

White Paper

The Affordable Care Act and Criminal Justice: Intersections and Implications

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EXECUTIVE SUMMARY

The federal Patient Protection and Affordable Care Act, signed March 23, 2010, as amended by the Health Care and Education Reconciliation Act, is more commonly referred to as the Affordable Care Act or as “health care reform.” Included in the act are provisions intended to expand health coverage, contain rising health care costs, and improve health care delivery systems. The U.S. Supreme Court upheld most provisions of the act in a decision issued June 28, 2012.

Various provisions of the Affordable Care Act—including the expansion of Medicaid, investments to be made in health information technology, establishment of health insurance exchanges, and minimum essential coverage—have direct and indirect implications for criminal justice. Success in implementing the Affordable Care Act has the potential to decrease crime, recidivism, and criminal justice costs, while simultaneously improving the health and safety of communities. Conversely, the criminal justice population has been recognized by the U.S. Surgeon General as a cost containment opportunity for health care systems.

Currently, states are engaged in health care reform implementation and planning activities across the country. As of April 2012, \$856 million in federal funding has been invested in state planning efforts, which have been underway in most jurisdictions without the input of criminal justice stakeholders. In order to position criminal justice entities as informed partners, several potential systems planning, training, and technical assistance opportunities have been identified.

I. INTRODUCTION

The Affordable Care Act creates new opportunities for diversion and intervention at each point along the continuum of criminal justice systems, specifically during early diversion decision-making, court problem-solving strategies, and alternatives to incarceration. The act may potentially affect the level of correctional health care provided and will have major ramifications for the reentry process. Additionally, the act places increased attention on improving the health of uninsured and underinsured individuals across the nation. As one of the largest catchment areas for individuals with mental health and substance use disorders, infectious diseases, and chronic health conditions, the criminal justice system should be informed and integrated into state health care reform planning and implementation efforts (CSG, 2011).

“Pockets of excellence” exist around the country where criminal justice stakeholders are actively engaged in preparing and planning for the impact of the Affordable Care Act on their systems and populations; in addition, several stakeholders maintain existing practices and programs that could serve as models under health care reform, many of which are highlighted (though not exhaustive) throughout this document. Though the Affordable Care Act will not be a panacea for the challenges facing justice and health systems, it can serve as a tool for broad-scale system improvements—as outlined within this paper—that will require significant collaboration among health, social service, and criminal justice stakeholders (McDonnell et al., 2010; Hamblin et al., 2010).

II. PROVISIONS OF THE AFFORDABLE CARE ACT: AN OVERVIEW

The Affordable Care Act includes provisions intended to control the rising cost of health care, make quality and health system improvements, protect consumers and expand insurance coverage, shift the health care focus onto wellness and prevention, increase the health care workforce, and make quality and system improvements in health care. In addition to some of the provisions that will be detailed throughout this paper, other provisions addressed in the Affordable Care Act include, but are not limited to, the following:

Insurance Reforms

- Covers certain preventive care, such as immunizations, screening for certain adults for conditions such as high blood pressure, high cholesterol, diabetes, and cancer;
- Prohibits discrimination based on health status;
- Prohibits insurers from denying coverage to people with preexisting conditions; and
- Limits annual and lifetime caps on insurance coverage.

Coverage Expansion

- Covers young adults on parents’ policies to the age of 26;
- Provides Medicaid coverage of tobacco cessation services for pregnant enrollees;
- Increases funding in health profession scholarship and loan programs;
- Supports training programs for nurses;
- Increases funding for community health centers; and

- Targets outreach and enrollment efforts at “vulnerable populations.”

Delivery System Redesign

- Encourages new primary care models, such as patient-centered medical homes (PCMH) and team management of chronic diseases; and
- Creates Medicaid emergency psychiatric demonstration projects.

Payment Reform

- Establishes demonstration projects to develop payment mechanisms to improve efficiency and results;
- Provides for testing of new delivery and payment system models in Medicaid and Medicare;
- Makes investments in health information technology; and
- Encourages efforts to reduce health care fraud and abuse.

MEDICAID EXPANSION

One of the most significant provisions of the Affordable Care Act is the expansion of eligibility under Medicaid. This expansion will provide a new coverage option for millions of currently uninsured adults who have historically been excluded from Medicaid. Beginning in 2014, Medicaid eligibility will be determined based on income, rather than on categorical criteria such as having a disability or being a child, parent, or pregnant woman. As a result, this ends a historical coverage gap for nondisabled, nonelderly, low-income adults (commonly referred to as “childless adults”).

The number of low-income, uninsured Americans estimated to enroll nationally in Medicaid under the Affordable Care Act’s expansion in 2014 varies:

Estimated number of new Medicaid enrollees in 2014	Source
16 to 17 million	Congressional Budget Office
18 million	Centers for Medicare and Medicaid Services
8.5 to 22.4 million ¹	Health Affairs Journal

More specifically, the Affordable Care Act allows all Americans under the age of 65, who continue to meet residency and lawful citizenship requirements, with family income at or below 133 percent² of the federal poverty level (FPL) to qualify for Medicaid. The newly eligible adults, under the Medicaid expansion, will qualify for full federal financing for 3 years beginning in 2014, after which the increased federal matching payment will level off to 90 percent in 2020. This enhanced funding, however, will not apply to newly enrolled individuals who would otherwise have been eligible prior to the Affordable Care Act’s expansion of Medicaid.

¹ Range of 13.4 million depending on outreach and enrollment efforts

<http://content.healthaffairs.org/content/early/2011/10/24/hlthaff.2011.0413.full>

² 138 percent of poverty, including the 5 percent that the Affordable Care Act requires states to disregard when calculating eligibility.

As childless adults will make up a large percentage of the newly eligible population, there is great interest in anticipating their characteristics and health needs in order to appropriately plan outreach efforts and treatment capacity. For example, there is the hypothesis that individuals involved in the criminal justice system will be among the newly eligible adults, as many jail inmates are young, low-income males who did not previously qualify for Medicaid (NACo, 2012).

The only national estimates of the impact of the Medicaid expansion on inmates indicate that 33.6 percent of inmates released annually (approximately 245,000 in 2009) will be eligible for Medicaid coverage, while an additional 23.5 percent of inmates released annually (approximately 172,000 in 2009) will be eligible for subsidies through the state health insurance exchanges (Cuellar and Cheema, 2012). Other state or local estimates, however, anticipate larger numbers of new Medicaid enrollees in 2014:

- Community Oriented Correctional Health Services completed an analysis of 58 counties within California, which estimates that 70 percent of males between ages 18 and 24 will be newly eligible for Medicaid;
- New York City, which has already expanded eligibility to childless adults in the state, has stated that 80 percent of individuals in jails are either enrolled or eligible to be enrolled in Medicaid; and
- Illinois is estimating between 500,000 to 800,000 new Medicaid enrollees, of which approximately 300,000 are anticipated to be justice involved (e.g., jail bookings, on felony probation, or released from prison).

Some states have already expanded Medicaid eligibility to childless adults. Experiences from some such states could serve as indicators for what to expect in 2014. Some findings included the following:

- Among the most costly diagnoses of childless adults in Maine were mental health and substance use disorders (Hamblin et al., 2010); and
- Data from Washington and Maine suggest that the subset of the expansion population with jail involvement is likely to include many low-income, nonworking adults with chronic health needs with a very high prevalence of mental health and substance use disorders (Hamblin et al., 2010).

Salt Lake County, Utah

By actively communicating with the state Medicaid office, Salt Lake County officials were able to gather information demonstrating that most inmates in the county's jail system will fall into the new Medicaid expansion population category (NACo, 2012). The county has specifically created a health care services integration coordinator position to anticipate and plan for some of the issues that the jail will need to consider in 2014 (Ibid, 2012).

HEALTH INSURANCE EXCHANGES

Beginning in 2014, subsidies to defray the cost of health insurance will be available to U.S. citizens and legal immigrants who purchase health care coverage in the new health insurance exchanges (“exchanges”) and who have income up to 400 percent of FPL. To be eligible for the subsidies, individuals must not be eligible for public coverage—including Medicaid, the Children's Health Insurance Program, Medicare, or military coverage—and must not have access to health insurance through an employer. Since Medicaid coverage will be available to individuals who have income up to 133 percent of FPL, this effectively makes subsidies available to those who fall between 133 percent and 400 percent of FPL.

2011 FPL Guidelines
(48 states* and the District of Columbia)

Family Size	FPL	133% of FPL	400% of FPL
1	\$10,890	\$14,483.70	\$43,560
3	\$18,530	\$24,644.90	\$74,120

For larger families, add \$3,820 for each additional person

*Income levels are higher in Alaska and Hawaii

Exchanges will provide a new, web-based, regulated insurance marketplace for consumers to compare plans on measures of cost, quality, provider network, and benefits and buy health insurance (CCHA, 2012). Within the exchanges, insurance plans are to be offered in four tiers designated from lowest cost to highest cost: bronze, silver, gold, and platinum. The bronze-level benefit packages will be the most basic and least expensive plan and designed for those closest to the 133 percent of FPL, while the platinum level benefit packages will be the most expensive plan and targeted for those closer to the 400 percent of FPL. Each of these plans will also be limited in how much can be charged annually to enrollees: no more than \$5,950 for an individual’s coverage and \$11,900 for family coverage.

Departments of corrections will potentially interface with the health insurance exchanges in several ways. Some states already have criminal justice stakeholder engagement on health insurance exchange task forces (Montana, Nebraska, New York, Illinois, and New Jersey). The Nebraska Department of Insurance, for example, met with members from the Nebraska correctional system to discuss how the exchange might interact with the current correctional health system.³

PENDING DISPOSITION

Included within the Affordable Care Act legislation is new language addressing incarcerated individuals. Within section 1312, the legislation states, “all qualified individuals may purchase qualified health plans” and “[a]n individual shall not be treated as a qualified individual if, at the time of enrollment, the individual is incarcerated, other than incarceration *pending the disposition of charges* [emphasis added].” Similar language was also inserted in section 1501 of the legislation within the context of the individual mandate. While the incorporated language

³ www.doi.ne.gov/healthcarereform/exchange/quarterly_reports/2011.09.30.pdf

does not appear to change the underlying prohibition of participation in Medicaid for incarcerated individuals, criminal justice stakeholders and advocacy groups are awaiting further clarification from the Centers for Medicare and Medicaid Services (CMS) through future subregulatory guidance.

INDIVIDUAL MANDATE

Beginning January 1, 2014, nearly everyone will be responsible for maintaining health insurance coverage or will be subject to a penalty tax, commonly referred to as the “individual mandate.” Though nearly everyone is required to be enrolled in an approved health insurance plan every month beginning in 2014, there are some exemptions. Groups exempted from the penalty⁴ include, but are not limited to:

- Incarcerated individuals (other than incarceration pending the disposition of charges);
- Individuals who cannot afford coverage;
- Taxpayers with income under 100 percent of FPL;
- Members of Indian tribes;
- Those with gaps in coverage for a continuous period of less than 3 months; and
- Those experiencing a hardship, as determined by the Secretary of Health and Human Services (HHS).

BENEFITS AND SERVICES

Several combined provisions under the Affordable Care Act will enable a dramatic expansion of coverage for mental health and substance use disorders. These combined provisions include the establishment of a basic benefit package, extensions of parity, and the overall expansion of coverage to historically uninsured adults. These will increase the availability of Medicaid-financed, community-based mental health and substance use disorder services for many more individuals to receive treatment (Hamblin et al., 2010). Prior to the Affordable Care Act, Medicaid benefit packages were not required to cover prescription drugs and mental health and substance abuse services (Ibid, 2010).

The Affordable Care Act requires that specific health insurance plans, both inside and outside of exchanges, offer a comprehensive package of items and services, known as “essential health benefits” (EHB). These EHBs must include items and services within the following 10 categories:

Essential Health Benefits*	
Ambulatory Patient Services	Prescription Drugs
Emergency Services	Rehabilitative and Habilitative Services and Devices
Hospitalization	Laboratory Services
Maternity and Newborn Care	Preventive and Wellness Services and Chronic

⁴ Affordable Care Act Subtitle F, Part 1, Section 1501(d) and (e).

	Disease Management
Mental Health and Substance Use Disorder Services, incl. Behavioral Health Treatment	Pediatric Services, incl. Oral and Vision Care

*Insurance policies must cover these benefits in order to be certified and offered in exchanges, and all Medicaid state plans must cover these services by 2014.

In a guidance issued in December 2011, HHS clarified that each state would have the flexibility to define the specificity (length and scope of services within each EHB category) of their basic state “benchmark” benefit package, as long as each of the 10 EHB categories are covered. As a result, states are currently in the process of determining basic benefit packages to be offered in their individual states for both private and public health insurance coverage policies.

In 2008, the Mental Health Parity and Addiction Equity Act (MHPAEA) did not mandate that insurance plans provide mental health or addiction coverage, but rather it mandated that if plans opted to include such coverage, then they had to be “on par” with the medical and surgical benefits covered under the same plan. Generally, the effect of the mental health and addiction parity provisions in the Affordable Care Act is to extend the applicability of the federal MHPAEA requirements. Additionally, where essential health benefits are required, parity is now also required. Thus parity will be a requirement, rather than an option, for plans required to cover essential health benefits.

Department of Corrections, New Jersey

New Jersey’s Department of Corrections (DOC) is currently working with its state health insurance exchange planners to define the bronze-level benefit package within the state and is exploring what the benefit package should look like to address the complex and multiple health needs of justice-involved individuals. New Jersey also has a DOC–Medicaid taskforce that has been addressing Medicaid eligibility issues within the state. To date, New Jersey has secured grant dollars for an enrollment manager and Medicaid eligibility worker inside the jails to enable enrollment into Medicaid within 24 hours of release.

INTEGRATED CARE

New incentives under the Affordable Care Act are created for community health teams to manage chronic diseases in order to control costs and improve outcomes. Other incentives focus on the integration of primary and behavioral health care, PCMHs, and additional incentives available to physicians to form “accountable care organizations,” all designed to improve care and reduce unnecessary hospital admissions. Groups that are able to improve care and reduce costs will be able to retain some of the resulting savings (CCHA, 2012).

San Francisco Community College

The “Transitions Clinic Network: Linking High-Risk Medicaid Patients From Prison To Community Primary Care”⁵ project targets 11 community health centers in Alabama, California, Connecticut, the District of Columbia, Maryland, Massachusetts, New York, and Puerto Rico. It

⁵ <http://innovations.cms.gov/initiatives/Innovation-Awards/alabama.html>

was awarded \$6,852,153 by the CMS Innovation Center at HHS and is estimated to result in savings of \$8,115,855 over the 3-year project period.

The project's goal is to address the health care needs of high-risk/high-cost Medicaid- and Medicaid-eligible patients released from prison. The program will work with the Department of Corrections to identify patients with chronic medical conditions prior to release and will use community health workers trained by the City College of San Francisco to help these individuals navigate the care system, find primary care and other medical and social services, and coach them in chronic disease management. The outcomes will include reduced reliance on emergency room care, fewer hospital admissions, and lower cost, with improved patient health and better access to appropriate care.

A specific opportunity available under the Affordable Care Act is the creation of an optional Medicaid State Plan benefit for states to establish "health homes." Health homes will be designed to coordinate care for beneficiaries with chronic conditions, which will encourage the integration and coordination of all primary, acute, behavioral health, and long-term services and supports to treat the whole person. A priority under the Affordable Care Act is the coordination of care for individuals with mental illnesses, substance use disorders, and other chronic conditions (Nardone et al., 2012). Health homes⁶ will be allowed to target specific populations, diseases, and geographic locations, and will be able to provide the following services:

- Comprehensive care management;
- Care coordination and health promotion;
- Comprehensive transitional care/follow-up;
- Patient and family support;
- Referral to community and social services; and
- Use of health information technology (HIT) to link services.

There will also be state flexibility in designating providers for treating beneficiaries who have:

- Two or more chronic conditions (mental illness, substance use disorder, asthma, diabetes, heart disease, obesity);
- One chronic condition and risk for another; or
- A serious and persistent mental health condition.

New York City, New York

New York City has targeted individuals with criminal justice involvement in the development of its health homes. It has specifically included re-incarceration rates as a quality outcome metric for health homes. Additionally, it is requiring all health home providers to have direct partnerships with housing agencies to encourage successful engagement in chronic care management activities (Nardone, et al., 2012).

⁶ www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Support/Integrating-Care/Health-Homes/Health-Homes.html

INFORMATION TECHNOLOGY

Under the Affordable Care Act, there is considerable emphasis placed upon the use of HIT for electronic health record (EHR) documentation, care coordination within and across systems, and the use of data to inform clinical decisions and to facilitate communication among a variety of treatment providers. The Office of the National Coordinator for Health Information Technology, located within the Office of the Secretary for HHS, is at the forefront of the administration's HIT efforts and works to promote nationwide health information exchange to improve health care.

Utah

The Division Director of Salt Lake County's Substance Abuse Services, Pat Fleming, envisions an information continuum in which it's possible to log onto the state's health information exchange and determine whether an individual is eligible for Medicaid; enroll the individual online; follow the individual's interactions with the court system, treatment community, and eventually the health insurance exchange; and receive notification if the individual suffers a relapse and needs to go back into treatment (Gilmore, 2012).

Some criminal justice stakeholders have identified this as a particular opportunity for jails and prisons to establish linkages that support bidirectional relationships among community providers and county, state, and regional health partners to exchange information and promote continuity of care (Gilmore, 2012). Investments in HIT will allow for monitoring, followup, and accountability across health and justice systems. Currently, the Treatment Research Institute (TRI), in partnership with the Substance Abuse and Mental Health Services Administration (SAMHSA), has an established working group dedicated to focusing on increasing effective communication between criminal justice and treatment settings using HIT. The TRI/SAMHSA working group is also considering potential challenges in maintaining confidentiality and obtaining informed consent across systems.

Rikers Island Jail System, New York

The Rikers Island Jail System has an outpatient EHR adapted for correctional health—E-Clinical Works (eCW). The eCW system also has the ability to generate claims using health care claims coding (CPT and ICD9).

Medical care within jails has already benefited from data regarding prior encounters and admissions, and providers can better see the full spectrum of care received. Fundamental challenges identified included:

- Training staff to use the system;
- Matching/changing workflows; and
- Strengthening and adjusting quality assurance processes.

Next steps identified include:

- Strengthening skills of clinical staff using eCW; and
- Procuring and implementing a pharmacy system and to begin information exchange with outside entities (Stazesky et al., 2012).

III. PRACTICAL CONSIDERATIONS

ELIGIBILITY AND ENROLLMENT

In order to enroll individuals into Medicaid and other health insurance coverage, several issues must be taken into consideration, including conducting outreach to target those who lack coverage and collecting knowledge of existing coverage. If an individual does not have coverage, an eligibility determination then takes place. A single, streamlined enrollment application will be used in eligibility determinations for all health insurance plans offered through the exchanges, including Medicaid. This single enrollment application is intended to make the eligibility determination as trouble-free as possible for applicants. However, while applicants will submit only one application, significant coordination will be required among all entities involved in enrollment.

The Affordable Care Act specifically requires states to provide targeted outreach to facilitate the enrollment of underserved and vulnerable populations in Medicaid and CHIP (NACo, 2012). While regulations have not yet specified who comprises “vulnerable populations,” some jurisdictions have estimated that there will be a considerable amount of newly eligible individuals who have been justice involved. As such, these communities are considering criminal justice populations in the development of their outreach and enrollment strategies for targeting those who are hard to reach. Potential points of contact with these newly eligible individuals may include public defenders, county jails, prisons, probation, and parole, among others within the criminal justice system. All of these entities could be considered as potential allies for enrollment for this population, which would require corrections staff and skills capacity that may or may not exist, to assist with and conduct screening and enrollment for those newly eligible under Medicaid (Ibid, 2012).

New York City, New York

The Department of Health and Mental Hygiene with assistance from the local department of social services invests substantial resources into Medicaid eligibility screening and pre-enrollment services for mentally ill inmates, who account for about one-third of the New York City jail population, totaling approximately 30,000 admissions per year (NACo, 2012).

With regard to outreach and enrollment, beginning in 2014 exchanges will be required to contract with “navigators” to support special populations in selecting and enrolling in appropriate coverage. Currently, some departments of corrections and other inmate advocate organizations are beginning to consider whether they may qualify as navigators (CCHA, 2012). Funded through grants from the state exchanges, navigators will be required to provide unbiased, clear information in a linguistically and culturally competent manner. A variety of different types of entities will serve as navigators and will not need to hold professional licenses. This will enable those with the greatest expertise working with low-income and hard-to-reach individuals to serve in this capacity. Many individuals who will gain new access to public and private coverage in 2014 will have had little to no previous experience interacting with the health care system or health insurance, which will make the role of navigators a critical component for success in outreach and enrollment efforts.

Oklahoma: A program implemented in 2006 to improve discharge planning for inmates with mental illnesses involved the use of “integrated services discharge managers.” Findings from an evaluation of the program suggest that the intervention significantly increased Medicaid enrollment and service use (Ireys, 2010).

Minnesota: The state utilizes specialized release planners within its correctional system to assist with eligibility determinations and enrollment.

King County, Washington: The county also has a strong release planning program that engages key partnerships and processes to facilitate pre-release public benefit enrollment for reentering offenders.

Based upon the experiences of some states that began enrolling childless adults prior to 2014, newly eligible individuals with justice involvement will likely have limited literacy skills or lack of experience using computers, resulting in increased need for assistance as they apply for health coverage. Other challenges included obtaining the proof of income needed by inmates to confirm the poverty level requirement for Medicaid, as well as proof of citizenship. Providing proof of income will continue to be a challenge for individuals leaving prison or jails. Given the challenges experienced by some states in enrolling this population, it may prove useful to establish collaboration between health and justice systems in order to incorporate corrections information into eligibility determination systems. Additionally, states are currently receiving federal assistance, made available under the Affordable Care Act, to assist in the design and implementation of their enrollment technology.

Massachusetts

Massachusetts’ (MA) electronic “virtual gateway” application made a significant improvement in the rates of MA inmates leaving with Medicaid coverage. Since the MA system began with a manual application, it has seen its rates climb from 40 percent to 90 percent of offenders leaving incarceration with Medicaid coverage in place. MA’s electronic system has also assisted in identifying the underlying rationale for the 10 percent who remain without access. The 10 percent fell into groups that either 1) refused participation, 2) had plans to live outside of the state, 3) were already enrolled, 4) had issues with immigration status, or 5) were included in a group of parolees that the state is now actively targeting. The components critical to the success in MA have been identified as use of a Medicaid new member booklet, a strong relationship with the Medicaid counterparts in MA, and outreach to inmates prior to release. The state system also reflected that its efforts were greatly appreciated by probation officers, and it made released probationers in MA more favorable clients for community providers to serve given that they had already established insurance coverage.

Additionally, within MA, data has shown that 22 percent of people with substance use disorders are not enrolled in health programs, in comparison with a 2 percent statewide non-enrollment rate. This data indicates that targeted Medicaid enrollment efforts in the criminal justice system to focus on people with substance abuser disorders may be useful towards narrowing such enrollment gaps.

SUSPENSION VS. TERMINATION

Given that childless adults will make up a large percentage of the newly eligible population (and thus eligible for full federal financing for 3 years), there has been mounting interest in how Medicaid coverage will be handled for those childless adults who are currently incarcerated. Medicaid's current policy regarding the coverage of inmates was clarified by CMS in a 1997 memorandum sent to states.

The memorandum stated that for inmates of a public institution, federal funding is not available; however, an individual is not considered to be an inmate of a public institution if the individual has been admitted as an inpatient to a medical institution, separate from the penal system, for a 24-hour period or longer. Later guidance issued by CMS in 2004 reiterated that the above rule only relates to federal funds being available and does not affect the eligibility of an individual.

As such, the cost of inpatient services provided to Medicaid-eligible inmates of prisons or jails can be supported by federal dollars. However, in order to receive federal funding for providing Medicaid-covered services to inmates who are receiving inpatient care at a hospital, the inmate must already be determined eligible by the state. Thus, incarcerated individuals may be enrolled in the program before, during, and after the time in which they are incarcerated. The cost savings to Salt Lake County based on this approach to billing Medicaid have been estimated at nearly \$350,000 per year of a total cost of \$4 million for hospital services for inmates (NACo, 2012).

When an individual enrolled in Medicaid is detained, some states may terminate Medicaid benefits, despite federal guidance that allows for the suspension of Medicaid for individuals involved in the criminal justice system whose eligibility for the program is not linked to Supplemental Security Income (SSI). As systems move forward in establishing eligibility and enrollment systems and practices, an understanding of the suspension and termination policies and eligibility in each state will be useful. Policies allowing for the suspension, rather than termination, of Medicaid benefits for incarcerated individuals can function to ease transitions from incarceration to the community by reducing delays in benefits, as well as federal funding for the provision of such benefits and services, should inpatient hospital services be required during the period of incarceration.

WORKFORCE CAPACITY

Given the anticipated demand for health care capacity under the Affordable Care Act, the primary care workforce available to communities, as well as to corrections systems, might be significantly strained. Preparations for such increased demands on health care providers and safety net services are being considered both inside and outside of the criminal justice system.

Provisions within the Affordable Care Act were included to strengthen the health workforce, such as the establishment of the Community Health Center Fund that provides \$11 billion (2011 through 2015) to build new health centers (also referred to as Federally Qualified Health Centers) and improve or expand services. Additionally, the capacity of the mental health and behavioral health workforces are identified as being a high priority under the Affordable Care Act's National Workforce Strategy.

The American Correctional Association has begun to consider including workforce recruitment and retention strategies in its model private health provider vendor contracts, and it is evaluating health care process improvements that could reduce health care costs, increase efficiencies, and maximize existing health care resources within corrections systems and facilities (CCHA, 2012).

CONTINUITY OF CARE

With the anticipated increases in health care coverage under the Affordable Care Act, there may exist increased opportunities for the diversion of individuals identified as having low criminogenic risk and high health care needs. The direction and redirection of people into community health care with structured supervision might also be incentivized by two factors: reducing cost and avoiding potential litigation.

With rising correctional health care costs, it becomes necessary to identify opportunities for cost savings. Identifying the opportunity for savings involves looking at treatment costs associated with treatment locations. For example, the cost per day for an inpatient bed at a psychiatric hospital is \$1,200, while the cost per day for a bed at a 14-bed crisis residential treatment program is \$340 (CSG, 2010). Reducing costs at this point in the criminal justice system will need to involve law enforcement officers who have broad discretion in choosing whether to arrest an individual; whether to transport them to an available treatment provider, emergency department, or mental health facility; or whether to leave them at the scene (Ibid, 2010). As first responders within the criminal justice and emergency health care systems, their decisions have important implications for the flow of people into these systems. They also present a critical intercept point for the potentially appropriate diversion of people with mental health and substance use problems for emergency rooms and jails (Ibid, 2010). Full federal financing for years 2014 through 2016 for individuals identified as being newly eligible under Medicaid also serves as a cost-saving incentive to enroll individuals in Medicaid.

Regarding potential opportunities for litigation, the increased health insurance coverage proposed under the Affordable Care Act could result in individuals increasingly entering the criminal justice system with treatment and medication plans already established. As individuals enter jails or prisons, there might be an implied level of responsibility placed on these criminal justice systems to maintain such established levels of care.

Enabling the appropriate diversion of individuals will require thorough screening and assessment of levels of risk and need at each point along the criminal justice system. Screening for health and behavioral health needs in addition to existing and prior receipt of public benefits will help to inform decisions both at intake and pre-release in determining the correct placement for each individual. With regard to pre-release planning, screening for benefits—either suspended or terminated—will indicate whether an individual has a history of coverage. If no history is identified, it might be possible to then determine whether or not the individual is eligible for Medicaid and assist with their enrollment into the program (McDonnell et al., 2010).

Screening all entering detainees and potentially enrolling them into coverage could raise workforce capacity issues within criminal justice systems that will need to be taken into

consideration. As part of the health care safety net, community health centers, apart from being able to provide comprehensive primary and behavioral health care, can assist with such enrollment. As treatment begins in jail, the opportunity to develop relationships with community health providers will increase inmates' link to treatment as they return to communities or are sentenced to probation. Additionally, health homes, under the Affordable Care Act, can serve as a way to maintain care coordination as people transition in and out of the criminal justice system.

MANAGED CARE

With the expansion in Medicaid and increased parity in mental health and substance use treatment coverage, Medicaid funding rules will govern to a large extent how substance use and mental health care will be structured, reviewed, and approved. Additionally, criteria for reimbursement will be based on medical necessity, as determined by state Medicaid agencies. Each state Medicaid agency will be responsible for developing its own definition of what will constitute medical necessity (McDonnell et al., 2010). It is also important to note that Medicaid is fully engaged in moving beneficiaries into managed care plans across the nation. This is referred to as "Medicaid managed care," which is operated by managed care organizations (MCO). In turn, managed care will dictate how most people receive their health care, including drug and alcohol treatment (CCI, 2004). Additionally, the emphasis on integrated care and coordinated treatment through the establishment of PCMHs and health homes through the Affordable Care Act, and associated Medicaid incentives, will change the delivery of behavioral health treatment.

In considering access to treatment, drug courts in particular may want access to a broad range of treatment modalities. It is in this light that an understanding of Medicaid managed care may prove important. For example, MCOs can limit treatment in several ways (e.g., type of treatment covered, length of treatment, and requiring beneficiaries to see providers within their established network) (McDonnell et al., 2010). Another provision of the Affordable Care Act, addressing patient choice of providers, could have implications for justice systems that mandate treatment participation under a specified provider (Ibid, 2010). Models of effective collaboration between courts and managed care entities exist in both New York and Pennsylvania.

New York State

In the mid-1990s, New York's legislature adopted a bill requiring Medicaid managed care to pay for court-ordered treatment, resulting in the court's ability to determine type, length, and provider of treatment (CCI, 2004).

IV. MOVING TOWARD 2014

In order to position criminal justice systems and stakeholders as informed community partners, several potential systems planning, training, and technical assistance opportunities have been identified.

CROSS-SYSTEMS PLANNING

More and more states are starting to realize that health care reform will have a major impact on justice-involved populations. Leveraging health care reform for these populations will require intention, leadership, strategic planning, and deliberate coordination across health, social service, and criminal justice systems (McDonnell et al., 2010). This might present an opportunity to convene a collaborative planning group or council composed of representation from key stakeholder groups who have decisionmaking authority and invested commitment. Identified stakeholders and partners within a jurisdiction could include county government officials, the governor's office, the department of public health, the state Medicaid agencies, insurance directors, county IT directors, the judiciary, community health centers and other treatment providers, criminal justice administrators for the department of corrections, jails, and parole and probation systems, among others.

Such cross-collaboration for the design of systems could be guided by established principles, such as the need to:

- Understand relevant legislation, regulations, and policies;
- Ensure effective information sharing; and
- Coordinate performance measures, evaluation, and financing mechanisms (CSG, 2010).

Convening a health and justice planning council could facilitate collaboration among these stakeholder groups to inform upcoming decisions about the types of services that will be covered by Medicaid, the procedures for outreach and enrollment, and workforce capacity planning in each community related to justice-involved populations.

This type of cross-system collaboration is already underway in several states (New Jersey, New York, Pennsylvania, and Washington) where cross-agency task groups have been developed to address and improve services coordination among their populations, and three of the four have specifically worked with their local welfare and Medicaid agencies to ensure expedited re-enrollment for eligible individuals upon jail release (NACo, 2012). In addition to the aforementioned states, several others have already expressed interest in health care reform planning assistance for their correctional populations.

As states advance in their planning for health care reform, it might prove useful to establish such cross-systems planning pilot programs to inform other criminal justice stakeholders in the field in preparation for the changes going into effect in 2014.

Cook County, Illinois

Cook County is currently engaged in cross-system collaborative planning to engage in improved health care access for people under justice supervision. Planners are working to develop an integrated action plan that will allow Cook County to maximize the benefits of health care reform for their complex population, including reductions in future arrests and incarceration. Activities are scheduled to include the development and identification of:

- Strategies and infrastructure to screen and link people under justice supervision with substance use disorder, mental health, and medical treatment in the community;
- Needed community capacity expansion;
- Health care purchasing challenges specific to people under justice supervision;
- Challenges to health care purchasing for people under justice supervision in the new health networks, Medicaid managed care, and health exchange systems;
- A plan for evaluating progress on systems integration, outcomes, and cost/benefit from 2014 to 2019; and
- A workable model for other jurisdictions and states.⁷

TRAINING AND TECHNICAL ASSISTANCE

Criminal justice system leadership will benefit from understanding the key elements of the Affordable Care Act and how its implementation provides opportunities and challenges for criminal justice systems. The Affordable Care Act will affect opportunities available during early diversion decisionmaking, court problem-solving strategies, alternatives to incarceration, and potentially the level of correctional health care provided; and it will have major ramifications for the reentry process. Understanding how the Affordable Care Act will affect corrections and correctional health care, in particular, is critical as planning and implementation progresses (CCHA, 2012). A thorough environmental scan to document what is already taking place could be of assistance in informing models and practices for the field to replicate and enhance under health care reform. Additional education, training, and technical assistance could also help inform criminal justice system administrators and policymakers as they prepare for the changing landscape of health care reform in 2014.

Such education, training, and technical assistance could address:

- Understanding health care reform 101;
- Federal vs. state Medicaid rules on eligibility and financing;
- Understanding managed care (and Medicaid managed care) and health care financing and contracting;
- Systems planning matrices;
- How the Affordable Care Act impacts mental health and substance abuse treatment;
- Essential health benefits;
- Developing Medicaid expansion estimates;
- Determining and developing effective outreach and enrollment strategies, including potential opportunities under the navigator program; and
- Integrated care models such as health homes that are emphasized under the Affordable Care Act.

⁷ Information provided by Illinois TASC point of contact.

The **American Correctional Association** is currently developing technical assistance detailing:

- Steps to determine existing coverage;
- Enrolling inmates in Medicaid or other insurance;
- Filing claims on existing coverage;
- Using existing health coverage; and
- Steps involved in engaging Medicaid representatives and others in the state to enroll eligible inmates in Medicaid.

Additionally, pilot programs or demonstration projects could target:

- The feasibility of developing electronic medical records for criminal justice populations;
- HIT and the utilization between justice and health entities; and
- Patient navigator opportunities.

In order to develop informed criminal justice systems and stakeholders, specific to health care reform, it will be necessary for current training and technical assistance providers to understand the scope and breadth of implications presented by the Affordable Care Act.

V. CONCLUSION

While the intent of the Affordable Care Act is directed toward the expansion of health coverage, containment of rising health care costs, and improvement of health care delivery, the potential achievements of health care reform are not limited to the health care field. Success in implementing the Affordable Care Act has the potential to improve the health and safety of communities. In order to maximize the tools made available through the Affordable Care Act, it is important to position the criminal justice field as an informed partner that can actively engage in planning that is currently underway across the country.

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