact social change to enhance ways in which not only women offenders but other jail-involved individuals can be enrolled in Medicaid and have access to health care coverage. This could include examining the level of care received while in jail as well as linkages and

collaborations between correctional facilities and community health organizations to enhance continuity of care.

References

Andersen, R. M. (1995). Revisiting the behavioral model and access to medical care: Does it matter. *Journal of Health and Social Behavior*, *36*, 1-10.

Babitsch, B., Gohl, D., & Von Lengerke, T. (2012). Re-revisiting Andersen's Behavioral Model of Health Services Use: A systematic review of studies from 1998-2011. *GMS Psycho-Social-Medicine*, 9, 1-15. http://dx.doi.org/10.325/psm000089

Bandara, S. N., Huskamp, H. A., Riedel, L. E., McGinty, E. E., Webster, D., Toone, R. E., & Barry, C. L. (2015). Leveraging the Affordable Care Act to enroll justice-involved populations in Medicaid: State and local efforts. *Health Affairs*, *34*, 2044-2051. http://dx.doi.org/10.1377/hlthaff.2015.0668

Bechelli, M. J., Caudy, M., Gardner, T. M., Huber, A., Mancuso, D., Samuels, P., ... Venters, H. D. (2014). Case studies from three states: Breaking down silos between health care and criminal justice. *Health Affairs*, *33*, 474-481. http://dx.doi.org/10.1377/hlthaff.2013.1190

Binswanger, I. A., Nowels, C., Corsi, K. F., Long, J., Booth, R. E., Kutner, J., & Steiner, J. F. (2011). From the prison door right to the sidewalk everything went downhill: A qualitative study of the health experiences of recently released inmates. *International Journal of Law and Psychiatry*, *34*, 256-263. http://dx.doi.org/10.1016/j.ijlp.2011.07.002

Boutwell, A. E., & Freedman, J. (2014). Coverage expansion and the criminal justice-involved populations: Implications for plans and service connectivity. *Health Affairs*, *33*, 482-486. http://dx.doi.org/10.1377/hlthaff.2013.1131

Brooks, C. (2014). What is unique about incarcerated women. *American Jails*, *27*, 64-66.

Bureau of Justice Statistics. (n.d.). All terms and conditions. Retrieved from https://www.bjs.gov/index.cfm?ty=tda#

Cardwell, A. (2012). *County jails and the Affordable Care Act: Enrolling eligible individuals in health coverage* [Issue brief]. Washington, DC: National Association of Counties.

Cobbina, J. E. (2010). Reintegration success and failures: Factors impacting reintegration among incarcerated and formerly incarcerated women. *Journal of Offender Rehabilitation*, *49*, 210-232

Cobbina, J. E., & Bender, K. A. (2012). Predicting the future: Incarcerated women's views of reentry success. *Journal of Offender Rehabilitation*, *51*, 275-294. http://dx.doi.org/10.1080/10509674.2012.683323

Creswell, J. W. (2007). *Qualitative inquiry and research design: Choosing among five approaches* (2nd ed.). Thousand Oaks, CA: Sage Publications, Inc.

Creswell, J. W. (2009). *Research design: Qualitative, quantitative, and mixed methods approaches* (3rd ed.). Thousand Oaks, CA: Sage Publications.

Cuellar, A. E., & Cheema, J. (2012). As roughly 700,000 prisoners released annually: About half will gain health coverage and care under Federal laws. *Health Affairs*, *31*, 931-938. http://dx.doi.org/10.1377/hlthaff.2011.0501

Dennis, A., Manski, R., & Blanchard, K. (2014). Does Medicaid coverage matter: A qualitative multi-state study of abortion affordability for low-income women. *Journal of Health Care for the Poor and Underserved*, *25*, 1571-1585.

http://dx.doi.org/ 10.1353/hpu.2014.0151

Doherty, S., Forrester, P., Brazil, A., & Matheson, F. I. (2014). Finding their way: Conditions for Successful reintegration among women offenders. *Journal of Offender Rehabilitation*, *53*, 562-586. http://dx.doi.org/10.1080/10509674.2014.944740

Ejike-King, L., & Dorsey, R. (2014, April 18). Reducing ex-offender health disparities through the Affordable Care Act: Foster improved health care access and linkages to integrated care. *AIMS Public Health*, 1, 76-83. http://dx.doi.org/10.3934/public health.2014.2.76

Fitzgerald, T., Cohen, L., Hyams, T., Sullivan, K. M., & Johnson, P. A. (2014). Women and health reform: How national health care can enhance coverage, affordability, and access for women. *Women's Health Issues*, *24*, e5-e10. http://dx.doi.org/10.1016/j.whi.2013.11.006

Flores, J. A., & Pellico, L. H. (2011). A meta-synthesis of women's postincarceration experiences. *Journal of Obstetric, Gynecologic & Neonatal Nursing*, *40*, 486-496. http://dx.doi.org/10.1111/j.1552-6909.2011.01256.x

Frankfort-Nachmias, C., & Nachmias, D. (2008). *Research methods in social sciences* (7th ed.). New York, NY: Worth Publishers.

Garcia, M., & Ritter, N. (2012). Improving access to services for female offenders returning to the community. *NIJ Journal*, *269*, 18-23. Retrieved from https://www.ncjrs.gov/pdffiles1/nij/237725.pdf

Gelberg, L., Andersen, R. M., & Leake, B. D. (2000, February). The Behavioral Model

for Vulnerable Population: Application to medical care use and outcomes for homeless people. *Health Services Research*, *34*, 1273-1302. Retrieved from http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1089079/

Hammett, T. M., Roberts, C., & Kennedy, S. (2001, July 3). Health-related issues in prisoner reentry. *Crime & Delinquency*, *47*, 390-409. http://dx.doi.org/10.1177/0011128701047003006

Herrschaft, B. A., Veysey, B. M., Tubman-Carbone, H. R., & Christian, J. (2009). Gender differences in the transformation narrative: Implications for revised reentry strategies for female offenders. *Journal of Offender Rehabilitation*, *48*, 463-482.

Iglehart, J. K. (2014). The ACA opens the door for two vulnerable populations. *Health Affairs*, *33*, 358. http://dx.doi.org/10.1377/hlthaff.2014.0157

Janesick, V. J. (2011). *Stretching exercises for qualitative researchers* (3rd ed.). Thousand Oaks, CA: SAGE Publications.

Kellett, N. C., & Willging, C. E. (2011). Pedagogy of individual choice and female inmate reentry in the U.S. southwest. *International Journal of Law and Psychiatry*, *34*, 256-263. http://dx.doi.org/10.1016/j.ijlp.2011.07.003

Koester, K. A., Morewitz, M., Pearson, C., Weeks, J., Packard, R., Estes, M., ... Myers, J. J. (2014). Patient navigation facilitates medical and social services engagement among HIV-infected individuals leaving jail and returning to the community. *AIDS Patient Care and STDs*, *28*, 82-90. http://dx.doi.org/10.1089/apc.2013.0279

Lenox, M. I. (2011). Neutralizing the gender collateral consequences of the War on

Drugs. *New York University Law Review*, *86*, 280-315.

Malave, E. (2014). Prison health care after the Affordable Care Act: Envisioning an end to the policy of neglect. *New York University Law Review*, *89*, 700-738.

Mallicoat, S. L. (2011). The incarceration of women. *Women and crime: A text reader* (pp. 461-511). Retrieved from http://www.sagepub.com/upm-data/44337_10_(final).pdf

Mark, J. S., & Turner, N. (2014). The critical link between health care and jails. *Health Affairs*, *33*, 443-447. http://dx.doi.org/10.1377/hlthaff.2013.1350

Maruschak, L. M., Berzosky, M., & Unangst, J. (2015). *Medical problems of state and federal prisoners and jail inmates: 2011-12* (NCJ 248491). Retrieved from www.ojp.usdoj.gov

Maxwell, J. A. (2013). *Qualitative research design: An interactive approach* (3rd ed.). Thousand Oaks, CA: Sage Publications, Inc.

McDonnell, M., Brookes, L., & Lurigio, A. J. (*2*014). The promise of healthcare reform services for jail releases and other criminal justice populations. *Health and Justice*, 2, 1-9. http://dx.doi.org/10.1186/2194-7899-2-9

McNabb, D. E. (2013). *Research methods in public administration and nonprofit management* (3rd ed.). Armonk, NY: M.E. Sharpe, Inc..

Miles, M. B., Huberman, A. M., & Saldana, J. (2014). *Qualitative data analysis: A methods sourcebook* (3rd ed.). Thousand Oaks, CA: Sage Publications, Inc.

National Institutes of Justice. (n.d.-a). Offender reentry. Retrieve from https://www.nij.gov/topics/corrections/reentry/Pages/welcome.aspx

National Institutes of Justice. (n.d.-b). Recidivism. Retrieve from https://www.nij.gov/topics/corrections/recidivism/Pages/welcome.aspx

Patel, K., Boutwell, A., Brockmann, B. W., & Rich, J. D. (2014). Integrating correctional and community health care for formerly incarcerated people who are eligible for Medicaid. *Health Affairs*, *33*, 468-473. http://dx.doi.org/10.1377/hlthaff.2013.1164

Patton, M. Q. (2002a). *Qualitative research and evaluation methods* (3rd ed.). Thousand Oaks, CA: Sage Publications, Inc.

Patton, M. Q. (2002b). *Variety in qualitative inquiry: Theoretical orientations* (3 ed.). Thousand Oaks, CA: Sage Publications.

Phillips, L. A. (2010). Substance abuse and prison recidivism: Themes from qualitative interviews. *Journal of Addictions & Offender Counseling*, *31*, 10-24. http://dx.doi.org/10.1002/j.2161-1874.2010.tb00063.x

Regenstein, M., & Rosenbaum, S. (2014). What the Affordable Care Act means for people with jail stays. *Health Affairs*, *33*, 448-454. http://dx.doi.org/10.1377/hlthaff.2013.1119

Rich, J. D., Cortina, S. C., Uvin, Z. X., & Dumont, D. M. (2013). Women, incarceration, and health. *Women's Health Issues*, *23*, e333-e334. http://dx.doi.org/10.1016/j.whi.2013.08.002

Rosen, D. L., Dumont, D. M., Cislo, A. M., Brockmann, B. W., Traver, A., & Rich, J. D. (2014). Medicaid policies and practices in US state prison systems. *American Journal of Public Health*, *104*, 418-420.

http://dx.doi.org/10.2105/AJPH.2013.301563

Salem, B. E., Nyamathi, A., Idemundia, F., Slaughter, R., & Ames, M. (2013, March). At a crossroads: Reentry challenges and health care needs among homeless female ex-offenders. *Journal of Forensic Nursing*, *9*, 14-22. Retrieved from http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3783031/

Scott, C. K., & Dennis, M. L. (2012). The first 90 days following release from jail: Findings from the Recovery Management Checkups for Women Offenders (RMCWO) experiment. *Drug and Dependence*, *125*, 110-118. http://dx.doi.org/10.1016/j.drugalcdep.2012.03.025

Scroggins, J. R., & Malley, S. (2010). Reentry and the unmet needs of women. *Journal of Offender Rehabilitation*, *49*, 146-263. http://dx.doi.org/10.1080/10509670903546864

Somers, S. A., Nicolella, E., Hamblin, A., McMahon, S. M., Heiss, C., & Brockmann, B. W. (2014). Medicaid expansion: Considerations for states regarding newly eligible jail-involved individuals. *Health Affairs*, *33*, 455-461. http://dx.doi.org/10.1377/hlthaff.2013.1132

Spjeldnes, S., & Goodkind, S. (2009). Gender differences and offender reentry: A review of the literature. *Journal of Offender Rehabilitation*, *48*, 314-335. http://dx.doi.org/10.1080/10509670902850812

Springer, S. A. (2010). Improving healthcare for incarcerated women. *Journal of Women's Health*, *19*, 13-15. http://dx.doi.org/10.1089/jwh.2009.1786

Starks, H., & Trinidad, S. B. (2007). Choose your method: A comparison of

phenomenology, discourse analysis, and grounded theory. *Qualitative Health Research*, *17*, 1372-1380. http://dx.doi.org/10.1177/104973230730703

Stuber, J., & Bradley, E. (2005, February). Barriers to Medicaid enrollment: Who is at risk. *American Journal of Public Health*, *95*, 292-298. http://dx.doi.org /10.2105/AJPH.2002.006254

The Sentencing Project. (2012). *Incarcerated women* [Fact sheet]. Retrieved from http://www.sentencingproject.org/doc/publications/cc_Incarcerated_Women_Fact sheet_Sep24sp.pdf

Trochim, W. M. (2006). Qualitative validity. Retrieved from http://www.socialresearchmethods.net/kb/qualval.php

Wright, E. M., Van Voorhis, P., Salisbury, E. J., & Bauman, A. (2012). Gender-responsive lessons learned and policy implications for women in prison: A review. *Criminal Justice and Behavior*, *39*, 1612-1632. http://dx.doi.org/10.1177/0093854812451088

Rashid, M., & Antai, D. (2014). Socioeconomic Position as a Determinant of Maternal Healthcare Utilization: A Population-Based Study in Namibia. *Journal Of Research In Health Sciences, 14*(3), 187-192. Retrieved from http://jrhs.umsha.ac.ir/index.php/JRHS/article/view/1543

Appendix A: Letter to Participants

Dear Participant,

My name is Morrisa Rice and I am a student at Walden University. I am working on a study that will allow me to understand your thoughts as a woman offender related to Medicaid enrollment.

In this study, I will talk with you about your experiences with Medicaid enrollment. Medicaid is a State and Federal program that helps low-income individuals and families pay for medical costs if they qualify. With Medicaid expansion, you may be able to get Medicaid when released from jail.

The information collected will be through interviews with you. The interviews will be taped and I will take notes. Your honest answers are appreciated and will not impact the services you are getting in jail.

If you have any questions you can reach me through the Reentry Manager at this jail. I am hoping that you will consider participating in this study. I look forward to speaking with you soon.

Sincerely,

Morrisa B. Rice, MHA

Appendix B: Qualitative Study Interview Guide

Introduction

- The privacy and confidentiality of all participants in this study will be protected from start to end. However, if a participant discloses any criminal activity or illegal activities, then it is the responsibility of the researcher to disclose this information to the jail officials. Otherwise the responses provided during the interview will not be shared with anyone other than the researcher. Do you have any issue or concerns regarding this study?
- Do you have any questions or concerns regarding the informed consent form?
- Do you give me permission to audio tape this interview?

Study Number:_____

Interview Questions

1. What does Medicaid coverage mean to you?
2. What is your attitude towards the opportunity to have access to Medicaid enrollment in jail prior to release?
3. What has been your experience with Medicaid coverage under the ACA while in jail? (Prompt questions: access to affordable services such as women wellness exams, substance abuse services, and mental health services.)
4. Access to health care insurance is important, so have you met with someone to discuss Medicaid enrollment upon reentry or release from jail? If so, tell me

about this experience/process and the type of support you have received? (Prompts: Programs, access to patient navigator, healthcare enrollment specialist, women-specific programs).

5. What do you believe to be working well (facilitator) with Medicaid enrollment while in jail? (Prompts: A person who is dedicated to Medicaid enrollment, forms available, easy to understand)
6. What do you believe is not working well (barrier) with Medicaid enrollment while in jail? (Prompts: Forms complicated, no ID, not interested in Medicaid enrollment, not organized or consistent)
7. How do you think these barriers/facilitators to Medicaid enrollment will influence your access to health care when released from incarceration?
8. Are there any health concerns that you feel can be addressed by having Medicaid coverage upon release from incarceration? If so please identify these health concerns?
9. What is your level of comfort that you will be linked with the appropriate community health organizations to receive the services to meet your health care needs?
10. Is there anything else you would like for me to know that we have not already addressed in this interview?

Again thank you for your time. The information will be analyzed, summarized, and kept confidential by the researcher. Do you have any additional questions or need to me to

further explain anything? Your honestly regarding this study is greatly appreciated and will not impact in any way the services you are currently receiving.

If you have any additional questions or concerns you can always reach me through the Reentry Manager at the Montgomery County Department of Correction and Rehabilitation Detention Services Division. Take good care.