

IMPLICATIONS OF IMPLEMENTATION THE AFFORDABLE CARE ACT AND CRIMINAL JUSTICE

A forum presented by the Criminal Justice Coordinating Council's Substance Abuse Treatment and Mental Health Services Integration Taskforce in partnership with the Public Welfare Foundation and the Legal Action Center

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AGENDA

WELCOME REMARKS

Steve Baron

Director, Department of Behavioral Health

IMPLICATIONS OF IMPLEMENTATION: THE AFFORDABLE CARE ACT AND CRIMINAL JUSTICE

Paul N. Samuels

Director and President, Legal Action Center

LEVERAGING HEALTHCARE REFORM TO TRANSFORM CRIMINAL JUSTICE AND BEHAVIORAL HEALTH SYSTEMS

Pamela F. Rodriguez

President, Treatment Alternatives for Safe Communities

Maureen McDonnell

Director for Business and Health Care Strategy Development, Treatment Alternatives for Safe Communities

DISTRICT OF COLUMBIA HEALTH BENEFIT EXCHANGE AUTHORITY AND DC HEALTH LINK

Diane Lewis

Co-Principal and Executive Vice President, Alta Consulting
Chairperson, Health Benefit Exchange Authority Executive Board

THE AFFORDABLE CARE ACT AND MEDICAID ELIGIBILITY

Danielle Lewis

Associate Director for Eligibility Policy, Department of Health Care Finance

HEALTH HOME SERVICES: FINALIZING DESIGN, MOVING TO IMPLEMENTATION

Oscar Morgan

Director of Adult Services, Department of Behavioral Health

In July 2013, the Criminal Justice Coordinating Council's Substance Abuse Treatment and Mental Health Services Integration Taskforce (SATMHSIT) presented a forum that brought criminal justice and healthcare stakeholders together to share general information about the Affordable Care Act (the "ACA"), highlight the changes that had taken and would take place in light of the ACA, and explore the implications of the ACA for those involved in the criminal justice system.

The SATMHSIT has partnered with the Public Welfare Foundation and the Legal Action Center to present this follow up to the July forum, which will focus on strategies for bridging healthcare gaps to ensure continuous healthcare for the criminal justice-involved population. National and local experts will discuss best practices, strategies, enrollment, and a breakdown of the numbers.

MODERATED Q&A SESSION

Nancy Ware

Director, Court Services and Offender Supervision Agency

CLOSING REMARKS

Mannone A. Butler

Executive Director, Criminal Justice Coordinating Council



IMPLICATIONS OF IMPLEMENTATION THE AFFORDABLE CARE ACT AND CRIMINAL JUSTICE

ACKNOWLEDGMENTS

The Criminal Justice Coordinating Council’s Substance Abuse Treatment and Mental Health Services Integration Taskforce would like to thank our distinguished speakers for sharing their insight and expertise on this important topic with us.

Paul N. Samuels
Director and President
Legal Action Center

Pamela F. Rodriguez
President
Treatment Alternatives for Safe Communities

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Department of Behavioral Health

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Danielle Lewis
Associate Director for Eligibility Policy
Department of Health Care Finance

***Substance Abuse Treatment and Mental Health
Services Integration Taskforce Co-Chairs***

Steve Baron
Director, Department of Behavioral Health

Nancy Ware
Director, Court Services and Offender Supervision Agency



IMPLICATIONS OF IMPLEMENTATION

THE AFFORDABLE CARE ACT AND CRIMINAL JUSTICE

A FORUM PRESENTED BY CJCC'S SATMHSIT IN PARTNERSHIP WITH THE PUBLIC WELFARE FOUNDATION AND THE LEGAL ACTION CENTER

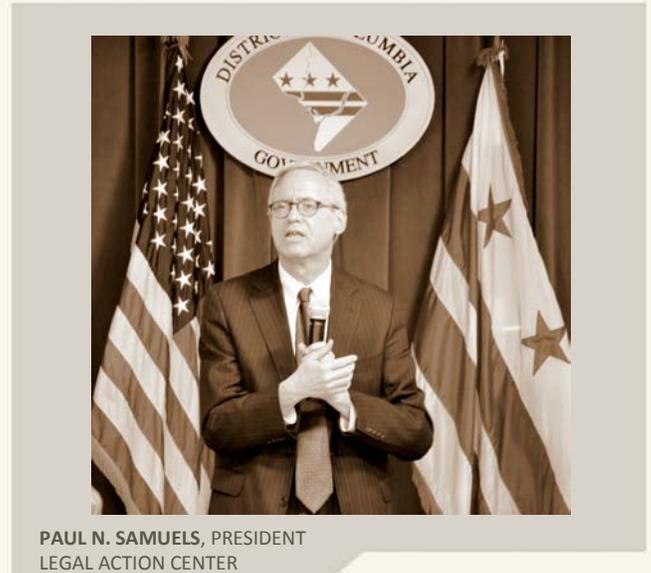
In July 2013, the Criminal Justice Coordinating Council's Substance Abuse Treatment and Mental Health Services Integration Taskforce ("SATMHSIT") presented The Affordable Care Act and Criminal Justice, a forum that brought criminal justice and healthcare stakeholders together to share general information about the Affordable Care Act ("ACA"), highlight the changes brought about by the ACA, and discuss the implications of the ACA for individuals involved in the criminal justice system. The SATMHSIT partnered with the Public Welfare Foundation and the Legal Action Center to present this follow-up forum, titled Implications of Implementation: The Affordable Care Act and Criminal Justice, which focused on strategies for bridging healthcare gaps to ensure continuous care for the District of Columbia's criminal justice-involved population.

National and local experts presented on topics including the opportunities created by the ACA to expand and improve access to care for justice-involved individuals, best practices and strategies for addressing barriers to healthcare access, an overview of the relationship and interaction between the healthcare system and the criminal justice system, changes to Medicaid under the ACA, and justice and health initiatives currently being developed and implemented in the New York, Illinois, and the District of Columbia.

IMPLICATIONS OF IMPLEMENTATION: THE AFFORDABLE CARE ACT AND CRIMINAL JUSTICE

With respect to provision of care, both the health care and criminal justice systems experience very similar types of problems, such as ineffectively addressing chronic illnesses, particularly addiction and mental health; great disparities in providing care to people of color and the poor; and overuse of the most expensive and least effective health care settings (i.e. emergency rooms, hospitals, prisons, and jails). However, effective implementation of the ACA creates many possibilities for reform.

There are high rates of physical health problems, mental illness, and substance use disorders in the criminal justice system, with three times as many seriously mentally ill persons in jails and prisons than in



hospitals. As a result, state and local court systems and correctional agencies spend huge amounts of money on care. Complicating this problem, most returning citizens have little or no health insurance coverage upon returning to the community. There is a clear relationship between criminal justice system involvement, high rates of recidivism, and untreated mental health and substance use disorders. Drug overdose is the highest cause of death for returning citizens, whose risk of death is twelve (12) times higher during the first two weeks after release. Access to appropriate care allows health outcomes to improve, which in turn leads to declines in recidivism as well as costs for correctional and health systems.

Barriers and Opportunities

Achieving overarching system-wide change is difficult, requiring the dedication of significant resources, training, and staff, and requiring the cooperation of key stakeholders (i.e. law enforcement, corrections, health officials, etc.). The fundamental obstacle to achieving inter-system change is the lack of understanding of each other's operations, culture, and language. Criminal justice, health care, Medicaid, and social services systems must work together, connecting IT and data systems in order to make efficient enrollment possible.

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ACA implementation presents an opportunity to 1) improve public health; 2) increase public safety; and 3) reap substantial cost savings in the process. Research shows that treating mental health and addiction improves overall health and reduces crime. As a result, enrolling the criminal justice population in Medicaid and getting them care as early as possible, beginning with arrest and pretrial, and continuing at jails and prisons, reentry, and community corrections, will reduce health problems and crime and save taxpayer dollars. Through Medicaid coverage, the federal government covers most of the cost. In fact, current Medicaid rules allow federal reimbursement at the usual match levels, even for incarcerated persons needing community-based institutional care. Under the ACA, substance use disorders, mental health services, and corresponding medications are essential health benefits which must be covered at parity, under the Mental Health Parity and Addiction Equity Act.

It is recommended that practitioners begin the process of gathering, planning and collaboration. This includes determining the District process for insurance enrollment, understanding how to determine coverage options, convening a local planning process to work together, and incorporating enrollment into each agency's system. In addition, practitioners should identify ways in which court-involved individuals can be better connected to community-based care, and should educate colleagues and clients about the benefits of the ACA.

Examples of Local and Statewide Initiatives

In the state of New York, collaboration efforts are underway between the Deputy Secretary of Public Safety and the Deputy Secretary of Health to capitalize on opportunities to improve the enrollment of the criminal justice population into the healthcare system through state Medicaid and federal ACA implementation. The New York initiative aims to begin enrollment as early as possible and link individuals to health home pilot programs both as a means of providing care and as an alternative to incarceration or reentry programs.

LEVERAGING HEALTHCARE REFORM TO TRANSFORM CRIMINAL JUSTICE AND BEHAVIORAL HEALTH SYSTEMS

The goal of leveraging healthcare reform for the criminal justice-system involved population is the creation of a robust, expanded community behavioral health treatment system, which will be achieved through collective and individual agency planning and action. Successful implementation of the ACA will require: 1) the protection of current capacity, 2) the building of greater capacity, and 3) improvement of the effectiveness and efficiency of the administration of medical and mental health care. If the justice system generates a greater demand for health services, community treatment capacity must be able to respond to this increased demand.

ACA in Action in the Justice System

The Cook County (IL) Justice and Health Initiative began in 2012 with four (4) goals in mind: 1) determine how to facilitate applications for persons entering the justice system; 2) develop infrastructure supporting universal linkage to medical, mental health, and substance abuse treatment; 3) support expansion of



PAMELA RODRIGUEZ, PRESIDENT
TASC-IL

IMPLICATIONS OF IMPLEMENTATION

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care in the community; and 4) expand diversion from jail and prison to care in the community. Since the initiative’s inception, over 14,000 new Medicaid applications were initiated in Cook County. The Cook County Health Initiative enacted several efforts that may be applied in the District of Columbia: 1) Improved Jail Intake Application Process; 2) Jail-to-Community Continuity of Care; and 3) the “Health Care Reform Ready” Court, which is designed to function as a normal felony court, but which takes advantage of all the medical, mental health, and addiction services that exist in the community. There are also efforts underway to leverage Medicaid coverage in making pretrial detention decisions.

DISTRICT OF COLUMBIA HEALTH BENEFIT EXCHANGE AUTHORITY AND DC HEALTH LINK

The DC Health Benefit Exchange Authority (DCHBX) was established in March 2012, merging the ACA implementation efforts of the Department of Health Care Finance (DHCF), the Department of Health (DOH), the Department of Human Services (DHS), and the Department of Insurance, Securities and Banking.

DCHBX’s main priority has been to build an information technology system capable of handling the online insurance marketplace – DC Health Link. Its work on this critical issue is ongoing. It is estimated that approximately one in six of the individuals expected to enroll in the District’s expanded Medicaid program and one in 10 of those expected to enroll through health insurance marketplaces will have spent some time in jail during the past year.

Through a partnership with the Court Services and Offender Supervision Agency (CSOSA), DC Health Link has increased enrollment of returning citizens who are Medicaid eligible, as well as those who are low-to-moderate income (100% to 400% of the Federal Poverty Level) who may be eligible for tax credits. Among the most pressing current challenges to enrollment are: 1) the lack of providers with Medicaid certification, 2) the lack of coordination of care from jail to community, and 3) the lack of integration of

primary and behavioral health care. Members of the criminal justice-involved population often have medical conditions (i.e. hypertension, asthma, etc.) requiring primary care that have not been addressed for many years.



MAUREEN MCDONNELL, DIRECTOR FOR BUSINESS AND HEALTHCARE STRATEGY DEVELOPMENT, TASC-IL



DIANE LEWIS, CHAIRPERSON DCHBX EXECUTIVE BOARD

IMPLICATIONS OF IMPLEMENTATION

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THE AFFORDABLE CARE ACT AND MEDICAID ELIGIBILITY

In order to be eligible for DC Medicaid coverage, an individual must be a District resident, a U.S. citizen or have qualified immigration status, have income at or below the income threshold for the eligibility group, and cannot be an inmate in a public institution, unless as an in-patient in a medical facility. The ACA expands access to affordable coverage, creating a new eligibility group consisting of childless adults aged 19-64 with income up to 133% of the Federal Poverty Level (FPL). The District implemented this option in July 2010 and secured a waiver to cover childless adults with income of up to 200% of FPL. Today, the District covers 50,000 childless adults in this category.

The ACA has modernized the eligibility verification system for Medicaid, which now accepts online applications, utilizes local and federal electronic data sources to determine eligibility, and allows for the performance of passive renewals.

Federal law prohibits payment for services once an individual is in a public institution, including jail, prison, detention center, or halfway house. This rule applies to both pre- and post-adjudication institutionalization. However, Medicaid does allow for coverage for incarcerated individuals who are admitted for in-patient services in a medical facility for at least 24 hours; the exception does not extend to outpatient services, regardless of where the services are administered. While Medicaid coverage is not available for individuals in jail or prison, these individuals nevertheless retain their eligibility while incarcerated and may enroll. The District is currently working to create policy that would suspend, rather than terminate, Medicaid eligibility upon incarceration. Additionally, inmates may obtain Medicaid eligibility by applying either by paper, by telephone, or online through DCHealthlink.com. Inmates can apply while in jail or prison, during an inpatient hospital stay, or prior to release as part of the pre-release planning process.

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Persons incarcerated in another state for more than 90 days are not considered District residents. If the individual is returning to the District, that person must verify their District residency before they can be approved for Medicaid.



DANIELLE LEWIS, ASSOC. DIRECTOR FOR ELIGIBILITY POLICY
DEPT. OF HEALTH CARE FINANCE



OSCAR MORGAN, DIRECTOR OF ADULT SERVICES
DEPT. OF BEHAVIORAL HEALTH

HEALTH HOME SERVICES: FINALIZING DESIGN, MOVING TO IMPLEMENTATION

Health Homes are a joint effort currently being developed by the Departments of Behavioral Health (DBH) and Health Care Finance (DHCF) to improve care coordination and prevent avoidable hospital and ER visits, thereby improving the health of persons with serious mental illnesses and reducing health care costs. The Health Home Initiative is comprised of Core Services Agencies (CSA) and Assertive Community Treatment (ACT) providers in the DBH network. These Health Home providers are responsible for providing access to individualized case management, preventive care, behavioral and primary care, illness management, and a community support network. They must also demonstrate the capacity to use health information technology to facilitate care coordination. In order to be eligible for Health Home service, individuals must be 18 years of age, be Medicaid eligible, have a serious mental illness, and may or may not have a co-existing chronic physical condition.

Efforts are under way to ensure proper staffing and training at Health Home service providers, as well as to bring an IT system online to manage information

collection and reporting. The Health Home Initiative is presently scheduled to be rolled out by the end of this calendar year.

NEXT STEPS

- The Substance Abuse Treatment and Mental Health Services Integration Taskforce (SATMHSIT) will follow up with Claudia Schlosberg (DHCF) and Danielle Lewis (DHCF) to address the challenges managing the partially federal incarceration system in the District. For instance, because District inmates are housed throughout the country, complications arise with efforts to sign them up for Medicaid prior to their release because, despite their intention to return to the District upon their release, they are not considered District residents under the current definition, having resided outside of the District for more than 90 days as a result of their incarceration. Additionally, continuity of care challenges include the inability to quickly refresh desperately needed prescription medications upon returning to the District.
- The Court Services and Offender Supervision Agency (CSOSA), Department of Behavioral Health (DBH), the Pretrial Services Agency for the District of Columbia (PSA), and the Department of Health Care Finance (DHCF) will work in concert to determine which vendors are Medicaid eligible and ensure that there is sufficient capacity to serve the health needs of justice-involved individuals.
- The SATMHSIT will also leverage existing partnerships among its stakeholders to facilitate and coordinate the collaborative process between criminal justice and health agencies in the District.

The Criminal Justice Coordinating Council's point of contact for the Substance Abuse Treatment and Mental Health Services Integration Taskforce is Michen M. Tah, Esq. She can be reached at michen.tah@dc.gov or (202) 442-9282.

IMPLICATIONS OF IMPLEMENTATION

The Affordable Care Act and Criminal Justice

Paul N. Samuels
President/Director
Legal Action Center

Criminal Justice Coordinating Council's Substance Abuse Treatment and
Mental Health Services Integration Taskforce Forum

April 28, 2014

What We'll Discuss Today

- The relationship between health and involvement in the criminal justice system
- What are the ACA's (Affordable Care Act) major opportunities to expand coverage for services and to improve access to care for justice-involved individuals?
- What steps have certain jurisdictions taken to enroll justice-involved people in health insurance and link them to care?

Health care system:

- Not very effective addressing chronic illnesses, especially addiction (90% of 23 million Americans with SUDs receive no specialty care) and mental health (1 / 3 of those with SMI and 1/2 overall receive no care)
- Great disparities in providing care to people of color, poor and working poor
- Overuse of the most expensive and often least effective settings: ER's and hospitals
- BUT: ACA has created new landscape with lots of possibilities for reform

Criminal justice system (can be described in much the same ways):

- Not very effective addressing those with addictions: Decades of drug law and overly punitive policies caused mass incarceration and perpetual punishment through “new Jim Crow” of legal barriers to successful reentry
- Great disparities in treatment of people of color – vast majority of drug arrests and incarceration despite whites using drugs at least as often – and the poor
- Overuse of the most expensive and often least effective settings: prisons and jails
- BUT: widespread rejection of these failed policies and policy reforms in sentencing and reentry policies, plus, unlike health care reform, growing bi-partisan consensus for reform

Health Characteristics of Justice-Involved Individuals ¹³

- High rates of physical health problems, mental illness and substance use disorders (SUDs) in the criminal justice system
 - 65% of all people incarcerated in jails and prisons meet medical criteria for a substance use disorder
 - There are three times more seriously mentally ill persons in jails and prisons than in hospitals
- State and local court systems and correctional agencies have spent huge amounts of money on care
 - Recent report found that prison health care spending in 44 states totaled \$6.5 billion in 2008; spending rose on average by 52 percent over 7 years

Health Characteristics of Justice-Involved Individuals ¹⁴ cont'd

- Most people reentering from incarceration have no or little health insurance coverage in the community
 - 70 to 90 percent of individuals with criminal justice involvement are uninsured at reentry
- Even for individuals with health insurance, coverage for mental health and substance use disorder benefits has been inconsistent and often lacking
- Most people have had poor access to health care
 - 90 percent of the 23 million Americans with substance use disorders receive no specialty care
 - One-third of those with serious mental illness and half of people with mental health conditions overall receive no care

Health and Recidivism

- Relationship between criminal justice system involvement, high rates of recidivism and untreated mental health and SUD
 - Drug overdose is the highest cause of death for individuals reentering the community
 - Twelve-times higher risk of death in the first two weeks after release
- However, with access to care, health outcomes improve, and recidivism rates and costs to the correctional and health systems decline
 - Findings from the Washington State study

Barriers

Systems change is difficult

- Change in a large and sometimes bureaucratic system is hard, let alone 2 large systems
- Need to devote resources to staff, training, etc.
- Need to have different state and local governments work together
- Need to get key stakeholders (including law enforcement, corrections, etc.) invested in and working toward this shift

Barriers cont'd

- Fundamental problem: understanding each other's operations, culture and even language
- Need health/Medicaid/cj and/or social services systems to work together, connect IT and data systems, etc. to make the enrollment happen
- Sometimes different and occasionally contradictory goals: most appropriate care vis-à-vis public safety; cj players favoring some approaches (e.g., long-term residential addiction treatment) and prohibiting others (e.g., methadone and other medication-assisted therapies)

Opportunities

- Triple Goal: Improve Public Health, Increase Public Safety, and Reap Substantial Cost Savings While Doing So
- Opportunity to enroll millions of Americans in criminal justice system in Medicaid (and sometimes in private insurance with subsidies through the Insurance Marketplaces) —thereby providing huge infusion of federal funding to provide health coverage and link them to the care they need

ACA'S Opportunities for the Criminal Justice ¹⁹ System: Coverage Expansions and Infusion of Federal Dollars

- The ACA presents a huge opportunity to improve public health, increase public safety, and save states huge amounts of money
 - The ACA dramatically expands health insurance coverage to millions of people
 - In the 27 states expanding their Medicaid population, federal Medicaid will for the first time pay for non-disabled adults with no dependent children up to 138% FPL
 - Huge federal investment: federal dollars will cover 100% of the costs for first 3 years, decreasing to 90 percent indefinitely
 - Federal dollars likely create greater incentives in states and counties for systems reforms and collaborations
 - Opportunities for reimbursement for enrollment activities

Opportunities of ACA

- Research shows treating addiction and MH effectively improves health and reduces crime. Thus, enrolling cj population in Medicaid and getting them care as early in the process as possible, beginning with arrest and pre-trial and for those in prisons/jails and under community supervision, not only will reduce health problems and crime and save taxpayer dollars, the federal government will pay most of the cost
- Plus, current Medicaid allows federal reimbursement at usual match even for people incarcerated who need community institutional care

Enrolling Justice-Involved Individuals in Health Insurance and Linking them to Care

- Opportunities at every intercept for enrollment and linkage to care
 - Initial contact with law enforcement/emergency services
 - Initial detention/initial court hearing
 - With courts (including specialty courts)

Enrolling Justice-Involved Individuals in Health Insurance and Linking them to Care

- Opportunities at every intercept for enrollment and linkage to care (continued)
 - In jails and prisons
 - Restrictions continue on federal Medicaid spending for individuals while they are incarcerated but ACA's federal dollars create greater state/county incentives to enroll all eligible individuals and to create systems that maintain enrollment, and support transitions and continuity of care
 - At reentry
 - Community corrections

Importance of the ACA to the Criminal Justice²³ System: Improved Coverage for and Access to Addiction and Mental Health Services

- The ACA will dramatically improve coverage for and access to substance use disorder (SUD) and mental health (MH) services
 - Under the ACA, SUD and MH services are essential health benefits which must be covered at parity (Mental Health Parity and Addiction Equity Act) with other covered medical benefits
 - Requirements apply to most Medicaid and private insurance coverage; access improvements will apply to millions
 - Parity requirements relate to scope of MH and SUD services and medications covered, financial requirements, and quantitative and non-quantitative treatment limitations

Importance of the ACA to the Criminal Justice²⁴ System: Improved Access to Care for People with Chronic Health Conditions

- The ACA has a strong focus on creating incentives to help people with multiple chronic health conditions
- Section 2703 of the ACA created the new health home Medicaid option for beneficiaries with multiple chronic conditions.
 - Health homes are meant to build on other care coordination models to create linkages to community and social supports, enhance coordination of physical health, mental health and substance use care, and to improve health outcomes for high-cost patients.
 - Enhanced federal funding
 - Huge opportunity to both improve health and reduce entry and reentry into the criminal justice system by getting people enrolled and linking them to care as early as possible

Steps court practitioners can take: information-gathering, planning and collaboration, cont'd

- Determine the process for insurance enrollment
 - Specific policies and practices to enroll justice-involved individuals?
 - Process for certifying agencies for enrollment activities state-based
- Understand the landscape of decision-makers and how to determine coverage options
 - Which services, including MH and SUD services, will be covered under Medicaid expansion? Is your state a Health Home state? Who is running your state's Marketplace? Which Marketplace plans provide the strongest coverage options for people with complex health needs?

Steps court practitioners can take: information-gathering, planning and collaboration, cont'd

- Convene or support a local planning process
 - Critical need for health and criminal justice stakeholders to work together
 - Role for the State Medicaid agency, the State health insurance exchange board and community care providers with court and justice decision-makers and stakeholders
- Incorporate enrollment into your system
 - Support enrollment at various points of contact; incorporate the application process into existing intake and screening processes
 - Time the application process to coincide with transition planning
 - Ensure that work to update and coordinate technology systems include court and corrections decision-makers

Steps court practitioners can take: information-gathering, planning and collaboration, cont'd

- Identify ways in which court-involved individuals can be better connected to community-based care
- Educate your colleagues and your clients about the benefits of the ACA

Local and statewide examples of²⁸ court systems and corrections

- New York enrollment and health home activity
- Spokane Community Court
- Illinois enrollment and work to link people to care
- CMS Innovation Grant to the Foundation for California Community College

New York State's Initiatives

- Meeting of the minds between Deputy Secretaries of Public Safety and Health led to recognition that much of the criminal justice population suffers from multiple chronic conditions, including HIV/AIDS, mental illness and addiction, and hence are exactly the patients that health homes have been designed to serve.
- Efforts are underway to capitalize on opportunities to improve the engagement of the criminal justice population into the healthcare system through the state Medicaid Redesign and federal ACA implementation.

New York's Goals

- Enrolling All Eligible Individuals in the Criminal Justice System onto Medicaid, beginning with prisons and jails but also earlier in the process
- Linking Individuals in the Criminal Justice System to Health Homes
- Including criminal justice services in the Medicaid waiver and through other mechanisms that allow payment with Medicaid funds for rehabilitation services.

NYS Criminal Justice and Health³¹ Home Workgroup

- In 2011 New York State Deputy Secretaries for Public Safety and Health asked LAC to co-lead, with NYS Department of Health, a project to develop linkages between the criminal justice system and health homes.
- With DOH, co-leading workgroup of more than 40 state, city and county agencies, selected health homes, and advocates and service providers
- Goal: Identify models for successful collaborations between the health care and criminal justice systems to engage and serve this population most effectively.
- Workgroup oversees and develops protocols in real time with health home pilots – effort to pioneer effective engagement of people in state prisons, local jails and probation and courts, alternative to incarceration/reentry programs.

NYS CJ and HH Workgroup

- Established six pilots that are identifying and implementing model policies and practices that will maximize engagement of the criminal justice population in obtaining needed health care.
 - Pilots were chosen among locations that were first in establishing health homes
 - 2 in Brooklyn
 - 2 in Bronx
 - 1 in Monroe County/Rochester
 - 1 in Erie County/Buffalo

NYS CJ and HH Workgroup cont'd

- Operations Sub-Committee to look at existing infrastructure for providing health care to criminal justice population and where holes exist, and consider policies and strategies for filling those holes
- Metrics Sub-Committee to determine valid metrics for determining the impact of health interventions on the criminal justice population
- Mandated care sub-committee to explore solutions to the issue of care (mostly addiction treatment care) that is mandated by a judge.
 - New York has a law requiring insurance and managed care companies to pay for care mandated by a judge. However, there are concerns about judges trying to achieve public safety goals in their choice of treatment modality, and judges denying MAT.
 - The Committee is working to create guidelines that all parties can accept

NYS CJ and HH Workgroup cont'd

- DOH also has an acuity “tiger team” committee
 - Because admissions to health homes are largely based on prior Medicaid use (and those who are incarcerated do not have a Medicaid history), the committee is working to create guidelines to determine who in the criminal justice population should be eligible for health homes services
- The Working Group assisted with one data match between those on Rikers Island and Medicaid, and is trying to create a second data match, using statewide data

NYS CJ and HH Workgroup cont'd

- A number of projects already off the ground
 - Pilot in Rochester has staff placed in local jail, partnering with local DA, drug court, looking to partner with State prison in the area
 - Pilot in Bronx partnering with Rikers
 - Pilot in Brooklyn partnering with Probation
- LAC is also working with the pilots to create “pilots within the pilots” by helping develop better linkages between the pilots and various parts of the criminal justice system and/or the programs that serve this population

NYS CJ and HH Workgroup cont'd

- Challenges have included:
 - Engaging DOCCS
 - Determining appropriate reimbursement rates
 - Medicaid enrollment
 - Having people linked to services as soon as they are released
 - Linkages to appropriate services
 - Specialized needs of CJ population (e.g. increased difficulty of obtaining employment)

NYS CJ and HH Workgroup cont'd

- Housing – HHs have repeatedly identified this as one of the most immediate needs facing this population and one they are struggling to figure out how to fill this need.
- Findings—still too early to tell although most promising initial potential with Rikers since they had infrastructure in place to do this.

In Closing:

What does this all mean for you?

- Links between health care and criminal justice in ways we have never seen before
- More clients in both systems receive better services
- More resources, more efficiency utilized
- Better outcomes
- Lots to learn: Medicaid, linkage with health care, collaborating across systems

Questions and Discussion

Paul N. Samuels
psamuels@lac.org

212-243-1313
www.lac.org

Leveraging Healthcare Reform to Transform Criminal Justice and Behavioral Health Systems

Center for Health and Justice at TASC

Pamela F. Rodriguez
Maureen McDonnell





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Getting Where We Want to Go: Community Service Systems In Transition

Pamela F. Rodriguez

A Brief Timeline

- **DC Medicaid expansion – 2010**
 - Mental Health Services began transition to Medicaid
- **Substance Abuse plan amendment – 2012**
 - Substance Abuse Services in Transition to Medicaid now

Transitions in Multiple Large Interconnected Systems – At the same time!

- health systems
- justice systems
- mental health
- substance use
- primary medical



Key Questions for a Mid-Course Strategic Assessment

- **Where do you want to be in 5 years?**
- **This question is equally important for:**
 - the district-wide substance abuse treatment system,
 - AND for
 - each individual community provider



What we want:

a
robust
vibrant
expanded

community behavioral health treatment
system

How do we get there?

Collective planning and action
**Individual agency planning and
action**

Where are we now?

1. What are our current strengths and challenges?

- What are we delivering well?
- Where are we falling short of our expectations and our clients needs?
- What are our infrastructure & capacity needs?

Biggest Challenge = Biggest Opportunity

- **Considerable expansion of people with coverage means more customers**
- **Shift from grant funding to Medicaid/Health Plans as primary payer for these customers requires major administrative effort**

If it seems like everything is changing at once ... it is

- **Providers need to be Medicaid-certified**
- **Need to negotiate contracts with Medicaid MCOs & health plans**
 - Including competitive reimbursement rates
- **Need infrastructure for prior authorization and continuing stay reviews**
- **Risk management is critical**
- **Will demand materialize**

This will impact providers differently

Grant Funded-Only Provider	Small-Medium Sized Provider, Multiple Payers	Large Provider, Multiple Payers
<p>At beginning stages of building capacity to negotiate rates, contracts. Must obtain Medicaid certification.</p>	<p>Has infrastructure in place, but may not be large enough to dominate the local or regional market.</p>	<p>Has capacity to work with multiple payers, likely to remain viable in new environment.</p>
<p>Questions: Should we continue as we are? Should we build our own infrastructure? Should we merge with a larger agency?</p>	<p>Questions: Can we remain viable as we are? How can we negotiate favorable rates, terms & processes?</p>	<p>Questions: How can we expand services within the new payer streams? How can we improve care? How can we help meet regional goals?</p>

SA Safety Net Priorities During this Transition:

1. Protect current capacity

- Especially during payer transition

2. Build more capacity

- Particularly to meet recovery needs of people in justice system

3. Improve effectiveness and efficiency

- Integrating care with medical and mental health
- Expanding use of best practices

Protect Current Capacity

- **Ex: Retain providers who work with the most vulnerable populations**
 - Assist them in finding a viable path into the future (Medicaid certification, merging with larger organizations)
 - Require MCOs to contract with “essential community providers”
 - Use of block grants

Build More Capacity

- **Determine where the newly eligible/insured will be**
 - Underserved communities
 - Justice system
- **Assess likely demand for services**
- **Expand continuum of care where necessary**

Build More Capacity

- **Incentivize expansion to meet demand**
 - Provide initial investment that facilitates hiring, etc. through grants or revolving loan fund

Integrate and Improve Care

- **Build recovery-oriented systems of care**
- **Increase integration with primary care**
 - From mutual referrals to co-location to SBIRT
- **Health homes**
- **ER deflection programs**
- **Telehealth**

Public Evaluation is Critical

- **Provides a framework for understanding what is important during the transition**
- **Tracks progress on objective criteria**
 - What worked as hoped and what did not
- **Provides the basis for necessary changes to plans in 2016**



Justice System Must Generate Demand
&
**Treatment System Must
Respond**

Collaborative Planning with Justice System

- To address the needs of a very vulnerable population
- To improve public safety
- To increase engagement in treatment and recovery

Goals of Treatment in the Criminal Justice System:

- To provide clinical interventions that enhance neurobiological recovery AND the emotional, cognitive behavioral interventions necessary to achieve sobriety and reduce criminal behavior
- To organize a system of behavioral healthcare that offers clinical interventions accessible at all points in the criminal justice system, enhancing offender accountability and community safety
- To organize community resources to support and sustain durable recovery and reduce recidivism
- Reduce jail and prison crowding through increased use of diversion (e.g. supervised release) and reduced recidivism

ACA IN ACTION IN THE JUSTICE SYSTEM: Cook County

Maureen McDonnell



Cook County Justice & Health Initiative

- **August 2012 – Planning process convened by the Honorable Paul P. Biebel, Jr., Presiding Judge of the Criminal Division**
- **The Justice and Health Initiative (JHI) Steering Committee includes leadership from**
 - All Cook County justice agencies
 - County Health and Hospitals System
 - Community substance abuse and mental health providers
 - Community foundations
- **Builds on Cook County’s early expansion of Medicaid (2012)**
- **JHI was developed and led by TASC with Chicago Community Trust funding; other foundations joined**



Justice & Health Initiative Goals:

- Determine how to facilitate applications for all eligible persons entering the justice system
- Develop infrastructure and processes that support universal linkage to medical, mental health, and substance abuse treatment
- Support expansion of care in the community that meets the needs of people under supervision
- Expand diversion from jail and prison to care in the community under appropriate supervision

JAIL INTAKE APPLICATION PROCESS:

Partnership between Cook County Health & Hospitals System, Cook County Sheriff's Office and TASC

Operational Goals: Maximize Applications & Use of Care

- **Complete full application during intake**
 - Fingerprint-based identifying information used to verify inmate identity
 - Applications are completed online using state and county Medicaid application websites and jail management system records
- **Process must fit in fast-paced secure environment**
 - 200-300 new detainees/day
 - Cannot impede security or medical flow
 - Each application takes approximately ten minutes
- **Encourage applicants to use care after release**

RESULTS: Over 14,000 Medicaid applications initiated to date (April 2013 – March 2014)

JAIL-TO-COMMUNITY CONTINUITY OF CARE

I. Planning Process

- How to establish processes that link people with serious mental illness, severe substance use disorders and chronic medical conditions to needed care in the community, given jail release timeframes?

II. Demonstration Project

- Link 30 people with serious mental illness released each day to care in the community
- Partnership between Sheriff's Office, Cermak Mental Health Services and TASC

“HEALTH CARE REFORM READY” COURT

- Court that uses all available funding streams and all community resources to link probationers to services
- Prison diversion court
- Model for all felony courtrooms after testing

**Under Development: Further Approaches to Jail and Prison Diversion*

Expanding Substance Abuse & Mental Health Treatment Capacity in Community

- **JHI Meetings with Presiding Judge (Fall 2012 – present)**
 - Focus on the opportunity & the need
 - Describing the increasing referrals that will be coming from the justice system
- New reimbursement stream & provider readiness
- Integration of Medicaid managed care
 - Medical necessity vs. judicial order
 - Continuing stay reviews



CENTER FOR
HEALTH & JUSTICE

AT TASC

Pamela F. Rodriguez

President & CEO
TASC, Inc.
1500 N. Halsted Street
Chicago, IL 60642
312.573.8372
prodriguez@tasc.org
www.tasc.org

Maureen McDonnell

Director, Business & Health Care
Strategy Development
TASC, Inc.
1500 N. Halsted Street
Chicago, IL 60642
312.573.8222
mmcdonnell@tasc.org
www.tasc.org

Implications of Implementation: ACA and Criminal Justice

Diane Lewis, Chairperson

DC Health Benefit Exchange Authority
Executive Board

DCHBX - Establishment

- DC Health Benefit Exchange Authority established - March 2012
- Executive Board installed –July 2012
- Prior to DCHBX, implementation of ACA
 - Department of Health Care Finance
 - Department of Health
 - Department of Human Services
 - Department of insurance, Securities and Banking

DCHBX – First Year

- First year Focus:
 - Policy questions left to the states by ACA.
 - **IT development: Building the on-line marketplace – On-going.**
 - Establishing the Authority, including staffing, purchasing equipment and office space.

DC Health Link – On-line Insurance Marketplace

- Major Insurers offering coverage:
 - Aetna
 - CareFirst BlueCross BlueShield
 - Kaiser Permanente
 - United HealthCare
 - Small Business Marketplace - 267 products- HMOs, PPOs, with nation-wide provider networks.
 - Individual Marketplace – 34 insurance plans

Enhancing Health Coverage

- As of April 9, 2014, 41,745 people were covered by DC Health Link:
 - 10,187 - private health plans
 - 18,535 – Medicaid eligible
 - 13,023 – enrolled in small business marketplace

Enhancing Health Coverage-con' t.

- “About one in six people expected to enroll in Medicaid under the health reform expansions and nearly one in ten expected to enroll in qualified health plans through the health insurance Marketplaces will have spent some time in jail during the past year.” (*What the Affordable Care Act Means for People with Jail Stays*, Marsha Regenstein and Sara Rosenbaum)

DC Health Link - Enrollment

- In August 2013, DCHBX awarded grants totaling \$6.4 million to over 30 community based organizations.
- These organizations were tasked to train Assisters to enroll uninsured hard-to-reach District residents and small businesses.
- All DC Health Link Assisters completed more than 30 hours of course work, including privacy and security to protect personal information.

Partnership-CSOSA and DC Health Link

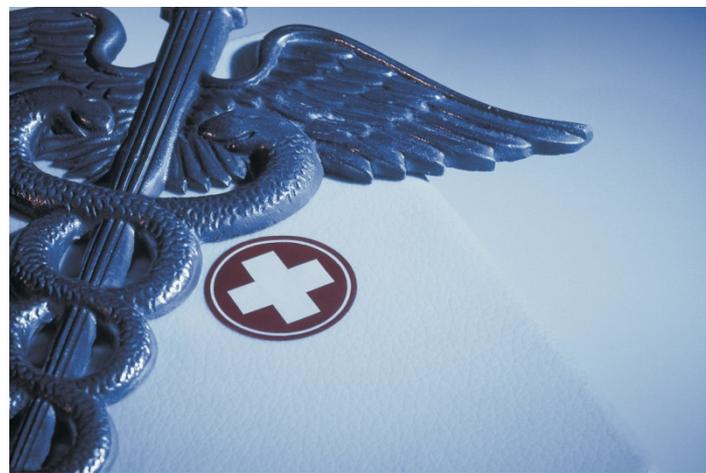
- Increasing Enrollment
 - Returning citizens who are Medicaid eligible.
 - Returning citizens who are low to moderate income (100% to 400% FPL) who may be eligible for APTC-premium tax credits.
 - Through the partnership, Assisters have accessed eight (8) CSOSA Access Points and participated in more than 40 monthly meetings and other activities.

Assister Organizations - Enrollment

- Assister organizations – Returning Citizens:
 - Summit Health Insurance for Research and Education (SHIRE)
 - Us Helping Us, People Into Living
 - East of the River Clergy Police Community partnership (ERCPCP)
 - St. Paul AME Church
 - Calvary Healthcare

Challenges - Solutions

- Emerging Issues:
 - Medicaid Certification
 - Continuity of Care – Provider Systems
 - Integrated Primary, and Behavioral Health Care
 - Coordination of Care – Jail to Community
 - DC Jail
 - Out-of-State Prisons



Affordable Care Act and Medicaid Eligibility

Danielle R. Lewis, MPA
Associate Director for Eligibility Policy
Department of Health Care Finance



What is Medicaid?

- Joint Federal/State program
- Provides health care coverage for low-income and disabled individuals and families
- Every state has a unique Medicaid program
- Medicaid services include doctor visits, hospitalization, transportation, mental health, prescriptions, and other services
- 1 out of every 3 District residents receive quality health insurance through Medicaid



Who is eligible for DC Medicaid⁸⁰ Services?



In order to qualify to receive DC Medicaid, you must:

- Be a District resident
- Be a U.S. Citizen or have qualified immigration status
- Have income at or below the income threshold for your eligibility group



Medicaid Under the ACA

Expands Access to Affordable Coverage

- Creates new eligibility group for childless adults aged 19-64 with income up to 133% of the Federal Poverty Level (FPL)
 - D.C. implemented this option effective July 2010
 - D.C. secured waiver to cover childless adults with income up to 210% FPL (\$25,091/year Household of 1)
 - Today, DC covers approximately 50,000 childless adults with incomes up to 200% FPL
- Creates new mandatory eligibility group for foster care youth who age out of the system – they will be eligible for Medicaid coverage up to age 26



Medicaid Under the ACA:



Simplifies Medicaid and CHIP

- Replaces complex income rules in place today for non-disabled parents, children, pregnant women, and childless adults
- Modernizes eligibility verification rules to rely primarily on electronic data



Medicaid Under the ACA – *Simplifies Medicaid and CHIP*



- Modernizes eligibility verification system to:
 - Accept online applications
 - Utilize local and federal electronic data sources to determine eligibility
 - Perform passive renewals



What is MAGI?

MAGI = Modified Adjusted Gross Income

- MAGI is the new method of calculating income that replaces current income-counting methodologies
 - Income based on adjusted gross income
 - New household composition rules affect whose income is included in eligibility determinations
 - Will not affect eligibility for most current beneficiaries
 - Effective beginning October 1, 2013

Income Levels for DC Medicaid

There is no asset or resource test
Across the board 5% income disregard
Uses MAGI income methodology

- **Childless Adults (Adults w/o Dependent Children): 210% FPL**
- **Parent/Caretaker Relatives: 216% FPL**
- **Pregnant women and Children: 319% FPL**

Threshold in FPL	1 person household, monthly	2 person household, monthly	3 person household, monthly	4 person household, monthly
210%	\$2,042	\$2,753	\$3,463	\$4,174
216%	\$2,101	\$2,831	\$3,562	\$4,293
319%	\$3,723	\$5,018	\$6,313	\$7,608



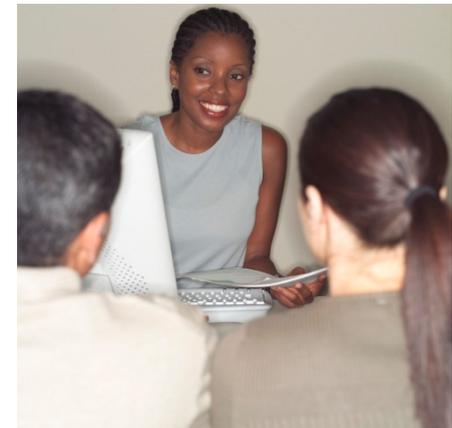
Medicaid Application Process



Effective October 1, 2013:

- MAGI-based applicants can apply through an online portal (DC Health Link), or by phone, email, fax, or in person at a service center
- Electronic data sources check eligibility factors in real time for quick determinations
- Automated renewals of eligibility – no need to come into a service center (in most cases)
- Application assistance available by phone or in person

**Many ways to apply –
“No wrong door”**





Incarcerated Individuals and Returning Residents



Medicaid Coverage for Justice-Involved Individuals



- Federal Medicaid law prohibits payment for services once an individual is in a public institution, including a jail, prison, detention center, or half-way house (i.e., services provided cannot be paid for by Medicaid).
- Rules apply to:
 - Adults and Children
 - Pre and Post-Adjudication

42 U.S.C. §1396d(a)(27)(A); 42 CFR §435.1009(b)



Incarcerated Individuals



The Exception: Inpatient Hospitalization

- Medicaid coverage is available for incarcerated individuals who are admitted for in-patient services in a medical facility for at least 24 hours.
- This exception does not extend to outpatient services, regardless of where the outpatient services are furnished.
 - 42 U.S.C. §1396d(a)(27)(A); 42 CFR §435.1009(b)



Medicaid Coverage: Suspension vs. Termination

Medicaid Suspension	Medicaid Termination
<ul style="list-style-type: none">• Federal guidelines allow for states to suspend rather than terminate Medicaid upon incarceration.• A previously enrolled beneficiary would be not be required to reapply for Medicaid in the event of a potentially billable hospital stay and upon re-entry into the community.• States are prohibited from claiming FFP for an individual when eligibility is suspended.	<ul style="list-style-type: none">• Currently, in the District, an individual's Medicaid enrollment is terminated upon incarceration.• A previously enrolled beneficiary would be required to reapply for Medicaid in the event of a potentially billable hospital stay and upon re-entry into the community.• States are prohibited from claiming FFP for an individual whose Medicaid eligibility is terminated.



Questions

- Does an inmate retain Medicaid Eligibility?
 - Yes. Medicaid *coverage* is not available for individuals in prison or jail (i.e., services provided cannot be paid for by Medicaid), but individuals who are otherwise eligible retain their *eligibility* while in prison or jail and can enroll.
 - 42 U.S.C. §1396d(a)(27)(A); 42 CFR §435.1010
 - DC is currently working on a policy that would suspend, rather than terminate, Medicaid eligibility when a Medicaid beneficiary becomes incarcerated in DC.
 - Beneficiaries incarcerated outside of DC for more than 90 days will no longer be eligible for DC Medicaid due to residency.



Questions

- If inmates do not have Medicaid eligibility, how do they get it?
 - Inmates may apply for Medicaid in the event of a potentially billable hospital stay and upon re-entry into the community.
 - Applications for Medicaid can be filed by paper, by telephone or, online through [DCHealthlink.com](https://www.dchealthlink.com).
 - Inmates can apply while they are in jail with the assistance of DC DOC
 - Inmate can apply at the hospital during an inpatient stay
 - Inmates can apply prior to release as part of pre-release planning



Questions

- How does incarceration affect a family's eligibility for Medicaid?
 - Inmates incarcerated in DC for more than 30 days:
 - Included in household if the household files a tax return.
 - Not included in the household if the family does not file a tax return.
 - When household size is reduced, the income threshold for that household also is reduced.
 - If Medicaid coverage is lost due to a change in household size or income, the family may still be eligible for subsidized private health insurance coverage. Incarcerated individuals are not eligible for private health insurance through the exchange.



Questions

- Will DOC be able to bill for Medical Services for inmates that are covered by Medicaid?
 - No, Medicaid coverage is not available for prison and jail inmates who are eligible for Medicaid and who are inpatients in non-correctional medical facilities for at least 24 hours.
 - Only a provider (i.e., the hospital) who is enrolled in Medicaid is eligible to bill DHCF for services.
 - 42 U.S.C.§1396d(a)(27)(A); 42 CFR§435.1009(b)
- DHCF, in collaboration with DOC and ESA, will implement suspension of Medicaid eligibility for individuals incarcerated in DC and utilize the inpatient exception in the Summer of 2014.



Contact information

Claudia Schlosberg, JD

Acting Senior Deputy/Interim Medicaid

Department of Health Care Finance

202-442-9075

claudia.schlosberg@dc.gov

Danielle R. Lewis, MPA

Associate Director of Eligibility Policy

Department of Health Care Finance

202-442-9052

danielle.lewis@dc.gov



Health Home Services: Finalizing Design, Moving to Implementation April 28, 2014

Steve Baron, Director
Department of Behavioral Health

Oscar Morgan, Director of Adult Services
Department of Behavioral Health

Why Health Homes in the District?

Joint Effort by Departments of Behavioral Health (DBH) and Health Care Finance (DHCF) Geared Towards:

- Improving Care Coordination
- Preventing Avoidable Hospital and Emergency Room Visit
- Improving Overall Health Status of Persons with Serious Mental Illnesses
- Reducing Health Care Cost

First a Recap – Health Home Program Development

- Developed Service Delivery Model
 - Designated Providers
 - Participant Eligibility
 - Staffing Requirements
 - Standards of Care
 - Training

Designated Providers

- Core Services Agencies (CSA) and Assertive Community Treatment (ACT) Providers in the DBH network
- Health Home Provider Responsibilities:
 - Coordinate and Provide Access To:
 - Comprehensive Individualized Care Management
 - Preventive Care
 - Behavioral and Primary Care
 - Illness Management
 - Community Support Network
 - Demonstrate Capacity to Use Health Information Technology to Facilitate Care Coordination
 - Establish Continuous Quality Improvement Program
 - Collect and Report Data
 - Participate in Program Evaluation

Eligibility

- Eligibility for Health Home Service
 - 18 Years of Age or Older
 - Medicaid Eligible
 - Have a Serious Mental Illness
 - May or may not have a co-existing chronic physical condition

Staffing at the Mental Health Provider

Role	Function
Health Home Director (new role)	Leadership and Administration
Primary Care Liaison (new role)	Physical Health Care Consultation
Registered Nurse Care Manager (new role)	Comprehensive Care Management
Care Coordinator (existing Community Support or ACT staff member(s))	Supports for Comprehensive Care Management (activities related to coordination, communication, information management)

Required Reporting

Health Home Quality Metrics	
	Measure
CMS- Mandated	Adult BMI Assessment
	Ambulatory Care Sensitive Condition Admission
	Care Transition - Transition Record Transmitted to Healthcare Professional
	Follow-Up After Hospitalization for Mental Illness
	Plan - All Cause Readmission
	Screening for Clinical Depression and Follow-Up Plan
	Blood Pressure Screening
	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
DC- Mandated	TBD
	TBD
	TBD
	TBD

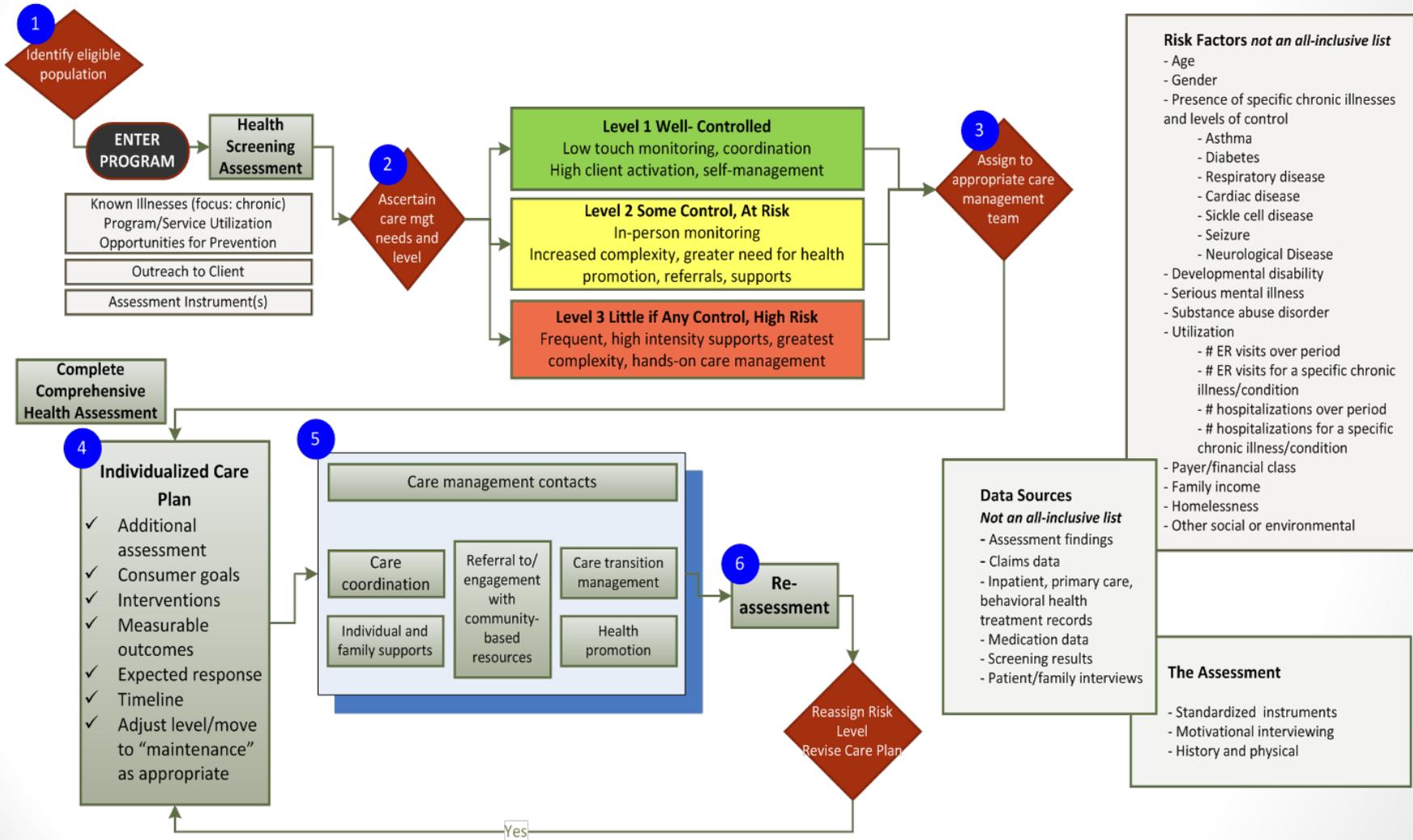
Training

Modules:

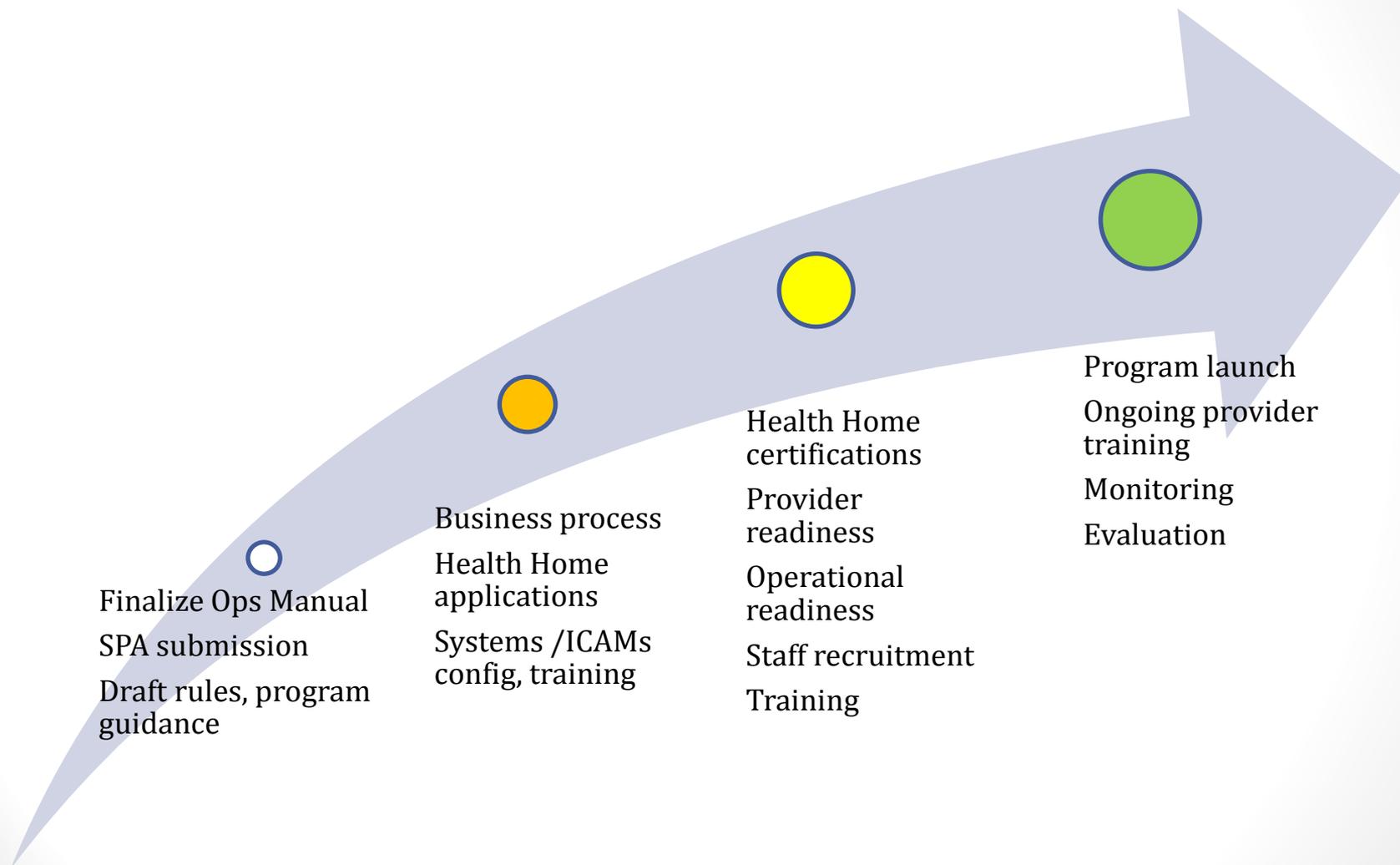
- Change Management
- Orientation to Health Homes
- Information Management and Data Analysis
- Comprehensive Care Management
- Leadership and Collaboration

How It Works in Practice

Health Home Care Management - Program Life Cycle Illustrated



Milestones To “Go Live”



THANK YOU!

IMPLICATIONS OF IMPLEMENTATION

THE AFFORDABLE CARE ACT AND CRIMINAL JUSTICE

BIOGRAPHIES

Stephen T. Baron, Director, Department of Behavioral Health

Stephen T. Baron is the Director of the Department of Behavioral Health where he leads the development and management of the District's mental and substance use disorder treatment services and supports.

The Department of Behavioral Health provides emergency psychiatric care and ongoing community based services and support to about 30,000 residents, and includes a network of private mental health rehabilitation services and substance abuse treatment providers, unique government delivered services, and Saint Elizabeth's Hospital—the District's inpatient psychiatric facility.

Mr. Baron was appointed the Director of the Department of Mental Health in 2006 where he served until the merger of the Department with the Addiction Prevention Recovery Administration on October 1, 2013. While director of the Mental Health Department, Mr. Baron led the implementation of initiatives that increased access to care and expanded the range of available services, including emergency mobile crisis services, an urgent care clinic at Superior Court for on the spot referrals to mental health treatment, and evidence-based programs for children proven to make a difference. In partnership with the Metropolitan Police Department, he started crisis intervention training on the most appropriate response to people with mental illness. Under his leadership, the Department ended the 37-year court oversight of the District's mental health services.

Before joining District government, Mr. Baron was president of Baltimore Mental Health Systems, Inc. for 17 years where he developed a range of innovative community-based programs for adults, increased affordable housing for people with mental illness, and expanded school-based and early childhood mental health services.

A Baltimore native, Mr. Baron has received numerous awards and honors, including the Champion Award from the District of Columbia Mental Health Association. He holds a Master of Social Work from Howard University and his field placement was with the Saint Elizabeth's Hospital outpatient program. He received a Bachelor of Social Welfare from Adelphi University in Garden City, New York.

Mr. Baron serves as secretary on the Board of Directors of the National Association of State Mental Health Program Directors Research Institute (NRI).

Mannone A. Butler, Executive Director, Criminal Justice Coordinating Council

Mannone A. Butler was appointed Executive Director of the District of Columbia Criminal Justice Coordinating Council (CJCC) in May 2011. CJCC, an independent District agency, serves as the forum to facilitate and support systemic planning, analysis, information sharing, problem solving and cooperation among local, federal, legislative, executive and judicial partners to address criminal and juvenile justice issues facing the District of Columbia.

IMPLICATIONS OF IMPLEMENTATION: THE AFFORDABLE CARE ACT AND CRIMINAL JUSTICE

Ms. Butler began her career with the CJCC in 2006 as a Legal Advisor/Program Analyst. In that capacity, she provided general legal and policy analyses on interagency criminal and juvenile justice issues. She also served as Deputy Executive Director where she was responsible for managing the implementation of the agency's strategic priorities and day to day operations. She was the Interim Executive Director prior to her appointment.

Before joining the CJCC, Ms. Butler was a Senior Associate in the Washington, DC law firm of Curtis White, Esq. specializing in telecommunications and information technology. She also served as the Senior Associate for ALTA Consulting Group, a Washington DC consulting firm specializing in public policy development, project management and organizational development. In addition, she served as the Director of Program Operations for the Urban Family Institute, a nonprofit organization that served youth and families nationally. While at the Urban Family Institute, she developed the Bridge, a program, supported by Maryland's Department of Public Safety & Correctional Services and in partnership with the Eastern Correctional Institution, for incarcerated fathers to engage and stay connected to their children.

Ms. Butler is a native Washingtonian and attended DC Public Schools. She earned her B.S. in Finance from Georgetown University and J.D. from Georgetown University Law Center. After graduating law school, Ms. Butler served as a Law Fellow for Georgetown University Law Center's Street Law Clinic.

Danielle R. Lewis, Associate Director for Eligibility Policy, Department of Health Care Finance

Danielle Lewis is the Associate Director for the Department of Health Care Finance, Health Care Policy and Research Administration's Division of Eligibility Policy. She is responsible for monitoring and interpreting federal and District eligibility related statutes and regulations and creating eligibility policies and procedures for the District's Medical Assistance Programs.

Danielle has over 11 years of expertise in eligibility policy. Her public sector experience includes serving as a Benefit Programs Specialist for the City of Richmond, Department of Social Services in Richmond, Virginia. In this capacity, Ms. Lewis interpreted federal, state, and local laws to determine eligibility for various public programs to include Medicaid, SNAP, and TANF for thousands of individuals and families.

Ms. Lewis is a subject matter expert on eligibility policies related to Medicaid, Children Health Insurance Program (CHIP), the Affordable Care Act, and the District's locally funded D.C. Health Care Alliance and Immigrant Children's Programs.

Prior to coming to DHCF, Ms. Lewis was a Capital City Fellow with the Government of the District of Columbia. She received her Bachelor of Science in Political Science with honors from Howard University, and was selected as a National Urban Fellow in New York City where she graduated from Baruch College School of Public Affairs with her Masters of Public Administration.

Danielle enjoys spending time with her family and mentoring others.

IMPLICATIONS OF IMPLEMENTATION: THE AFFORDABLE CARE ACT AND CRIMINAL JUSTICE

Diane C. Lewis, Chairperson, District of Columbia Health Benefit Exchange Authority Executive Board

Diane C. Lewis is Co-Principal and Executive Vice President of ALTA Consulting Group, Inc., Washington, D.C., a management consulting firm, with extensive experience in health care policy, and community development. Ms. Lewis has worked to extend the reach and effectiveness of health systems in underserved/under resourced communities. She has worked with the non-profit community and foundations to address health access for uninsured/underserved populations, and persons with disabilities, including - the availability of primary and specialty care, health workforce development, and advocacy.

Ms. Lewis is on the Board of the D.C. Health Benefit Exchange Authority and currently serves as its Chair. The Authority is working to ensure that people who live and work in the District of Columbia have access to comprehensive and affordable health insurance, and health care.

Ms. Lewis also serves on the Board of House of Ruth, a non-profit providing service-enriched housing and supportive services to women, children and families. The House of Ruth addresses homelessness and dislocation -- building and strengthening community assets in Washington, DC.

Ms. Lewis is also on the Board of the HSC Foundation, National Youth Transition Center – a collaborative learning community to benefit youth with disabilities and returning veterans. In addition to providing direct services, the Center serves as a national clearinghouse for research, advocacy, and evaluation of support systems for youth with disabilities in transition.

Ms. Lewis is a graduate of the City College of New York (B.A. Economics) and the Woodrow Wilson School of Public and International Affairs, Princeton University (MPA).

Maureen McDonnell, Director for Business and Health Care Strategy Development, Treatment Alternatives for Safe Communities of Illinois

As the leader of TASC's health care reform planning efforts and co-author of several articles on the topic, Maureen McDonnell is an expert in the practical implications of health care reform for criminal justice systems. She has more than 20 years' experience in developing programs for people with substance use and mental health conditions who are involved in justice systems, and has led the planning of several leading-edge interventions in Illinois. Ms. McDonnell holds a BA in Economics from Northwestern University.

Oscar L. Morgan, Director of Adult Services, Department of Behavioral Health

IMPLICATIONS OF IMPLEMENTATION: THE AFFORDABLE CARE ACT AND CRIMINAL JUSTICE

Pamela F. Rodriguez, President, Treatment Alternatives for Safe Communities of Illinois

Pamela F. Rodriguez is president of TASC, Inc. of Illinois, a statewide, nonprofit agency that provides independent case management for people with substance use and mental health conditions. TASC serves approximately 27,000 adults and youth each year who are referred by Illinois courts, corrections, and child welfare systems. Ms. Rodriguez has co-authored several journal articles on health care and addiction recovery in criminal justice and juvenile justice systems.

In national policy leadership, Ms. Rodriguez was appointed in 2007 to serve as a practitioner member of the Coordinating Council on Juvenile Justice and Delinquency Prevention, an independent organization in the U.S. executive branch that coordinates all federal juvenile delinquency prevention and detention programs. She served as Texas Christian University's criminal justice partner on the national Criminal Justice-Drug Abuse Treatment Studies (CJ-DATS) Steering Committee.

In Illinois, Ms. Rodriguez was appointed in 2013 to serve on the Illinois Advisory Council on Alcoholism and Other Drug Dependency. She is active on numerous boards and task forces focused on increasing alternatives to incarceration, improving juvenile justice, and decreasing the disproportionate incarceration of people of color. Among these are *Redeploy Illinois*, which supports local efforts to offer community-based alternatives to incarceration for juvenile offenders.

Ms. Rodriguez earned her master's degree in Social Service Administration from the University of Chicago.

Paul N. Samuels, Director and President, Legal Action Center

Paul Samuels is Director/President of the Legal Action Center. Mr. Samuels has participated in groundbreaking litigation defending the rights of people with alcohol and drug histories, HIV disease and criminal records; worked on and overseen numerous advocacy campaigns to combat discrimination, expand services, reform sentencing laws, and effect other important public policy advances; testified before numerous Congressional and state legislative committees; lectured in more than 25 States; and served on numerous national and state advisory groups.

He has received a number of awards, including the Robert Wood Johnson Innovator Award (2002), The Betty Ford Award, AMERSA (1998), New York City Coalition of Alcoholism and Substance Abuse Organizations (1997), Veritas Villa (1995), New York State Association for Alternative Sentencing Programs (1994), and National Association of State Alcohol and Drug Abuse Directors (1992 and 1994).

Mr. Samuels joined the staff of the Legal Action Center while a law student in 1976, became a staff attorney upon graduation from Columbia Law School in 1979, and became Executive Vice President in 1983 and Director/President in 1992. He is a graduate of Harvard College.

IMPLICATIONS OF IMPLEMENTATION: THE AFFORDABLE CARE ACT AND CRIMINAL JUSTICE**Michen M. Tah**, Policy Analyst, Criminal Justice Coordinating Council

Michen M. Tah joined the Criminal Justice Coordinating Council as a Policy Analyst in December of 2012. Her areas of focus are adult and juvenile reentry, substance abuse and mental health, and warrants. Prior to her current position, Ms. Tah practiced civil and criminal law as an associate attorney at Dudley, Topper, and Feuerzeig, LLP. She has also served as a law clerk to the Honorable James S. Carroll III, Judge of the Superior Court of the Virgin Islands.

Ms. Tah received her A.B. in Politics and a Certificate in African-American Studies from Princeton University in 2005 and her law degree from Georgetown University Law Center in 2008. She is licensed to practice law in Maryland and the U.S. Virgin Islands.

Nancy M. Ware, Director, Court Services and Offender Supervision Agency for the District of Columbia (CSOSA)

Director Nancy M. Ware serves as the Agency Director of the Court Services and Offender Supervision Agency for the District of Columbia (CSOSA). In that capacity, she leads the agency's 800 federal employees in providing community supervision for over 15,000 adults on probation, parole, and supervised release in the District of Columbia.

Nancy Ware has over three decades experience in the management and administration of juvenile and adult criminal justice programs on the local, state and national level. Prior to assuming leadership of CSOSA, Ms. Ware guided the Agency's compliance with the Government Performance and Results Modernization Act of 2010 (GPRA), focusing on strategic planning and performance measurement. Her organizational experience includes serving as the first Executive Director of the District of Columbia Criminal Justice Coordinating Council (CJCC), where for eight years she developed the infrastructure to promote collaboration between the District of Columbia government and the executive and judicial branches of the federal government on critical public safety issues. One of Ms. Ware's proudest accomplishments at the CJCC was the development of the technical capability to support criminal justice information sharing among CJCC member agencies.

Ms. Ware's other professional experience includes serving as Director of Technical Assistance and Training for the Department of Justice's Weed and Seed Program and as Director of National Program for the Bureau of Justice Assistance, Office of Justice Programs. Early in her career she also served as Executive Director of the Rainbow Coalition, Executive Director of the Citizenship Education Fund and Executive Director of the District of Columbia Mayor's Youth Initiatives Office.

Nancy Ware is a native Washingtonian who has devoted her professional career to public service and has spent the last several years working to ensure that the nation's capital remains safer for residents, workers, and visitors, and that juveniles and adults who have become involved in the criminal justice system are provided opportunities to contribute and thrive. Ms. Ware holds a Bachelor's and Master's degree from Howard University and has three children and three grandchildren.