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Prisons and Corrections Forum

A Publication of the State Bar of Michigan's Prisons & Corrections Section

Contents

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Women and Incarceration

Join the section on Zoom for our Program on Saturday, June 5, 2021 9:45 a.m. until 3:30 p.m.

Program and Registration information are in this issue at page 13.

Medicaid and Continuity of Coverage for the Justice-Involved Population

Editor's Note: The following is an edited excerpt from the report, Medicaid and Continuity of Coverage for the Justice-Involved Population: An Assessment of Select Michigan Counties and Jails, a collaborative report written by TBD Solutions and Wayne State University School of Social Work Center for Behavioral Health and Justice and published by the Center for Behavioral Health and Justice in 2020. A link to the full report, references, and contact information is at the end of this article.

Overview

It has been widely reported that Medicaid coverage of the justice-involved population positively impacts health outcomes and reduces recidivism (Plotkin & Blanford, 2017). Federal law requires counties to provide health care to people housed in jails, however, Medicaid funds may not be used to cover services provided to an incarcerated individual.

Despite the Federal requirement and without comprehensive Medicaid screenings, continuity in health care coverage for released individuals is often overlooked. Only 28% of jails nationwide are screening for Medicaid eligibility to ensure post-release care coverage (Plotkin & Blanford, 2017). This continuity is critical as Medicaid eligibility expands the universe of services an individual leaving jail can access (i.e. mental health, substance use disorder treatment, case management, and physical health care).

Once released, individuals often face barriers to accessing health care services, which contribute to recidivism, drug use, and poor and costly health outcomes (Gates et al., 2014). The lack of eligibility screening, disrupted continuity of health care coverage, and bleak health outcomes for the justice involved population point to the need for Michigan's health care leaders to prioritize this issue.

The Wayne State Center for Behavioral Health and Justice (CBHJ) contracted with TBD Solutions of Grand Rapids in June of 2020 to conduct a focused study of current Medicaid enrollment and reactivation processes with the currently or previously incarcerated population.

The purpose of this report is to inform Michigan's efforts to strengthen Medicaid enrollment practices for the justice-involved population by developing and enforcing consistent policy. Specifically, this report:

- Identifies and documents current practice, including barriers and examples of

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Continued from page 1

innovation, in select Michigan jails by interviewing jail and Community Mental Health (CMH) staff

- Summarizes best practices from other states that were gleaned through national research
- Outlines recommendations to improve access to necessary Medicaid services for individuals recently released from jail[1]
- Provides potential funding and cost saving opportunities for state-wide and jail-level Medicaid activities

Jail versus Prisons

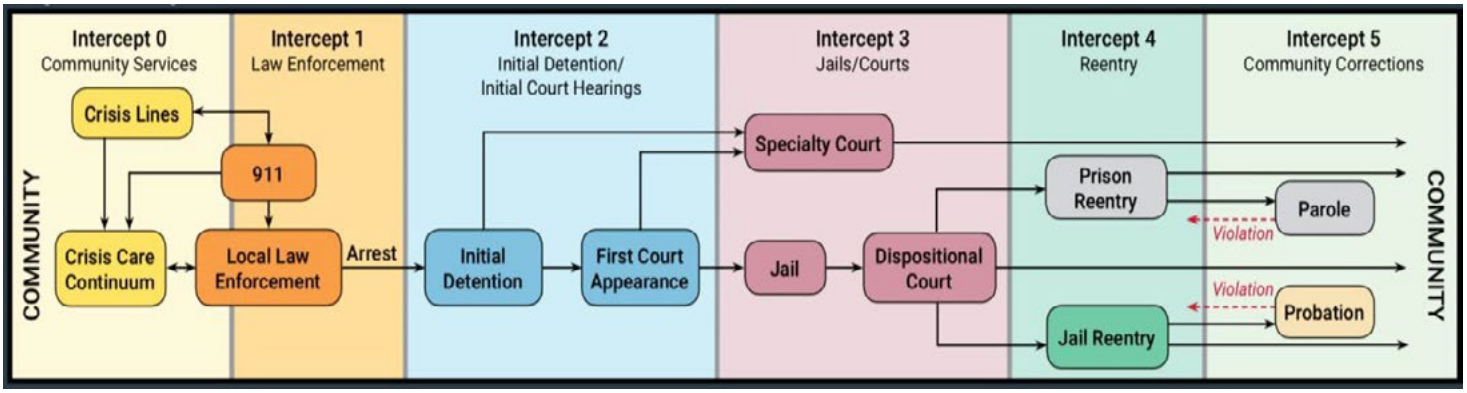
The Michigan Department of Corrections (MDOC) oversees health care provided to individuals housed in state prisons. County jails are managed by their respective counties, and as such, there is no overarching authority over all jails in the state. Due to the complexities and differences between jail and prison related to Medicaid enrollment, and health care, this report only discusses the experiences of individuals and administrators in select Michigan jails. Although individuals released from prison may experience similar or additional barriers to accessing health care or Medicaid, the plight of those previously or currently incarcerated in state or federal prisons is outside of the scope of this report.

Medicaid and Jails: The Basics

Medicaid is a federal- and state-funded benefit plan available to low-income individuals, eligible pregnant women, children, and individuals receiving Supplemental Security Income (CMS, 2020). With Medicaid, individuals can access important services such as doctor visits, mental health services, substance use disorder treatment, prenatal and maternity care, medications, and preventive care services. As of March 2020, Medicaid provided coverage to 2,300,000 individuals in Michigan (Norris, 2020). With the Affordable Care Act's Medicaid Expansion opportunity, Michigan's plan (named Healthy Michigan) expanded coverage to an additional 650,000 people in early 2020 (Norris, 2020). The Healthy Michigan Plan expanded the number of incarcerated individuals eligible for Medicaid, which increased the urgency and importance of clarifying jail Medicaid enrollment and eligibility practices.

Mission Statement

The Prisons and Corrections Section of the State Bar of Michigan provides education, information and analysis about issues of concern through meetings, seminars, public service programs, and publication of a newsletter. Membership in the Section is open to all members of the State Bar of Michigan.



Abreu, Dan, et al. "Revising the paradigm for jail diversion for people with mental and substance use disorders: Intercept 0." Behavioral sciences & the law 35.5-6 (2017): 380-395.

Incarceration *does not* impact an individual's eligibility for Medicaid enrollment: According to the Centers for Medicare and Medicaid Services (CMS), "if an individual meets all applicable eligibility requirements the state must enroll or renew the enrollment of the individual effective before, during, and after the period of time in the correctional facility."

Coverage During Incarceration

The Medicaid Inmate Payment Exclusion Policy forbids Medicaid reimbursement for services provided in jails (MAC Learning Collaboratives 2017). The only exception is care delivered outside the institution, such as at a hospital or nursing home, when the person is admitted for 24 hours or more (Dickinson, 2016).

Without coverage for care provided while incarcerated, counties bear responsibility for the cost of health care for incarcerated individuals housed in their jails (Chase et al., 2019).

Sequential Intercept Model

The Sequential Intercept Model is a framework developed to map the locations (or intercepts) in which an individual interacts with the criminal justice system. To best tackle the needs of individuals currently, previously, or at risk for involvement in the criminal justice system, solutions at each intercept must be considered. Specifically, Medicaid enrollment and reactivation must be considered at every intercept in the model to ensure comprehensive coverage and continuity. This report will reference intercepts on the Sequential Intercept Model and utilize its framework to describe or propose solutions. For more information about the Sequential Intercept Model and its uses, visit the www.SAMHSA.gov website or the Urban Institute (Willison et al., 2018). *See graphic above.*

Research and Interview Methods

To better understand the barriers faced by jails and community partners, TBD Solutions conducted interviews with subject matter experts in select county jails and CMHs. Between August and September 2020, 34 individuals were interviewed in 14 interview sessions.

Interviewees for this study were selected based on their existing relationships with the Center for Behavioral Health and Justice (CBHJ), their job titles and responsibilities, and their rural-urban classifications as defined by the Michigan Department of Corrections.

Interviewees represented 12 Michigan counties, including Barry, Eaton, Jackson, Kent, Marquette, Monroe, Muskegon, Washtenaw, Wayne, Ogemaw, Iosco, and Oscoda counties. Representatives from Ogemaw, Iosco, and Oscoda counties were interviewed in one group interview. Interviewees from the three counties reported their barriers and innovations collectively. Subsequently, these three counties are considered one "jurisdiction."

The job titles of interviewees included, Sheriffs and other jail administrators, CMH employees providing in-jail and community services, jail nurses employed by third-party providers, and in-jail clinicians employed by third-party behavioral health providers.

The experience of Michigan's Department of Health and Human Service (MDHHS) field staff are critical to fully understand the scope of Medicaid enroll-

ment and reactivation. However, MDHHS field office workers were not included in the scope of this project.

Background information provided by the CBHJ and results from the Jail Medication Assisted Treatment (MAT) Survey[2] were used to develop specific questions, reduce duplication of research efforts, and ensure the interviewers had useful contextual information to guide this effort. Two TBD Solutions employees conducted and summarized interviews.

Suspension versus Termination

Because most care is not covered by Medicaid during incarceration, states are left to decide how they will "deactivate" and "reactivate" Medicaid coverage for individuals currently incarcerated. In 16 states, including Michigan, Medicaid eligibility is suspended, not terminated, when an individual is incarcerated. This, ideally, allows coverage of Medicaid services to resume immediately upon re-entry into the community.

Once an individual re-enters their community, it is critical for their Medicaid Program Enrollment Type Code (PET Code) to no longer indicate their incarcerated status via a "INC" indication. If the PET Code wrongly indicates incarceration status, Medicaid coverage is interrupted.

For the sake of this research summary, the terms "Medicaid Suspension" or "Medicaid Suspension Status" are referring to individuals having the INC PET Code assigned to their Medicaid information. (Dickinson, 2016).

Challenges with Care in Jail Settings

Care Delivery

Jails admit 18 times more individuals than state or federal prisons, and these individuals stay a relatively short time (26 days or less) (Chase et al., 2019; Zeng, 2019). Given the ever-changing environment and short lengths of stay, jails are forced to focus on short-term solutions to potentially chronic and unmanaged health care concerns.

Pre-Trial Detainees

Unlike prison, jails house both sentenced individuals and unsentenced individuals. Sixty-five percent of local jail inmates are pretrial and are still presumed innocent. These individuals cannot receive most Medicaid services while in jail awaiting trial. Those who receive a public recognizance bond, in contrast, can enroll and participate in Medicaid covered services in the community.

Policy Challenges

Michigan has no clear policy regarding the role nor the process for county jails to use in determining eligibility or enrolling eligible jail residents in Medicaid. This lack of statewide policy or guidance creates an inconsistent, fragmented, and inequitable system for individuals incarcerated in jail. Timeliness to enrollment and Medicaid reactivation varies from county to county creating access disparities depending on an individual's location of incarceration.

Meet Frank: A Case Example

Frank was recently arrested for attempted robbery and is awaiting trial and presumed innocent. His insufficient savings made "bonding out" impossible, Frank must remain in jail while he awaits his trial. Frank's friend, Jack, was also arrested for attempted robbery in the same incident. He was able to post bail and is now back to working and living in his community.

Jack can access his Medicaid and seek care from his primary care physician. Frank cannot access his Medicaid coverage for health care needs while he is in jail. When he leaves jail, he will likely wait days or weeks for his Medicaid to be reactivated. Even if he was proven innocent, Frank's essential health care coverage was interrupted.

Inconsistent Suspension Status

No pattern or correlation was identified between which jailed individuals were placed in suspension status and which were not. Some individuals left after a 6-month incarceration with full active Medicaid, while others stayed a short time, and their Medicaid was suspended.

Despite Michigan being a suspension state, one interviewee reported Medicaid was terminated for individuals at booking and release. Due to compounded wait times for Medicaid reactivation and a shortage of substance use disorder providers, individuals in this jurisdiction with

substance use disorders waited up to 10 weeks post-release to receive an assessment for substance use disorder services. The county jail and local Department of Health and Human Services office in this county collaborated to resolve the wrongful termination with no solution identified at the time of interviews.

Without a reliable system to identify to predict Medicaid suspension status, collaborators struggled to provide consistent reactivation and release support.

Difficult Reactivation Process

Most interviewees reported a similar process for Medicaid reactivation. Generally, this process included the following steps:

- Learn of Suspension: An individual learned of their suspension (either through a pre-release screening or on their own).
- Reactivation: The DHHS case worker reactivated Medicaid for the individual to receive health care coverage. Most often, individuals were expected to visit their local DHHS office in-person following release with proof of incarceration (retrieved from the jail) paperwork to reactivate their Medicaid.
- Wait for reactivation: Upon reactivation through DHHS, individuals were still left waiting up to 45 days until reactivation was realized in their Medicaid record.

Interviewees explained that released individuals faced significant barriers to reactivating their Medicaid including:

- Lack of Understanding of Medicaid and How it Can Help Insufficient Transportation to and from DHHS Office
- Inaccessible or Lack of "Proof of Incarceration" Paperwork
- Challenges in Navigating Community Agencies
- Lack of Cellphone or Reliable Communication
- Unstable or No Address for Formal Communication or Mail
- Unmet Basic Needs (Such as immediate housing, food, and family needs)

Many interviewees reported their county jail communicated automatically or manually with MDHHS local offices on individuals' booking in the jail. However, only a few jail administrative interviewees sent reports to MDHHS about an individual's release. Interviewees reported it was unclear how Medicaid is suspended and what informs this suspension. Several interviewees hypothesized suspension is informed by jail booking reports sent to the Social Security Administration.

The barriers and hurdles faced by Michigan's jails to communicate suspension and reactivation information are mirrored in other states. An article published in 2019 by the Kaiser Family Foundation (Wachino & Artiga, 2019) said,

> "…creating automated processes to suspend and reinstate coverage is challenging and requires overcoming major technology hurdles and addressing variations in systems and processes across agencies and corrections facilities."

Ineffective Partnerships

Although most interviewees built strong relationships between jail personnel, CMHs, and other community agency staff, some experienced problematic communications and relationships with collaborators. Incongruent belief systems were the most significant cause of an ineffective partnership. For example, one interviewee reported collaboration was difficult if jail employees (specifically correctional officers working directly with incarcerated individuals) did not believe in the Medicaid reactivation or enrollment efforts facilitated within the jail. Interviewees reported jail cooperation in Medicaid reactivation and enrollment efforts was essential to continuity of care.

One interviewee, a CMH employee, expressed that CMH collaborations and innovations created additional burdens on the jail and its staff. Coordinated Medicaid efforts (including enrollment and activation) in the jail required increased inmate engagement with CMH or provider staff. Increased inmate engagement necessitated additional jail staff to transport and supervise meetings and additional jail facility space to house meetings. Telecommunicated meetings did not mitigate the need for staffing and facility space and require increased capacity for technology.

Relationships with local DHHS offices varied greatly among interviewees. In some cases, interviewees reported they noted local DHHS workers were unaware of the implications of incarceration on Medicaid coverage, eligibility, and reactivation. Generally, interviewees shared their relationships and level of collaboration with DHHS offices depended on individual employees' cooperation and experience.

Lack of Resources

Many interviewees, both those employed by the jail and by community agencies, expressed a need for additional funding or support to fully implement Medicaid reactivation and improved enrollment practices in jails. Specific needs included:

- Personnel: a need for more jail personnel, specifically correctional officers, to provide inmate supervision during coordination meetings, send and receive bookings and release reports, and communicate with community partners on Medicaid issues.
- Facility: a need for improved or additional space for coordination meetings in the jail, either during an individual's incarceration or during the release process. Space used to coordinate Medicaid benefits must consider privacy, access to jail administrative staff, and security.
- Technology: a need for jail-approved technology including computers, access to appropriate health records or benefits records, and access to reliable internet. Interviewees typically gleaned Medicaid information using CMH portals. CMH employees reported they had limited information about individuals never served by CMH or those served by a CMH outside of the county conducting the inquiry.

Resource and funding restrictions limited jails and their collaborators in who they could assist or what reactivation, preparation, or enrollment services could be provided. For example, several interviewees provided Medicaid eligibility-related services through grants limited to individuals with substance use disorders, or specific opioid use disorders.

County resources were stretched thin due to the challenge of providing health care to a population with high levels of chronic illness and behavioral health disorders, and the inability to tap into Medicaid coverage.

Unpredictable Release Dates and Times

Consistently, interviewees from jails and CMHs expressed unpredictable release dates as a barrier to reactivating Medicaid. Jails shared that bonds and pre-trial releases made release dates difficult to specify. The COVID-19 pandemic made defining release dates even more difficult to manage as individuals were released early to reduce the spread of the disease. Often, jails worked to manage release protocols and did not have adequate time to inform their community partners of upcoming releases.

Interviewees reported the least challenging release dates to manage are for individuals who have already been convicted and sentenced. Unpredictable release days and short jail stays are a barrier nationally and make coverage coordination difficult (Wachino & Artiga, 2019).

Identified Innovations

Interviewees reported resolving or mitigating barriers with new and strengthened processes that ensured more individuals accessed Medicaid coverage. The four key innovations included

- Comprehensive screening for Medicaid status
- Standard discharge protocol
- Collaboration between partners
- Use of peers

Two interviewees engaged all four of the key innovations. Their efforts created clear and inclusive processes for ensuring individuals leaving jail have access to key services. Many of the recommendations provided later in this report are based on the innovations already practiced in counties across Michigan.

Comprehensive Screening for Medicaid Status and Activation

Jail staff reported conducting a screen for all individuals booked into their jails. However, jails did not report they conducted comprehensive Medicaid screenings. Only two interviewees reported conducting a Medicaid screening on all jailed individuals and verified the information with the CMH or DHHS. Only one jail (Eaton County) conducted Medicaid enrollment activities for all eligible individuals in their jail.

Of the jurisdictions who asked jailed individuals about insurance at screening (8 out of 10), most asked on an "as needed" basis or were not validating information from another source. The booking process was the most common time to gather information on an individual's insurance status.

Some interviewees reported innovative Medicaid screenings where staff (jail, CMH, or DHHS staff) thoroughly screened all individuals booked into the jail. They reported submitting released individuals' names through the CMH electronic health record or by sending a booking report to MDHHS for review. From those screenings, jails and collaborators collected information on an individual's Medicaid status (activated or suspended) and eligibility for the unenrolled. Once the screening was complete, innovative jurisdictions conducted several release activities to support individuals who were confirmed to have suspended Medicaid or were eligible to enroll. These release activities included:

- Reactivation of Medicaid through DHHS collaboration
- Communication with DHHS to prepare for reactivation efforts
- Transportation and housing coordination
- Reactivation of other supports including food benefits

Standard Discharge Protocol

In well-developed, collaborative jurisdictions, release dates for sentenced individuals were known to community partners in advance of release, standard release protocols were followed, and individuals had their Medicaid reactivated the day of their release.

Standard release protocols varied among interviewees. Some interviewees prepared the individual for reactivating their own Medicaid upon release. Other interviewees offered comprehensive release activities with the individuals, including scheduling and attending a DHHS reactivation meeting, scheduling and attending a primary care appointment on the day of release, retrieving medications from a pharmacy, and securing housing.

Collaboration Between Partners

Key collaborations created pathways for care continuity and improved the transition from jail back to community. Innovative counties and jurisdictions developed collaborations between jails, CMHs, DHHS, Federally Qualified Health Centers (FQHCs), and pharmacies.

DHHS: Most interviewees, especially CMH interviewees, reported an existing relationship with DHHS (or individual DHHS employees) that improved timeliness of Medicaid reactivation for recently released individuals. Interviewees with the most robust relationships and collaborations often had DHHS onsite either at the jail or the provider site (at a CMH or a FQHC). A third of the interviewees had a DHHS worker onsite at a collaborating CMH. DHHS workers onsite at CMHs were most helpful in reactivating Medicaid onsite.

Although this innovation has reportedly improved Medicaid reactivation and enrollment efforts for individuals who are eligible for CMH services, it does not address reactivation needs for the entire population. Individuals recently released that do not qualify for CMH services are left out of the benefits of increased DHHS collaborations at CMH locations. DHHS collaboration at other sites outside of the CMH system (ex. In the jail) would further refine this innovation.

Jail and CMH: Interviewees with the least-expressed barriers and the most innovative approaches reported strong relationships between jail leadership and CMH leadership. These collaborative interviewees directly changed jail policy (e.g., increased inmate engagement in preparation for release, regular booking and release communications, regular collaboration to improve Medicaid enrollment or reactivation activities) to address barriers to Medicaid continuity of care. Relationships between CMH administrators and jail administrators were critical in innovative communities. Regular communications at an executive or leadership level allowed for open communication, collaborative problem solving, and frank discussions about the limitations of both organizations. The strong relationships between decision-makers at both the CMH and the jail were reflected in "on-the-ground" cooperation between staff members working one-on-one with incarcerated individuals preparing to be released.

Strong and concerted relationships between jails and CMHs improves care continuity. However, the communities that rely solely on CMH relationships to bridge gaps between jail and community leave out an entire population of people who do not qualify for CMH ser-

vices. Individuals with physical health conditions who do not qualify for CMH services are often left out of conversations of care continuity.[3]

Recommendations

The recommendations were developed using the innovations described by interviewees across the state, recommendations of interviewees, and national research on the topic. Although many Medicaid reactivation and enrollment activities were facilitated at the local level, larger system changes would expedite advancement across the state. Where possible, state-level recommendations are provided in each section.

Recommendation One: Expedited Medicaid Reactivation. Access to Medicaid reactivation upon release from jail is critical to an individual's overall health and likelihood to recidivate (Paradise & Garfield, 2013). Delays in reactivation put the released individual at risk of losing their Medicaid coverage altogether. Below are recommendations to improve the reactivation process:

Community Services: Intercept 0

Portal: Create and support a portal or website where existing crisis line provider staff can access eligibility and reactivation information for all individuals. The portal would assist staff in referring individuals to enrollment services or DHHS for reactivation of their Medicaid. This would require collaboration with MDHHS.

Community Corrections: Intercept 5

Portal: Create and support a portal or website where parole and probation staff can access eligibility and reactivation information for all individuals. This would require collaboration with MDHHS and MDOC.

At the Jail Level: Intercept 2, 3 & 4

Kiosk: Create and support a kiosk (a computer with reliable Wi-Fi that connects to a DHHS portal) at location of release where individuals can access and reactivate their own Medicaid during the release process. According to interviewees, a kiosk should be implemented during the release process instead of as an optional "stop" after release.

The CBHJ, at the time of this report [September 2020], was using a foundation grant to provide tablets to jails across the state of Michigan, including 8 of the counties interviewed in this report. These tablets are primarily utilized for care coordination and behavioral health services. However, this technology could be a starting point to enrich enrollment and reactivation activities in Michigan jails.

Staffing: Create and support an in-jail position focused on identifying and addressing reactivation needs for incarcerated individuals. This position could be filled in collaboration with a local FQHC, CMH, or DHHS employee.

Portal: Create and support a portal or website where jail provider staff can access eligibility and reactivation information for all individuals.

Expedited Medicaid Reactivation at the State Level

In addition to the number of recommendations at the community services, jail, and community corrections level, the State of Michigan could play a pivotal role in expediting Medicaid reactivation including:

Automatic reactivation whereby Medicaid would automatically reactivate using jail booking and release reports. The state could receive booking and release reports and immediately reactivate the individual's Medicaid information (by changing the PET Code). This solution would alleviate the many responsibilities placed on individuals leaving jail and improve their health as they re-enter their communities. A change at the state level is the most sustainable option for jails, CMHs, and previously incarcerated individuals. This change would likely eliminate the need for the additional recommendations implemented in other levels of the system (CMS, 2020).[4]

Designated DHHS Coordinator Role in which jails are supported by a DHHS liaison to coordinate jail reactivation services for all jailed individuals. Currently, some jailed individuals have their own DHHS caseworker responsible for several activities. A county jail could have many DHHS caseworkers involved in the reactivation of Medicaid post release. A designated DHHS caseworker responsible for reactivating Medicaid for all released (or soon- to-be-released individuals) would centralize caseworkers' reactivation efforts.

Recommendation Two: Improved Enrollment Activities. Communities must consider developing Medicaid enrollment capacity at other points on the

Sequential Intercept Model. Increased enrollment points would relieve pressure on jails and increase the likelihood that more individuals involved in the criminal justice system can access Medicaid.

Community Corrections Eligibility Specialist: In collaboration with the local CMH and DHHS office, enrollment activities should expand into community corrections. With more intercepts fulfilling enrollment activities, individuals are less likely to fall through the cracks.

Jail Level Eligibility Specialist: Jails that do not already have an eligibility specialist should seek partnership with their DHHS field office to position one in the jail. This would improve enrollment activities and facilitate collaboration between jails and community resources.

At the State Level

The State of Michigan can assist in the facilitation of enrollment activities in jails across the state. The below recommendations would reduce geographical disparities in jail Medicaid enrollment activities and create sustainable funding systems for enrollment efforts.

Develop Legislation to guide Medicaid enrollment practices in jails. Legislation could direct jails to inform MDHHS regarding the incarceration status of eligible individuals. This would put some "teeth" behind any guidelines sent out to jails by MDHHS. Administrative efficiencies leading to state budget savings is the argument for legislating this strategy.

Funding Expansion using Medicaid Match funds to help cover jail administrative expenses related to enrollment activities. States can apply for Federal match funds ranging from 50-90% coverage of costs for establishing jail information exchanges with the state departments (Plotkin & Blandford, 2017) and supporting jail enrollment activities through funding to jail administrations (Jannetta et al., 2017).

Recommendation Three: Increased Collaborations. All innovative interviewees reported well-developed collaborations between jails and community partners. Increased collaboration can prevent individuals from falling through the cracks as they transition from jail back into communities. Collaboration looks different for each community as financial resources and partners vary. Leaders at jails and community organizations can facilitate collaborative efforts through relationship building and discussing common goals.

At All Intercepts

Collaborations between community partners varies in communities based on available resources, existing relationships, and needs of those served. Key partners include DHHS, FQHCs, CMHs, Prepaid Inpatient Health Plans (PIHPs), providers of behavioral health services, primary care providers, Certified Community Behavioral Health Clinics, local health departments, court systems, and other available community resources.

Engaging partners in Medicaid access can reduce financial burdens on counties, create pathways for care, improve health care access, and reduce recidivism rates. Utilizing existing community resources is a great place for communities to start

Recommendation Four: Comprehensive Discharge Planning. Discharge planning assists individuals leaving jail in preparing for life back in the community. This process, however, is not standardized across the state and can even vary within an individual jail. Improved discharge planning processes would result in comprehensive preparation for individuals returning to communities. Discharge planning should include an insurance component where discharge planners review an individual's Medicaid status and eligibility, next steps for reactivation and enrollment, and connection to health care services in the community.

Discharge Planning: Intercept 0, 3 & 4

Standardized Process: A standard discharge process created in collaboration with jails and community services would improve the health and welfare of individuals released from jail. Collaboration should include multiple collaborators such as FQHCs, CMHs, Medicaid Health Plans, and CCBHCs. Robust standardized discharge planning processes include:

- Screening of Medicaid activation and eligibility
- Connections to an eligibility specialist
- Referrals to provider of behavioral health or physical health

- Connections to Social Determinants of Health including transportation, housing, and food benefits

Ideally, all individuals released from jail would receive assistance in reactivating their Medicaid. However, because some individuals leave jail under short notice (due to bonding out, results of court proceedings, or other unexpected situations), it is unlikely comprehensive discharge processes could be facilitated with this population.

Recommendation Five: State Policy Levers. MDHHS should use the findings from this report in carrying out Phase II of the ICJIP project, funded by the Michigan Health Endowment Fund. This promising project will provide six jails across the state with access to CareConnect 360 which strives to improve coordination of care for jailed individuals and strengthen their continuity of care upon release. Medicaid enrollment and maintenance of eligibility are key to this project's success. The information contained in this report about existing Medicaid enrollment and eligibility practices in jails will be helpful in mapping out these strategies.

A second goal of Phase II ICJIP is to "improve Medicaid policy for the justice-involved population". The innovations and recommendations in this report will help shape this state-wide policy.

Amend MDHHS Medicaid Health Plan contracts to include incentives for Medicaid Health Plans to take responsibility for coordination of care activities for their members at release from jail (including Medicaid enrollment) (Nye et al, 2018).[5] Provisions in managed care contracts can require Medicaid Health Plans to engage with eligible members while still incarcerated and assign them a care coordinator. From there, a care coordinator could connect them to services as part of re-entry efforts.

Utilize health home models by incorporating the recently released population into primary care health home, opioid health home, and behavioral health home models (New York Medicaid, 2019).[6] In light of Michigan›s plans to expand behavioral health and opioid health homes due to their promising outcomes, this could be an opportune time to consider this policy solution. Existing health home eligibility criteria (e.g. individual leaving jail must have opioid use disorder and be at risk of developing another chronic condition) would remain intact, but the referral base would be broadened to include those being released from jails. Given the preponderance of individuals with chronic health conditions and serious behavioral health issues among the justice-involved population, a warm handoff to an existing health home where they can receive comprehensive care management, and integrated primary and behavioral health care makes good policy sense.

Submit an 1115 waiver application to Centers for Medicare and Medicaid Services (CMS) to authorize federal matching funds for the provision of targeted Medicaid services to eligible justice-involved populations in the 30-day period prior to release. This step would help prevent adverse health outcomes following release. As of 2019, 15 states have initiatives targeting the justice-involved population in approved waivers or waivers pending review. The details of these states' experiences and appropriateness for Michigan should be carefully reviewed (Blewett & Zylla, 2020).

Conclusion

The research reveals widespread barriers faced by county jails to accessing and reactivating Medicaid for the previously incarcerated population. These barriers are yet another hurdle faced by an already disenfranchised population. It is clear that some counties initiated solutions, thereby improved continuity of care. However, these advancements, in most cases, were temporary workarounds to a larger and more systemic issue of Medicaid access post-release.

The research highlights many short- and long-term community-driven and state-led recommendations. In the short-term, interviewees indicate that a state-wide guideline outlining consistent Medicaid eligibility and enrollment practices would go a long way in reducing some of the reported barriers. These findings may help inform that document and any subsequent training to jail staff.

The most promising long-term solution to address enrollment and reactivation pitfalls is to establish an automatic, centralized IT mechanism with daily feeds to and from the jails that would be triggered when an individual enters and leaves jail. According to CMS guidelines, it is possible that Medicaid matching funds could be used to reduce the economic burden on the state of putting this structure in place. Taken together, these (along with the other recommendations in this report) would go a

long way toward creating realistic, sustainable, equitable changes the justice-involved population deserves, while improving health outcomes and reducing recidivism.

The full report with resources is available at the Center's webpage, at https://behaviorhealthjustice.wayne.edu/medicaid-tbds.

For inquiries about the report: Joanne Sheldon, JoanneR@TBDSolutions.com, (877) 823-7348; Remi Romanowski-Pfeiffer, RemiR@TBDSolutions.com, (616) 228-0764; Center for Behavioral Health and Justice, cbhj@wayne.edu, (313) 577-5529.

Endnotes

1 Youth in secure placements may experience similar barriers to care continuity. This report is focused on adults.

2 Conducted by Maureen Welch-Marahar and Dr. Debra Pinals with MDHHS in collaboration with the MDOC and the Michigan Sheriffs' Association in late 2019.

3 The CBHJ focuses on behavioral health innovations. Although the CBHJ acknowledges it is vital to understand the needs of individuals with physical health conditions, it was outside of the scope of this report.

4 Centers for Medicare and Medicaid Services (CMS) cover expenses the State incurs in setting up its automated reporting system with the jails.

5 Many states are engaging Medicaid MCOs in this function, including Ohio, Louisiana, and New Mexico.

6 In New York state six of its Medicaid health home programs were designed with the needs of the justice – involved population in mind. Participants are eligible for health home services upon leaving jail, and they are referred while still incarcerated.

Letter from Lansing: the CMH System

By Marianne Huff, LMSW

Editor's Note: Integrated mental health care in the community is vital to preventing lapses in care that result in those living with mental health conditions becoming vulnerable to criminal justice involvement. The following Letter from Lansing describes recent challenges to care integration in the CMH system.

As long as I have been in and around the community mental health system in Michigan (my first experience began in 1991 with a family member who needed mental health treatment), which spans 30 years of both professional and personal involvement, the "CMH System" has experienced threats and challenges from a variety of sectors. Pressure and threats have arrived in the form of forced policy changes originating at the state and/or federal level. At other times, the threats have been due to changes in the healthcare environment such as the emphasis upon "integrated care" that was part of the Affordable Care Act.

Over the years I have been an observer of and, at times, a participant in the "system", I have watched as CMH has become under-funded and changed in myriad ways to "serve the people" better—which often did not mean the people were "served better." I have witnessed numerous attempts to "integrate" the system, "improve" the system, and rearrange its funding so there can be increased administrative efficiencies. And yet, despite much talk about improving public mental health and despite various mental health commission reports, such as the Mental Health Commission report in 2004 and the Mental Health and Wellness Commission report in

2014 and the recommendations of the Section 298 Work Group in 2016, little has been done to improve access to and the quality of behavioral health services at the service delivery level. And yet, here we are again, with another plan to make monumental "changes" to a "system" that is currently under-funded, unable to keep up with the demands that are imposed upon it, and has, for a variety of reasons, over-promised and under-delivered. Albert Einstein said it best, "Insanity: Doing the same thing over and over again and expecting different results."

A major impetus behind the movement to care integration has been lost along the way. What many may not know is that integrated care, which remains to be universally defined, is a concept that developed on the heels of a research paper by, Ron Manderscheid, PhD and Craig Colten entitled, "Congruencies in Increased Mortality Rates, Years of Potential Life Cost, and Causes of Death Among Public Mental Health Clients in Eight States" (May 2006; Preventing Chronic Disease) found that, "public mental health clients had a higher relative risk of death than the general populations of their states." This is based on a research study conducted in Arizona, Missouri, Oklahoma, Rhode Island, Texas, Vermont, and Virginia. Integrated care is not a bad idea.

A long-time MHAM board member and mental health professional with many years of experience in the field of psychiatry made these observations about care integration in Michigan, " First, with all of issues and machinations that this subject has generated, I fear the real and only legitimate justification for creating integrated care (which, if done right, I favor) has been lost sight of. At least, maybe, if this integration happens, the State will, and should be required to, monitor over time what the health of covered individuals turns out to be! Specifically, the justification for integrating care at all (other than everybody's chance to dip into the money pot) is to address a very disturbing problem: People with significant mental disorders die on average two decades or more before those without. And second, if I recall and understand my history correctly, the reason a budgetary "carve out" for mental health and disability services was created was, only by earmarking and protecting a specific amount of money, could that part of the State budget be protected from incursions into the money provided from all sides. Perhaps this is "100,000 feet" at the 11th hour. But, I believe these issues need to be mentioned by someone." Thank you for this observation. You are right.

There are no easy answers about "what to do" and "how to do it". At the same time, since Michigan's public mental health system is based in government, the political environment has been a major factor in shaping the structure and form of community mental health and this will continue. In some respects, one could argue there would be no "CMH" system without the will of state and local government to fund it. This argument is correct. At the same time, one could also argue the over-involvement of politics in a "system" that is supposed to be serving the most vulnerable citizens in Michigan has been, at times, beneficial and, at others detrimental. It is hoped there will be meaningful and positive changes created in the "CMH system" that will, ultimately, be for the benefit of those who need to have access to quality behavioral health care. One thing that has become clear to me over these past almost 30 years is this, if there is going to be meaningful redesign of the "system", then it needs to be done from the "bottom up" and not from the "top down". And all changes most certainly need to be conceived and birthed with an ear to the voices of those who matter most, the persons served by CMH, their families and those who love them.

About the Author

Marianne Huff, LMSW*, is the President and CEO of the Mental Health Association in Michigan, https://www.mha-mi.com.*


The Prisons and Corrections Section is now on Facebook and Twitter. "Like" us by searching "Prisons and Corrections Section of the State Bar of Michigan" on Facebook and follow us on Twitter at @SBM_PCS.

State Bar of Michigan Prisons and Corrections Section Council – June Program

Women and Incarceration

Saturday June 5, 2021 | Online Via Zoom

9:45 - 10:00 a.m. Welcome

10:00 – 10:15 a.m. **Centering Practice,** *Kintla Striker*

10:15 – 11:15 a.m. **The Neurobiology of Trauma, Mind-Body Interventions, and Incarcerated Women**
Kintla Striker
Attendees will gain a foundational understanding of the neurobiology of trauma, how to recognize traumatic stress, key outcomes of the KYT Method, supportive research, mind-body interventions as they relate to incarcerated, women and girls, and the five Ws and one H of implementing one mind-body, intervention.

11:15 – 11:30 a.m. Break

11:30 – 12:30 p.m. **Five Issues Plaguing Incarcerated Women**
Representative Tenisha Yancey and Annie Sommerville, Chief of Staff to Senator Jeff Irwin
There are more than five issues plaguing incarcerated women. In this session, we will focus on issues to better understand the problems and possible solutions.

12:30 – 12:45 p.m. Break

12:45 – 2:15 p.m. **Our Voices: A Dialogue With Impacted Women**
Monica Jahner, Kim Woodson, Jen Szenay, Lawanda Hollister, and Justine van der Leun of The Appeal, moderated by Siwatu-Salama Ra
In this session, we will hear from a panel of remarkable women who once served time inside and who are now home. We will also hear from individuals who have loved ones inside, and will hear from an investigative journalist who studies issues of trauma and incarceration.

2:15 – 2:30 p.m. Closeout

Registration for the online event is $20. Register at https://na.eventscloud.com/pc060521.

The registration page will ask you for your State Bar of Michigan email. If you are not a member of the State Bar of Michigan, you are still welcome to register by entering your email address.

If you have a hardship and would like to request a fee waiver, please contact Marilena David-Martin at mdavid@sado.org, 313-670-0309 to register.

Michigan Supreme Court Administrative Order Aids Access to Courts for Pro Per Prisoners Filing Criminal Appeals During the COVID-19 Pandemic

By Raymond C. Walen, Jr.

If there is a bright spot in the COVID-19 pandemic for those of us in prison, it is the Michigan Supreme Court's Administrative Order 2020-21 that tolls the deadline for filing certain appellate filings in Michigan courts.

At prisons on "outbreak" status — those with positive cases of COVID-19 — there is no in-person law library use. The only way to access publications is to fill out a form giving the exact citation needed, and send the form to the law library. Without an exact citation there are additional delays. The form allows you to request five items, but some libraries limit users to a single item. At those prisons, if you request more than one item they will write back and ask which one you want. Then you reply and wait. To get the next thing you need, you must return what you have received, request another form, and go through the same process again. Research which could have been done in minutes in person can take weeks. Recognizing the potential impact of these problems, the Court began with the following findings:

"As of November 20, 2020, nearly half of Michigan's prisons are considered outbreak sites of the COVID-19 virus. As a result, many prison facilities have restricted access to or closed the prison libraries, where self-represented inmates primarily work on pursuing their legal claims. These restrictions are impeding the ability of incarcerated individuals to complete the necessary legal pleadings to proceed with a criminal appeal."

As a remedy, Administrative Order 2020-21 provides for tolling the time limit for incarcerated pro per litigants to file an application for leave to appeal to the Michigan Supreme Court or an application for leave or a claim of appeal in the Michigan Court of Appeals in criminal appeals only. They must notify the pertinent court by letter of their intent to file a claim or application:

"The letter shall state that the incarcerated person is unable to complete and submit the necessary materials because of restrictions in place due to COVID-19, and shall be filed within the time for filing the application or claim of appeal under MCR 7.305(C)(2), MCR 7.204, or MCR 7.205. The letter will have the effect of tolling the filing deadline as of the date the letter was mailed from the correctional facility."

A January 5, 2021 amendment of AO 2020-21 requires that the letter to the court contain "the trial court case number and, if applicable, the Court of Appeals case number that is the subject of the intended appeal," and it provides that one "who filed a timely notice during the initial tolling period is not required to file a new notice during the extended period."

Once the tolling period ends, the appellant has the same number of days to file as he or she had when the tolling period began.

The January 30, 2021 amendment contains the additional finding that remote sentencing proceedings may result in "difficulty or delay in obtaining and submitting forms to request appellate counsel." To address this problem, the Court extended the 42 day deadline to return the request for appointed appellate counsel:

"If the defendant is indigent, a request for the appointment of appellate counsel under MCR 6.425(F)(3) must be granted if it is received by the trial court or the Michigan Appellate Assigned Counsel System (MAACS) within 6 months after sentencing. See MCR 6.425(G)(1)(d). This provision applies to all cases in which sentencing took place between March 24, 2020 and the end of the tolling period."

The Court's initial order set January 4, 2021 as the expiration date of the tolling period. Since then, monthly amendments have extended the tolling period and, under the latest May 3, 2021 amendment, the tolling period remains in effect until June 1, 2021.

About the Author

Raymond C. Walen, Jr. *worked as a staff paralegal at Prison Legal Services of Michigan, Inc., from 1987 to 2008.*

Expanded Expungement Laws Take Effect

As of April 11, 2021 Michiganders have increased opportunities to seek expungements following six of the seven new Clean Slate laws that have taken effect. We are now in the two-year implementation period for the final Clean Slate bill, which will automate expungements in many cases. The extra time is needed to create the technology needed to allow the computer systems used by various courts to communicate with each other. The package of bills was signed into law last fall by Governor Gretchen Witmer.

According to Michigan Attorney General Dana Nessel, the laws are expected to impact as many as one million people. The changes make it easier for people who have committed certain felonies and misdemeanors to have their records expunged. A significant number of those crimes are traffic and marijuana related.

Passage of the new laws was the culmination of a bipartisan legislative process that drew broad support from both sides of the aisle. Over the past several years, lawmakers from across the political spectrum in Michigan worked together to work on criminal justice reforms that will benefit everyone in our state.

Attorney General Nessel described the previous expungement system as time-consuming and confusing, preventing too many people "from employment, education, and stable housing as a result of their prior convictions." She also recognized the need to modernize the related technology, announcing a new webpage to help people understand the new laws and apply for expungement, at http://mi.gov/agexpunge.

"The new law brings about overdue change for so many residents who would otherwise have to carry around the burden of a public criminal record well past the point of having paid their debt to society," Nessel said in an April 12 press release. "Our new expungement webpage is a resource for residents to assess eligibility and better understand the process for applying to have their records expunged."

Clean Slate legislation was drafted with the goal of simplifying the process of receiving an expungement in mind. However, expungement by petition remains a legal process that can be intimidating to people who may lack the means or legal expertise to navigate the court system. To celebrate the start of expungement expansion, Safe & Just Michigan held a Clean Slate Kickoff on Monday, April 12 showcasing new free, low-cost legal resources for expungements provided by nonprofit organizations across the state for people who want an expungement. The Safe & Just Michigan event was recorded and is available at http://bit.ly/CSKickoffVideo.

From October 2022 moving forward

An automated system for expunging convictions without the necessity of filing an application is under development by multiple state agencies.

Up to 2 felony convictions will automatically be expunged the later of 10 years after sentencing or the person's release from custody; up to 4 misdemeanors will automatically be expunged 7 years after sentencing.

The following convictions will *not* be eligible for automatic expungement:

- convictions for "assaultive crimes"
- convictions for "serious misdemeanors"
- convictions for offenses punishable by 10 or more years imprisonment
- convictions that involve a minor, a vulnerable adult, injury or serious impairment of a person, death of a person
- convictions that involve human trafficking
- any conviction that cannot be expunged under new MCL 780.621g

Sources

Michigan Attorney General official website, http://mi.gov/agexpunge.

Press Release, Lt. Gov., Attorney General, Chief Justice among officials celebrating start of expungement expansion in Michigan, Safe & Just Michigan, April 12, 2021, available at https://www.safeandjustmi.org/wp-content/uploads/2021/04/Clean-Slate-Kickoff-Event-April-12-2021.pdf.

Michigan's Problem-Solving Courts Overcome Pandemic Challenges

The Michigan Supreme Court has released the FY 2020 MSC Problem-Solving Courts (PSC) Annual Report. The findings include that graduates of adult drug court programs were nearly 2 times less likely to be convicted of a new offense within three years of admission to a program. Also, unemployment dropped dramatically among drug and sobriety court graduates, as well as veterans treatment court graduates.

The problem-solving courts focus on providing treatment and intense supervision to offenders as an alternative to incarceration. These include drug and sobriety, mental health, veterans, and other nontraditional courts. The Supreme Court, through its State Court Administrative Office, assists trial court judges in the management of these courts by providing training, education, operational standards, monitoring, certification requirements, and funding.

Despite working through the COVID-19 pandemic during the second half of Fiscal Year 2020, the Michigan judiciary has remained open for business—with millions of hours of virtual hearings—and have been operating to the fullest extent possible under health and safety restrictions that have remained in place. The Michigan Supreme Court and its State Court Administrative Office (SCAO) have made this possible by providing courts with a solid framework of guidance through administrative orders, education, technology, and many other tools.

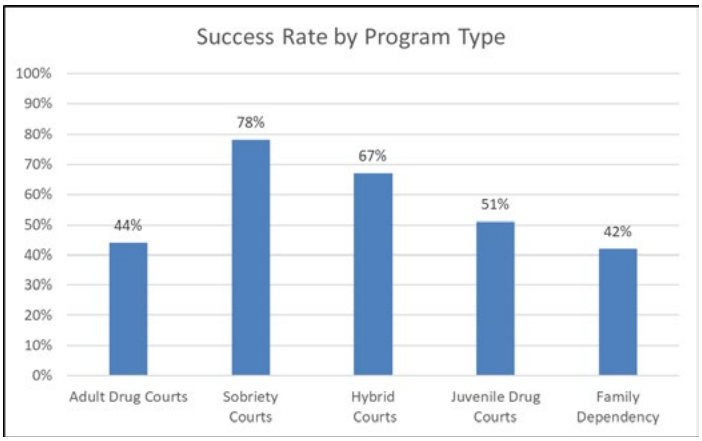
Lockdowns necessitated alternate methods of communication that these programs use to keep the strong sense of community participants come to rely on for their recovery. While problem-solving court (PSC) teams could not always meet with participants in person, they employed remote technologies such as Zoom, Skype, and text messages to make compliance checks, perform reviews, and provide the encouragement participants needed to stay on course.

In Fiscal Year 2020 the work of PSCs remained effective and successful during a most challenging time. PSCs remained accessible to virtually every Michigan resident; they engaged the community by supporting participants as they work to overcome addiction and/or mental illness through treatment; and they help communities save money and stay safe. Additional findings follow.

Success Rate

The overall success rate for participants of juvenile and adult drug court programs was 68 percent in FY 2020. Twenty-seven percent were discharged unsuccessfully due to noncompliance, abscondence, or a new offense. The remaining 5 percent were discharged for reasons such as voluntary withdrawal, "other," or death.

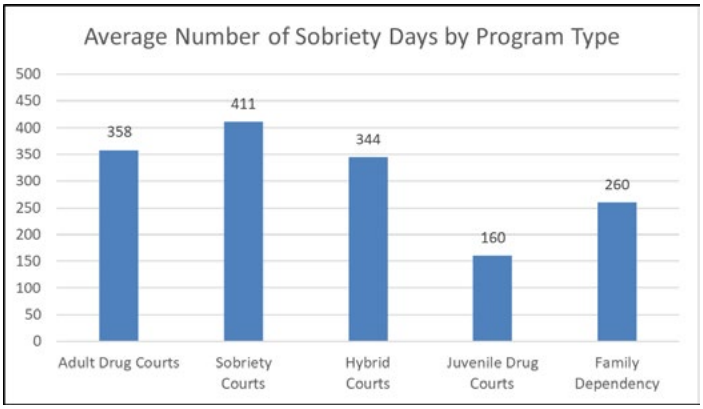
When broken down by program type, as shown in the graph, sobriety courts had the highest percentage of successful completions (78 percent). Sobriety courts accept only drunk/drugged driving offenders into their programs, addressing their alcohol abuse to reduce the threat of repeat driving offenses that pose the greatest harm to safe drivers. Hybrid courts, which accept drunk/drugged driving offenders, and other offense types, had the next highest percentage of successful completions (67 percent). Hybrid courts make up the majority of Michigan's adult treatment courts, targeting all types of offenders within statutory limits that have substance use disorders. Juvenile drug courts, serving youths 13 to 17 years old graduated over half of their participants. Adult drug courts specifically target offenders with offenses other than drunk/drugged driving and had the next highest completion rate (44 percent). The majority of these programs are circuit court programs taking felony offenders who identify opioids or methamphetamine as their drug of choice. The smallest number of adult treatment court programs, family dependency treatment courts, had a success rate of 42 percent. These programs address the addiction of the parent(s), while treating entire families in conjunction with DHHS.



Consecutive Sobriety

Based on best practices, participants should have a minimum of 90 consecutive days of clean time from alcohol and/or drugs before graduating a program. Sobriety days are calculated with a daily counter that is only reset by a

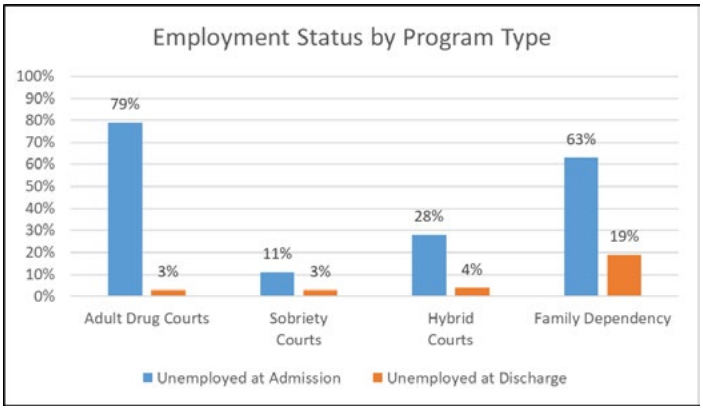
positive drug test. Juvenile drug courts have the smallest average of consecutive sobriety days, but are shorter in duration than other programs. Graduates of family dependency treatment court programs accept neglect and abuse petitions that are typically adjudicated within one year.



Employment Status

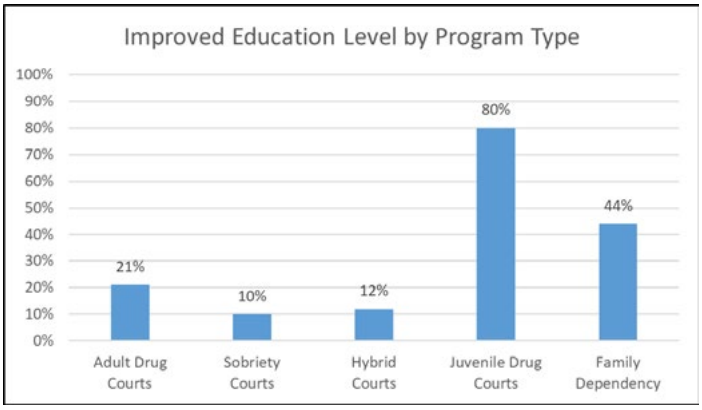
Substance abuse among adult offenders often interferes with productivity on the job, the ability to maintain employment, or being proactive in seeking employment. Treatment courts offer more than just treatment for addiction and frequent drug testing and monitoring; they are robust programs designed to ensure participants become contributing member of the community. Ancillary services, such as resume building and vocational training, help participants find employment once they become stabilized and engaged in recovery. Best practices states: "In order to graduate, participants who are able to join the labor force must have a job or be in school, in instances where health insurance and other social benefits are not at risk."

The number of graduates who were unemployed at admission was compared to the number of participants who were unemployed at discharge by program type. Among adult drug courts, 79 percent were unemployed at admission; at discharge, 3 percent were unemployed. This resulted in a 96 percent reduction in unemployment in adult drug courts. Hybrid courts had an 86 percent reduction in unemployment, while sobriety courts had a 73 percent reduction and family dependency courts had a 70 percent reduction. Juvenile drug court participants were not included because their main goal while working a program is to improve their education level.



Education

Youth offenders who enter juvenile drug courts (JDC) are often truant from school, hindering their advancement from one grade to the next. JDCs work closely with school officials, sometimes including them on their drug court team to ensure youth are attending school and completing their schoolwork. JDCs had the highest rate of improved education level, meaning that participants were successful in advancing to the next grade. Among adult programs, sobriety courts typically have a higher functioning population where a GED, high school diploma, or higher education were already obtained; therefore, advancing their education is not as necessary of a component to the program compared to those who have not yet earned a GED. There was a 26 percentage point increase from FY 2019 to FY 2020 among graduates of family dependency treatment courts that improved their education. It is unclear why, but it is possible that the loss of jobs due to the pandemic led to parents pursuing GEDs or higher education.



Sources

FY 2020 MSC Problem-Solving Courts (PSC) Annual Report, available at https://courts.michigan.gov/Administration/SCAO/Resources/Documents/Publications/Reports/PSCAnnualReport.pdf;

Press Release, Justice Clement Joined by Judges, Prosecutor & Community Partner to Share New Data, Success Stories from Michigan Problem-Solving Courts, Michigan Courts, April 21, 2021.

SECTION MEMBERSHIP APPLICATION FOR NON-BAR MEMBERS

Section Name	No.	$ Amount	
Administrative & Regulatory Law • Individuals involved in regulatory affairs, teaching, or administrative agency opperations	01	20.00	❑
Alternative Dispute Resolution You **MUST** complete the membership application form at http://www.connect.michbar.org/adr/home/join to join the ADR section • Law faculty • Individuals "engaged in the use or advancement of ADR through practice or teaching	02	40.00	❑
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Elder Law & Disability Rights • Employed with a public or non-profit body, firm, corporation or agency serving the elderly in general • Providers of care to elders • Providers of counseling, aid, or assistance for the health, welfare and financial needs of elders * Consultant members shall be appointed by the Section Council	26	40.00	❑
Health Care Law • Law faculty	28	45.00	❑
Information Technology Law • Law faculty	06	25.00	❑
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Labor & Employment Law You **MUST** complete the application at http://www.connect.michbar.org/laborlaw/council/ to join the Labor & Employment Law Section • Individuals involved in labor & employment law	14	35.00	❑
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Please note your qualification for joining the section:

_____

Several Sections of the State Bar offer membership to non-Bar members whose area of business is aligned with the Section area of practice, yet are neither attorneys, paralegals, or law students.

All non-Bar member applications are subject to review by the State Bar and individual Section's council as required by the Section's bylaws to ensure that the applicant is appropriately employed within the field of practice as described by the bylaw requirements.

The dues billing cycle for non-Bar members is aligned with the Bar year, October 1 through September 30. New member applications are accepted year round, and dues amounts will be applied to the current Bar year.

Regarding non-Bar member renewal procedures, please note that it is not possible to pre-pay dues for concurrent Bar years. Membership must be renewed annually via application and dues amounts submitted timely, by November 30 of each year, unless an extension has been provided for by the State Bar and the Section.

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Please check the section(s) you would like to join and submit with prepayment. The membership year is October 1 to September 30. Membership begins immediately through September 30.

	Section	No.	Cost
☐	Administrative & Regulatory Law	01	$20
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☐	Agricultural Law (70+ years of age)	37	FREE
☐	Alternative Dispute Resolution	02	$40
☐	Alternative Dispute Resolution (judges)*	02	FREE
	*Section dues free for sitting judges.		
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☐	Animal Law	32	$25
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☐	Environmental Law	08	$35
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☐	Government Law (70+ years of age)	19	FREE
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☐	Immigration Law	42	$35
☐	Immigration Law (70+ years of age)	42	FREE
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☐	Labor & Employment Law***	14	FREE
	***Section dues free if you are an emeritus member.		
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	(Probate registers and probate court administrators contact section for waiver)		
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☐	Workers' Compensation Law	22	$35
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