



Preparing for Medicaid Expansion: Ensuring Health Care Access for Individuals with Criminal Justice Involvement

September 16, 2013

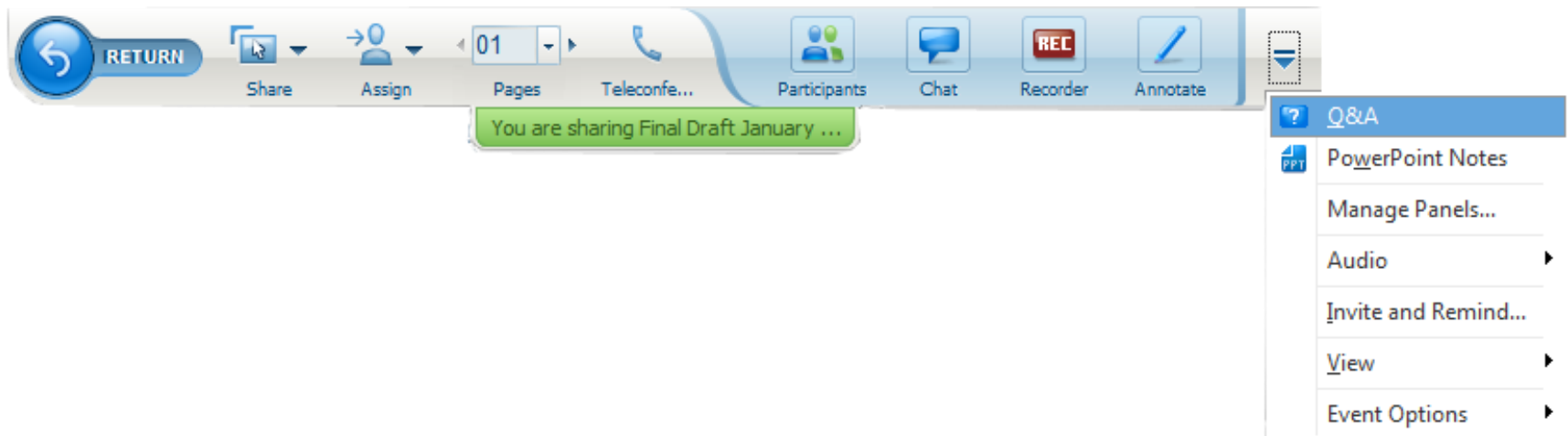
revised 10/11/13

1:30 PM-3:00 PM EST

Dial-In: 800-245-1683 // Passcode: 444807

Questions?

Ask a Question Online: Click the **Q&A** icon located in the hidden toolbar at the top of your screen.



Agenda

- I. Introduction**
- II. Implementation Considerations for the Criminal-Justice Involved Subset of the Expansion Population**
- III. Perspectives from the Field**
- IV. Group Discussion/ Q&A**

CHCS

Center for Health
Care Strategies, Inc.

A non-profit health policy resource center dedicated to improving services for Americans receiving publicly financed care

- ▶ **Priorities:** (1) enhancing access to coverage and services; (2) advancing quality and delivery system reform; (3) integrating care for people with complex needs; and (4) building Medicaid leadership and capacity.
- ▶ **Provides:** technical assistance for stakeholders of publicly financed care, including states, health plans, providers, and consumer groups; and informs federal and state policymakers regarding payment and delivery system improvement.
- ▶ **Funding:** philanthropy and the U.S. Department of Health and Human Services.

Select CHCS National Initiatives

Enhancing Access to Coverage and Services

Technical Assistance for State Health Reform Assistance Network

Charity Care Affinity Group

Advancing Quality and Delivery System Reform

Technical Assistance for the State Innovation Model Resource Center*

Medicaid and CHIP Learning Collaboratives*

Advancing Medicaid Accountable Care Organizations: A Learning Collaborative

Integrating Care for People with Complex Needs

Complex Care Innovation Lab

Technical Assistance for CMS Integrated Care Resource Center*

CMS Medicaid Health Homes Technical Assistance *

Building Medicaid Leadership and Capacity

Medicaid Leadership Institute

Annual Medicaid Boot Camp

Relevant Activities to Date

2010

- COCHS Conference and Paper

2011-
2012

- Criminal Justice Workgroups

2013

- Medicaid Workgroups

Framing the Opportunity

Steven Rosenberg

President

Community Oriented Correctional Health Services (COCHS)

Steve Rosenberg has more than 30 years of experience providing technical assistance and directing projects that increase access to health care for vulnerable populations. He founded COCHS in 2006 to develop a public health approach to serving populations that cycle through jails, and connecting them to community-based health care.

Who's In Jail

- ~ 12 million jail admissions and releases annually, involving about 10 million individuals.
- Many released on bail pending trial after a few hours or a few days, with 64% turnover each week.
- Only about 4% of jail admissions result in sentences to prison. OR, in other terms...
- 96% of jail detainees and inmates return *directly* to the community from jail, along with their often untreated health conditions.

Section II

Implementation Considerations for the Criminal-Justice Involved Subset of the Expansion Population

Today's Focus: Coverage Post-Release

- Federal Financial Participation is not available in expenditures for services provided to individuals who are inmates of public institutions
- Medicaid can pay for inpatient treatment for inmates/ detainees who would otherwise be eligible for Medicaid
- Eligibility for Marketplace coverage is maintained for individuals pending disposition of charges

Demographics of the Jail-Involved

Jail population is disproportionately:

- Young
- Male
- Minority
- Poor
- With low education levels

(Veysey, 2010)

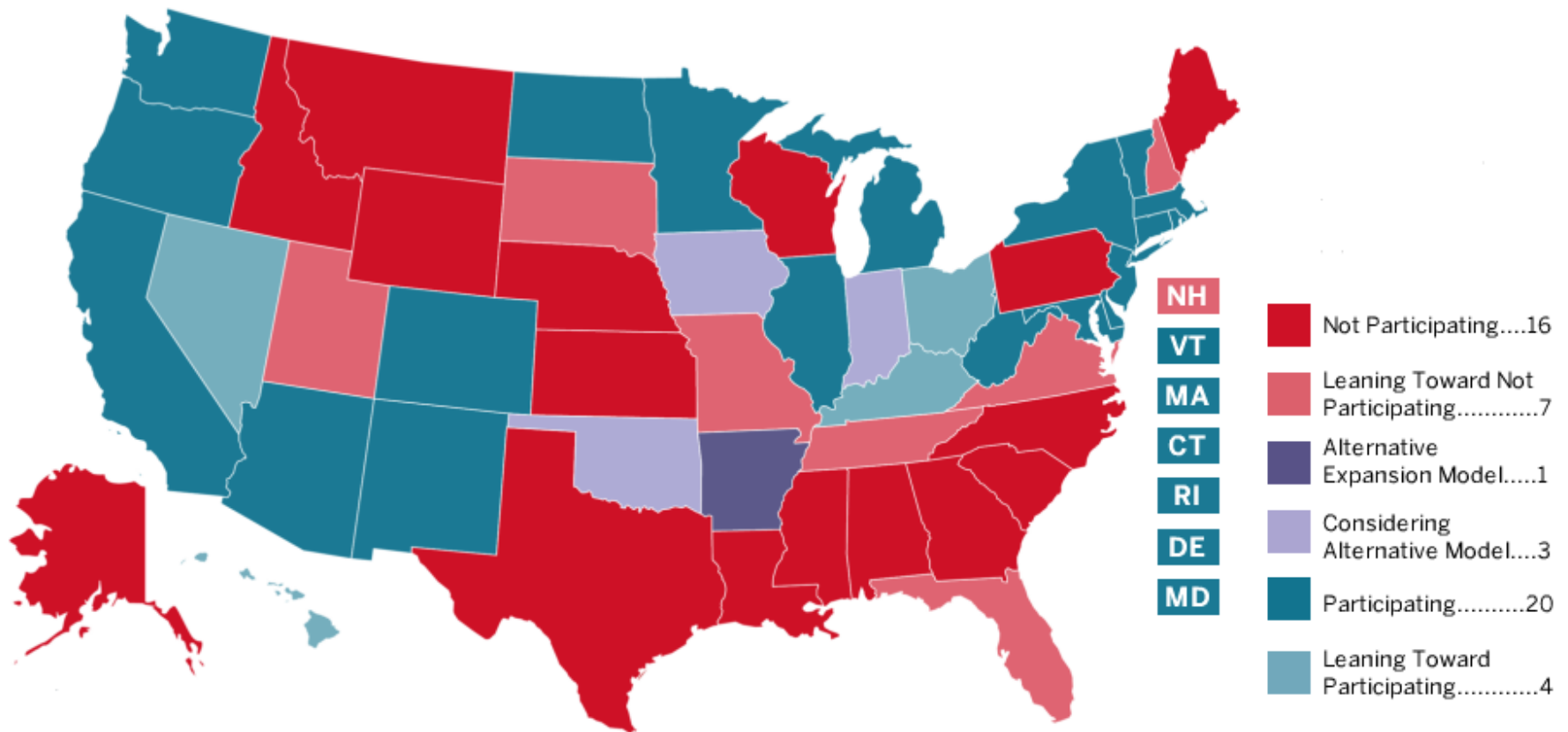


- The majority (~ 90%) of those entering jails today have no health insurance, with health costs paid predominantly by states or counties.

Medicaid Expansion: An Unprecedented Opportunity

- Expansion of Medicaid eligibility to all non-elderly adults up to 138% of the federal poverty level (\$15,800 for a single adult, \$32,500 for a family of four)
- Federal government will pay 100% of the costs of the new population 2014-2016
- July 2012 Supreme Court ruling made the expansion optional for states

State of Play on Medicaid Expansion



As of September 6, 2013. Source: Advisory Board. "Beyond the pledges: Where the states stand on Medicaid."
<http://www.advisory.com/Daily-Briefing/Resources/Primers/MedicaidMap>

Impact of the Medicaid Expansion

- **9 - 13 million new Medicaid enrollees (2013-2023)**

(Congressional Budget Office, May 2013)

- **Approximately 60% of jail inmates had pre-arrest personal income less than 138% FPL**

(Bureau of Justice Statistics, 2002 Profile of Jail Inmates)

- **11.6 million admissions to local jails during the 12-month period ending June 30, 2012**

(Bureau of Justice Statistics, Jail Inmates at Midyear 2012)

Impact of the Medicaid Expansion (continued)

- 6 - 7 million individuals cycling out of jails are likely to qualify for Medicaid based on income
- Depending on state decisions to expand Medicaid, 3 - 4 million could enroll
- Individuals cycling out of jails could represent up to 30% of the 2014 Medicaid expansion*

*Note, slide updated 10/11/13 to clarify populations cycling out of jails versus current inmates. Medicaid funding is not available for health care services provided in jails or prisons.

(M. Regenstein, Webinar, June 18, 2013)

Washington State Experience

- 30% of very low-income childless adults (up to 38% FPL) in state-funded general assistance had prior arrests (Hamblin et al., 2011)
- State officials expect the “vast majority” of the 160,000 unique individual adults booked annually in jails will be eligible for Medicaid in 2014 - only 20 percent of whom have been previously eligible (Mancuso and Felver, 2010)

Behavioral Health and Substance Use Disorders among the CJ Involved

- More than 50% of the jail-involved have a diagnosable substance use (SU) disorder
(Chandler, Fletcher and Volkow, 2009)
- 14.5% of men and 31% of women in jail have a serious mental illness (Steadman et al., 2009)
- Over 70% of people in jails with serious mental illness also have a co-occurring substance-use disorder (Rowe et al., 2007)

Improving Access to Health Care for Former Jail Inmates

- Lack of access to health care in the community upon release leads to:
 - ▶ Increased morbidity and mortality
 - ▶ Overreliance on costly emergency room services
 - ▶ Avoidable hospitalization
 - ▶ High rates of recidivism for people transitioning from incarceration back to the community

(Merall et al, 2010; The National GAINS Center, 2001)

- A solution: improved health care access through Medicaid enrollment

Key Considerations for Effective Enrollment and Connection to Services: Application

- Could jails and/or other correctional settings serve as enrollment centers?
 - ▶ Who would conduct E&E activities?
 - ▶ When would these activities occur?
- What resources could be available to assist these individuals to complete applications?

Conducting Enrollment in Correctional Settings: Who?

HHS Staff

- Common practice to outstation E&E workers in high opportunity settings
- Expertise in E&E functions
- Particularly viable in states using county-based E&E models

DOC Staff

- Familiar with population and setting
- Opportunity to build into existing workflows
- Greater access to correctional information systems

Consumer Assistors

- Individual states may have significant resources to leverage
- Opportunity for community partnerships

Consumer Assistance and the ACA

Navigators

- Individuals in community-based organizations who will link consumers to the Marketplace
- Funded through operating revenues of the Marketplace

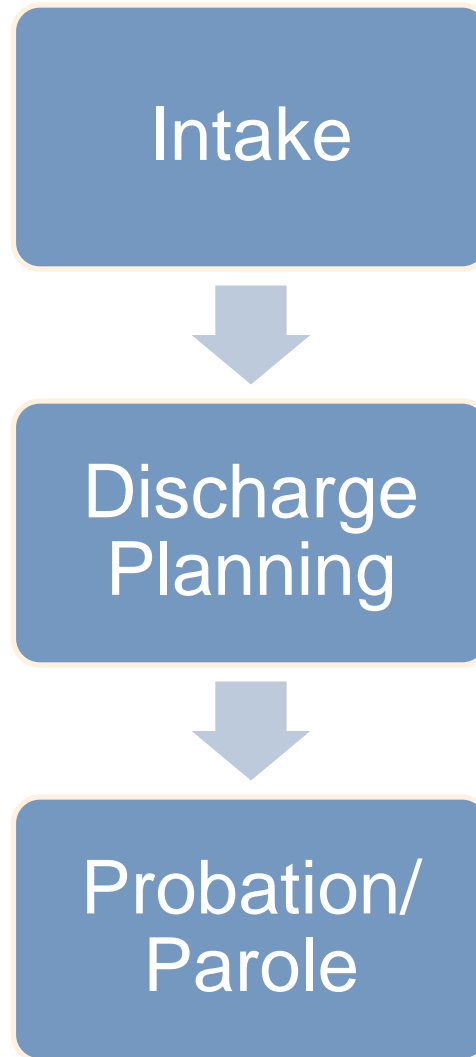
In-Person Assistors

- Similar duties and requirements as Navigators
- Funded through Marketplace establishment grant funds

Certified Application Counselors

- Not paid by the Marketplace
- Similar functions as Navigators
- Similar training requirements, security standards, and conflict of interest rules

Conducting Enrollment in Correctional Settings: When?



Key Considerations for Effective Enrollment and Connection to Services: Benefits

- What benefits and services will the jail-involved population need upon release?

Alternative Benefit Plan (Benchmark Coverage) Required for the Adult Expansion Group

- Alternative Benefit Plan must:

- ▶ Cover 10 essential health benefits (EHBs)
- ▶ Provide EPSDT services for those under age 21
- ▶ Provide non-emergency transportation
- ▶ Provide family planning services and supplies
- ▶ Provide FQHC and rural health clinic services
- ▶ Meet mental health parity requirements



10 EHBs

1. Ambulatory patient services
2. Emergency services
3. Hospitalization
4. Maternity and newborn care
5. Mental health and substance use disorder services
6. Prescription drugs
7. Rehabilitative and habilitative services and devices
8. Laboratory services
9. Preventive and wellness services and chronic disease management
10. Pediatric services, including oral and vision care

Mental Health and Substance Abuse in the ACA

- Mental Health Parity requires coverage of mental health and substance use disorder services at a level no more restrictive than in medical or surgical benefits.
- Mental health and substance use services, including behavioral health treatments are included in the EHB
- “Medically frail” includes individuals with chronic substance use disorders

Benefit Design Considerations for CJ Involved

- Harm reduction services
- Medication assisted treatment
- Outpatient addiction treatment, focused on evidence-based practices
- Residential treatment for those at highest risk of relapse/reincarceration
- Sober supportive housing
- Vocational rehab and supported employment
- Case management for those with complex needs
- Risk-stratification to determine need for specific services

Key Considerations for Effective Enrollment and Connection to Services: Data

- What data sources are available for application and enrollment processes?
- How can data integration streamline enrollment processes or improve an individual's transition from jail to the community?

Current Initiatives to Enroll Individuals: CT

Pre-Release Enrollment Program



- Collaboration between DOC and DSS
- Discharge Planners based in correctional facilities complete paperwork to apply for Medicaid prior to release, then fax to state Medicaid agency
- Short-form application ensures expediency
- Entitlement specialists at state Medicaid agency process applications; daily e-feed of population list results in benefits being “switched on”

Current Initiatives to Enroll Individuals: MD

HealthCare Access Maryland



- Case managers placed at the Baltimore City Detention Center help inmates 45-90 days prior to release access public benefits
- Assist with applications for health insurance, food stamps, and linkage to care
- Process application; approved within 24 hours post release
- Case managers follow up for at least 30 days after release
- 85% success rate for benefit enrollment

Challenges to Address

- Workflow issues
- Staff training
- Funding
- Identity verification
- Unknown release date for non-sentenced population
- Potential lag prior to health plan enrollment
- Provider competencies in treating justice-involved populations

Section III

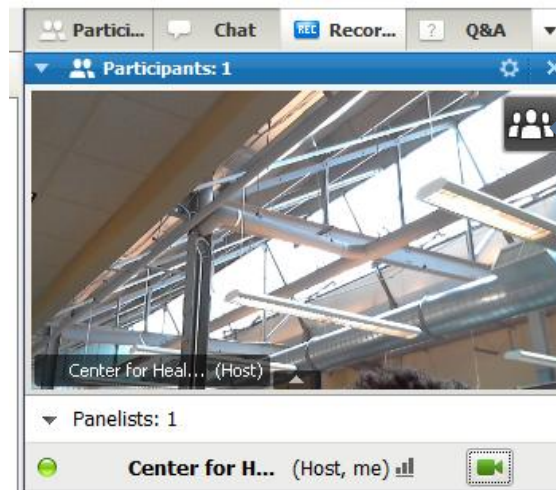
Perspectives from the Field

Video Panelist Discussion

To access the live video feed open the participants window.



Click the participants button in the hidden toolbar at the top of the screen to view video.



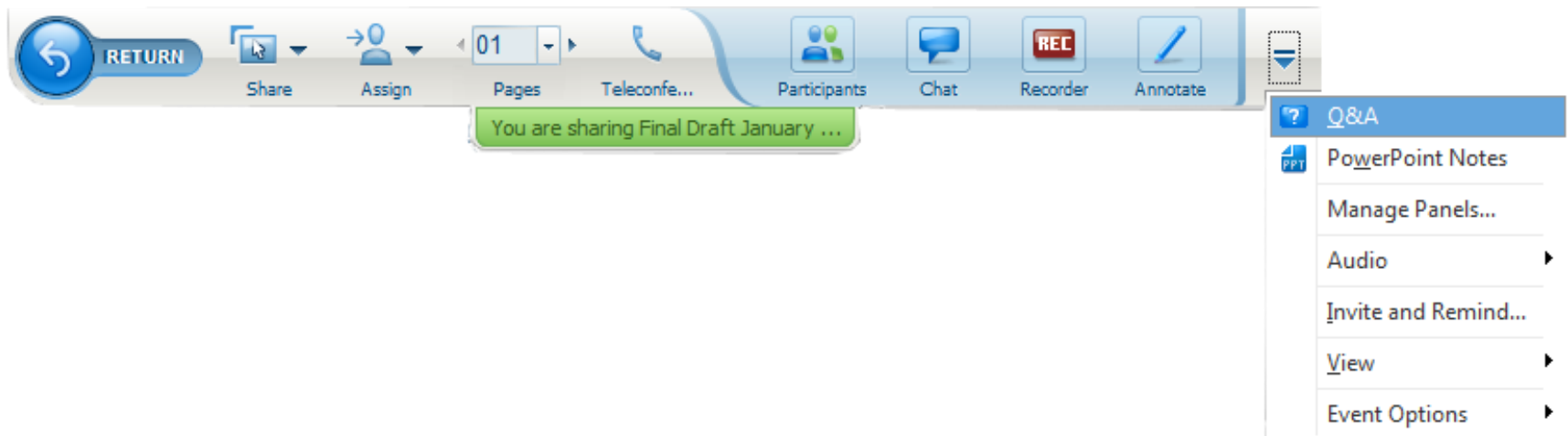
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Section IV

Group Discussion/ Q&A

Questions?

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Additional Resources

www.cochs.org

www.chcs.org