COMMUNITY ORIENTED CORRECTIONAL HEALTH SERVICES
Linking Community Health and Public Safety

Working Group on Health Reform and Criminal Justice: Implications for the Delivery of Behavioral Health Services to the Criminal Justice Population Cycling through Jails

Executive Report

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This report documenting the proceedings of *The Working Group on Health Reform and Criminal Justice: Implications for the Delivery of Behavioral Health Services to the Criminal Justice Population Cycling Through Jails* is the work of COCHS, and COCHS alone is responsible for its content.

Sponsorship of the Working Group

Financial support from the Robert Wood Johnson Foundation allowed COCHS to convene and manage the working group. Additional support from the Substance Abuse and Mental Health Services Agency through its Center for Substance Abuse Treatment and its Strategic Initiative on Trauma and Justice covered travel expenses for key working group members without which the meetings could not have taken place. The Center for Health and Justice at TASC-IL provided food and beverages for the meetings.

Working Group Members, Observers and Presenters

The four working group sessions were organized around agendas that included formal presentations and open discussion. Each session featured several presenters, invited as the series progressed in order to meet the evolving agenda and informational needs of the members. The topics ranged from reports on research about Washington State's substance abuse treatment program for childless adults and best practices for benefit design and rate setting to information on the particular behavioral health needs of the population that cycles through jails.

The core working group membership was comprised of state Medicaid and substance abuse authority leaders from Illinois, Louisiana, Massachusetts, North Carolina, Oklahoma, Pennsylvania, Tennessee, Virginia and Washington State. Other members were policymakers invited from the Substance Abuse and Mental Health Services Agency, the Center for Substance Abuse Treatment, the Substance Abuse Mental Health Services Agency Strategic Initiative on Trauma and Justice, the Office of National Drug Control Policy, the Centers for Medicare and Medicaid Services, and the Office of the Assistant Secretary for Planning and Evaluation at the Department of Health and Human Services. Not-for-Profit members included the Center for Health Care Services and Treatment Alternatives for Safer Communities, Inc.–Illinois.

Observers to the working group included representatives from not-for-profit, advocacy and philanthropic agencies including the National Association of State Alcohol and Drug Abuse Directors, National Academy for State Health Policy, Legal Action Center, the Robert Wood Johnson Foundation, and Community Oriented Correctional Health Services. The working group members and observers are listed in the appendix.

Experts who presented but were not members or observers of the working group included Denise Podeschi of Mercer Health and Benefits, LLC, and Jim Sorensen, PhD, CPA, from the University of Denver.

I. Executive Summary

The Working Group on Health Reform and Criminal Justice Implications for the Delivery of Behavioral Health Services to the Criminal Justice Population Cycling through Jails was convened with the goal of building a knowledge bridge between two parts of the health care system that will be working in a more integrated manner to serve the Medicaid expansion population starting in 2014. Over the course of four meetings in early 2011, the working group discovered a tremendous opportunity to cross-fertilize expertise and experience from thought leaders and practitioners in the areas of behavioral health care and in Medicaid policy and finance; the reasoned, lively and informative discussions resulted in a set of findings and recommendations that will, no doubt, will help inform states and local jurisdictions as they explore new opportunities for serving the criminal justice population under the Patient Protection and Affordable Care Act.

"The whole is greater than the sum of its parts"—a quote attributable to Aristotle—fairly summarizes the achievements of the group, which identified some of the opportunities where the behavioral health care sector and the Medicaid policy and finance sectors of the system may create a mutually beneficial impact in serving the criminal justice population. For example, while the behavioral health care sector has experience working with highly vulnerable populations coming out of the criminal justice system, the Medicaid sectors have the technical expertise to ensure efficient and effective outcomes, and to manage cost. Additionally, while Medicaid does not yet have a lot of experience reaching the low-income criminal justice population that has very high rates of chronic disease, it is very familiar with treating chronic diseases of all kinds.

The working group engaged in a dialogue with behavioral health specialists and technical experts in health plan benefit design, rate setting, and contracting and performance standards. It examined the 2006 Massachusetts health reform initiative and a unique program in Washington State that offers substance abuse treatment to very low-income childless adults. Data from both suggest that there are potential cost savings to be achieved in reaching and treating low-income people with mental health and substance use disorders, characteristics that mirror the criminal justice population.

The core working group membership was comprised of state Medicaid and substance abuse authority leaders, and policymakers and thought leaders from federal agencies focused on health care delivery, mental health and substance abuse. Several not-for-profit advocacy groups participated as well.

Findings and Recommendations

The result of the four meetings is a list of twelve recommendations meant to combine the best practices and experience of Medicaid and behavioral health systems to create new opportunities for improved health and reduced criminal involvement for the expansion population, and cost savings across health care and criminal justice systems.

1. Define a benefit package for newly eligible beneficiaries under the Patient Protection and Affordable Care Act using evidence-based practices that meet the range of needs of

individuals involved in the criminal justice system. This benefit package will have the dual goals of improving care and outcomes as well as containing costs across the health care and criminal justice systems.
2. A substantial portion of newly eligible individuals will have criminal justice involvement. Effective partnerships between the health care and criminal justice systems are needed in order to facilitate their enrollment and ensure continuity of care.
3. Assess the community capacity to provide prevention, treatment, recovery, and integrated services under a benefit package for justice-involved populations. Of critical importance is the development of the infrastructure necessary to deliver these services.
4. Use payment policy to develop service capacity, close service gaps, and expand evidence-based services.
5. Develop performance standards that encourage capacity expansion, establish accountability for effective services and health outcomes, and ensure access.
6. Assure cultural competency and effective practice for justice-involved populations through contracting, licensing, and network development standards.
7. Ensure adequate training and education of plans and providers on evidence-based practices.
8. Use care management approaches that address the specific needs of the justice-involved subset of chronically ill populations.
9. An integrated multi-agency data system will be critical to evaluate both public safety and health care outcomes. Such data are necessary to support appropriate state and local investments.
10. Exchange of electronic health information will be needed to monitor and ensure quality of care, particularly for those crossing the behavioral and physical health and criminal justice systems.
11. Multiple state and federal funding streams, including the Substance Abuse Prevention and Treatment (SAPT) and Mental Health (MH) Block Grants and others, may continue to play an important role in the financing of preventive, treatment, recovery and integrated services for justice-involved individuals.
12. Educational forums and technical assistance are needed now to implement these findings and recommendations.

II. Purpose and Rationale for the Working Group

The Working Group on Health Reform and Criminal Justice: Implications for the Delivery of Behavioral Health Services to the Criminal Justice Population Cycling Through Jails was conceptualized as one of several follow-on activities to a conference convened in November 2010 by Community Oriented Correctional Health Services[1]. The goal of that conference was to focus attention on the opportunities that the Patient Protection and Affordable Care Act (PPACA) may create for American communities to better serve the physical and behavioral health care needs of childless adults who will become newly eligible for Medicaid in 2014, and

1 *Exploring Health Reform and Criminal Justice: Rethinking the Connection between Jails and Community Health* is the title of the November 2010 invitation-only conference that was held in Washington, DC for 212 participants. The conference was conceived to bring together leaders from law enforcement, criminal justice, community health, government and philanthropy to consider the potential impact of health reform on local correctional systems. It was sponsored by The Robert Wood Johnson Foundation and The Jacob and Valeria Langeloth Foundation.

identify the next steps that may occur by policymakers in criminal justice, public health and substance use treatment and local, state and federal levels.

The interest generated by the conference resulted in plans to convene several small working groups focused on specific constituencies and issues relevant to the implementation of health reform with a focus on the vulnerable segment of the American population that revolves in and out of jails.[2]

Health care reform and its accompanying Medicaid expansion have created a new set of opportunities and challenges for public safety and criminal justice systems across the country. The criminal justice system has become the de facto health care safety net for people caught in the revolving door of the criminal justice system, particularly misdemeanants and low-level felons who frequently are unable to post bail and who often are released at adjudication for time served pre-trial. When this population is released from jail into the community, typically, individuals are without access to care for the underlying issues (often mental health and substance abuse) that may have produced the behavior that led to their arrest. *The Working Group on Health Reform and Criminal Justice: Implications for the Delivery of Behavioral Health Services to the Criminal Justice Population Cycling Through Jails* was convened to investigate how health reform has the potential to alter this cycle of crime and arrest to improve the outcomes of offenders and the safety of their communities.

This working group began with the goal of building a knowledge bridge between the behavioral health care services sector and the Medicaid policy and finance sectors that will be working in a more integrated manner to serve the Medicaid expansion population. Over five months of engaged and thoughtful discussion in the first half of 2011, the working group identified opportunities for the behavioral health sector and Medicaid leadership to work together to create opportunities to better serve the needs of people in the Medicaid expansion population, many of whom will have involvement with the criminal justice system.

The working group examined two major initiatives that have expanded Medicaid eligibility to non-elderly childless adults: Massachusetts' Commonwealth Care Health Insurance Program, which created universal coverage for all state residents in 2006, and Washington State's Alcohol and/or Drug Treatment Expansion Initiative, which extended substance abuse treatment services to very low income residents. In Washington State, data collected in recent research demonstrates significant cost savings to health care and criminal justice systems—and a decrease in re-arrest rates—when very low-income persons are made eligible for and referred to state subsidized chemical dependency treatment.[3] Dubbed by the working group as "the Mancuso Effect" to indicate concurrent savings in health care delivery costs and lowered re-arrest rates, it

2 Two other working groups were convened in the spring of 2011: The Working Group on Health Reform and Criminal Justice: Re-tooling the Relationship, and a National Association of Counties meeting with county administrators focused on strategies to coalesce the interests of public health and public safety in planning for implementation of the PPACA, were both sponsored by The Public Welfare Foundation and The Robert Wood Johnson Foundation.

3 Mancuso D, Felver, B, Bending the Health Care Cost Curve by Expanding Alcohol/Drug Treatment, Washington State DSHS Research and Data Analysis Division, RDA Report 4.81 (Oct 2010).

served as a stimulus for the discussion over the four sessions. Is the Mancuso Effect replicable? If so, what are the program elements that are essential to achieve it?

Lessons learned from both programs catalyzed the working group discussion as it sought to understand the most effective route to reach and treat the criminal justice system-involved population in order to improve public health and public safety, and to achieve cost savings for both systems. The group also engaged speakers with technical expertise in behavioral health care delivery to the criminal justice population, Medicaid benefit design and rate setting, contract requirements and performance standards, case management, and quality standards.

III. Highlights from the Proceedings

A. *February 16, 2011: "The Mancuso Effect" in Washington State and Agenda Setting for the Working Group Series*

The agenda for this first session was developed to identify policy issues at the intersection of public health and public safety that government agencies might consider as they plan for Medicaid expansion. As a case study to set the stage for discussion, David Mancuso, PhD, Senior Research Manager for the Washington State Department of Social and Health Services, and David Dickinson, Director of the State of Washington Department of Social and Health Services, reported on their state's experience with an extension of substance abuse treatment services to low-income non-categorical adults initiated in 2005 using several state-funded programs. Their report provided strong evidence for cost savings and reduced crime and recidivism based upon expanded access to treatment for substance use disorders (SUDs). This model may be illustrative to other states planning to implement the PPACA. Key points include the following:

1. For the purposes of discussion, the "Mancuso Effect" is defined as the decrease in both health care costs and criminal justice costs in Washington State since the implementation of expanded utilization of substance abuse treatment (SAT) and related services in certain low-income adult populations with SUDs.
2. Using an intent-to-treat analysis[4] of people referred for SAT, re-arrest rates dropped by about one third in one group receiving SAT, and dropped 17% or more in two other groups. Calculating the impact on the criminal justice costs of this decline in arrest rates, the direct savings to the criminal justice system was approximately the same as the cost to provide SAT services. If the cost impact to the public of this reduced level of crime was factored in, the cost savings due to SAT were substantial.[5]
3. In addition to reduced crime and criminal justice system operating costs, health costs also fell for the group receiving SAT, primarily due to a drop in high-cost events. A cost benefit analysis showed a separate return on investment of 2:1 to the State, in

4 In other words, the group receiving SAT was compared to the group not receiving SAT, whether participants completed SAT or not. Hence, the improvement in recidivism rates were not accounted for solely by "cherry picking" the participants who actually completed SAT.

5 Mancuso D, Felver B, Providing chemical dependency treatment to low-income adults results in significant public safety benefits, Washington State DSHS Research and Data Analysis Division, Report 11.140 (Feb 2009)

terms of reduced health expenditures to medical and nursing facilities, attributable to expansion of SAT.[6]

4. There was a reduction in the rates of growth in medical costs for Disability Lifeline clients in need of SAT from 7.8% per year prior to SAT expansion to a minus 0.5% annual growth rate following SAT expansion. Similar trends were detected in the health care costs for the general Medicaid population in need of SAT.
5. Part of the program services involved enrolling some participants in the Disability Lifeline program to access supportive services. Because this was an integral part of the program structure in Washington State, it was difficult to assess the impact of SAT on slowing progression to disability status in the population under study.
6. Even so, it is highly plausible that instituting SAT earlier in the course of SUDs would achieve a reduced rate of progression to disability, generating cost savings to states. [Medicaid provided for disabled citizens involves a 50% state contribution, compared to a 10% (or less) state contribution that will be required for the Medicaid expansion population under the PPACA.]

The data generated by the Washington State program framed the discussion for the remainder of the session as working group members questioned what services would be needed to achieve the "Mancuso Effect" in other states, and how could they be translated into a Medicaid, Title 19 benefit package. How could outpatient and residential services be organized and apportioned? How could the workforce for substance abuse treatment be expanded to meet the new demands of the expansion population? How should states set priorities for treatment, and priorities for data collection? And, finally, what are political considerations involved in developing policy and systems at the nexus of public health and public safety?

B. *March 24, 2011: Best Practices, Benefit Design, Rate Setting, and Performance Requirements*

The second working group session focused on delineating some of the factors that might underlie the Mancuso Effect in order to consider how it might be replicable in other states. Ken Robertson of the Substance Abuse and Mental Health Services Agency and Timothy Condon of the Office of National Drug Control Policy led a discussion on best practices in substance abuse treatment with a focus on evidence-based treatments appropriate to the criminal justice population (CJP). Their conclusions included several important points: that there appears to be little difference in best practices for the CJP and other populations regarding SAT with the exception of the use of an assessment tool for the CJP (the Level of Service Inventory-Revised, or LSIR); that there is an opportunity to exploit the rewards and sanctions of the criminal justice system when using SAT for the CJP; and, that the American Society of Addiction Medicine provides guidance on placement criteria, admission to treatment, continuation of care, and utilization management that can be useful to state planners.

Anne Herron, Division Director, Substance Abuse and Mental Health Services Agency, led a discussion on benefit design that began with an acknowledgement that there may not be enough data to tell us what is distinctive about the CJP to help states design specific benefit programs for

6 Mancuso and Felver (Oct 2010).

it. There is a lack of connection between the research—that has not focused on the CJP—and the large numbers from the CJP that will be newly eligible for Medicaid services under the PPACA. A lively discussion ensued about differences in the meaning and practice of "case management" between the health care and criminal justice systems—a discussion that highlighted the importance of convening decision-makers from both fields when defining benefits and services for this population. Another point that emerged from this discussion was that the CJP is difficult to engage, and hard to reach and treat. The PPACA may provide greater opportunities to leverage the criminal justice system, especially pre-trial, to reach and treat this population.

Professor Jim Sorensen, PhD, CPA, of The University of Denver, provided the working group with a tutorial on rate setting for health care services. His focus was on the importance of understanding exactly what services will be provided, what the costs are for delivering each service, and, finally, setting rates. He used the following example to illustrate the challenges that states will face in planning for implementation of the PPACA: the cost of detoxification services for the CJP is particularly complex to calculate, involving hospitals, jails and outpatient resources. Detoxification services typically are delivered differently in each setting, and thus have different unit of service costs to consider when developing provider reimbursement rates.

There was discussion about whether Medicaid would develop new rate categories (or "cells") for the CJP or work within existing frameworks and cells. There is some overlap between the CJP and the vulnerable homeless population that Medicaid already serves. Data collected by Dr. Mancuso in Washington showed that greater savings were generated by the SSI-like population than the TANF-like population, which may provide some guidance for states as they categorize rates for the CJP. The discussion also considered the political importance of setting rates that could provide an incentive to providers to deliver services to the CJP.

Allison Hamblin, Director, Complex Populations, at the Center for Health Care Services, Inc., presented a session on state performance requirements that could ensure compliance amongst providers and plans in the delivery of health care services to the CJP. Her focus was on a survey of state RFPs and contracts for Medicaid services and current practices in Managed Care Organizations for chemical dependency treatment. The CJP is difficult and expensive to treat for both physical and behavioral health conditions, and, for the most part, has not been eligible for subsidized insurance. States have not established broad provider networks for behavioral health services that are culturally competent to serve highly vulnerable populations. The PPACA could change this paradigm with 100% co-pay for several years as an incentive to reach, enroll and treat the expansion population.

C. *May 12, 2011: Enrollment Strategies in Massachusetts, Case Management for the Criminal Justice Population, and Performance Standards*

The aim of the third session of the working group was to examine the challenges of enrollment, best practices for case management, and the performance standards and contracts that will promote the delivery of quality health care to childless adults in the expanded population. Michael Botticelli, Director, Bureau of Substance Abuse Services, Massachusetts Department of Health, reviewed some of the challenges of expanding eligibility of health care services in

Massachusetts; of particular relevance was the difficulty of ensuring that those who are nominally enrolled in a health care plan are aware of their enrollment, and actually get the services for which they qualify. Despite the expansion of eligibility, data from Massachusetts indicates that many low-income young people, ages 18-25, and in particular those dealing with substance abuse and mental health problems, remain un-enrolled for needed chemical dependency treatment services. Given the parallels between this demographic and the characteristics of the criminal justice population cycling through jails, this presentation explored the gaps in eligibility and enrollment in Massachusetts, and examined strategies for improving the delivery of health care services through achieving higher rates of enrollment.

Maureen McDonnell, Director of Business Development, TASC-IL, delivered a presentation on best practices for case management for the CJP that was prepared in cooperation with the Office of National Drug Control Policy and Center for Substance Abuse Treatment. The presentation focused on the historic importance of case management in behavioral health care systems to streamline operations, reduce costs and improve care. The behavioral health sector has deep knowledge and experience working with the criminal justice population, which will be essential to apply to new scenarios of health care delivery under the PPACA. The presentation addressed the topics of case management, risk assessment, resource allocation, treatment and support for long-term recovery, and the need to align incentives between behavioral, medical and criminal justice systems.

Denise Podeschi, Partner, Mercer Health and Benefits, Inc., concluded the meeting's presentations by leading a discussion on contract requirements and performance standards. There is a movement at the state level away from fee-for-service plans for behavioral health care to more innovative plans like health homes, accountable cares organizations and managed care organizations. These plans can provide specialized rate systems for comprehensive services more readily than fee-for-service plans.

Under the PPACA, parity applies only to Medicaid comprehensive managed care health plans, so it is likely that states will put behavioral health care into managed care organizations. In general, existing managed care organizations either lack expertise regarding the Medicaid expansion population or they lack sufficient capacity for the expansion in 2014. However, actions undertaken by the states to structure terms and incentives for managed care organizations can help the existing systems expand to cover these gaps in needs.

This session was focused on the performance requirements that states should consider for managed care contracts to ensure adequate access and quality of care for the Medicaid expansion population, particularly the new Medicaid recipients coming out of the criminal justice system.

D. *June 27, 2011: Quality Standards, Enrollment Lag, and The Coalition for Whole Health Criminal Justice Committee*

In this last of a series of four meetings, a substantial amount of time was devoted to tapping the collective wisdom on the findings of our previous sessions and to developing a unified perspective to share with our constituencies, leadership and policymakers in health care. The meeting kicked off with two presentations responding to issues raised in the third meeting

regarding quality standards and access to treatment, and a third to present the work of the Coalition for Whole Health's Criminal Justice Committee. The bulk of the meeting, however, focused on constructing recommendations.

Maureen McDonnell, Director of Business Development, TASC-IL, spoke about the critical elements of quality standards for the delivery of behavioral health services. Although successful case management approaches have been identified for adult offenders under supervision, less is known about case management for young defenders and adults who leave jail without probation or parole. Contracts between states and health care agencies charged with caring for Medicaid populations will require careful planning and assessment; the specific competencies of state agencies and managed care companies may need to be defined similarly to accreditation standards—and expanded—for the criminal justice population.

Allison Hamblin of the Center for Health Care Strategies, Inc., followed with a presentation on options to minimize enrollment lag for the criminal justice population. Her presentation focused on the commonly occurring lag between enrollment in Medicaid and access to treatment, a lag that is critical to minimize for chronic diseases requiring treatment, including SAT due to the risk of repeat drug or alcohol binge and associated criminal behavior. Some of the options raised were utilizing fee-for-service enrollment as an initial step towards managed care assignment, improving enrollment mechanisms with better use of information technology, and overcoming barriers to enrollment due to the specific culture and life context of the criminal justice system-involved population. One of the main obstacles to enrollment that will need to be addressed for the CJP in the expansion population is proof of identification. Efficient coordination between the Social Security Administration and correctional institutions will be critical in verifying identification and supporting enrollment in Medicaid.

IV. Further Research

Over the course of the four meetings, the working group identified several outstanding issues for further research that were not resolved:

- Would it be possible for states to apply an AIDS Drug Assistance Program (ADAP)—like model of paying co-pays and deductibles for HIV patients to substance use treatment in 2014?
- The group was unable to locate a national inventory of state-specific licensing and certification requirements for mental health and substance abuse providers.
- The group was unable to establish a correlation of health care costs and criminal justice system costs outside of Washington State.

V. Working Group Findings and Recommendations: Annotated

The working group developed the following twelve findings and recommendations at its final session on June 27, 2010. They represent an effort to combine the best practices of the behavioral health sector with Medicaid's experience and expertise in creating effective plans and benefits for—and strategies to reach and treat—the expansion population of childless adults. Working group members agreed that each member and agency could use the findings and recommendations for the purposes of outreach, education, planning and preparation for

implementation of the PPACA at federal, state and local levels. They are not presented here in any particular order of priority.

1. **Define a benefit package for newly eligible beneficiaries under the Patient Protection and Affordable Care Act using evidence-based practices that meet the range of needs of individuals involved in the criminal justice system. This benefit package will have the dual goals of improving care and outcomes as well as containing costs across the health care and criminal justice systems.**

Behavioral health conditions including substance use disorders are often prevalent in the nine million separate individuals who pass through county jails across the USA annually. A carefully crafted Medicaid service package, with expanded coverage to treat SUDs, could reduce health care costs, disability payments and criminal justice expenses for states and counties, as well as other costs to victims of crime.

Despite the obvious characteristics of the CJP (criminogenic factors, minority or racial factors), the presenters did not find much difference between SAT for the CJP and SAT for other populations, except for the type of assessment that is used (e.g., the Level of Service Inventory—Revised, the LSIR). Research on evidence-based practices does not show major differences for the CJP, although comparative research is limited. In addition to assessment, the other difference—and opportunity—for providing SAT to the CJP is added capacity for rewards and sanctions provided by the criminal justice system.

The American Society of Addiction Medicine (ASAM) issues guidance on placement criteria, admission to treatment, continuation of care, and utilization management. Specific evidence-based practices are correlated to the various levels of placement defined by ASAM. ASAM criteria are ultimately about both placement and treatment and are transparent and easily evaluated and understood.

There is data about what types of behavioral health interventions are effective in substance abuse treatment for the CJP. These best practices, including but not limited to Cognitive Behavioral Therapy, Motivational Interviewing, Criminal Thinking Intervention, Contingency Management, Medication-Assisted Therapy, and Recovery Management, should be incorporated into Medicaid benefit packages.

The Mancuso data was based solely on exposure to CDT (any degree of CDT *vis a vis* completion), hence a more robust intervention might generate (even) more impressive data.

2. **A substantial portion of newly eligible individuals will have criminal justice involvement. Effective partnerships between the health care and criminal justice systems are needed in order to facilitate their enrollment and ensure continuity of care.**

Fragmented service systems in communities need to be addressed because there is no single point of entry for accessing community health programs, there is little coordination across programs, and, the support for these programs comes from multiple funding streams, which are limited and declining.

Recent data from Massachusetts revealed a significant enrollment gap among the population segment that shares many of the typical behavioral health characteristics of the criminal justice population. Twenty-two percent of people with SUDs are not enrolled in health programs, in comparison with a 2% statewide non-enrollment rate. The data indicates that energetic efforts directed to Medicaid enrollment in the criminal justice system to target substance abusers may be useful towards narrowing the enrollment gap.

There are challenges to enrollment at the time of intake or during confinement in jail: the context of booking is not conducive to reaching good decisions about choosing a health plan, and many arrestees desire "invisibility" due to child-support claims or gang-involvement.

In addition to the enrollment gap, there is a typical lag between enrollment and access to services. The 30-day coverage-waiting period is counter-productive for those individuals leaving jails—many of whom are dealing with substance use disorders—because they are likely to relapse with their addiction before they qualify for addiction treatment. In fact, the first 72 hours after release from jail or prison is the critical period during which people either relapse or engage with treatment. Hence, there needs to be a mechanism for access to treatment as soon as people leave the jail or prison. It may be possible to pay for health care during the hiatus between enrollment in a health plan and the onset of coverage by using a fee-for-service model, or a short-term immediate enrollment plan with the option to continue with an assigned provider as was developed in a partnership between Unity Health Care and the Washington, D.C. Jail. Similar to the way eligibility for school lunch programs is used as a basis for enrolling children in health programs, individuals leaving jails could be presumptively assumed eligible and enrolled in health care. It is important to note, however, that some states currently prohibit presumptive enrollment.

Accurate identification is required for enrollment in Medicaid, and the criminal justice system already collects and verifies the identification of arrestees. Jails may become efficient entry points into the health care system through partnerships with local social services agencies charged with enrollment.

Case management, a hallmark of both behavioral health care and probation and parole systems, is essential to ensure continuity of care for the criminal justice population with substance use disorders. Greater coordination between case managers from both systems would be essential to resolve problems such as non-compliance in treatment tied to terms of probation/parole.

A priority should be placed on educating the judiciary about evidence-based practices and outcome measures for substance abuse treatment in order to secure its support for partnerships between local criminal justice and health care systems. Data supporting the "Mancuso Effect" achieved in Washington State can be used to point out the reduction in arrest rates associated with healthcare intervention, and to enlist criminal justice system support.

3. **Assess the community capacity to provide prevention, treatment, recovery and integrated services under a benefit package for justice-involved populations. Of critical importance is the development of the infrastructure necessary to deliver these services.**

In Massachusetts, the issue that developed with Medicaid expansion was not getting people in, but getting too many people in. People were beginning to enroll for services at Federally Qualified Health Centers, but there wasn't a system in place for scaling the treatments available to meet the needs of the population. The issues of capacity and infrastructure development for the delivery of services to the expanded population cannot be minimized in planning for implementation of the PPACA.

Depending on each state's treatment network, the criminal justice population with SUDs may not readily fit into existing Medicaid-funded safety net provider networks. Likewise, the providers who treat the CJP may lack experience in billing Medicaid, and may not interface readily with Federally Qualified Health Centers and state regulatory agencies. In order to fully benefit from the opportunities presented by the PPACA, substance use treatment providers serving the criminal justice population will need to integrate into the mainstream health care delivery infrastructure without compromising the cultural competency that increases their effectiveness with this population.

A recent article in *Health Affairs* substantiated many of the issues raised by the working group including the need to develop providers' ability to participate in Medicaid.[7] It reports that substance abuse treatment is typically delivered in not-for-profit or government specialty clinics and rehabilitative centers rather than in general medical settings, and is provided by staff who have limited professional training and supervision. It goes on to say that "about 40% of SAT providers do not accept either private insurance or Medicaid or both, and about half do not have any contracts with managed care plans." (p. 1403)

Health Homes funded through federal resources create a host of new opportunities for specialty care by putting a team in place to bridge medical care and behavioral health. States that can promote health homes for specific criminal justice subpopulations may be better positioned to maximize the potential under the PPACA to promote social integrity and global cost containment.

4. **Use payment policy to develop service capacity, close service gaps and expand evidence-based services.**

The working group discussed at length the need for State Substance Abuse Authorities to better understand Medicaid financing mechanisms and standards. Given that, historically, most SAT has been delivered through block grant-funded programs, there is a knowledge gap that exists about Medicaid fee-for-service and managed care program participation and performance standards.

7 Buck, Jeffrey A. The Looming Expansion And Transformation Of Public Substance Abuse Treatment Under The Affordable Care Act, Health Affairs 30, No. 8 (2011): 1402-1410.

Medicaid rate setting to determine costs of services and reimbursement rates to providers for service delivery is complicated and exacting. Rates for SAT services should be specific to the service provided, not an average rate per any kind of SAT service. Medicaid rates are driven by staffing models and service delivery location among other factors, all of which can vary tremendously. For example, the cost of detox is particularly complex as it may be delivered in hospitals, jails, or outpatient settings.

Despite the complexity of determining rates, Medicaid payment policy can include incentives to providers to close service gaps and expand evidence-based services. As there is a lot of overlap between the CJP and other vulnerable populations that Medicaid already treats (eg., homeless, TANF, SSI), finding linkages between them for services they need is the charge for states as they think about developing payment policy under the PPACA.

There needs to be a better alignment of incentives between medical, behavioral health, and criminal justice systems. The delivery of behavioral health services may reduce medical costs and criminal justice system costs. However, the savings do not always accrue to the system paying for the services, even though all three systems are in the public sector. (Moreover, the public sector is divided between federal, state, and county governing bodies, each with their respective and separate budgets.) Given that some of the savings from delivering behavioral health care services to the criminal justice population may accrue to the criminal justice system in the form of reduced arrest rates, the savings should be included in the data presented to legislators and policymakers to justify expansion of services.

5. **Develop performance standards that encourage capacity expansion, establish accountability for effective services and health outcomes, and ensure access.**

Access, quality and coordination across systems create a good framework for the development of performance standard in contracts.

States already have developed standards to assess performance, and systems to coordinate benefits regarding SAT. There is no need to create them de novo, but to pull them together from different state programs already in existence. For example, Iowa and Maryland blend funding for mental health and substance abuse treatment with Medicaid benefits, and North Carolina also blends funding for an integrated payment system, integrated service definitions, and has one payment rate.

Given current budget constraints, one of the biggest needs on the Medicaid side of the ledger may be prioritizing higher need, high-cost clients. This is another critical factor for the CJP—it needs quick attention and treatment to avoid recidivism. Since the number of arrests is predictive of the severity of mental illness, the greatest cost savings will most likely be achieved by treating those most frequently incarcerated. There often are timeline requirements in state contracts for "access to the health care system." Therefore, identifying CJP as a priority population is an important part of this process.

6. **Assure cultural competency and effective practice for justice-involved populations through contracting, licensing, and network development standards.**

A critical factor for the CJP to obtain SAT will be requiring managed care organizations to

develop provider networks. There will be a relationship between cultural competency and enrollment rates.

Smaller providers often provide care that is more culturally competent than that delivered by larger providers. However, their capacity to serve newly eligible Medicaid beneficiaries will be limited. In addition, one survey found that only 65% of small providers accepted Medicaid. When possible, these smaller providers should be incorporated into larger networks.

7. **Ensure adequate training and education of plans and providers on evidence-based practices.**

Although each state may be unique in its culture, needs and resources, federal Medicaid regulations may be uniform. Under the PPACA, compliance with Medicaid regulations and national standards of practice will become important for behavioral health plans and providers that presently operate under rules determined by state and local grant programs as well as private and philanthropic funding streams. At present, many providers do not operate at scale or with an imperative to follow evidence-based practices such as those determined by ASAM. Plans and providers will need education and training on evidence-based practices to improve access to and participation in Medicaid financing structures for reimbursement.

Each state defines its own licensing standards for drug and alcohol counselors, such as a specified number of hours in providing cognitive behavioral therapy. However, there is significant variability between states, which may lead to variable outcomes. The International Certification and Reciprocity Consortium (IC&RC) attempts to establish international standards in this field and to administer an International Certification Examination for Criminal Justice Addictions Professionals, in collaboration with Schroeder Measurement Technologies. There are currently no accreditation standards for mental health agencies.

Regarding SAT, ASAM recommends Suboxone or Methadone as an evidence-based practice, but most wardens resist use of these medications in jails due to expense and security issues. Also, there is a stigma associated with the use of medication, the opinion from jail staff and from 12-Step programs that medication is just another drug. The PPACA offers incentives (such as potential reimbursement for SAT provided pre-trial) that may help sway wardens away from historical approaches to detox and SAT for the CJP.

The SAMHSA Criminal Justice section has a toolbox of treatment tools and evidence-based practices in behavioral health that work in the criminal justice setting that can be used in outreach and education efforts to providers.

8. **Use care management approaches that address the specific needs of the justice-involved subset of chronically ill populations.**

Case management and the linkage it provides creates continuity between care provided in institutions like jails and care provided in communities. Effective case management can streamline operations, reduce costs and improve care. Health care and criminal justice systems both employ case managers but tend to define their roles differently. As with other differences between these systems, the clarification of roles and terminology will be necessary as they interact to treat the chronically ill criminal justice population.

The "single case manager" requirement of Medicaid may not be adequate to address the needs of the CJP. Despite the belief that probation/parole should not become the nexus of SAT, there is a push to expand SAT responsibilities for probation/parole officers. While probation/parole officers can conduct screening, assessment and drug testing, they do not have the training or credentials to deliver treatment.

The Veterans Administration has already incorporated intensive case management into Medicaid and frames it by provider type and services. More work needs to be done in this area to develop models of behavioral health treatment for the chronically ill and the CJP.

Residential SAT services tend to be costly and inefficient but favored by criminal and drug courts - and often by State Legislatures - for public safety reasons. A better option may be to focus on housing plus appropriate outpatient treatment and care management instead of residential treatment.

9. **An integrated multi-agency data system will be critical to evaluate both public safety and health care outcomes. Such data are necessary to support appropriate state and local investments.**

In order to enable policymakers to bridge the silos of health care and criminal justice, and to quantify the costs and benefits of serving the CJP under Medicaid expansion, there needs to be data integration between systems. In Washington State, the data collected from health care and criminal justice systems on SAT for an expanded population by Dr. Mancuso demonstrated significant cost savings to the health care system and reduced cycling through the criminal justice system. Cost savings to the criminal justice system as indicated by reduced re-arrest rates for those referred to SAT were analyzed to be approximately equal to the cost of delivering the SAT services. When the cost impact to the public of this reduced level of crime was factored in, the cost savings due to SAT were substantial.

The working group did not find examples of any other state that has integrated data sets available for analysis. There was broad interest among the group in finding ways to substantiate Washington State's experience with data from their own states in order to develop appropriate benefits, services, rates and networks to serve the expanded Medicaid population. Group members expressed a desire to develop baseline data to assess access to services, quality assurance measures, and performance standards, and to perform cost-benefit analyses to ensure budgetary efficiencies. Ultimately, it will take data to identify the groups most responsive to particular treatment approaches and to evaluate different treatment approaches and payment strategies.

10. **Exchange of electronic health information will be needed to monitor and ensure quality of care, particularly for those crossing the behavioral and physical health and criminal justice systems.**

Given that a large portion of the CJP will be eligible for Medicaid, that the PPACA will require electronic health records for Medicaid services, that the Centers for Medicare and Medicaid Services is placing a priority on the development of health information technology, and that there is strong evidence that substantiated cost savings are useful in determining effective benefits and

services, the integration of data systems between health care and criminal justice systems would be a worthwhile investment at this timely juncture.

There are multiple challenges that will need to be addressed in the development of information technology systems and data collection policies and procedures as sharing electronic health information becomes standard practice. In particular, HIPAA privacy rights and procedures to secure consent to health care treatment from arrestees will be complicated by the involvement of law enforcement and public safety concerns.

11. **Multiple state and federal funding streams, including the Substance Abuse Prevention and Treatment (SAPT) and Mental Health (MH) Block Grants and others, may continue to play an important role in the financing of preventive, treatment, recovery and integrated services for justice-involved individuals.**

The Centers for Medicare and Medicaid Services has not yet determined which services and benefits will be provided under Medicaid for the expansion population. Optimal treatments for the criminal justice population with substance use disorders are likely to require greater service outlays than will be included in the expanded Medicaid benefit package alone. States and plans may have options that will allow them to develop unique programs from multiple funding streams. Given the potential for variation between states and plans, and the fact that durable recovery from behavioral health conditions requires integrated treatment strategies, careful thought should be given to the role of diverse funding streams.

The current system of treatment for SUDs, which emphasizes residential treatment programs for the CJP, may favor less optimal utilization of treatment resources due to inflated fears that diversion to more economic outpatient treatment could result in high-profile crimes.

12. **Educational forums and technical assistance are needed now to implement these findings and recommendations.**

The PPACA includes many provisions that will affect federal, state and local health care delivery systems. For those agencies that provide substance abuse and mental health treatment to the expansion population including the criminal justice population, there is a steep learning curve regarding new opportunities to participate in Medicaid. Education and technical assistance at the state and local levels will be crucial elements to include in preparation for health care reform. The target audiences should include health care and criminal justice policymakers, state legislators, state budget secretaries, county administrators and agencies, law enforcement and health care providers, among others.

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