The Affordable Care Act and Criminal Justice

A Forum Presented by the Substance Abuse Treatment
and Mental Health Services Integration Taskforce (SATMHSIT)

TABLE OF CONTENTS

July 18, 2013

12:30pm to 2:00pm

441 4th Street NW
Old Council Chambers

CRIMINAL JUSTICE COORDINATING COUNCIL for the DISTRICT OF COLUMBIA
CJCC

The Affordable Care Act and Criminal Justice

A Forum Presented by the Substance Abuse Treatment and Mental Health Services Integration Taskforce (SATMHSIT)

AGENDA

July 18, 2013

12:30pm to 2:00pm

441 4th Street NW
Old Council Chambers

- **Welcome Remarks**
  - Mannone A. Butler
    Executive Director of the
    Criminal Justice Coordinating Council
- **Introduction of Speakers**
  - Diane C. Lewis (Moderator)
    Co-Principal and Executive Vice President of ALTA Consulting Group
- **Presentations and Panel Discussion**
  - Mila Kofman
    Executive Director of the DC Health Benefit Exchange Authority
  - Dr. Linda Elam
    Senior Deputy Director and State Medicaid Director of the DC Department of Health Care Finance
  - Deborah Carroll
    Administrator for the Department of Human Services Economic Security Administration
- **Questions and Answers**
- **Closing Remarks**
  - Nancy Ware
    Director of the Court Services and Offender Supervision Agency for the District of Columbia
    SATMHSIT Co-Chair

July 18, 2013

The Affordable Care Act and Criminal Justice

A Forum Presented by the Substance Abuse Treatment and Mental Health Services Integration Taskforce

SATMHSIT Co-chairs:

- **Nancy Ware**
  Director

  Court Services and Offender Supervision Agency
- **Stephen T. Baron**
  Director

  Department of Mental Health
- **Frances Buckson**
  Interim Senior Deputy Director

  Addiction Prevention and Recovery Administration

Acknowledgments

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

Speakers (in order of presentation)

Mila Kofman, Executive Director
DC Health Benefit Exchange Authority

Dr. Linda Elam, Senior Deputy Director and State Medicaid Director
Department of Health Care Finance

Deborah A. Carroll, Administrator
Department of Human Services Economic Security Administration

Moderator

Diane C. Lewis, Co-Principal and Executive Vice President
ALTA Consulting Group, Inc.

Forum Summary

Introduction

The Affordable Care Act and Criminal Justice was a forum presented by the Criminal Justice Coordinating Council's Substance Abuse Treatment and Mental Health Services Integration Taskforce (SATMHSIT) to bring criminal justice and healthcare stakeholders together to share general information about the Affordable Care Act (the "ACA"), highlight the changes that have taken and will take place in light of the ACA, and explore the implications of the ACA for those involved in the criminal justice system. The forum consisted of three (3) presentations covering various aspects of the Affordable Care Act, during which attendees learned about the types of insurance options and assistance resources that will be available to District residents; received an overview of the expansion of Medicaid and its impact on District residents in general and returning citizens in particular; were advised of the Medicaid eligibility criteria, the application process, as well as other issues associated with healthcare reform.

New Rights, New Benefits, New Responsibilities

The overarching goal of the ACA is to provide every person with public or private insurance coverage that works when they need it most. The ACA establishes federal rules to protect consumers against unfair insurance industry practices and provides consumers with insurance options that do not currently exist in the private insurance market. Insurance companies can no longer deny individuals coverage based on current or past medical conditions, exclude preexisting medical conditions from coverage, charge higher rates for persons with medical conditions, or place annual or lifetime caps on coverage. In addition, all insurance policies must cover, among other things, prescription drugs, lab tests, preventive tests and services, mental health care, and substance use disorder services.

It is important for returning citizens to take note of the numerous changes to coverage that will result after the implementation of the ACA. For example, the ACA's prohibition against excluding preexisting medical conditions from coverage and the requirement that mental health coverage be included in all insurance policies means that returning citizens will be covered for any required mental health services for problems that developed during a period of incarceration.

Along with new benefits and protections, the ACA imposes new responsibilities on consumers. Under the ACA, all persons must have some form of insurance coverage, whether public or private. Those not covered by insurance will be subject to a monetary penalty. This penalty will be $95 in 2014, or 1% of income, whichever is greater. The uninsured penalty will increase to around $700 in 2017. Financial assistance will be available to reduce insurance premiums. Individuals unable to afford insurance coverage, even with extra financial assistance, will be exempt from the penalty.

DC Health Link

In order to facilitate a smooth implementation of the ACA the District has established an online marketplace where individuals, families, and small businesses can shop for high quality, affordable healthcare coverage, or apply for Medicaid; this marketplace is called DC Health Link. The goal of DC Health Link is to simplify the health insurance purchasing process for consumers. The information on the DC Health Link website (www.dchealthlink.com) will help persons determine their eligibility for Medicaid or for financial assistance for health insurance. If a person is not eligible for either Medicaid or financial assistance, DC Health Link helps match the person to an affordable private insurance plan through the marketplace.

Additional Help and Key Dates

In addition to the services available through DC Health Link, the DC Health Benefit Exchange Authority Contact Center will be open 24 hours a day, 7 days a week during the open enrollment period (October 1 through March 31) to assist DC residents purchase an insurance plan or apply for Medicaid. Community-based organizations will also have trained in-person assisters that will help to enroll residents. Open enrollment will begin on October 1, 2013, but coverage will not go into effect until January 1, 2014.

Medicaid and the Affordable Care Act

Medicaid provides health coverage to low-income and disabled individuals and families. It is a joint federal and state-run program, which means Medicaid programs are unique on a state-by-state basis. In the District, Medicaid covers every 1 in 3 residents, which is the highest rate of Medicaid coverage of any state in the nation. As a result, changes to Medicaid have a significant impact on the District as a whole. In addition to Medicaid, the District has a locally-funded healthcare program – DC Healthcare Alliance. As part of the ACA expansion of Medicaid, many DC Healthcare Alliance recipients were moved to the Medicaid program. The District was among the first states to enact Medicaid expansion.

Among the new Medicaid benefits available to District residents, substance abuse benefits will become available on October 1, 2013. The cost of providing Medicaid substance abuse benefits will be higher than originally anticipated due the high prevalence of HIV/AIDS and the behavioral health medications needed by this segment of the population.

Medicaid Coverage and Incarcerated Individuals

Under the current system, Medicaid benefits are terminated for individuals upon incarceration and they must reapply for benefits upon their return to the community. This hinders persons from obtaining the health coverage they need immediately upon returning to the community, and also affects the services they receive while incarcerated.

Under the new Medicaid eligibility system, administrators will have the ability to simply suspend Medicaid eligibility for incarcerated persons, instead of terminating benefits, thereby allowing returning citizens to simply reactivate their Medicaid benefits upon their return to the community and eliminating the need to reapply. Although returning citizens will not be able to apply for coverage prior to release, social workers and case managers will be able to submit the individual's application online and get a real-time determination regarding that person's eligibility.

The Future of Medicaid Applications

From a consumer standpoint, the new DC Health Link website will feature functions designed to create a more user-friendly experience, including a Help Desk, a "chat" feature, and informative pop-ups. The system will also feature self-help kiosks for persons who do not have access to computers. A mobile phone-based DC Health App is also currently being discussed. The website will have a "My Account" feature that will allow consumers to see notices, check benefits, and upload any requested documents using a scanner.

Starting October 1, 2013, the application process will be streamlined to allow consumers to use DC Health Link to apply for both Medicaid and private insurance without having to enter all personal information twice. In the future, it is hoped that the Women, Infants, and Children (WIC) Food and Nutrition Service, the Low Income Home Energy Assistance Program (LIHEAP), and Child Care Subsidy Program applications will be added to the streamlined system as well. Beginning in 2015, users will not need to re-enter demographic information to apply for new programs as they are added to the system.

In order to complete applications online, users will need copies of any tax returns and pay stubs for themselves and for all household members, as well as social security numbers, and any immigration documents. If the user would like to be considered for financial assistance for insurance, this must be noted on the online application. Persons who are currently on Medicaid will not have to do anything different to continue receiving benefits.

Mental Health and Substance Abuse Coverage under the Affordable Care Act

Under the ACA, there will be no caps on private insurance coverage for mental health and substance abuse treatment, nor will there be a limit on the number of visits. For persons who do not currently have private insurance coverage, this feature will go into effect on January 1, 2014. For persons with private insurance, this feature will begin on the date of the individual's coverage renewal. District residents with Medicaid will continue to receive the same robust mental health and substance abuse treatment coverage as in the past. This new coverage expansion will not apply to persons covered by the DC Health Alliance, as the ACA's mental health parity standards will not apply to state-run programs.

Understanding Your Coverage

The District Medicaid program will work to develop an easy-to-read schedule of benefits fact sheet for partner agencies to distribute to their clients. In addition, the ACA requires all employers and insurance companies to develop a coverage summary document. This document must be no longer than 4 pages in length, be in plain English, include all coverage benefits, as well as those not covered, and co-payment information. This information will be available online.

Next Steps

Forum attendees were asked to help make all of this information available to their clients, in particular to returning citizens. The Department of Human Services (DHS) has already opened one avenue of communication by placing a staff member at the Department of Corrections to help disseminate information.

Action items that arose from the forum are:

- Share information with returning citizens about the series of informational town hall meetings regarding the issue of healthcare that will be held throughout communities all over the District.

- Foster relationship between the DC Health Benefit Exchange Authority Contact Center and the Office on Returning Citizens Affairs (ORCA) to ensure that those staffing such a crucial hub of information and assistance for citizens returning to the District will be able to address the healthcare concerns of returning citizens who visit the ORCA office.

- Develop literature (e.g. pamphlets and posters) and videos to share information about the Affordable Care Act with returning citizens.

- Engage representatives from the Department of Human Services, the DC Health Benefit Exchange Authority, and the Department of Health Care Finance/Medicaid to attend events to provide information about the Affordable Care Act to returning citizens.

The Affordable Care Act and Criminal Justice

DC HEALTH LINK
Get the facts. Get covered.

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

Thursday, July 18, 2013

12:30 p.m.

One Judiciary Square – 441 4th Street, NW

Goals of the New Health Law

- Protect consumers against unfair insurance industry practices
- Give consumers more insurance options

March 23, 2010

DC HEALTH LINK
Get the facts. Get covered.

New Rights

Insurance companies can no longer:

- Deny coverage based on current or past medical conditions
- Exclude from coverage preexisting medical conditions
- Charge higher rates to people with medical conditions
- Place annual or lifetime caps on coverage

New Benefits

All insurance policies must cover:

- Doctor visits
- Hospital stays
- Emergency room care
- Maternity and newborn care
- Prescription drugs
- Lab tests
- Preventive tests and services
- Rehabilitative and habilitative services and devices
- Mental health care
- Substance use disorder services
- Dental and vision care for children

New Responsibilities

For individuals and families:

- Most people have to have health insurance *(private health insurance, Medicare, Medicaid, Tricare, or other)* or pay a penalty
- Financial help will be available to reduce premiums
- Those who cannot afford insurance even with extra help are exempt from the penalty

Help Paying for Insurance

Many residents, without other coverage options, will be eligible for help paying premiums:

- Individuals with income up to $45,960
- Two-person families with income up to $62,024
- Four-person families with income up to $94,200

DC HEALTH LINK
Get the facts. Get covered.

What is DC Health Link?

- **DCHealthLink.com** -- An online marketplace where individuals, families, and small businesses can shop for high-quality, affordable coverage

- A place to access help paying for health insurance or applying for Medicaid

Who Can Shop for Health Insurance on DC Health Link?

Individuals and families who legally reside in the District including those who are:

- Uninsured
- Buy their own insurance
- Work part-time and aren't eligible for coverage through their job

Small businesses with 50 or fewer workers

DC HEALTH LINK
Get the facts. Get covered.

CHOICE OF 301 PLANS

Individual & Family Plans offered by all major insurers:

- Aetna
- CareFirst BlueCross BlueShield
- Kaiser Permanente

Small Group Plans offered by all major insurers:

- All of the above plus United HealthCare

Help is Available

DCHealthLink.com -- On October 1, 2013, DCHealthLink.com will be your online enrollment portal and informational resource

Contact Center -- Open 24-7 during open enrollment (Oct. 1 – Mar. 31)

In-Person Assisters-- Community-based organizations that have partnered with us to help people enroll

Brokers-- Insurance brokers are our partners and will be available to help advise on and enroll.

DC HEALTH LINK
Get the facts. Get covered.

KEY DATES

October 1, 2013 – Open Enrollment Begins

- For individuals and families, open enrollment continues through March 31, 2014 (6 months for uninsured; if insured can come in when current coverage ends)

- Small businesses can enroll at any time throughout the year

January 1, 2014

- Coverage becomes effective for people who enroll in the fall 2013

Affordable Care Act

MEDICAID OPTIONS

DC HEALTH LINK
Get the facts. Get covered.

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 covers many services to include doctor visits, hospital care, prescriptions, mental health services, transportation and other services

Medicaid Under the ACA

Expands Access to Affordable Coverage

- Creates new eligibility group for childless adults aged 21-64 with income up to 133% of the Federal Poverty Level (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

- Passive renewals

Medicaid Eligibility Changes Under ACA

Rules Today	New World Rules
1. Current Household: Based on legal responsibility; parents and children living together, spouse to spouse 2. Step-parent income not counted towards step-child 3. Children under 18 and siblings income not counted 4. Pregnant women counted as household of 2	1. MAGI Household: based on primary tax payer, their spouse and all tax dependents 2. Step-parent income is counted towards the step-child 3. If child under 18 makes enough money to be required to file taxes, income is counted 4. Pregnant Women(self + number of expecting children)

DC HEALTH LINK
Get the facts. Get covered.

Income Levels for Medicaid

There is no asset or resource test

Across the board 5% income disregard

Uses MAGI income methodology

- **Parent/caretaker and Childless adults (age 21-64): 200% FPL**
- **Family: 200% FPL**
- **Pregnant women and Children: 300% FPL**

Threshold in FPL	For 1 person household, monthly	For 2 person household, monthly	For 3 person household, monthly	For 4 person household, monthly
200	$1,915	$2,585	$3,255	$3,925
300	$2,873	$3,878	$4,883	$5,888

DC HEALTH LINK
Get the facts. Get covered.

Current Application Process

1. Fill out an application
2. Mail or fax the application and supporting documents to an ESA Service Center
3. ESA has up to 45 days to decide eligibility

- For Forms and Service Center Locations
  Call - (202) 724-5506

Service Centers Locations:

- Anacostia: 2100 Martin Luther King, Jr. Ave, SE
- Congress Heights: 4001 S. Capitol St., SW
- Fort Davis: 3851 Alabama Avenue, SE
- H Street: 645 H Street, NE
- Taylor Street: 1207 Taylor St., NW

Future Medicaid Process

Effective October 1, 2013:

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

Many ways to apply – "No wrong door"

DC HEALTH LINK
Get the facts. Get covered.

Questions?

For further information, please contact:

Danielle R. Lewis, MPA

Acting Associate Director

Division of Eligibility Policy

Phone: 202-442-9052

Email: danielle.lewis@dc.gov

Affordable Care Act

ELIGIBILITY OPTIONS

DC HEALTH LINK
Get the facts. Get covered.

How Do You Apply?

For Individuals/Families

- Online
- By phone
- By mail, fax, or email
- With a community assistor or broker
- With a DHS social service representative

Will The Application Process Be Different?

- YES!
  - **My Account-** status of case, notifications and account information
  - **Real time** eligibility determination for most
  - **Streamlined** medical insurance application
  - **Electronic** and paper applications and notices
  - **Digital imaging-** scan and upload or fax documents
  - Online and live **help** 24/7

Information You Need to Help You Apply

- Individuals
  - A copy of your federal tax return, and if you don't have one that's OK!
  - Recent Pay stubs or income information for you and your household members
  - Social Security numbers for you and your household members
  - Immigration documents, where applicable

Things You Should Know

- October 1, 2013- September 30, 2014 you will have to submit a separate application for Medical insurance than for other public benefits.
- In order to receive help with paying your insurance premiums, you must request financial help for insurance on the online application.
- If you are already receiving Medicaid you do not have to do anything different on

  October 1, 2013.

DC HEALTH LINK
Get the facts. Get covered.

Things You Should Know

- If you are not receiving Medicaid your eligibility will be determined under the new Medicaid rules
- In Fiscal Year 2015 -DHS will add all benefit programs- Only enter information 1 time
- In Fiscal Year 2016 there is a plan to add child care subsidy, LIHEAP, and WIC

Thank you!

To learn more:

- **Visit us at www.dchealthlink.com**
- **Like us on Facebook: DC Health Benefit Exchange**
- **Follow us on twitter @dchbx**

DC HEALTH LINK
Get the facts. Get covered.

Questions

DC HEALTH LINK
Get the facts. Get covered.

White Paper

The Affordable Care Act and Criminal Justice: Intersections and Implications

Andrea A. Bainbridge
Bureau of Justice Assistance
U.S. Department of Justice
July 2012

Contents

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 percent[2] 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 penalty[4] 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 homes[6] 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 its 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.

REFERENCES

Blair, P., Greifinger, R., Stone, T. H., and Somers, S. February 2011. *Increasing access to health insurance coverage for pre-trial detainees and individuals transitioning from correctional facilities under the Patient Protection and Affordable Care Act*. Community Oriented Correctional Health Services. Retrieved July 16, 2012 from www.cochs.org/files/ABA/aba_final.pdf.

Center for Court Innovation. 2004. *Drug treatment, managed care and the courts: From conflict to collaboration.* Retrieved July 8, 2012 from www.courtinnovation.org/sites/default/files/managed_care.pdf.

Coalition of Correctional Health Authorities. February 2012. *Key elements of the Affordable Care Act: Interface with correctional settings and inmate health care*. American Correctional Association.

Cuellar, A. E. and Cheema, J. May 2012. *As roughly 700,000 prisoners are released annually, about half will gain health coverage and care under federal laws*. Health Affairs, Vol. 31, No. 5, 931-938.

Federal Interagency Reentry Council. *Reentry mythbuster! On Medicaid suspension vs. termination.* Retrieved July 9, 2012 from www.nationalreentryresourcecenter.org/documents/0000/1205/Reentry_Council_Mythbuster_Juvenile_Medicaid.pdf.

Gilmore, M. April 2012. *Getting criminal justice and health information exchange off the ground: The role of counties*. Community Oriented Correctional Health Services. Retrieved July 16, 2012 from www.cochs.org/files/hieconf/GROUND.pdf.

Grantham, Dennis. May 2012. *Struggling with Medicaid limits on care for incarcerated persons*. Behavioral Healthcare. Retrieved July 16, 2012 from www.behavioral.net/article/struggling-medicaid-limits-care-incarcerated-persons.

Hamblin, A., Somers, S. A., Neese-Todd, S., and Mahadevan, R. November 2010. *Medicaid and criminal justice: The need for cross-system collaboration post health care reform*. Retrieved July 2, 2012 from www.chcs.org/publications3960/publications_show.htm?doc_id=12611922.

Ireys, H. October 2010. *Ensuring access to Medicaid for inmates with mental illnesses who are re-entering their communities in Oklahoma*. Presented at the Disability Policy Research Forum, Washington, DC. Retrieved July 2, 2012 from www.disabilitypolicyresearch.org/Forums/20101021/Ireys.pdf.

Mancuso, D. May 2011. *Behavioral health treatment: Opportunities for health care and criminal justice cost savings.* Retrieved July 16, 2012 from www.nationaltasc.org/conf_2011/PDF/Mancuso%20May%202011.pdf.

McDonnell, M. al. November 2010. *Realizing the potential of national health care reform to reduce criminal justice expenditures and recidivism among jail populations.* Retrieved July 9. 2012 from www.cochs.org/files/CHJ%20Final.pdf.

Nardone, M., Cho, R., and Moses, M. June 2012. *Medicaid-financed services in supportive housing for high-need homeless beneficiaries: The business case*. Center for Health Care Strategies, Inc. Retrieved July 16, 2012 from www.rwjf.org/vulnerablepopulations/product.jsp?id=74485.

National Association of Counties. March 2012. *County jails and the Affordable Care Act: Enrolling eligible individuals in health coverage.* Retrieved July 2, 2012 from www.naco.org/programs/csd/Documents/Health%20Reform%20Implementation/County-Jails-HealthCare_WebVersion.pdf.

National Health Care for the Homeless Council. June 2012. *Health reform and justice-involved populations: Opportunities for the HCH community.* Retrieved July 9, 2012 from www.nhchc.org/2012/05/health-reform-and-justice-involved-populations-opportunities-for-the-hch-community/.

Stazesky, R., Hughes, J., and Venters, H. April 2012. *Implementation of an electronic health record in the New York City jail system.* Retrieved July 9, 2012 from www.cochs.org/files/hieconf/IMPLEMENTATION.pdf.

The Council of State Governments Justice Center, 2010. *Collaborative law enforcement, health, and community mental health strategies in the care and emergency room diversion of people with mental illnesses: Principles and promising practices*.

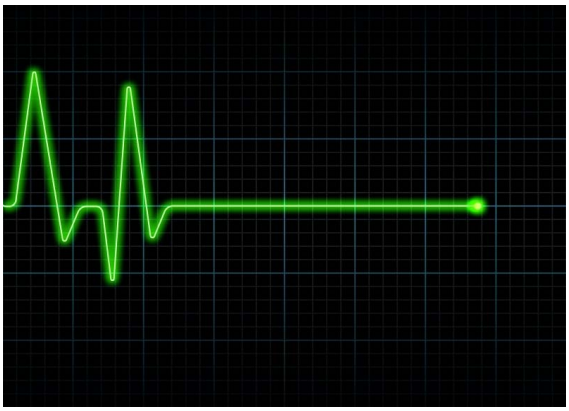
The Council of State Governments Justice Center. 2011. *Frequently asked questions: implications of the federal health legislation on justice-involved populations*. Retrieved July 9, 2012 from http://reentrypolicy.org/jc_publications/faqs-implications-of-the-federal-legislation-on-justice-involved-populations/FAQs_Federal_Health_Legislation_on_Justice_Involved_Populations_REV.pdf.

Wakeman, S. E., McKinney, M. E., and Rich, J. D. 2009. *Filling the gap: Importance of Medicaid continuity for former inmates.* Retrieved July 16, 2012 from www.ncbi.nlm.nih.gov/pmc/articles/PMC2695526/.

The Implications of the Affordable Care Act on People Involved with the Criminal Justice System

By Council of State Governments Justice Center

Published: 05/27/2013



In March 2010, President Barack Obama signed into law the Patient Protection and Affordable Care Act (ACA).[1] Following the Supreme Court's June 2012 decision upholding the constitutionality of the most critical components of the law,[2] states have been focused on efforts to implement health care reform, including deciding whether to adopt the expansion of Medicaid to nondisabled adults earning at or below 133 percent of the federal poverty level (FPL). This brief provides an overview of the implications of the ACA for adults involved with the criminal justice system, as well as information about how professionals in the criminal justice field can help this population access the services now available to them.[3]

The Opportunity

The implementation of the ACA represents an important opportunity to increase access to community health care for people involved with the criminal justice system by removing financial barriers to obtaining health insurance. The majority of this population is currently uninsured, low-income, and has high rates of chronic and communicable illnesses, as well as mental health and substance use disorders.[4] Under the provisions of the ACA, more than half of the 730,000 federal and state prisoners reentering the community each year are estimated to be newly eligible for either Medicaid or for federal subsidies to help buy health insurance from state health insurance exchanges (HIX).[5] Large numbers of individuals in jail and on probation and parole will also be newly eligible for health insurance.

There is a clear opportunity for court and corrections administrators to be actively involved in connecting this population with the health care services now available to them through the ACA. Pre-trial or pre-release transition planning that includes assistance in determining eligibility and enrolling newly eligible individuals for Medicaid

or another health plan in the HIX, as well as a facilitating "warm handoffs" to local health care providers could be critical to the success of many of those returning to their communities after incarceration.

Court and corrections agencies also have a role in the dialogue and decision making related to the implementation of the ACA at the state and local level. By encouraging policymakers to target and prioritize the justice-involved population in their planning, criminal justice professionals will have a direct stake in the law's success. The effective implementation of the ACA has the potential to improve the overall health status of this population, which in turn will provide long-term public health benefits, as well as enhance public safety by reducing crime, revocations, and the social costs associated with unmet mental health and substance abuse needs.

What ACA Means to People Involved with the Criminal Justice System

The ACA includes a range of provisions that are especially relevant to people involved with the criminal justice system, including:

- State options to expand minimum income eligibility threshold for Medicaid
- Premium tax credits and cost-sharing subsidies in state health insurance exchanges
- Dependent coverage
- Protection for pre-existing conditions
- Coordinated medical and behavioral health care for chronic illnesses
- Essential Health Benefits

Beginning January 2014, states have the option to expand Medicaid coverage to adults under the age of 65, with incomes at or below 133 percent of the Federal Poverty Level (FPL) without having to meet disability requirements.[7] For single adults, that is approximately $14,856 per year.[8] Many people involved in the criminal justice system will be included in this new eligibility group increasing their access to needed health care services.

The creation of state health insurance exchanges (HIX) is one of the key features of the ACA. These exchanges provide individuals and small businesses a way to easily purchase coverage from a range of options. The HIX also establish an individual's eligibility for subsidies including tax credits and cost sharing, which may be important to people reentering their community after incarceration who often are low income or lack employment. Dependent coverage is also a key feature of ACA, which allows for coverage of dependent children up to the age of 26, as is guaranteed coverage for pre-existing conditions, which are a significant concern for this chronically health-challenged population.

Essential Health Benefits are required for those newly eligible for Medicaid and for those plans offered in the HIX, and are defined broadly as ten categories of services: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance abuse disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness and chronic disease management; and pediatric services, including oral and vision care. The inclusion of mental health, behavioral health, and substance abuse disorder services is of critical importance to this population. States have the option of establishing "Health Homes" as a means to provide comprehensive case management and coordination of community and social supports, for people with multiple chronic conditions including serious and persistent mental disorders.

The Role of Criminal Justice Agencies

Corrections and court personnel are in a unique position to help individuals access critical health care services, specifically by creating processes and training to:

- Determine eligibility for coverage as a step at intake to correctional agencies and review insurance status prior to release;
- Facilitate the application and enrollment of eligible individuals in Medicaid or other coverage through a HIX;
- Collaborate with state or local health administrators on protocols to connect these individuals with appropriate community health care providers.

Determine Eligibility

ACA requires U.S. Department of Health and Human Services (HHS) to develop a single streamlined application form people can use to apply for coverage through Medicaid, CHIP, qualified health plans, as well as premium credits for health coverage in the HIX. State Medicaid offices must enter into an agreement with a HIX to coordinate eligibility determination and enrollment. Eligibility for coverage for Medicaid or a HIX is based on two criteria: immigration status and income.[9] People will be able to access the application online or at locations designated by the states' Medicaid Office. The submission of the application online, over the telephone, or by mail will trigger the electronic verification of an applicant's identity, citizenship, and whether his or her income meets eligibility requirements for Medicaid or some other form of assistance through the HIX. This verification is facilitated by a "data hub" that links information from the Social Security Administration and the Internal Revenue Service. The data hub will be operated by the Centers for Medicare and Medicaid Services (CMS), a division of HHS. Physical identification for verification of eligibility will not be required unless the electronic verification system is unable to verify the identification and citizenship information provided.

Regulations have allowed a 45-day limit on Medicaid eligibility determinations for non-disability applications. However, it is expected that the new streamlined process and on-line application will make real-time eligibility determinations for many of those who are clearly eligible.

Facilitate Enrollment

After determining eligibility, enrollment or re-enrollment in Medicaid or other coverage on the HIX should also be a step in pre-trial processing for discharge and pre-release reentry planning. It is important to facilitate enrollment before discharge from pre-trial detention or incarceration, or immediately at the start of supervision in order to enable the swiftest connection to community health care. The earlier administrators initiate the enrollment process for eligible individuals and are able to select a provider that can meet their health care needs, the better the chances are of avoiding a lapse in care or treatment as they transition back to their communities.

If an individual loses his or her health coverage while incarcerated, re-enrollment is necessary prior to discharge or immediately at the start of supervision. While the re-enrollment process may vary from state to state, to re-enroll, all that is needed is the individual's personal information (i.e., Social Security number, date of birth, and legal name). The CMS data hub will verify income to confirm eligibility. A mailing address is still required, but a permanent home address is no longer a requirement. New rules also define residency as the state where the individual lives or intends to live.[10]

Collaborate

With sufficient staff and appropriate training, corrections and supervision agencies could effectively connect the more than 700,000 people returning to communities from state and federal prison to the critical health care services for which they are now eligible. The long-term public health and safety implications of these connections would be invaluable.

By providing assistance with enrollment prior to discharge from custody, prison and jail

administrators can provide immediate benefit to the individuals transitioning to community supervision. As part of the facilitation of the enrollment process, corrections administrators should also have an efficient method for responding to requests for medical records or other information from community health care providers. When possible, advance visits from community health care and treatment providers would allow for "warm handoffs" to minimize disruption of care, especially for those with chronic diseases and/or behavioral health disorders. This kind of collaboration and relationship building with community health care providers can also benefit corrections personnel by providing access to valuable information about medical and behavioral health disorders of individuals newly entering detention facilities, which can enhance safety and security.

Supervision agencies can play a significant role in promoting the health of the nearly five million adults on probation and parole[11] by confirming or initiating enrollment during an office visit or by referring clients to support services that can assist with enrollment in Medicaid or another plan on the HIX. Supervision agencies are also in a unique position to help the individual identify, access, and remain engaged with the health care services available to them, which may significantly improve chances for successful reentry and reduce recidivism.

Finally, criminal justice agencies can help ensure that the expansion of benefits results in improved public health and safety outcomes by collaborating with policymakers in the implementation of the ACA at the state and local levels. To provide meaningful, impactful input in the planning process, criminal justice agencies should:

- Document the demographics and health care needs of individuals entering jails and prisons;
- Identify service gaps in the community specifically related to the population involved with the criminal justice system;
- Identify their own workforce training needs;
- Identify IT systems that require upgrades in order to link to Medicaid and HIX systems and other critical information infrastructure;
- Develop a financial statement demonstrating projected cost savings to criminal justice agencies under several scenarios (e.g., low, medium, and high participation in health care reform).

These efforts can help inform decision making, strengthen partnerships, and achieve public health and safety goals across multiple systems. In the future, criminal justice agencies should explore how ACA provisions may increase opportunities for diversion and promote continuity of care and treatment within their jurisdictions.

The Individual Mandate

The "individual mandate" is an ACA requirement that most individuals in the United States have a prescribed minimum level of health insurance coverage beginning in 2014. Among those exempt from the penalty associated with the individual mandate to carry a minimum level of coverage are people who are below the filing threshold for federal income taxes (set at $9,750 for single individuals under age 65 in 2012), as well as people who are incarcerated.[6] For those not exempt, penalties are assessed through IRS income tax filings, starting at $95 in 2014, and rising to $325 in 2015 and $695 in 2016. Those with incomes of between 100 and 400 percent of the FPL will be eligible for financial assistance to purchase private insurance plans through state exchanges. For people with incomes of 100 to 133 percent of the FPL, premium contributions will be limited to 2 percent of their income.

Illinois Prepares for Newly Eligible Medicaid Population in Corrections

The Illinois Governor's office took early steps to prepare local and state agencies for the state's estimated 200,000 individuals under correctional supervision that would be newly eligible for Medicaid. In March 2011, the Governor's Health Care Reform Implementation Council formed the Workgroup on Justice Populations (WJP). The workgroup goals include establishing universal enrollment, screening, and connection to community

medical and behavioral health treatment. This is expected to result in significant reductions in rearrests and future costs for incarceration. The workgroup was charged with developing a health reform implementation guide for justice-involved populations to assist system planning efforts in the county jail system, the court services system, the Illinois Department of Corrections, and the health and human services provider network. To achieve these goals, the WJP is considering options, such as expanding the Illinois Jail Data Link to cross match current Medicaid recipients with new inmates, improving the state's capacity to share information within federal regulations, and streamlining processes for reengagement into Medicaid-funded services upon release from incarceration.

Early planning has also involved the development of pilot projects including one led by Illinois' probation departments and a full implementation project in Chicago. Probation administrators in two counties are developing standardized processes to assist probationers with Medicaid applications and make referrals to human services providers and community health centers. In Chicago, Circuit Judge Paul P. Biebel, Jr. convened criminal justice and health system leaders at the Justice and Health Initiative. The goal is to align health reform resources across all points in the justice process, with a view to decreasing recidivism and creating options for jail diversion. Criminal justice and health agencies are building Medicaid enrollment processes and linkages to community medical and behavioral health services, leveraging Illinois' early expansion of Medicaid (2010). For more information, please contact Jennifer Koehler at jennifer.koehler@illinois.gov

Conclusion

The ACA is the most significant reform in health care in 45 years and much of the implementation will depend on the states. Most of the processes and objectives discussed in this brief depend on each state's decision on whether, and how, to participate in Medicaid expansion and the availability and capacity of community health care providers to meet the health needs of those who are involved with the criminal justice system. States have a number of choices they can make that could lead to improved health outcomes for this population, including facilitating more effective community partnerships, planning better reentry programs, and improving linkages to public health services. Should states successfully enable access to needed health services for people involved with the criminal justice system, it may be possible to reduce recidivism, decrease corrections expenditures for health care services, increase federal funding for health services delivered in the community, and decrease safety risks within the corrections system. Criminal justice administrators who emphasize at every opportunity the benefits of ensuring sufficient community health care have the potential to realize significant, measurable benefits within their own agencies.

Acknowledgments

The Council of State Governments Justice Center thanks Dr. Barbara DiPietro, Policy Director for the National Health Care for the Homeless Council, for her contribution to the development of this report. CSG Justice Center staff members Dr. Nicole Jarrett, Senior Policy Analyst, and Dr. Fred Osher, Division Director for Behavioral Health, advised on the project. The following experts provided valuable reviews and feedback: Dr. Lisa Braude, Senior Associate, DMA Health Strategies; Maureen McDonnell, Director for Business and Health Care Strategy Development, Treatment Alternatives for Safe Communities; Gabrielle de la Gueronniere, Director of National Policy, Legal Action Center; Laurel Stine; Michelle Dirst, Director of Public Policy, National Association of State Alcohol and Drug Directors; and Steven Rosenberg, President, and Dr. Keith Barton, Medical Director, Community Oriented Correctional Health Services.

Endnotes

1. The ACA encompasses Public Laws 111-148 and 111-152. A consolidated version of the law can be found at http://docs.house.gov/energycommerce/ppacacon.pdf.
2. 567 U.S. (2012). The National Federation of Independent Business v. Sebelius case was heard together with Florida v. Department of Health and Human

Services. For more information, see: The Henry J. Kaiser Family Foundation, Focus on Health Reform, A Guide to the Supreme Court's Aff ordable Care Act Decision (Menio Park: The Henry J. Kaiser Family Foundation, July 2012), available at http://www.kff.org/healthreform/upload/8332.pdf.

3. For more detailed information related to eligibility, financing, services, exemptions to the individual mandate, and enrollment, see: Barbara DiPietro, "Frequently Asked Questions: Implications of the Federal Health Legislation on Justice-Involved Populations," (New York: Council of State Governments Justice Center, 2011), available at http://www.reentrypolicy.org/jc_publications/faqs-implications-of-the-federal-legislation-on-justice-involved-populations/FAQs_Federal_Health_Legislation_on_Justice_Involved_Populations_REV.pdf.
4. For more information on health risks of incarcerated populations and people returning from jail and prison, see: the National Reentry Resource Center, "Frequently Asked Questions: Health, Mental Health, and Substance Use Disorders" (New York: Council of State Governments Justice Center), available at: http://www.nationalreentryresourcecenter.org/faqs/health; Kamala Mallik-Kane and Christy Visher, Health and Prisoner Reent ry: How Physical, Ment al, and Substance Abuse Conditions Shape the Process of Reint egration (Washington: Urban Institute, 2008), available at http://www.urban.org/url.cfm?ID=411617; The National Center on Addiction and Substance Abuse at Columbia University, Behind Bars II : Substance Abuse and America's Prison Population (New York: Columbia University, February 2010), p. 35; Henry Steadman, Fred C. Osher, Pamela Clark Robbins, Brian Case, and Steven Samuels, "Estimates on the Prevalence of Adults with Serious Mental Illnesses in Jails," Psychiatric Services 60 (June 2009): 761—65, available at http://www.consensusproject.org/publications/prevalence-of-serious-mental-illness-among-jail- inmates/PsySJailMHStudy.pdf.
5. Estimate is based on 100 percent state participation. Allison Evans Cuellar and Jehanzeb Cheema, "As Roughly 700,000 Prisons Are Released Annually, About Half will Gain Coverage And Care Under Federal Laws," Health Aff airs, 31 no. 5 (2012): 931—938.
6. For more information on 2012 filing thresholds, see: Internal Revenue Service, "Your Federal Income Tax" Publication 17, 2012, available at http://www.irs.gov/publications/p17/ch01.html#d0e1532.
7. On June 28, 2012, the Supreme Court ruled that the federal government could not withhold Medicaid funding from states that opt out of the Medicaid expansion. Medicaid income eligibility will be based on modified adjusted gross income (MAGI) with no asset test. Special adjustments will bring the effective eligibility to 138 percent of Federal Poverty Level (FPL). Prior to ACA, states had to apply for a waiver to expand Medicaid coverage for non-disabled adults without dependents. States may choose to maintain their current income thresholds or set income thresholds at or higher than 133 percent FPL.
8. Based on 2012 FPL Guidelines for the 48 Contiguous States and the District of Columbia. Federal Register, Volume 77 Number 17, Thursday, January 26, 2012.
9. Medicaid financial eligibility will be based on monthly modified gross adjusted income (MAGI), as defined by the IRS, at the time of the application. There will be no asset/resource tests for eligibility. Eligibility for premium credits will be based on annual income.
10. 42 CFR §435.403.
11. L.E. Glaze and T.P. Bonczar, Probation and Parole in the United States, 2010 NCJ 236019 (Washington: U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics, November 2011), available at: http://bjs.ojp.usdoj.gov/index.cfm?ty=pbdetail&iid=2239.

Comments:

Fred Davis on 05/28/2013:
Medicaid could very well be the straw that brings in great unintended economic

consequences.It is no compassion to take another persons money by force and give that money to businesses or unions that support the politically incestuous relationship between the Insurance companies that government owns and has invested in against the will of the working public,

Login to let us know what you think

User Name:

Password:

Remember me:

Log in Forgot password?

BIOGRAPHIES

The Affordable Care Act and Criminal Justice

A Forum Presented by the Substance Abuse Treatment and Mental Health Services Integration Taskforce

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.

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.

Deborah A. Carroll, Administrator, Department of Human Services Economic Security Administration

Deborah A. Carroll is the Administrator for the Department of Human Services Economic Security Administration. Ms. Carroll is a graduate of Temple University, where she obtained her Bachelor of Science degree in Therapeutic Recreation. After working in a hospital for persons with mental illness for over eight years, Ms. Carroll attended Temple University Law School and obtained her Juris Doctorate in 1991.

Ms. Carroll developed a private practice and served in a quasi-judicial position as a mental health review officer. She developed expertise in health privacy, child welfare, and mental health law and practice while representing the Departments of Health, Behavioral Health, and the Philadelphia Department of Human Services from 1999-2003. Additionally, Ms. Carroll served as legal counsel to the City of Philadelphia's Forensic Mental Health Task Force where she co-authored a treatise on Pennsylvania's mental health commitment laws, and participated in Pennsylvania's Southeast Region Forensic Mental Health Task Force.

She joined the Office of the General Counsel for the DC Department of Human Services in 2003, where she served as the Deputy General Counsel for DHS and served as principal attorney for the Economic

Security Administration. Ms. Carroll also served as the Acting General Counsel for DHS from 2006 through 2008 before she joined the agency in 2009 to serve as the Administrator.

Ms. Carroll is a Regional Representative to the Board of the American Association of SNAP Directors and past President of the National Bar Association –Women Lawyer's Division, Philadelphia Chapter.

Dr. Linda Elam, Senior Deputy Director and State Medicaid Director, Department of Health Care Finance

Linda Elam is Senior Deputy Director and State Medicaid Director at the District of Columbia's Department of Health Care Finance (DHCF). A cabinet level agency as of October, 2008, DHCF is the District's Medicaid agency, and it also administers the State Child Health Insurance Program (CHIP), the Immigrant Children's program and Medical Charities. As Senior Deputy Director for Medicaid, Dr. Elam oversees the offices responsible for program operations, policy and research, health care delivery management, health reform and innovation and the Office of the Medical Director. Previously, Dr. Elam served as the Director of the Health Care Policy and Planning Administration within DHCF. Dr. Elam also served as agency Interim Director during the transition between the Fenty and Gray mayoral administrations.

Prior to joining DHCF, Dr. Elam was a Principal Policy Analyst with the Henry J. Kaiser Family Foundation, where her areas of focus included prescription drug policy, racial and ethnic disparities in health care, and mental health. Dr. Elam's policy expertise, industry experience and basic science background give her a unique perspective on health care. She has authored and contributed to briefs, journal articles and book chapters, primarily in the area of prescription drug policy for low-income Americans. Dr. Elam received her B.S. in zoology from Howard University, her M.P.H. in Health Policy and Administration from the University of California at Berkeley, and her Ph.D. in Health Policy and Management from the Bloomberg School of Public Health at the Johns Hopkins University.

Mila Kofman, Executive Director, DC Health Benefit Exchange Authority

Mila Kofman is the Executive Director of the DC Health Benefit Exchange Authority. Appointed to the position by a unanimous vote of the Board of Directors, Kofman is a nationally recognized expert on private health insurance markets and has worked with states and all stakeholders to implement health insurance reforms. Her approach is informed by her hands-on experience as the former Superintendent of Insurance in Maine implementing health insurance reforms, being a former federal regulator working with states to implement HIPAA reforms of the 1990s, studying state-based reform efforts and markets, and working with employer purchasing coalitions seeking to leverage purchasing power for sustainable financing of medical care.

From March 2008 to May 2011 as the Superintendent of Insurance in Maine, Kofman regulated a multi-billion dollar insurance industry, heading an agency with 70+ staff and a multi-million dollar budget. A gubernatorial appointee, she was nominated and first confirmed in 2008 and in 2010 was re-nominated and unanimously reconfirmed to a new term. Her effective alliances with business groups, the insurance industry, consumer and patient advocates, physicians, trial attorneys, and sister state agencies helped to improve the state's insurance market for both consumers and companies. The property and casualty

market improved its ranking to third best in the nation. Kofman was successful in her priority legislative initiatives with some having passed unanimously. She also successfully undertook agency restructuring. She realigned resources to clear backlogs and improve services to the regulated community; created a market conduct examination unit responsible for ensuring compliance with the state's laws; created a formal and more effective enforcement process, going from a few to dozens of active enforcement cases; and improved consumer services processes making it easier for consumers to get help. Kofman improved transparency and government accountability by holding public hearings around the state on health insurance rates, efforts that were recognized by the White House and served as a model in other states.

In addition to serving on the Governor's Steering Committee on health reform implementation in 2010, Kofman served in key leadership positions at the National Association of Insurance Commissioners (NAIC). She was elected Secretary/Treasurer of the northeast zone and served on the NAIC's Executive Committee, she chaired the Health Insurance Regulatory Framework Task Force (responsible for ACA changes to NAIC models), co-chaired the Consumer Information Working Group (statutory working group under ACA with diverse membership of regulators, industry, consumers, physicians, agents, and other stakeholders), and was a member of the (B) Health Insurance and Managed Care Committee, the Exchanges Working group, the Executive Committee's Professional Health Insurance Advisors Task Force, and Anti-Fraud Task Force. She was also a member of the Life Insurance and Market Regulation committees. She held the NAIC seat on URAC's Board of Directors.

From 2001 to 2008, Kofman was an Associate Research Professor and Project Director at the Georgetown University Health Policy Institute. She studied state private health insurance market reforms, regulation, products (including alternative products like discount cards), and financing strategies. She rejoined the faculty at Georgetown University Health Policy Institute in July 2011 as a Research Professor and Project Director.

In addition to more than 30 peer reviewed publications, her work included papers on group purchasing and private-public purchasing partnerships (pre-cursors to exchanges). She led ground breaking research on associations, which continues to be used widely. Ms. Kofman was the first in the nation to document the third cycle of health insurance scams (a report published by BNA) – research that informed a GAO study and a subsequent Congressional hearing. She has testified before the US Senate, the US House of Representatives, and state legislatures. She also served as an expert witness in civil and criminal cases. Kofman served on the NAIC Consumer Participation Board of Trustees for 6 years, the Board of Directors for URAC for 5 years, and was co-editor for the Journal of Insurance Regulation for 3 years. In 2007, she was recognized by the American Council on Consumer Interests and was the 2007 Esther Peterson Consumer Policy Forum Speaker.

Ms. Kofman was a federal regulator at the US Department of Labor (1997-2001). She worked on legislation and implemented HIPAA and related laws. She was honored with the Labor Secretary's Exceptional Achievement Award. In 2000, she was appointed Special Assistant to the Senior Health Care Advisor to the President at the White House to work on legislative and regulatory initiatives -- the Patient's Bill of Rights, long-term care insurance, nursing home reform, and ERISA reform.

She has appeared on NPR, CNN, CBS Evening News, ABC News and has been cited in BusinessWeek, Consumer Reports, the NY Times, the Wall Street Journal, the Washington Post, the LA Times, the Chicago Tribune, Forbes, US News & World Report, AM Best, AP, and other press. Her blogs have appeared in Huffington Post, Health Affairs, and The New Republic.

Ms. Kofman holds a J.D. from Georgetown University Law Center and a B.A. in Government and Politics from the University of Maryland (summa cum laude).

Diane C. Lewis, Co-Principal and Executive Vice President, ALTA Consulting Group, Inc.

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, 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 empower them to select the health plan that provides the best value.

Ms. Lewis also serves on the Board of House of Ruth, a community organization, providing service-enriched housing and supportive services to women, children and families; through a network of community partners, 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).

Michen Tah, Policy Analyst, Criminal Justice Coordinating Council

Michen M. Tah joined the Criminal Justice Coordinating Council as a Policy Analyst in December of 2012. 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 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.