CALIFORNIA COURT PROGRAMS AND PRACTICES FOR WORKING WITH REENTRY, PRCS, AND MANDATORY SUPERVISION POPULATIONS

ADMINISTRATIVE OFFICE OF THE COURTS
JUDICIAL AND COURT OPERATIONS SERVICES DIVISION
CRIMINAL JUSTICE COURT SERVICES OFFICE

April 21, 2014

10:00 a.m. to 4:30 p.m. San Francisco

Agenda

Click on links below to access program materials provided at the event.

Program Evaluation Status Report This presentation provides findings from the Parolee Reentry Court project and an update of the program evaluation reported during the 2012 Reentry Court Roundtable
Courts Working with Supervising Agencies/Entities and Partnerships: Statewide Perspectives At the inception of the pilot Parolee Reentry Court Project a MOU was developed to enable the partners—CDCR, AOC, and the Reentry Courts—to work together. This session will discuss how the initial MOU was developed, modified, and worked.
Meeting the Challenges of Forming Local Partnerships This session focuses on local collaboration and coordination between and with partners and supervising agencies along with challenges and lessons learned.
Harlem Parole Reentry Court Learning from Research
Innovative Models and Practices for PRCS, Reentry, and Revocation Throughout the state, courts have developed local and more tailored approaches to their reentry, PRCS, parole, and probation populations. This session looks at some of these models and practices and explores problems and challenges they faced.
The Affordable Health Care Act (ACA) Opportunities for Reentry Courts The ACA expands eligibility and leverages federal funds to broaden access to health care for Reentry Court participants and other justice-involved individuals. This workshop will provide an overview of the new law, the opportunities it presents, examples of local approaches, and challenges in obtaining coverage for mental health and substance abuse treatment.
Access to Resources: Program Sustainability and Treatment Options Courts have successfully partnered with CDCR, accessed state funds and secured grants to start and sustain their reentry efforts and treatment options. This session will discuss models for accessing treatment, and opportunities, and challenges to program sustainability.

May 24, 2011

EXHIBIT A
PROGRAM OPERATIONAL STANDARDS

I. Team Members & Level of Participation

a) Each court with a parole reentry court (Reentry Court) shall have a court team (Court Team) comprised of a judge, court coordinator, and at least one parole agent. Each court may add other members to its Court Team as it determines are necessary or desirable. All members of the Court Team appointed by the California Department of Corrections and Rehabilitation (CDCR) and the court shall work together for the success of the program.
b) Court Team members are expected to attend all Court Team meetings and to be present for all Reentry Court proceedings.
c) If more than a single parole agent is assigned to parolee participants in a particular court, the parole agent Court Team member(s) shall serve as a liaison to the other parole agents assigned to parolees participating in the Reentry Court Program (Program).

II. Eligibility for Referral

a) Parole violators with a history of substance abuse and/or mental illness and under supervision in a county with a Reentry Court are eligible for referral to the Program.
b) Parole agents shall use a parole violation decision making instrument (PVDMI) to determine the most appropriate sanction for parole violations, including referrals to the Program.
c) The eligibility criteria for Program participation described below shall be considered for Program referrals.

III. Eligibility for Program Participation

a) Each Court Team shall develop appropriate eligibility criteria for participation in the Program, including the nature of services provided by the local Program, whether the parolee will benefit from the Program, the risk the parolee poses to the community, and the history and nature of the commitment offense. Additional factors may include gender, age, and other factors determined by the Court Team.
b) Each Court Team shall develop written protocols explaining the eligibility criteria for Program participation. The written protocol shall be signed by the judge and parole agent on the Court Team, and submitted to the Administrative Office of the Courts

(AOC) and the California Department of Corrections and Rehabilitation (CDCR) prior to the establishment of the Reentry Court.

IV. Offender Referral Information

a) The parole agent shall provide the court, at the time of referral to the Program and at subsequent court hearings or Court Team meetings, any relevant information permitted by law regarding the parolee being referred to the Program.
b) In accordance with the written protocol, each Court Team should develop referral information to provide to the court for the court's use in determining admission into the Program. Each Court Team shall determine the manner in which referrals are to be provided to the court. The referral information may include: risk/needs assessment information, information from the PVDMI, case files, the date by which an acceptance decision must be made by the court, the length of time remaining on the parole term, and a summary of such information.

V. Types of Referrals

a) Parolees whose pending criminal charges or formal probation status bring them under the dual jurisdiction of both CDCR and the local court (dual commitments) may be referred to the Reentry Court.
b) Parolees whose parole violation is being considered at a probable cause hearing may be referred to the Reentry Court.
c) Parolees who request to participate in the Reentry Court may be referred to the Reentry Court by a parole agent prior to their probable cause hearing.

VI. Roles

a) Courts
    i. The court shall have the discretion to determine whether the parolee will be admitted into the Program and shall provide its written decision to parole within five business days of referral to the Reentry Court.
    ii. Once a parolee is admitted into the Program, the court shall have exclusive authority to determine the appropriate conditions of parole, order rehabilitation and treatment services to be provided, determine appropriate incentives, order appropriate sanctions, lift parole holds, and hear and determine appropriate responses to alleged violations, unless and until the court terminates the parolee's enrollment in the Program. A jail sanction shall not exceed 14 consecutive days.
    iii. The court shall develop written protocols explaining the criteria for termination of participation in the Program. The written protocol shall be signed by the judge and parole agent on the Court Team, and submitted to the Administrative

Office of the Courts (AOC) and the California Department of Corrections and Rehabilitation (CDCR) prior to the establishment of the Reentry Court.

iv. Upon termination of participation in the Program, the parolee shall be referred back to the local parole authority, and the Reentry Court will have no further jurisdiction over the parolee.

v. The Court Team will not make decisions regarding parole revocation.

vi. The court's termination of a parolee's participation in the Program does not constitute initiation of a parole revocation proceeding and is not in itself a revocation of parole. The parole authority, however, may consider the conduct underlying the termination as a basis for revocation proceedings.

b) Parole agent

i. The parole agent shall assist the court in its determinations described in a.ii. above.

ii. The parole agent shall provide the court with any information pertaining to a Reentry Court participant that might impact the parolee's participation in the Program. Such information includes, but is not limited to, results of drug tests, program participation status, and mental health diagnoses.

iii. The parole agent shall consider parole discharge for those parolees who successfully complete the Program.

iv. The parole agent shall make available to participants in the Program all programs, resources, and services that are available to similarly situated non-participant parolees.

v. Upon the court's direction, parole agents shall have the authority to lift parole holds and to refer participating parolees to available programs, resources, and services.

c) Board of Parole Hearings

i. Upon referral to the Program, participating parolees may also be referred to the Board of Parole Hearings pursuant to the legal requirements under *Valdivia v. Schwarzenegger*, but the Board of Parole Hearings shall take no final, dispositive action with respect to the parolee until a determination within the timeframe stated in this agreement has been made regarding admission into the Program. The referral to the Board of Parole Hearings is for the purpose of preserving the rights of the parolee under *Valdivia v. Schwarzenegger* pending determination of the parolee's admission into the Program.

ii. The Board of Parole Hearings may refer a parolee to the Court for potential participation in the Program.

iii. Upon admission into the Program, the Board of Parole Hearings shall take no revocation-related action until after the Reentry Court terminates the parolee's participation in the Program.

iv. A parolee returns to the jurisdiction of CDCR when the Reentry Court terminates a parolee's participation in the Program.

v. In considering early parole discharge for eligible parolees, the Board of Parole Hearings is encouraged to look favorably upon a participant's successful completion of the Program.

VII. Financial Responsibility/Program Availability

a) Programs, resources, sanctions, and services including drug testing, medical and mental health services available to similarly situated non-participant parolees shall be available for use by the Court Team. CDCR will prioritize its resources among both Reentry Court participants and non-participants on the basis of risk and needs.

b) CDCR will provide an attorney to Court Teams upon request. The attorney will provide legal representation to the parolee participants in the Program. In the event CDCR is unable to provide an attorney upon request of the Court Team, CDCR will provide funding in an amount no greater than it would have spent on a CDCR provided attorney.

VIII. Other Operational Issues

a) Other operational issues between the Reentry Courts and CDCR that may arise in the implementation of the Reentry Courts and the Program shall be brought to the attention of an interagency committee to be established by the AOC and CDCR. The committee shall be co-chaired by representatives of the AOC and CDCR. The AOC and CDCR shall also designate court and parole representatives to serve on the committee.

This Exhibit A supersedes any prior version. Consented to and initialed by the parties:

AOC	CDCR
S. C.	LS.
Shelley Curran,	**Lee Seale,**
Manager, Community Corrections Program	**Deputy Chief of Staff**

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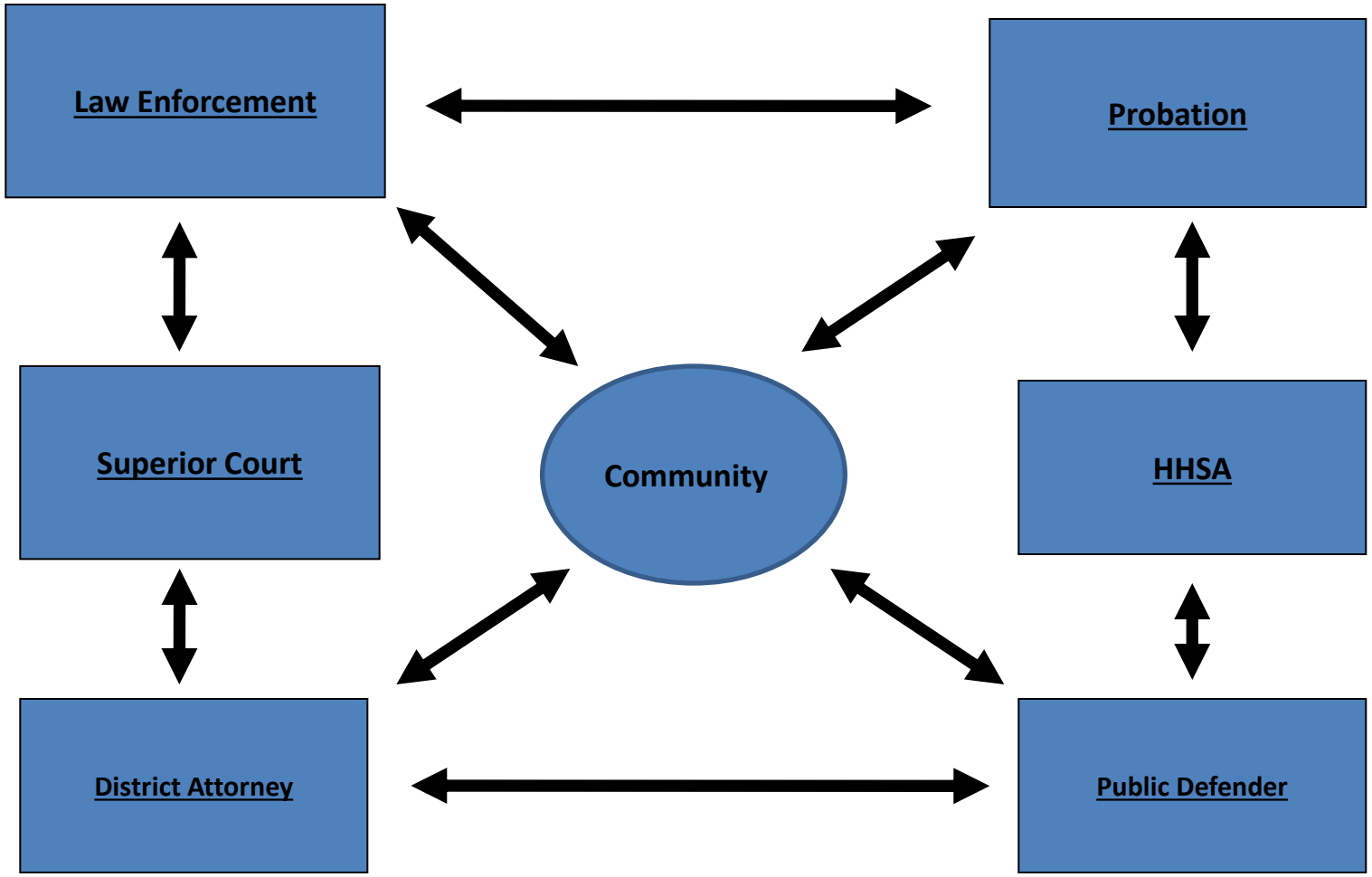
Meeting the Challenges of Forming Local Partnerships

This session focuses on local collaboration and coordination between and with partners and supervising agencies along with challenges and lessons learned.

Interdependencies in Criminal Justice System (4 pages)

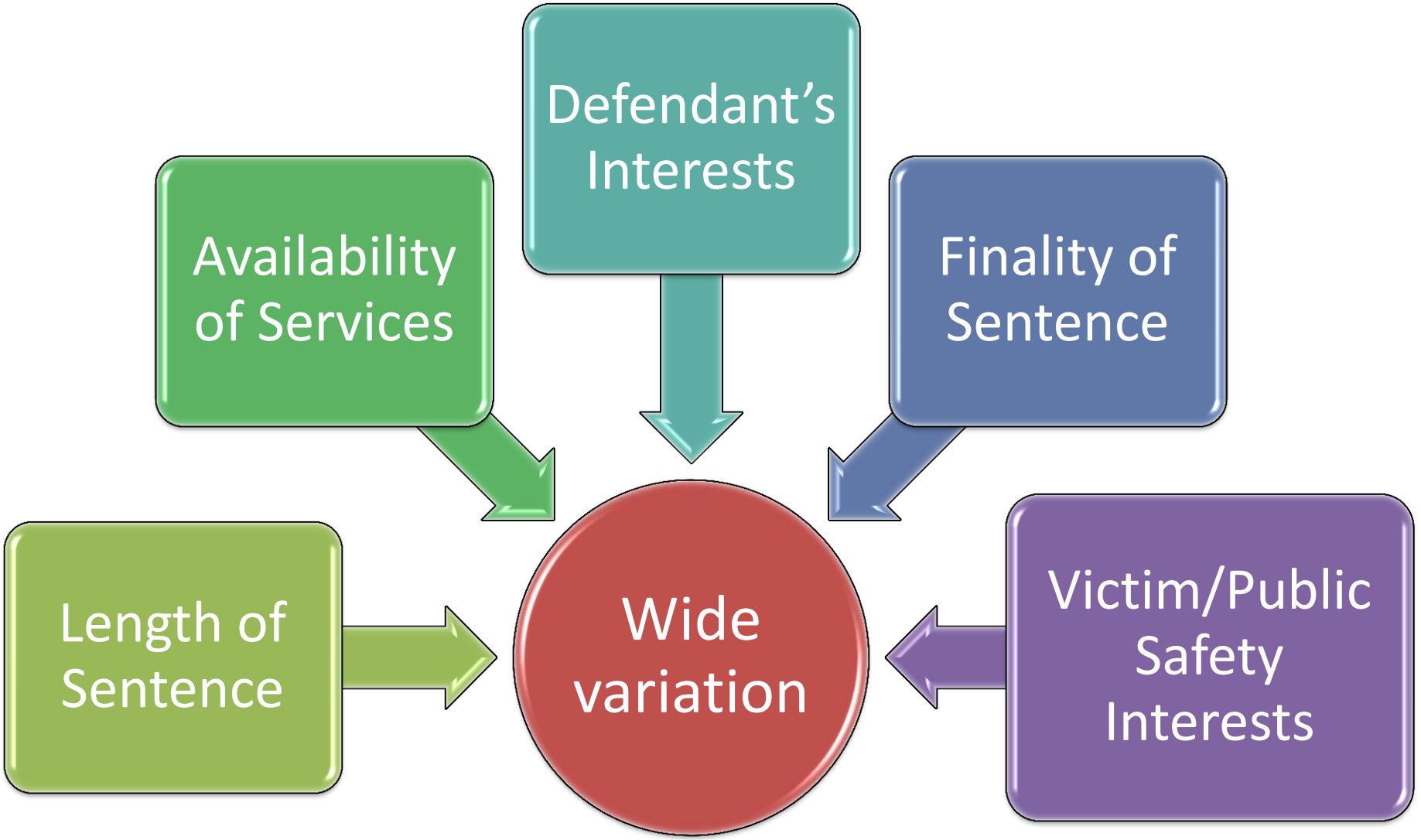
San Diego Operational Agreement and MOU

Interdependencies in Criminal Justice System

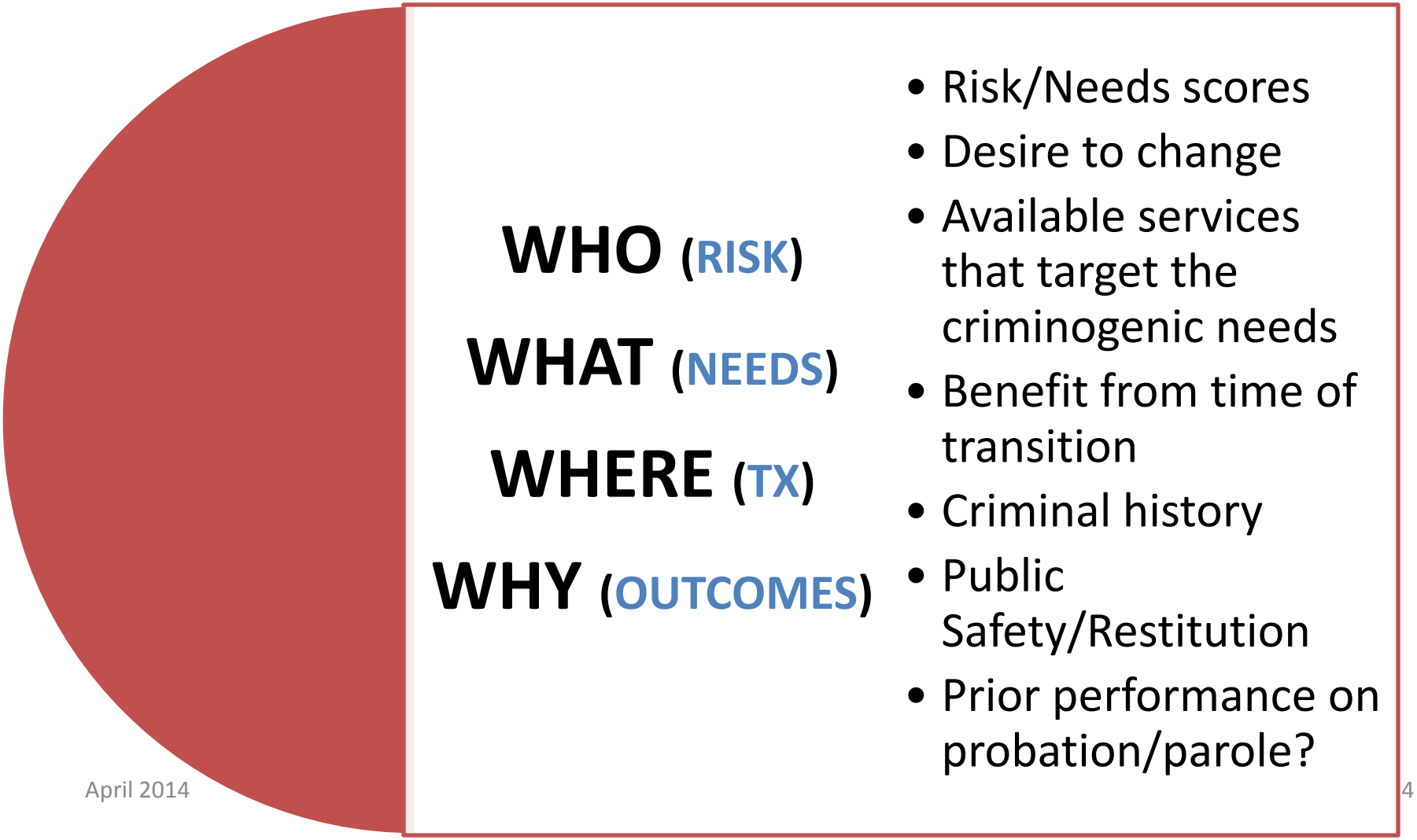


Challenges of Mandatory Supervision

To Split or Not to Split?



Evidence Based Practices: Considerations for a split



Operational Agreement and Memorandum of Understanding
for the operation of:

SAN DIEGO REENTRY COURT

Between

County of San Diego
Health and Human Services Agency
Office of the District Attorney
Office of the Primary Public Defender
Probation Department
Sheriff's Department

San Diego Police Department

Superior Court of California, County of San Diego

A. Background

This Operational Agreement and Memorandum of Understanding (Operational Agreement) replaces the previous agreement between the above-named parties which was executed in January 2011 for the operation of the San Diego Parolee Reentry Court, which is transforming into San Diego Reentry Court to conform with California's Criminal Justice Realignment Act of 2011.

The Parolee Reentry Court began operation on January 11, 2011 using a grant awarded by the California Emergency Management Agency (CalEMA) to the Superior Court of California, County of San Diego (Superior Court), using funds derived from the federal American Recovery and Reinvestment Act. Between January 11, 2011 and December 31, 2012 the program served approximately 140 participants (*authorized under Penal Code §3015*). Moving forward, the San Diego Reentry Court Operational Agreement and Memorandum of Understanding sets forth the operating procedures and collaborative practices for the program. This revised Agreement is designed to continue the comprehensive, multi-jurisdictional approach that has served the Reentry Court partner agencies, program participants, and community.

B. Program Scope

This Operational Agreement and Memorandum of Understanding stands as evidence that the above named entities intend to work together toward the mutual goal of providing a coordinated and collaborative response to address reentry issues of formerly incarcerated individuals, including, but not limited to substance abuse and addiction, co-occurring disorders, group and individual counseling, accountability, education and vocational training, and stable housing. To this end, each entity agrees to participate in the planning and implementation of the Reentry Court program, attend steering committee and/or reentry court team meetings, and support the objectives of the program described herein.

This Operational Agreement provides the framework for the operation of the San Diego Reentry Court, which serves participants through the Central Division of the Superior Court, and operates under the following mission, vision and goals:

Mission: To reduce recidivism and protect public safety by leveraging integrated community resources and services to a target offender population through the implementation of the key components of collaborative justice.

Vision: The vision of the Reentry Court is to promote accountability, integrity, independence and personal development through close supervision and treatment using a phased, multi-disciplinary approach that is responsive to the needs of the participant and community.

Strategic Goals: Consistent with the goals of the Legislature and Penal Code § 3015, the goals of the Reentry Court are to: (1) reduce recidivism, (2) reduce revocation of post-release community supervision and mandatory supervision, (3) utilize evidence-based rehabilitative programming, and (4) collect relevant data regarding participant progress and overall program success.

The Reentry Court is a collaborative justice court, based on the National Association of Drug Court Professionals' (NADCP) 10 "Key Components," as described in "Defining Drug Courts: The Key Components." These tenets promote accountability by combining judicial supervision with rigorously monitored rehabilitation services. The 10 "Key Components," are summarized as follows:

1. Integrate services with justice system processing.
2. Emphasize achieving the desired goals without using the traditional adversarial process.
3. Identify participants early and promptly placed in the Reentry Court.
4. Provide access to a continuum of services, including treatment and rehabilitation services.
5. Monitor participant compliance frequently.
6. Coordinate a strategy that governs the court's responses to participants' compliance, using a system of sanctions and incentives to foster compliance.
7. Provide ongoing judicial interaction.
8. Evaluate the achievement of program goals and gauge effectiveness.
9. Attend continuing interdisciplinary education.
10. Forge partnerships among collaborative justice courts, public agencies, and community-based organizations to increase the availability of services, enhance the program's effectiveness, and generate local support.

In addition, the Reentry Court understands that effective collaborative justice courts emphasize a team and individual commitment to cultural competency. Awareness of and responsiveness to diversity and cultural issues help ensure an attitude of respect within the collaborative justice court setting. Toward this end, the team members will seek and attend training in order to understand and then implement the key components.

Participants

Participants referred to Reentry Court will be under the sole jurisdiction of the superior court, until termination or successful completion. Upon successful completion of Reentry Court, the participant will be maintained on formal probation in after-care. The population to be served will be non-violent adult male and female offenders assessed as having a high risk to re-offend and high need for rehabilitative services. Participants will enter the Reentry Court process when convicted of a new felony offense, which occurred while under supervision, including but not limited to post-release community supervision as defined in Penal Code § 3450 or probation on a PC § 1170(h) felony offense. Persons under mandatory supervision as defined in Penal Code § 1170(h)(5)(B), with more than 18 months remaining on their mandatory supervision term, may also be referred to Reentry Court for the concluding portion of their term if deemed appropriate and suitable, and they have not been charged with a new felony offense.

Upon being admitted into the Reentry Court program the participant will undergo substance abuse and mental health assessments so that a case plan may be created. The program consists of a five phase system that requires regular and random drug tests, regular reentry court appearances, case management, group and individual counseling. It is anticipated that successful participants will graduate from Reentry Court after approximately 18 months, based upon personal achievement.

In accordance with Penal Code § 3015, Superior Court, with assistance and input from the Reentry Court team, shall have the discretion to determine if the participant will be admitted into the program and, in making this determination, shall consider, among other factors, whether the person will benefit from the program, the risk the person poses to the community, and the history and nature of the offense(s). The following eligibility, exclusionary, and termination criteria will also be considered:

Eligibility Criteria

- Participant must be a legal resident of San Diego County and have a history of alcohol or substance abuse.
- Participant must have a stipulated prison sentence and be eligible for a new 3-year probation term. Offenders must stipulate to a stayed prison sentence.
- Participant must voluntarily and willingly agree to participate in the Reentry Court.
- Participant must have the mental capability to make discernments and actively participate in the Reentry Court program.
- Current commitment offense is non-serious, non-violent, non-sexual.
- Domestic violence or child abuse related offenses, as described in Family Code § 6211, that do not involve death, great bodily injury or permanent disability, will be screened on a case-by-case basis if the defendant remained free from prison for at least five years after the commission of the above-described felony.
- The participant must be eligible to serve the prison term pursuant to Penal Code § 1170(h), unless CDCR enters into a financial agreement with the County of San Diego, in which case prior convictions for violent felonies within Penal Code § 667.5(c), or serious felonies within Penal Code § 1192.7 (c), that do not involve death, great bodily injury or permanent disability, may be screened on a case-by-case basis if the defendant remained free from prison for at least five years after the commission of the above-described felony.

Exclusionary Criteria

- Current offense or prison commitment must not be for a violent offense defined within Penal Code § 667.5 (c).
- Current conviction(s) must not be for domestic/family violence described in Family Code § 6211.
- Persons who have already entered the drug court program on the current case and been terminated from the program.
- If the defendant committed any crime (including the current one) wherein the victim suffered death, great bodily injury, or a permanent disability, the defendant is excluded.
- No documented member of a recognized prison/jail gang.
- No active confidential informant.
- No Penal Code § 290 Registration (Sex Offender).
- No Penal Code § 457.1 Registration (Arson).
- No admissions of Penal Code § 186.22 allegations.
- No Felony holds, detainers, or warrants by another jurisdiction, or interstate case.

Grounds for Termination

If the participant is NOT amenable to treatment in the Reentry Court program, the court may terminate the participant from the program. Grounds for termination may include, but not be limited to, the following:

- Substitute/alter/try to change bodily fluids at drug test.
- Use device to alter urine.
- Multiple positive drug tests.
- Forged meeting documentation.
- Walk-away/discharge from residential treatment.
- Possession of Drugs/Possession of Drug Paraphernalia.
- Possession of weapons.
- Threats of violence towards others.
- Commission of new crime.

Upon a recommendation for termination by the team, and approval by the judge, the participant will be advised of his/her rights and, if requested, afforded an evidentiary hearing concerning the facts of the termination. Persons who abscond for longer than 90 days, without valid excuse, will be considered terminated from the program. Public safety is of the utmost importance. Therefore, Law Enforcement team members should exercise their powers of arrest when there is a reasonable suspicion that a felony has been committed by the participant or when any crime has been committed in the officer's presence.

C. Reentry Court Team

The Superior Court will develop and operate the Reentry Court with the following partnering agencies:

- California Department of Corrections and Rehabilitation, Division of Adult Parole Operations (Parole) for offenders on parole
- County of San Diego, Health and Human Services Agency, Behavioral Health Services (BHS)
- County of San Diego, Office of the District Attorney (DA)
- County of San Diego, Office of the Primary Public Defender (Public Defender)
- County of San Diego, Probation Department (Probation)
- County of San Diego, Sheriff's Department (Sheriff)
- San Diego Police Department (SDPD)

D. Coordination of Services and Governance

In accordance with Penal Code § 3015, the Reentry Court Steering Committee will be co-chaired by the Superior Court and San Diego County District Attorney. Members of the steering committee will represent the following entities/groups: law enforcement, prosecutor, public defender, San Diego County Behavioral Health Services, treatment and case management, and local community partners. The steering committee will be responsible for overseeing the general operation and administration of the Reentry Court. The Reentry Court Team including the Reentry Court Judge, DA, law enforcement, Probation, Parole, Public Defender, and Treatment Case Manager will participate in case conferencing and Reentry Court sessions. The team will use evidence-based rehabilitative programming to achieve the goals and objectives of the program. Collaborative community partnerships will be established and service systems that are accessible and available to program participants will be in place. The steering committee will meet periodically to set policy and review program and participant progress toward meeting the program goals.

E. Provision of Services

In order to promote the Mission, Vision, and Goals of the Parolee Reentry Court, each agency will:

1. Provide project staff to coordinate, plan, and collaborate for services within their expertise;
2. Attend regularly scheduled meetings to discuss the Reentry Court program; and,
3. Provide relevant participant-level data when requested by the court to meet grant or program evaluation requirements.

The individual team member's responsibilities will involve, but may not be limited to, the following:

<u>CDCR/Parole</u>
The California Department of Corrections and Rehabilitation, Division of Adult Parole Operations will monitor parolee compliance and provide expertise. Parole Agents will be a part of the law enforcement team in Reentry Court and carry out their law enforcement powers in conjunction with San Diego Police Department, San Diego County Sheriff, and San Diego County

Probation Department. In accordance with the statewide Parolee Reentry Court MOU between the Judicial Council's Administrative Office of the Courts and California Department of Corrections and Rehabilitation, a separate agreement between Superior Court and local Parole Office will be created on an as-needed basis.

HHSA, Behavioral Health Services (BHS)

The County of San Diego, Department of Behavioral Health Services (BHS) will contract for case management and treatment services using National Registry of Evidence Programs and Practices (NREPP) best practices. Case Management/Treatment will include conducting and/or ensuring that all participant assessments are completed, and a case plan is developed for each participant. BHS will contract for short- and long-term residential treatment, non-residential treatment and sober living services and monitor subcontractor contract compliance. BHS will ensure that all case management and treatment services meet the participant's needs identified in the initial assessment.

Case Management/Treatment will also:

- Participate on the Reentry Court Team
- Provide treatment and recovery services
- Provide mental health counseling for those participants who have mental health issues
- Provide individual and group counseling
- Conduct drug testing
- Provide referrals to community based organizations that provide specialized mental health counseling for eligible clients, employment, education, vocation, veterans' services and housing programs
- Provide Reentry Court Team with reports on participant progress in treatment
- Oversee and ensure quality assurance for all participant data
- Compile and provide reports to Superior Court as requested or mandated

District Attorney (DA)

The County of San Diego, Office of the District Attorney will represent the people in order to:

- Participate on the Reentry Court Team
- Screen eligible participants, based on established criteria
- Provide recidivism information to the BHS and Superior Court, based on mutually agreed upon formats and reporting frequency
- Act as co-chairperson of the steering committee
- Assist with the management of the San Diego Reentry Court to facilitate goals and objectives

San Diego Police Department (SDPD)

San Diego Police Department, as part of the monitoring and supervision team, will work with CDCR, Sheriff and Probation to:

- Participate on the Reentry Court Team
- Enforce immediate sanctions when necessary

- Make recommendations regarding sanctions and incentives
- Work with law enforcement team to supervise participants' compliance with court-ordered conditions
- Conduct home checks and drug tests to ensure participant compliance

San Diego County Probation

The County of San Diego, Probation Department, as part of the monitoring and supervision team, will work with CDCR, Sheriff, and San Diego Police to:

- Participate on the Reentry Court Team
- Conduct pre-sentence investigations
- Conduct home checks and drug tests to ensure participant compliance
- Conduct or facilitate criminogenic assessments for purposes of formulating individual case plans
- Work with law enforcement team to supervise participants' compliance with court-ordered conditions

San Diego County Public Defender

The County of San Diego, Office of the Public Defender will represent the participant in order to:

- Participate on the Reentry Court Team
- Represent and advise participant to facilitate resolution of legal issues
- Identify and recommend referrals of eligible persons to Reentry Court
- Review Reentry Court agreement with defendant prior to placement into the program

San Diego County Sheriff

The San Diego County Sheriff is part of the courtroom and law enforcement team that will be responsible for various aspects of the program.

- Providing courtroom security
- Administering jails, transport participants to/from jail/prison
- Facilitating assessments when a participant or prospective participant is in jail custody
- A County Parole and Alternative Custody Unit Deputy will participate on the Reentry Court Team
    - Enforce immediate sanctions when necessary
    - Make recommendations regarding sanctions and incentives
    - Work with law enforcement team to supervise participants' compliance with court-ordered conditions
    - Conduct home checks and drug tests to ensure participant compliance
    - Providing GPS Electronic Monitoring for home detention, when ordered and agreed upon by the team
    - Providing a County Parole & Alternative Custody (CPAC) officer to the Reentry Court team

San Diego Superior Court

The Superior Court of California, County of San Diego, as organizer of the Reentry Court, will execute its constitutional and statutory powers and obligations in a fair and impartial manner. Toward this end, the court will:

- Designate a Reentry Court Judge, Bailiff, and Courtroom clerk(s) for all Reentry Court Team meetings and court proceedings in the Central Division;
- Act as co-chairperson of the steering committee, call meetings, create agendas, establish committees, and oversee the management of the San Diego Reentry Court to facilitate goals and objectives; and,
- Administer grants and prepare, with the assistance of the Reentry Court Team, all necessary agreements for financial reimbursement, required monthly and quarterly statistical reports and financial statements; act as liaison with the Administrative Office of the Courts' program evaluation team; and, manage the project goals, timelines and objectives.

All participating agencies/entities will comply with the Reentry Court policies and procedures developed for the operation of the program, and attend conferences and training seminars, based on availability and funding.

F. Performance Measures

In order to monitor individual participant and program progress, each partner entity will provide relevant information to complete and abide by evaluations of the Reentry Court program. This includes reportable data at program entry, criminal history, program activities, and program exit information as required by the Judicial Council of California and coordinated, collected, compiled, and reported by the court to Judicial Council. In addition, periodic statistical reports will be provided to the San Diego Community Corrections Partnership.

G. Financial

The Community Corrections Partnership, established pursuant to Penal Code § 1230, et seq, will provide funds for treatment of participants using Criminal Justice Realignment funds. These funds are estimated to be $1,040,000 to serve 100 to 120 participants per year.

With support from the steering committee and Reentry Court Team, collaborating partners are encouraged to seek additional funds to support the operation of the Reentry Court. Upon receiving awards, the collaborating partners agree to establish contracts to ensure fiscal accountability and mutually agreed upon budgets for services.

H. Term of Agreement

This Agreement is effective starting October 1, 2012 through June 30, 2014, and may be renewed each year after that period upon mutual written agreement of the collaborating partner agencies.

I. Terms and Conditions

All terms and conditions of the Agreement are subject to the continuation of Reentry Court funding to include these additional services, including, but not limited to, drug treatment and counseling, drug testing, law enforcement supervision, and court operational costs associated with Parolee Reentry Court participants.

J. Termination of Memorandum of Understanding

Upon mutual consent of all parties, this Memorandum of Understanding is subject to further negotiation and revisions as required to support the needs of the Reentry Court program. Any changes shall be in writing and signed by all parties herein or their duly appointed representatives authorized to act on their behalf. This Memorandum of Understanding may be terminated by any party for any reason by providing a thirty (30) calendar day written notice.

K. Mutual Indemnification

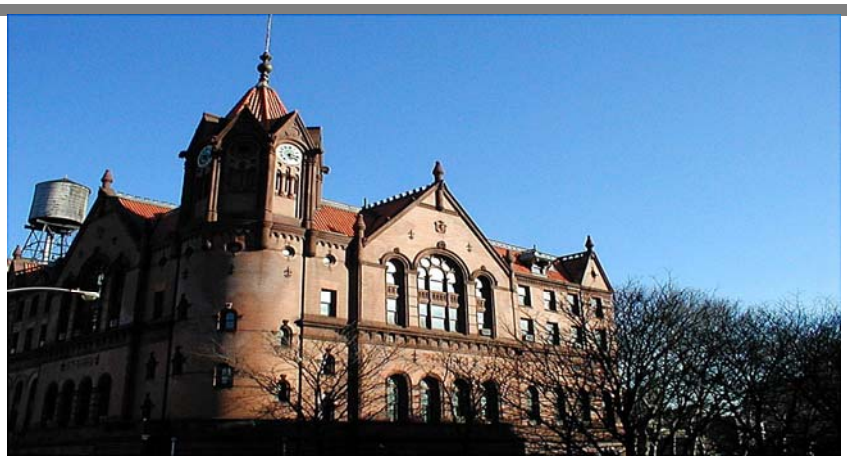
The participating agencies agree to indemnify, defend and hold harmless each other and their officers, agents and employees from any and all claims, actions or proceedings arising solely out of the acts or omissions of the indemnifying agency in the performance of this Operational Agreement and Memorandum of Understanding. The participating agencies agree that each is acting in an independent capacity and not as officers, employees or agents of the other agencies.

HARLEM COMMUNITY JUSTICE CENTER

Harlem Parole Reentry Court

Learning from Research

The Justice Center



Reentry Programs

Goals

- Reduce Recidivism
- Strengthen Local Collaboration
- Support Learning in the Field
- New: Improve Legitimacy of the Law/Parole

How it works?

- Reentry Team: Judge, Parole Officers, Coordinator, Case Managers
- Serve 250 high risk persons annually on parole who reside in Harlem for the first 9 months of their release.
- Pre-Release engagement
- Assessment
- Initial hearing/report and regular ongoing hearings every two weeks, or as needed.
- Weekly “micro-team” meetings & monthly “macro-team” meetings
- Rapid attachment to substance abuse services, housing and employment training.

Client Profile

- Mostly Male (97%)
- High Risk of Recidivism
- Mean Age is 35
- African American 67.6%; Hispanic 32.4%
- 46% participated in a substance abuse program
- 7.9% received mental health services

The data presented here is from 182 parolees total, 68 assigned to the Harlem Reentry Court (referred to as “Harlem”) and 114 assigned to the comparison group, during late 2011 and 2012.

Graduation!

Known Unknowns: Uncovering the Dark Matter

A retrospective analysis looking at 2001 to 2008 found that Reentry Court participants were:

- Less likely to be re-arrested
- 10% less likely to be re-convicted
- BUT, more likely to be revoked and returned to prison

Changing the Tires on a Moving Car

Programming Changes

- Motivational Interviewing
- Cognitive behavioral therapy (CBT)
- COMPAS risks & needs assessment tool
- Graduated sanctions and rewards
- Evaluation!

Adaptive Changes

- Engage parole staff & leadership in the change process
- Build staff capacity & commitment
- Engage ex-offenders, family members and community members as a resource

Resources & Contact Info

Rethinking Reentry Blog
http://rethinkingreentry.blogspot.com/

www.courtinnovation.org/project/harlem-community-justice-center
Twitter: @HarlemJusticeCt

Christopher Watler
Project Director
Harlem Community Justice Center
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(212) 360-4110
watlerc@courtinnovation.org

CALIFORNIA COURT PROGRAMS AND PRACTICES FOR WORKING WITH REENTRY, PRCS, AND MANDATORY SUPERVISION POPULATIONS

ADMINISTRATIVE OFFICE OF THE COURTS
JUDICIAL AND COURT OPERATIONS SERVICES DIVISION
CRIMINAL JUSTICE COURT SERVICES OFFICE

Innovative Models and Practices for PRCS, Reentry, and Revocation

Throughout the state, courts have developed local and more tailored approaches to their reentry, PRCS, parole, and probation populations. This session looks at some of these models and practices and explores problems and challenges they faced.

Innovative Models PowerPoint

Sacramento County Pilot Re-Entry Court program summary

Re-entry court: Sacramento's spin on realignment
Sacramento Bee February 9, 2014

Innovative Models and Practices for PRCS, Re-Entry, and Revocation

Moderator: Scott Brown

Panelists

SUPERIOR COURT JUDGES:

- Lawrence Brown, Sacramento
- Desirée Bruce-Lyle, San Diego
- Stephen Manley, Santa Clara

Discussion Topics

58 California Counties have been tasked with implementing Criminal Justice Realignment, which involves populations that are new to Superior Courts:

- Post-release community supervision
- Mandatory supervision [PC § 1170(h)(5)(B)]
- Parolees

Innovative Models, #1

San Diego
Mandatory Supervision Court

- In-custody programming with Sheriff
- Pre-release hearings
- Post-release status hearings
- Incentives & Sanctions
- Custody alternatives

Innovative Models, #2

Santa Clara

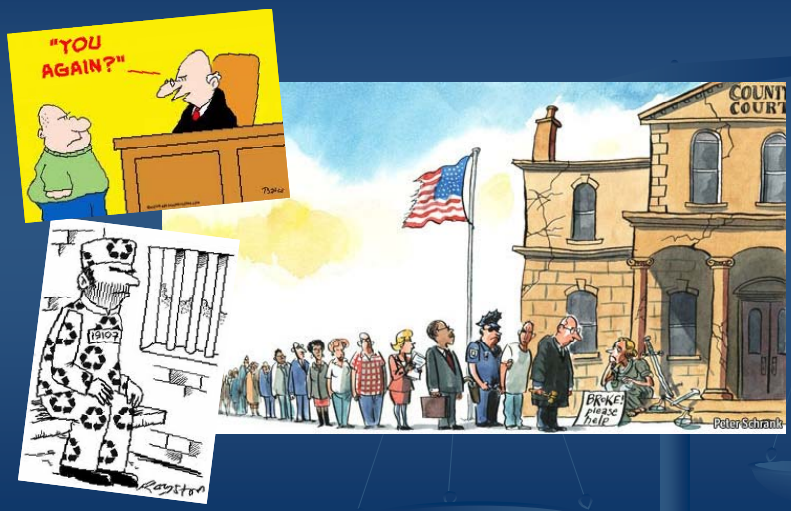
- Pilot track Mandatory Supervision
  - Special calendars
  - Pre-release hearings
- Two-Judge Model
  - Risk tracks
  - Case management

Innovative Models, #3

Sacramento Re-Entry Court

- Started in 2013 after attending re-entry summit in 2012 and visiting pilot courts.
- Utilize existing community resources in a new way.
- Lessons-learned about addiction and experience with new sanctions.
- Revocation Hearings and PRCS population.

Activity or Questions?



Lawrence Brown
Judge

SUPERIOR COURT OF CALIFORNIA
COUNTY OF SACRAMENTO

SACRAMENTO COUNTY PILOT RE-ENTRY COURT

The Reentry Court targets offenders on supervision who have committed a new offense and/or supervision violation and have been determined suitable by the court, district attorney, public defender, and probation to participate in a treatment-focused, collaborative court setting.

Reentry Court meets every Friday at 1:30 p.m. in Department 1.

ELIGIBILITY CRITERIA

OFFENSE

- Current offense(s) are non-violent, non-serious, and non-sexual.
- Offender is eligible for County Jail Prison.
- PRCS, Mandatory Supervision (MS) and Parole technical offenders are eligible on their revocation commitments.
- Case-by-case limited eligibility for offenders on felony probation.
- Technically-ineligible offenders admitted only on unanimous agreement of the Multi-Disciplinary Team, in the interests of justice.

OFFENDER

- Preference for non-parolee offenders participating in the Adult Day Reporting Center (ADRC) treatment program, on agreement by ADRC of offender's continuing participation.
- Offender is a Moderate to High Risk (to reoffend) per risk assessment.
- Participant is a legal resident of Sacramento County.
- Participant wants to participate in the Reentry Court.

EXCLUSIONARY CRITERIA

- Offender has a prior conviction for a violent felony offense within Penal Code § 667.5 (c) or a serious felony offense pursuant to Penal Code § 1192.7 (c). Unless the offender is entering Re-entry court on a technical parole or PRCS violation.
- Offender's current offense is a felony violation of Penal Code § 273.5 or falls within the meaning of Family Code §6211
- Offender is a current participant in Batter Treatment Program (BTP) or has a prior failure to complete BTP.
- Offender's current offense or prior conviction involves a victim who suffered death, great bodily injury, or a permanent disability.
- Offender's current offense or prior conviction is for Penal Code § 451 Arson.

- Offender's current offense includes a gang allegation under Penal Code § 186.22, or the offender has previous convictions of Penal Code § 186.22(a) or the Penal Code § 186.22(b) enhancement was admitted or found true.
- Offender's current offense is for driving under the influence.
- Offender's current offense involves possessing or being armed with a firearm.
- Offender's current offense is being prosecuted by District Attorney's Major Narcotics Unit, unless unit supervisor authorizes referral in the interests of justice.
- Offender is actively participating in a criminal street gang or as a "shot caller."
- Offender is an active confidential informant for a law enforcement agency.
- Offender is subject to felony holds, detainers, warrants by another jurisdiction or interstate CDCR cases.
- Offender's current case is post- Preliminary Hearing, unless parties and court agree in the interest of justice to refer to Reentry Court.

REFERRAL PROCESS

- Chief Deputy Public Defender Steve Lewis and Deputy District Attorney Chris Carlson, after informal consultation with the offender's supervising agency, concur that the offenders appears both qualified and suitable for Reentry Court.

- If court where new offense/violation is pending concurs, a plea will be taken, with the offender advised of negotiated county jail prison term if not accepted into, or terminated from, Reentry Court. After change of plea, case will be referred to Probation for preparation of a PSR, returnable to the department where the plea was taken. In the PSR, Probation will opine whether offender is qualified/suitable for Reentry Court.

- On return of PSR, if Probation has made a favorable recommendation for Reentry Court participation, the court and parties concur, and the offender has entered Arbuckle and 20-day sentencing waivers, Judgment & Sentence will be scheduled on a subsequent Friday at 1:30 p.m. in Department 1, and in no case sooner than three court days. Offender's custody status to remain unchanged until appearance in Department .

CONSQUENCES OF FAILURE TO COMPLETE PROGRAM

- If offender is deleted from Reentry Court, probation is revoked and terminated, and stayed county jail prison term is imposed.
- Offender will not be awarded credits for time previously imposed as sanctions.

LENGTH OF PROGRAM/CONSEQUENCE OF GRADUATION

- Program typically will last 12-18 months.
- On successful completion of program, offender "graduates" from Reentry Court. Upon graduation, suspended county jail prison term is lifted, and length of probation recalculated to two years from date of graduation, subject to final payment of any outstanding restitution.

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Re-entry court: Sacramento's spin on realignment

By Andy Furillo
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Last September, Sacramento County probation officers conducted a routine search on Sonnita Dixon's apartment and discovered 20 grams of cocaine. They took Dixon to jail, and prosecutors filed charges against her – for the 22nd time in the past 14 years.

In the old days of California criminal justice, Dixon, 34, very likely would have served a third term in state prison, cycling through with tens of thousands of others like her, who for years have been punching their clocks in and out of the system on small-time convictions.

These days, with the advent of California's criminal justice realignment, lower-level offenders are part of a new sentencing frontier; and for Dixon and about two dozen other select offenders in Sacramento County, the focus on helping them change has never been more intense.

Under realignment, California for the last 21/2 years has been shifting responsibility for the drug addicts and small-time thieves who used to crowd the state prisons to the 58 counties, giving local jurisdictions latitude in how to deal with the offenders.

In Sacramento, officials have created a "re-entry court" as the local twist on realignment. Now in its seventh month, the program involves officials from every branch of the county's criminal justice apparatus, who meet weekly to sort through the flood of incoming Sonnita Dixons and gauge who among them might stand a chance of a turnaround.

Defendants who take part in re-entry court agree to plead guilty or no-contest to the charges lodged against them, and are sentenced to a substantial term in county jail. The court then suspends the sentence – but holds the time over their heads as leverage, pressing them to complete a yearlong immersion in drug treatment, vocational courses and other educational classes designed to alter their criminal mind-set.

"If you want to change, if you don't want to do that time, you're going to do the program," said Dixon who took the re-entry court path beneath the sword of a three-year, eight-mon[illegible]ail term. "You're going to do that program – anybody smart, at least. I'm not looking back.

If Dixon completes a year in the program, her case will be dismissed.

As of Jan. 23, Sacramento County was responsible for 2,502 offenders who would not have been its problem before October 2011, when realignment became law. The number includes 507 men and women in county jail who otherwise would have been in a California prison and 1,995 people on probation who, in the prerealignment era, would have been monitored by state parole agents.

The numbers parallel state figures that show 683 fewer prisoners from Sacramento County inside state lockups as of June 30, compared with December 2007. As of June 30, there were also 1,180 fewer Sacramento offenders being monitored by state parole agents.

In the months since Sacramento launched re-entry court, about 25 car snatchers, petty thieves, drug users, commercial burglars and other realigned offenders have come under its jurisdiction. Officials said they hope to expand the program by 50 to 100 more offenders, depending on how much additional funding the state provides for treatment programs.

Superior Court Judge Laurie M. Earl pushed for creation of the re-entry court last year when she presided over the local bench. She said she would consider the program a success if it can keep just one offender from coming back into the system.

"If we can give them the tools they need that they wouldn't ordinarily get, and lower their recidivism and save the sheriff some bed space, then I think that is successful," Earl said. "My goal is that this becomes part of our culture."

While the numbers so far are small, the hopes are big. Sacramento probation chief Lee Seale, who chairs the Community Corrections Partnership that oversees the rollout of realignment at the local level, said re-entry court is "critically important" toward making the whole thing work.

"It brings all of us together so we're on the same page, communicating as we work through these new challenges," Seale said.

Breaking down walls

Like the drug and mental health courts that have been around for years, re-entry courts are "collaborative" by design. Judges and representatives for the Probation Department, the district attorney and the public defender – with input from treatment providers and the Sheriff's Department – cull through lists of eligible offenders to determine who might benefit. The idea is to break down the adversarial nature of the criminal justice system – prosecution vs. defense – and get everybody on the same team.

The process begins with attorneys from the Public Defender's Office sifting through cases to find candidates who meet the eligibility criteria. Offenders in for a serious, violent or sexual offense do not qualify. If the DA signs off, probation officers work up a pre-sentencing report for the judge to stamp for the re-entry court transfer.

Once they make their selections, the attitudes of some of the professionals tend to soften. Public defenders sometimes go along with recommendations that a few days in jail for a drug-relapsed client – "flash incarceration," they call it – might get him back on track. Prosecutors have been known to write letters on behalf of offenders they formerly targeted for jail time.

"We're not fighting all the time," said Chief Assistant Public Defender Steve Lewis. "It's a different role for us, and it's a different role for the DA. It's turning everything on its head from the typical criminal justice system that we're all used to."

Once the offenders are accepted into the program, they appear weekly in front of Sacramento Superior Court Judge Larry Brown, who goes over their progress reports. Brown cheers them on if they're staying on track – and orders them locked up if they have reoffended, fled or tested positive for drugs.

Brown is the former acting U.S. attorney of the Eastern District of California, as well as a former executive director of the California District Attorneys Association. He sees re-entry court as an efficient way for the county to manage lower-level offenders in a time of limited resources.

"We're seeking to address offenders with long criminal histories and trying to get them on a different path," said Brown, who has been a judge for four years. "I think that's one of the charges we have under realignment, to look not just at the offense but at the offender -- what drives his or her criminality, whether it's drug abuse or mental illness or a combination of both, or lack of opportunities, and see if those factors can be addressed."

The idea, Brown said, is "to reduce the number of inmates serving in the criminal justice system at any given time," and combat a recidivism rate that is the nation's worst: Traditionally, 70 percent of California prison inmates are back in prison within three years of their release.

'I didn't want to fail'

Brown holds court every Friday in Department 1 on the ground floor of Sacramento's downtown courthouse. On a recent Friday, a couple dozen offenders, most of them men, waited outside the courtroom while the re-entry team went over their files with the judge. Many of the offenders sported tattoos that covered their arms or climbed above the collar. A couple wore suits, as if coming for a job interview.

In a session last month, Brown bantered with the offenders, telling the earliest qualifier in the program, Barry Vierra, that he is the "canary in the coal mine." Convicted multiple times for car theft, Vierra, 49, is a recovering methamphetamine addict who suffered an early relapse in the program. Brown ordered him into a 90-day residential program run by Volunteers of America that emphasizes sober-living classes.

Since he finished the treatment program four months ago, Vierra has stayed clean, employed and trouble-free. He has a two-year, six-month sentence for car theft that has been held in abeyance.

"No pressure, Barry," Brown told Vierra. "Just keep making us look good."

On his way out of court, Vierra knocked knuckles with Deputy District Attorney Chris Carlson, who had written a letter on Vierra's behalf to Placer County authorities. Vierra was on probation in Placer County when he was charged in the Sacramento car theft that landed him in re-entry court, and Carlson persuaded Placer to hold off on revoking his probation.

"I don't have a problem writing the letter," Carlson said. "This is what this program is all about. If he messes up, he'll do the time he owes us here and the time he owes them there."

Vierra said the DA's support is just the kind of motivation he needs to help him plug away at recovery and get back into mainstream Sacramento. He is living in his own apartment, paying the rent with money he makes doing power-washing and wood restoration. Vierra regularly returns to the VOA program on North Fifth Street to pump up the recovery fraternity.

"They've put a lot of hard work into this and I didn't want to let them down," Vierra said. "I was the first guy to receive re-entry court, and I didn't want to fail."

During the sessions, Brown calls up the re-entry participants one at a time, cracking jokes and adding a personal touch they rarely see in a judge. There are smiles and laughter from just about everybody in the courtroom, from the judge to the clerk to the attorneys and probation officers. One after the next, the offenders talk about their efforts to change their criminal thinking and pursue recovery.

Dixon walked into re-entry court last month, in her seventh week in the program, pushing a stroller with her 11-month-old son. She had spent her week attending drug treatment and life-skill classes at the Adult Day Reporting Center on Del Paso Boulevard, compiling a perfect attendance record and demonstrating a will to take advantage of her re-entry court deal.

"Hi, buddy," the judge said to the child. He turned to Dixon and told her that in the team meeting, "They just couldn't say enough good things (about how) you are doing in the program."

Dixon beamed while the other offenders in the courtroom cheered.

Not always pleasant

Some weeks the court sessions are not so pleasant. Two weeks ago, Brown issued bench warrants for two men who walked away from the VOA program, and he locked up a woman who had tested positive for drugs. Plainly displeased with her new circumstance, she left the courtroom spitting expletives.

When Dixon returned for her weekly appearance, her cheery demeanor had evaporated. She said her probation officer had made her kick out a couch-surfing friend because officers found pot on him during a routine search of her apartment.

"I feel sometimes like I want to throw in the towel," Dixon said. "Jail time is easier. You don't have the pressure. You don't have to worry about being tested. Something about it settles into your bones."

Dixon lives on a stretch of Howe Avenue in Arden Arcade just off the Capital City Freeway, where black iron fences surround stucco apartments. The neighborhood is one of the poorest in Sacramento, marked by drug dealing, prostitution and street crime.

Many of the units in her complex are vacant and boarded, and she talks about "crazy gangsters" who live down the street. Dixon said she lived that street life for years and it's a challenge staying away from it now.

"I just got to stay in the house," said Dixon. "I just watch movies – I cope by watching movies. I go to church every Saturday and just try to do positive stuff."

She had a setback last week when the landlord evicted her sister – her child care backstop – because the sister wasn't on the lease. Dixon said her probation officers also wanted the sister out, contending her lifestyle wasn't conducive to Dixon's recovery. Her departure left Dixon in a bit of a bind: the sister didn't pay rent, but she helped stock the refrigerator. But Dixon acknowledges it's probably healthier to have her own space.

"I can't have that around me," she said about drinking and partying. "These people (in the Probation Department), they know what's a healthy lifestyle and what's an unhealthy lifestyle."

Inside the courtroom on a recent Friday, she told the judge, "I'm struggling right now." She has been a drug addict for a long time, she said, and that thinking doesn't just go away because you catch a break in court.

Brown said he liked Dixon's self-awareness. He told her that was reason enough to stay positive.

"I hope you pat yourself on the back for realizing that," he said.

'Best and brightest minds'

County officials say it's too early for conclusive data on whether re-entry court is a success, but the majority of participants are staying sober and out of trouble. Judge Brown said the county expects to celebrate the first graduations next summer, starting with Vierra, at which point "we'll have enough experience under our belts" to make an assessment.

The main constraint on expanding the program involves funding. This fiscal year, California is spending $1.08 billion on realignment, up from $940 million in 2012-13, according to the Department of Finance. Sacramento is receiving $51 million in realignment funds. Most of that – more than $39 million – is going to jail operations, while another $10.5 million has been set aside for probation. Re-entry court gets none of it.

Of the probation money, $4.1 million pays for three county reporting centers that accommodate 650 offenders, a number that has expanded as a result of realignment. The centers hire contractors to run the rehabilitation programs that the re-entry court relies on. Another $406,000 in realignment money pays for the 40-bed Volunteers of America residential program.

County officials say the state will have to come through with more money for day reporting centers, rehab services and residential treatment beds if programs like re-entry court are to expand. In his proposed budget, Gov. Jerry Brown calls for a $13 million bump for community corrections next fiscal year.

"More resources have to be directed toward the programs out in the community that are going to make these guys succeed," said Lewis, the assistant public defender.

Joan Petersilia, one of the state's top criminologists and the faculty co-director of the Stanford Criminal Justice Center, recently published a 256-page report on where California stands two years into its realigned new world. The results are mixed. Crime is up slightly, but the stats largely reflect law-breaking that took place before the $1 billion in programs got put in place, Petersilia said.

The good news, she said, can be found in places like Sacramento, taking a spin with something like re-entry court.

"Whether or not California can get it right, the legacy of realignment is you have the best and brightest minds thinking about it," Petersilia said. "It's 58 counties experimenting with whatever they think works for them."

Call The Bee's Andy Furillo, (916) 321-1141. Follow him on Twitter @andyfurillo.

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CALIFORNIA COURT PROGRAMS AND PRACTICES FOR WORKING WITH REENTRY, PRCS, AND MANDATORY SUPERVISION POPULATIONS

ADMINISTRATIVE OFFICE OF THE COURTS
JUDICIAL AND COURT OPERATIONS SERVICES DIVISION
CRIMINAL JUSTICE COURT SERVICES OFFICE

The Affordable Health Care Act (ACA) Opportunities for Reentry Courts

The ACA expands eligibility and leverages federal funds to broaden access to health care for Reentry Court participants and other justice-involved individuals. This workshop will provide an overview of the new law, the opportunities it presents, examples of local approaches, and challenges in obtaining coverage for mental health and substance abuse treatment.

Increasing Safety, Improving Health Outcomes and Reducing Costs through Health Coverage PowerPoint presentation.

California Assembly Bill No. 420

Anticipating the Impact of Health Care Reform on the Criminal Justice System

Barriers Remain Despite Health Law's Push To Expand Access To Substance Abuse Treatment; April 2014

Waiver for the Drug Medi-Cal (DMC) Program; January 2014

Medicaid and Financing Health Care for Individuals Involved with the Criminal Justice System; December 2013

Ten Ways Court Systems Can Help Make Connections to New Health Insurance Opportunities

Increasing Safety, Improving Health Outcomes and Reducing Costs through Health Coverage

Reentry Court Summit
San Francisco, CA
April 21, 2014

CALIFORNIANS FOR SAFETY AND JUSTICE

SAFEANDJUST.ORG

Background on Californians for Safety and Justice

- Statewide non-profit organization founded in 2012
- Funded by philanthropic foundations, including The California Endowment, The Ford Foundation, and others
- Aims to promote public safety strategies that stop the cycle of crime and build healthy communities
- Primary activities include victim/survivor outreach, public education, policy advocacy and support for state and local government

CALIFORNIANS FOR SAFETY AND JUSTICE

The Challenge: High Recidivism, High Costs

People involved in the justice system are:

- About three times more likely to have a serious mental illness
- Over six times more likely to have a substance use disorder
- About 4 times more likely to be uninsured – 75 to 90% of people in jail or on probation are uninsured
- Prevalence of untreated mental illness and addiction drives recidivism, longer jail stays, and high health and justice system costs

Source: “Enrolling County Jail and Probation Populations in Health Coverage: A Toolkit for Practitioners,” Californians for Safety and Justice, April 2013.

The Affordable Care Act Opportunity

- **New eligibility** = virtually everyone in the justice system is now eligible for health coverage and treatment

- **Enhanced benefits** for mental health and substance abuse treatment = more treatment can be covered

- **New federal funds** = new federal money to subsidize health costs and to help pay for cost of administering enrollment

Expanded Eligibility: New Health Coverage Options under the ACA

- Medi-Cal has expanded to cover new populations
- Covered California is a new health benefits marketplace where uninsured people can apply for Medi-Cal, purchase affordable private insurance, and access financial assistance to help pay for insurance

Estimated Eligibility Guidelines Based on Annual Income

Number of People in the Household	If Your Income* Is LESS THAN...	If Your Income* Is BETWEEN...
1	$15,857	$15,857 - $45,960
2	$21,404	$21,404 - $62,040
3	$26,952	$26,952 - $78,120
4	$32,500	$32,500 - $94,200
5	$38,047	$38,047 - $110,280
You may qualify for:	Medi-Cal	Premium assistance through Covered California

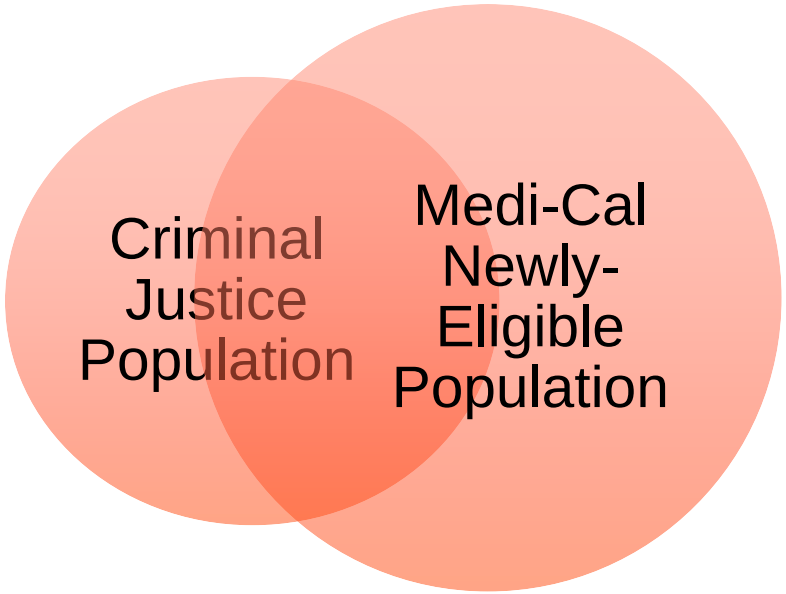
** Income levels are based on the year 2013*

CALIFORNIANS FOR SAFETY AND JUSTICE

Expanded Eligibility:
Who is able to enroll in Medi-Cal?

1. Income at or below 138% of the federal poverty line
2. Citizens and many non-citizens
3. Regardless of criminal record or incarceration

Coverage effective January 1, 2014
Enrollment open all year



Expanded Eligibility: What will Medi-Cal cover?

Health care costs for people in the justice system that Medi-Cal will pay:

1. Inpatient stays at a hospital or other non-correctional medical facility while incarcerated
2. Treatment or care received while residing in the community

Medi-Cal will not pay for non-inpatient treatment received while incarcerated.

AB 720: Inmate Health Care Enrollment

- Signed by Governor, effective January 2014
- The law:
  - Provides that counties shall suspend, rather than terminate, Medi-Cal benefits of individuals during the time they are incarcerated
  - Clarifies that inmates, if otherwise eligible, may enroll in Medi-Cal while incarcerated

State DHCS expects to issue guidance about AB 720 in January

CALIFORNIANS FOR SAFETY AND JUSTICE

Covered California: Eligibility

Covered California is the state's health benefits marketplace. It offers financial assistance to pay for private insurance for:

- Citizens and many non-citizens
- Income from 138-400% of the FPL

Covered California: Eligibility

Open enrollment closed for 2014 coverage. For 2015 coverage, open enrollment is from October 15 – December 7, 2014.

Not eligible to enroll:

- Individuals serving a sentence in jail at time of application
- Release from incarceration is a qualifying event that allows for enrollment outside the open enrollment period

CALIFORNIANS FOR SAFETY AND JUSTICE

Expanded Eligibility: Summary Chart

CJ Population	Medi-Cal* (>138 % FPL)	Covered California* (138 – 400 % FPL)
Jail (awaiting disposition)	Can apply, coverage will be effective upon release or if admitted inpatient. Benefits suspended during incarceration.	Can apply or maintain enrollment (specific plans will differ on which services are reimbursed during incarceration).
Jail (sentenced)	Can apply, coverage will be effective upon release or if admitted inpatient. Benefits suspended during incarceration.	Cannot apply, may be dropped from coverage.
Probation (PRCS, M.S.) Sheriff custody out of jail	Can apply for coverage and maintain coverage, coverage is the same as any person not in the justice system.	Can apply for coverage and maintain coverage. Specific plans will differ on which services are reimbursed.

* Single streamlined application

Details on New Federal Funds

For newly eligible Medi-Cal enrollees:

- 100% paid by the Federal government starting in 2014 through 2016
- Federal share steps down gradually from 2017-2020
- 90% from 2020 on by the Federal government, 10% by the state.

For financial assistance to purchase plans through Covered California:

- 100% of assistance paid by Federal government, starting 2014

Enhanced Benefits for Treatment: What Treatment does Expanded Medi-Cal Cover?

Pre-ACA:

- Some health insurance plans did not cover mental health or substance abuse treatment or offered very limited coverage
- Limited coverage under Medi-Cal: primarily methadone and pregnant women

Post-ACA:

- Medi-Cal and all exchange plans must cover mental health and substance abuse, which are “essential health benefits”
- Enhanced benefits will supplement existing Drug Medi-Cal, including residential recovery, de-tox, intensive day treatment

Funding Justice Population Enrollment

- Medi-Cal Administrative Activities (MAA) Program
- Covered California In-Person Assistance Program
- Inmate Inpatient Hospitalization Reimbursement
- County General Funds
- AB 109 (California criminal justice funding to counties)
- Philanthropic support

Affordable Care Act: Expanded Coverage for Mental Health & Substance Abuse Treatment in California

California Court Programs and Practices for Working with Reentry, PRCS, and Mandatory Supervision Populations

April 21, 2014

Bad Old Days

- Before the Affordable Care Act:
  - Very few offenders were eligible for the Medi-Cal program & few had private health insurance coverage
  - Reentry court participants generally had limited access to full range of county mental health services & drug treatment programs

Good News

- Vast majority of reentry court participants are eligible for health care coverage under Medi-Cal -- or subsidized plans
- Under ACA, effective Jan. 1. 2014, Medi-Cal and all subsidized plans must cover MH & SUD treatment as "Essential Health Benefits"
- In CA: increased access to MH & SUD treatment for reentry court participants
- Enhanced Drug Medi-Cal benefits, including residential recovery, de-tox, intensive day treatment

CA Coverage for Medi-Cal SUD & MH Treatment

- Beginning Jan. 1, 2014, treatment for mild to moderate MH issues is covered by standard Medi-Cal managed care plans
- "Specialty MH" treatment for serious mental illness continues to be covered by county health plans, as a "carve-out" from Medi-Cal
- SUD treatment is a separate "carve-out" from Medi-Cal, covered as "Drug Medi-Cal"
  - Realigned to counties' drug/alcohol programs in 2011

Access to MH & SUD Treatment Coverage

Three Elements to Coverage Framework

- Parity
- ACA Essential Health Benefits
- State Plans for Medi-Cal Mental Health & Drug Medi-Cal

Parity

- Core Parity Principle:

  For MH & SUD benefits, financial requirements (annual/lifetime $$ caps) and treatment limitations shall not be more restrictive than on medical benefits – Medi-Cal & subsidized plans

- Applicable to CA Medi-Cal but not as relevant to MH & SUD benefits because not required for "carve-out" delivery systems

- Parity laws allow non-quantitative treatment limitations

- Mental Health Parity Act, Pub. L. No. 104-204, 110 Stat. 2874 (1996)
- Mental Health Parity & Addiction Equity Act, Pub. L. No. 110-343, 122 Stat. 3765 (2008)

Non-quantitative Treatment Limitations

- Limiting or excluding benefits based upon **medical necessity** or medical appropriateness
- Prescription drug formularies
- Exclusions based upon failure to complete a course of treatment
- Restrictions based on geographic location, facility type, provider specialty, and other criteria
- Plan methods for determining usual, customary, and reasonable charges
- Medical management techniques (clinical efficacy; claim types with high percentage of fraud)

Affordable Care Act

- Huge expansion of Medi-Cal eligibility
- Essential Health Benefits:

  Requires ABPs (Medi-Cal for newly eligible) & QHPs (individual/small group) to include MH & SUD treatment as one of 10 Essential Health Benefits for which coverage must be provided
- Other ACA rules apply:
  - can't exclude pre-existing conditions
  - limits on rates & out-of-pocket expenses
  - prohibition on rescinding or cancelling policy once enrolled

ACA Mental Health & SUD Benefits in California

- California: MH/SUD services for all Medi-Cal recipients (not limited to newly eligibles)
- ACA extends MHPAEA parity provisions to QHPs & ABPs, BUT
- **Parity "urged", not required for "specialty MH" and drug & alcohol treatment provided by "carve-out" county MH & drug/alcohol programs
- Eligibility and **medical necessity** criteria for Medi-Cal specialty MH services have not changed

Medical Necessity & Treatment Authorization

For coverage, Medi-Cal & all plans require benefits to be "medically necessary"

- Medi-Cal Managed Care: Covered services must be provided if reasonable & necessary to protect life, to prevent a significant illness or disability, or to alleviate severe pain. WIC §14059.5
- Treatment Authorization Issues:
  - Initial determination: type of professional/licensure authorized to determine medical necessity for SUD (doctor) and MH treatment
  - Review and redetermination of medical necessity

California's MH Benefits

Available to formerly & newly eligible Medi-Cal population:

- Individual and group mental health evaluation and treatment (psychotherapy).
- Psychological testing when clinically indicated to evaluate a mental health condition
- Outpatient services for the purposes of monitoring drug therapy
- Outpatient laboratory, drugs, supplies and supplements
- Psychiatric consultation

California's Expanded SUD Benefits

- Counties provide expanded SUD benefits through Drug Medi-Cal program
  - Intensive outpatient day treatment
  - Residentially-based SUD recovery services
  - Inpatient detoxification
- CA plans to request a federal waiver to create an organized SUD treatment delivery system and add benefits not currently available

Remaining Gaps

Plans must cover MH & SUD hospital, emergency services, outpatient treatment, prescription drug

BUT

- Not required to cover all types of therapies, prescription drugs, or residential placements
- Only services provided by a Medi-Cal certified provider are reimbursable
- Some subsidized plans may have explicit exclusion for "court referral for evaluation" or "court-ordered treatment"
  - **Denial on that basis is likely not permissible

Other Problems

- Reductions in coverage or penalties for failure to obtain prior authorization
- Concerns about how non-hospital residential treatment will be covered
  - Exclusion for Institutes of Mental Disease
  - CA plans to request IMD exclusion waiver for short-term residential drug treatment
- Extremely low fee schedules
- Lack of providers for MH & SUD treatment
- Data sharing: potential IT or legal constraints

Resources

- Administrative Office of the Courts, Criminal Justice Court Services Office, http://courts.ca.gov/17309.htm
- Californians for Safety & Justice, http://www.safeandjust.org/
- California Mental Health Directors Association http://www.cmhda.org/go/public-policy/health-care-reform-resources
- Department of Health Care Services; Medi-Cal mental health policy, http://www.dhcs.ca.gov/services/mh/Pages/MCMHP.aspx
- Department of Managed Health Care; laws http://www.dmhc.ca.gov/aboutthedmhc/law/law_default.aspx

Local Solution

Alameda County is planning an initiative to enroll individuals into Medi-Cal at jail booking. Booking data will be used to pre-populate health coverage application, and county will serve as authorized representative for inmates for purposes of enrollment and eligibility.

CALIFORNIANS FOR SAFETY AND JUSTICE

Local Solution

In San Bernardino County, Probation has collaborated with county social services and behavioral health departments to

- Enroll probationers into Medi-Cal at Day Reporting Centers (DRCs)
- Co-locate mental health and substance abuse treatment providers in their DRCs
- Certify the DRC treatment providers to receive Medi-Cal reimbursement

CALIFORNIANS FOR SAFETY AND JUSTICE

Local Solution

In Los Angeles, the Sheriff's Department is implementing a program to enroll the jail population into Medi-Cal. The Department is also beginning work with the DA and other stakeholders to divert mentally ill individuals into community treatment programs.

CALIFORNIANS FOR SAFETY AND JUSTICE

Local Solution

San Francisco Adult Probation is creating a MAA claiming plan to maximize reimbursement for Medi-Cal outreach, referral and coordination performed by probation. They are also exploring whether certain treatment programs that probationers are commonly assigned to, such as cognitive behavioral therapy, batterer's intervention programs, or sex offender treatment, might be covered by Medi-Cal under certain conditions.

CALIFORNIANS FOR SAFETY AND JUSTICE

Possible Next Steps for Reentry Courts

- Find out whether your county has plans or a program that you can participate in to enroll justice populations and connect them to treatment
- Learn more about Drug Medi-Cal expansion and waiver, including potential ways to fund reentry services. To receive stakeholder notices on Drug Medi-Cal, email michele.taylor@dhcs.ca.gov

CALIFORNIANS FOR SAFETY AND JUSTICE

Questions?

For more information, please contact:

Jenny Montoya Tansey
Health Matters Project Director
Californians for Safety and Justice
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Assembly Bill No. 720

CHAPTER 646

An act to add Section 4011.11 to the Penal Code, and to amend Section 14011.10 of the Welfare and Institutions Code, relating to inmates.

[Approved by Governor October 8, 2013. Filed with Secretary of State October 8, 2013.]

LEGISLATIVE COUNSEL'S DIGEST

AB 720, Skinner. Inmates: health care enrollment.

Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid Program provisions. Existing federal law prohibits federal financial participation for medical care provided to inmates of a public institution, except when the inmate is a patient in a medical institution.

Commencing January 1, 2014, the federal Patient Protection and Affordable Care Act expands eligibility under the Medicaid Program for certain groups and enacts various other health care coverage market reforms that take effect on that date. Existing federal law requires the Secretary of Health and Human Services to develop and provide to each state a single, streamlined form that may be used to apply for all state health subsidy programs, as defined, within the state.

This bill would authorize the board of supervisors in each county, in consultation with the county sheriff, to designate an entity or entities to assist county jail inmates to apply for a health insurance affordability program, as defined. The bill would authorize the entity, to the extent authorized by federal law and federal financial participation is available, to act on behalf of a county jail inmate for the purpose of applying for, or determinations of, Medi-Cal eligibility for acute inpatient hospital services, as specified. The bill would provide that county jail inmates who are currently enrolled in the Medi-Cal program shall remain eligible for, and shall not be terminated from, the program due to their detention, unless required by federal law, they become otherwise ineligible, or the suspension of their benefits has ended. The bill would provide that the fact that an applicant is an inmate shall not, in and of itself, preclude a county human services agency from processing an application for the Medi-Cal program submitted to it by, or on behalf of, that inmate.

Existing law also provides for the suspension of Medi-Cal benefits to an inmate of a public institution who is under 21 years of age. Existing law requires county welfare departments to notify the department within 10 days

of receiving information that an individual under 21 years of age who is receiving Medi-Cal is or will be an inmate of a public institution.

This bill would instead make these provisions applicable without regard to the age of the individual, provided that federal financial participation would not be jeopardized. By expanding the duties of county agencies, this bill would impose a state-mandated local program.

The bill would also include a statement of legislative intent.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that, if the Commission on State Mandates determines that the bill contains costs mandated by the state, reimbursement for those costs shall be made pursuant to these statutory provisions.

The people of the State of California do enact as follows:

SECTION 1. It is the intent of the Legislature in enacting this act to, among other things, ensure that county human services agencies recognize that (a) federal law generally does not authorize federal financial participation for Medi-Cal when a person is an inmate of a public institution, as defined in federal law, unless the inmate is admitted as an inpatient to a noncorrectional health care facility, (b) federal financial participation is available after an inmate is released from a county jail, and (c) the fact that an applicant is currently an inmate does not, in and of itself, preclude the county human services agency from processing the application submitted to it by, or on behalf of, that inmate.

SEC. 2. Section 4011.11 is added to the Penal Code, to read:

4011.11. (a) (1) The board of supervisors in each county, in consultation with the county sheriff, may designate an entity or entities to assist county jail inmates with submitting an application for a health insurance affordability program consistent with federal requirements.

(2) The board of supervisors shall not designate the county sheriff as an entity to assist with submitting an application for a health insurance affordability program for county jail inmates unless the county sheriff agrees to perform this function.

(3) If the board of supervisors designates a community-based organization as an entity to assist with submitting an application for a health insurance affordability program for county jail inmates, the designation shall be subject to approval by the jail administrator or his or her designee.

(b) The jail administrator, or his or her designee, may coordinate with an entity designated pursuant to subdivision (a).

(c) Consistent with federal law, a county jail inmate who is currently enrolled in the Medi-Cal program shall remain eligible for, and shall not be terminated from, the program due to his or her detention unless required by federal law, he or she becomes otherwise ineligible, or the inmate's

suspension of benefits has ended pursuant to Section 14011.10 of the Welfare and Institutions Code.

(d) Notwithstanding any other state law, and only to the extent federal law allows and federal financial participation is available, an entity designated pursuant to subdivision (a) is authorized to act on behalf of a county jail inmate for the purpose of applying for, or determinations of, Medi-Cal eligibility for acute inpatient hospital services authorized by Section 14053.7 of the Welfare and Institutions Code. An entity designated pursuant to subdivision (a) shall not determine Medi-Cal eligibility or redetermine Medi-Cal eligibility, unless the entity is the county human services agency.

(e) The fact that an applicant is an inmate shall not, in and of itself, preclude a county human services agency from processing an application for the Medi-Cal program submitted to it by, or on behalf of, that inmate.

(f) For purposes of this section, "health insurance affordability program" means a program that is one of the following:

(1) The state's Medi-Cal program under Title XIX of the federal Social Security Act.

(2) The state's children's health insurance program (CHIP) under Title XXI of the federal Social Security Act.

(3) A program that makes coverage in a qualified health plan through the California Health Benefit Exchange established pursuant to Section 100500 of the Government Code with advance payment of the premium tax credit established under Section 36B of the Internal Revenue Code available to qualified individuals.

(4) A program that makes available coverage in a qualified health plan through the California Health Benefit Exchange established pursuant to Section 100500 of the Government Code with cost-sharing reductions established under Section 1402 of the federal Patient Protection and Affordable Care Act (Public Law 111-148) and any subsequent amendments to that act.

(g) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement this section by means of all-county letters or similar instructions, without taking regulatory action.

SEC. 3. Section 14011.10 of the Welfare and Institutions Code is amended to read:

14011.10. (a) Except as provided in Sections 14011.11, 14053.7, and 14053.8, benefits provided under this chapter to an individual who is an inmate of a public institution shall be suspended in accordance with Section 1396d(a)(29)(A) of Title 42 of the United States Code as provided in subdivision (c).

(b) County welfare departments shall notify the department within 10 days of receiving information that an individual on Medi-Cal in the county is or will be an inmate of a public institution.

(c) If an individual is a Medi-Cal beneficiary on the date he or she becomes an inmate of a public institution, his or her benefits under this

chapter and under Chapter 8 (commencing with Section 14200) shall be suspended effective the date he or she becomes an inmate of a public institution. The suspension shall end on the date he or she is no longer an inmate of a public institution or one year from the date he or she becomes an inmate of a public institution, whichever is sooner.

(d) Nothing in this section shall create a state-funded benefit or program. Health care services under this chapter and Chapter 8 (commencing with Section 14200) shall not be available to inmates of public institutions whose Medi-Cal benefits have been suspended under this section.

(e) This section shall be implemented only if and to the extent allowed by federal law. This section shall be implemented only to the extent that any necessary federal approval of state plan amendments or other federal approvals are obtained.

(f) If any part of this section is in conflict with or does not comply with federal law, this entire section shall be inoperative.

(g) This section shall be implemented on January 1, 2010, or the date when all necessary federal approvals are obtained, whichever is later.

(h) By January 1, 2010, or the date when all necessary federal approvals are obtained, whichever is later, the department, in consultation with the Chief Probation Officers of California and the County Welfare Directors Association, shall establish the protocols and procedures necessary to implement this section, including any needed changes to the protocols and procedures previously established to implement Section 14029.5.

(i) The department shall determine whether federal financial participation will be jeopardized by implementing this section and shall implement this section only if and to the extent that federal financial participation is not jeopardized.

(j) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department shall implement this section by means of all-county letters or similar instructions without taking regulatory action. Thereafter, the department shall adopt regulations in accordance with the requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code.

SEC. 4. If the Commission on State Mandates determines that this act contains costs mandated by the state, reimbursement to local agencies and school districts for those costs shall be made pursuant to Part 7 (commencing with Section 17500) of Division 4 of Title 2 of the Government Code.

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Anticipating the Impact of Health Care Reform on the Criminal Justice System

By Peter Coolsen and Maureen McDonnell

Introduction

In March 2010, the United States Congress enacted the Patient Protection and Affordable Care Act (ACA).[1] This comprehensive health care reform act has significant implications for services to individuals with substance abuse problems and the mentally ill. The ACA will create a unique opportunity for the criminal justice system that manages a population in which substance abuse and mental illness are pervasive. State governments, insurance providers, hospitals, physicians, and mental health and substance abuse treatment agencies are actively preparing for implementation. To leverage the full benefits of expanded coverage and access to behavioral health services, the criminal justice system must prepare as well.

Much of the change impacting the court system will occur through the expansion of Medicaid coverage for low-income adults, regardless of disability.[2] In the past, very limited funding has

State governments, insurance providers, hospitals, physicians, and mental health and substance abuse treatment agencies are **actively preparing** for implementation. To leverage the **full benefits** of expanded coverage and access to behavioral health services, the criminal justice system **must prepare as well.**

been available for substance abuse, mental health, and medical treatment for indigent people. This problem has been exacerbated for low-income individuals with mental illness and substance abuse problems entering the criminal justice system, a population that has often been marginalized in the greater community. A large body of research conducted over the past 40 years shows that providing this group with appropriate community services greatly reduces subsequent arrests.[3]

In most states, only a small proportion of these individuals are covered by private insurance or Medicaid today.[4] Under health care reform, their access to treatment will be greatly expanded through nearly universal eligibility for insurance coverage.[5] In essence, when these provisions are enacted in less than a year, there will be an unprecedented opportunity to provide comprehensive treatment for substance abusers and chronically mentally ill individuals. It is important that the courts — and agencies working with them — take full advantage of the "window of opportunity" in preparing for this transition.

The Patient Protection and Affordable Care Act of 2010

The ACA created structures and funding that will enable millions of Americans to gain insurance coverage. These include expansion of Medicaid to cover low-income single adults, regardless of disability, and creation of a new marketplace — health insurance exchanges — with premiums subsidized on a sliding scale. Medicaid eligibility will be expanded to all low-income citizens and legal residents with incomes at or below 133% of the Federal Poverty Level (FPL), regardless of disability, or about $14,400 for a single adult. Subsidized insurance premiums will be available to people purchasing their insurance in the health insurance exchanges that have incomes between 134–400 percent FPL.[6] More than 16 million uninsured Americans are expected to gain coverage when these provisions take effect in January 2014.[7]

The major provisions of the ACA were upheld under U.S. Supreme Court review in 2011. The Supreme Court released its decision regarding suits on the Affordable Care Act on June 28, 2012.[8] There were several key findings. First, the court upheld Congress' authority to tax for not complying with the mandate to purchase insurance. Second, the court found that the requirement for states to expand their Medicaid programs was legitimate, but that the penalty for non-compliance could not be the loss of all federal Medicaid funds.[9] From the perspective of the criminal justice system regarding the unmet medical and behavioral health needs of people under justice supervision, the fact that the ACA can progress in implementation is vitally important. The expansion of Medicaid, slated for 2014, is still a requirement of the ACA. However, by lessening the penalty for non-compliance, the court left an opening for states to elect not to make this expansion. In states that choose not to expand Medicaid for low-income adults, medical and behavioral health services in the community will not have the resources to expand, and therefore the criminal justice systems in those states will not be able to leverage those services to reduce recidivism and divert people from incarceration.

Opportunities in the Criminal Courts and Probation

Individuals coming into our criminal courts and jails today are greatly over-represented among the uninsured, with studies finding as many as 90 percent uninsured.[10] Lacking insurance, these men and women receive episodic acute care in jail and the community, which largely under-treats their chronic medical and behavioral health conditions, contributing to health disparities and recidivism. National research consistently shows elevated rates of substance use (70 percent)[11] and psychiatric disorders (16 percent),[12] infectious diseases and chronic conditions such as diabetes, heart disease, HIV, and tuberculosis[13] among this population. Most of these men and women will become newly eligible for health care coverage in 2014. As a result, insurance coverage will provide a source of funding for the expansion of community-based substance use disorder and mental health services for previously uninsured populations. When linked with criminal justice supervision — diversion, probation, parole, jail, health and re-entry stages — these resources can be leveraged to dramatically reduce probation and parole violations and recidivism due to untreated addiction and psychiatric disorders.

Courts, community supervision agencies, jails, jail health care providers, and prisons are well-positioned to facilitate Medicaid/insurance enrollment prior to release. With the participation of health providers, they can also provide screening and referral to community medical, mental health, and substance use disorder treatment services, whether or not these referrals relate to supervision mandates.

Government agencies, insurance providers, hospitals, health care providers, and substance abuse and mental health treatment agencies are actively preparing for implementation of the health care reform act. Currently states are focused on implementing health insurance exchanges and planning the "essential health benefits" that comprise the minimum services required in all health plans offered on the exchange and in the Medicaid expansion. Most state executive and legislative branches are holding public hearings, accepting position papers from stakeholders, and funding demonstration programs to prepare the community health care system for extensive change. The next 12 months will be a critical time for court and criminal justice system leaders — as key stakeholders with an interest in insurance and Medicaid expansion for this population — to influence planning for benefits Medicaid enrollment procedures, and other key provisions that will either expand or restrict the criminal justice system's ability to leverage these resources and increase public safety.

Positioning Criminal Courts for Health Care Reform

Although health care reform will undoubtedly have implications for civil courts, experience suggests that in the justice enterprise the greatest impact of the Patient Protection and Affordable Care Act will be on the criminal courts. Criminal courts traditionally have had a very high incidence of drug-related offenses on their caseloads. One of the greatest frustrations for criminal court judges is that their options are often very limited when it comes to finding adequate treatment resources for defendants with substance abuse problems. This is true whether or not the defendant is in a regular court or a specialty drug court, as community resources have not been able to keep up with the need. As a result, care is available for only a limited number of people, and often there are long waiting lists to begin treatment.[14]

For judges who hear misdemeanor and/or felony cases, the vast majority of people who appear in court after implementation of the Patient Protection and Affordable Care Act will be eligible for health insurance, whether through the Medicaid program or subsidized premiums through the health insurance exchanges. This substantially broadens the opportunity for judges to require all probationers with evidence of untreated substance use disorders and co-occurring mental health conditions to participate in clinically appropriate services.

We can see the potential impact of broad utilization of treatment by looking at the experience of Washington state. Over the last decade, Washington made a significant investment in expanding access to substance use disorder treatment for low-income adults. They demonstrated a reduction in arrests of 17–33 percent among those participating in treatment.[15] This was accomplished without additional criminal justice leverage. Based on research on criminal justice models over the last 40 years, we can expect that programs integrating criminal justice leverage with substance use disorder treatment will result in further reductions in criminal activity.[16]

A recent study of post-prison health care utilization in Massachusetts, where a pilot program allows prison inmates to apply for coverage prior to release, is also encouraging. The study conducted by the University of Massachusetts found that (1) most released inmates

sustained their coverage for at least a year after release; (2) releasees utilized preventive services, medical care, and behavioral health care services; and (3) they utilized emergency room visits even more appropriately than the comparison group from the general population.[17]

Specialty Courts

Another area in which health care reform will have a significant influence is specialty courts, including mental health courts, drug courts, veterans' courts, and other types of problem-solving courts.[18] As the dynamics in these courts differ due to the offender population being served, we will focus here on mental health courts as an example of the potential changes and opportunities for specialty courts through the ACA.

The number of mental health courts has increased significantly over the past few years from fewer than 10 mental health courts in 1997 to more than 250 such courts.[19] It is important to point out that mental health courts have always played a "gap filler" function for the local criminal justice and mental health systems addressing gaps in local services for the mentally ill. This reality has become increasingly obvious as underfunded state and county mental health systems have retreated from their statutory commitment to the mentally ill by drastically reducing mental health treatment services, both residential and community-based. Illinois is a striking example of this situation; the state is ranked 4th among states with the largest mental health cuts in recent years. Between fiscal years 2009 and 2012, the total general fund for the Illinois Division of Mental Health was cut by $187 million, reflecting a budget reduction of 31.7 percent.[20] As a result, in July 2010 the Illinois Division of Mental Health restricted mental health treatment primarily to Medicaid and Medicaid-eligible individuals. Subsequently, many individuals who would have been seen in community treatment centers are no longer receiving treatment. A significant number of these individuals are coming into the criminal justice system as defendants on both misdemeanor and felony charges.

One indicator of this influx of defendants with mental illness is evident at Cook County jail in Chicago, one of the three largest jails in the country and, by default, one of the largest facilities in the state providing treatment to people with mental illness. Cermak Health Services, which manages the Cook

Leveraging resources requires **cooperation** across areas of government that, in many states, do not routinely work together. State agencies are **looking at ways to facilitate Medicaid** enrollment and linkage with community mental health, substance use disorder, and medical treatment through **partnerships** with the criminal justice system.

County jail hospital, identified a 65 percent increase in seriously mentally ill defendants (i.e. those who are receiving psychiatric treatment and/or psychotropic medications) coming into their jail over the past year.[21] It appears that this increase is due in part to larger numbers of the mentally ill entering the system and, in part, to improved screening and diagnostic procedures. Cermak Health Services reports that currently 15 percent to 18 percent of male defendants coming into Cook County Jail screen positive for mental illness (that is, have a DSM IV, axis I diagnosis). The incidence is much greater for women detainees in that 50 percent of women who come into the jail screen positive for mental illness.[22]

An alarming number of mentally ill misdemeanants, often charged with social crimes, are coming to the attention of the criminal courts. Not only have the numbers of defendants increased, but they are presenting in court with far more severe symptoms that require immediate management. In the Criminal Division of the Circuit Court of Cook County, this phenomenon has led to the creation of a special competency or fitness call just to deal with the increasing numbers of unfit misdemeanant defendants, many of whom are appearing before the court with serious mental health challenges that preclude them from being fit to stand trial. During the two year period from July 2010 to June 2012, when significant community mental health service cuts took effect, 185 misdemeanant defendants were examined by the Forensic Clinical Services Department on fitness or restoration issues.[23]

Looking Ahead to a More Positive Future

In spite of this somewhat grim scenario, there is a remarkable opportunity on the horizon to address the needs of the chronically mentally ill in a much more comprehensive manner and to more appropriately align the role of courts to the increasing numbers of the mentally ill in the criminal justice system. The courts may be in a position, under national health care reform, to move from their current "gap filler" function to more of a convener and coalition builder function. In doing this, the focus of the traditional mental health court will need to shift from one of monitoring mentally ill defendants, with very limited access to treatment resources, to one of linking and referring defendants in an environment with expanded access to resources, albeit through a complex health care system. In this new environment, the criminal courts will be in a position to have a significant impact on services to the mentally ill and substance abusers by:

1. Mainstreaming mentally ill defendants within all of the criminal courts rather than limiting them to specialty courts.
2. Training all criminal court judges and court personnel in understanding the needs of mentally ill defendants and in accessing newly available pathways to treatment.
3. Targeting traditional mental health courts to serve defendants with "the highest risk and highest need."
4. Linking defendants with a comprehensive network of treatment providers.
5. Encouraging community resources to provide evidence-based mental health, dual diagnosis, and substance abuse services that are proven effective with people under justice supervision.

6. Serving as a catalyst for systems change with local service providers regarding services to mentally ill defendants. Influencing the development of a qualified community treatment infrastructure capable of handling the influx of mental health and substance abuse cases coming from the criminal justice system.

State and County Planning for Health Care Reform

Leveraging resources requires cooperation across areas of government that, in many states, do not routinely work together. State agencies are looking at ways to facilitate Medicaid enrollment and linkage with community mental health, substance use disorder, and medical treatment through partnerships with the criminal justice system. At the same time, justice agencies are looking to incorporate new mental health and substance use disorder treatment resources into system-wide supervision strategies that will reduce future arrests. State and county authorities are interested in leveraging these processes to reduce public expenditures for incarceration.

States have addressed the pressing problem of residents without health insurance in different ways over the past 30 years. Several have expanded coverage for low-income residents through partnership with the federal government (Medicaid waivers); others have expanded health coverage in more limited ways by using their own resources. States continue to take action in this area. To date, at least 12 states and the District of Columbia have some form of coverage for low-income adults,[24] including some coverage for mental health and substance use disorder treatment services. With the right planning, criminal justice systems in these states will be able to leverage these resources for system-wide access to necessary behavioral health services beyond those attained through smaller scale diversion and supervision programs and through specialty courts.

Illinois has advanced a proposal under a provision of the ACA that would allow its counties to expand Medicaid coverage to low-income adults prior to implementation of the ACA. Cook County, which includes Chicago, is actively preparing to expand Medicaid coverage to low-income adults served in its safety net health system beginning in 2012.[25] The Hon. Paul P. Biebel, Jr., presiding judge of the Criminal Division, Circuit Court of Cook County, has convened a multi-agency planning process to support all justice agencies in aligning their business processes with the new resources. The Justice and Health Initiative, led by TASC, Inc. and funded by the Chicago Community Trust, began meeting in August 2012. Its steering committee includes leadership from the judiciary, state's attorney, public defender, probation, sherriff's office, county clerk, state Medicaid agency, county health system, jail health services, and community foundations. Working groups in the justice system are identifying places where jail inmates, defendants, and probationers could make applications for the new coverage. The courts met with community substance abuse and mental health providers to discuss their intentions to refer many more probationers for services, needed capacity expansion, and quality measures. A working group on the issue of identification is forming to address the need for valid identification in order to enroll in coverage. When the county health system begins to enroll new members into its Medicaid expansion program, it is expected that people under justice supervision will be actively included. Experience here will inform how the courts statewide will address the broader expansion of coverage coming through the ACA in 2014.

Recognizing that large numbers of people under justice supervision will become eligible for Medicaid in 2014, Illinois has included the criminal justice system in its health care reform planning. To this end, the Illinois Governor's Health Care Reform Implementation Council/Working Group on Adult Justice Populations is reviewing broad policy issues, systems integration, and health care access opportunities. Participating agencies include the Illinois Department of Health Care and Family Services, the Illinois Department of Human Services, the Illinois Department of Corrections, the Administrative Office of the Illinois Courts, the Illinois Criminal Justice Information Authority, TASC, and other representatives of the state courts and the criminal justice systems. Collaborative work among these agencies has already led to the development of several policy, education, and demonstration program concepts.

Challenges Ahead

In summary, effective leveraging of these new resources on a broad scale will require unprecedented collaboration among justice agencies and between justice, health care purchasers, and medical and behavioral health care providers. Key challenges will need to be addressed including:

1. Establishing infrastructure for efficient Medicaid/insurance application processes that can

enroll detainees prior to leaving jail and enroll people under pre-trial and post-sentence probation supervision.

2. Developing universal screening for mental health, substance abuse, and chronic disease for populations under justice supervision with linkages to needed care in the community.
3. Assuring that substance abuse and mental health services in the "Essential Health Benefits" plans and the Medicaid program for the newly eligible include services of sufficient duration and intensity to allow people under justice supervision to change their behavior fundamentally, not just experience remission of symptoms.
4. Building sufficient capacity for mental health and substance abuse treatment services in the community to utilize the new resources.
5. Creating health care purchasing practices and policies that will not impede these linkages. For example, medical necessity criteria for substance abuse treatment in Medicaid, insurance plans, and managed care must anticipate that use ceases during incarceration but that people with recent histories of drug and alcohol use are likely to return to use after release.
6. Facilitating valid identification for people under justice supervision so they can enroll in the new resources.

Anticipating a Better Future

In this era of great pressure on state and county budgets and dwindling health and human service resources, the expansion of health insurance, through national health reform, creates a tremendous opportunity to address untreated substance use and psychiatric disorders among people under justice supervision. Dramatic gains in public safety and public health are possible, along with potential reductions in public expenditures for incarceration. In essence, by anticipating the future state courts have the opportunity to influence it and to help form significantly better outcomes for those individuals entering the criminal justice system with substance abuse and mental health problems.

ABOUT THE AUTHORS

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RESOURCES

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3. Critical findings have been distilled by the National Institute on Drug Abuse (NIDA), part of the National Institute of Health; the Substance Abuse and Mental Health Services Administration (SAMHSA), part of the U.S. Department of Health and Human Services; the Bureau of Justice Assistance (BJA) and the National Institute of Corrections (NIC), which are part of the U.S. Department of Justice. NIDA's *Principles of Drug Abuse Treatment* for Criminal Justice Populations distills these findings into key applications for justice agencies, community service providers and health care purchasing agencies . See National Institute on Drug Abuse, Principles of Drug Abuse Treatment for Criminal Justice Populations, Published September 1, 2006, Revised August 2012.

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Barriers Remain Despite Health Law's Push To Expand Access To Substance Abuse Treatment

TOPICS: CALIFORNIA, STATES, MARKETPLACE, HEALTH REFORM, DELIVERY OF CARE

By ANNA GORMAN
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The nation's health law has promised sweeping changes to help millions of people with drug or alcohol addiction get treatment. Many unable to afford services in the past now can receive them without first landing in jail or an emergency room, health officials say.

"There is no illness that will be more favorably affected [by the Affordable Care Act] than substance abuse," said A. Thomas McLellan, former U.S. deputy drug czar and now chief executive officer of Treatment Research Institute in Philadelphia. "This is the beginning of substance abuse disorders being part of mainstream health care."

The law requires that substance abuse treatment be offered to people newly insured through the insurance exchanges or Medicaid, the government health plan for the poor and disabled.

Jessica Schabel, 19, is under treatment at the Impact Drug and Alcohol Treatment Center in Pasadena, Calif., for heroin and methamphetamine addiction. Her insurance benefits only allowed for 30 days, but the facility paid for her to stay an additional 30 days to continue treatment (Photo by Heidi de Marco/KHN).

But serious impediments remain to widespread access, including a shortage of substance abuse providers and available beds nationwide, say treatment experts and government officials.

"We don't have enough capacity right now," said Becky Vaughn, executive director of State Associations of Addiction Services in Washington, D.C.

More than 23 million Americans needed treatment for an alcohol or drug problem in 2012 but only about 11 percent received it, according to estimates from the federal Substance Abuse and Mental Health Services Administration (SAMHSA).

One significant barrier to access is that drug treatment centers with more than 16 beds can't bill Medicaid for residential services provided to low-income adults. The restriction is due to a decades-old federal law designed to prevent Medicaid funding from going to private mental institutions. The purpose was to avoid warehousing of mental patients, treatment providers said.

As a result of the limitation, drug rehabilitation centers across the nation are turning away new Medicaid beneficiaries who need residential treatment and now are entitled to receive it under Obamacare.

"The unintended consequence is that you are discriminating against an adult who needs help," said Elizabeth Stanley-Salazar, a vice president at the Phoenix House, which offers drug treatment in a dozen states, including California, Florida and Virgina. "We don't do that for any other illness or disease. … Everyone recognizes that it needs to be fixed."

Health officials and treatment centers have raised concerns about the restriction.

In a letter to the Centers for Medicare & Medicaid Services last month, California's Health Care Services Department director Toby Douglas said that just 10 percent of the available inpatient beds in the state are in facilities that meet the federal government's size restrictions. He asked the federal government to give the state some flexibility in counting beds.

Similarly, the vast majority of the substance abuse treatment in Colorado is located in centers with more than 16 beds, said Arthur Schut, chief executive officer of Denver-based Arapahoe House. There are ongoing conversations among treatment providers statewide about how to legally get around the restriction so they can offer the newly available benefits to more people, he said.

"Everyone is in agreement about how dumb this is," he said. "It doesn't work economically and it doesn't work for the people seeking treatment.

There are no plans to change the law, said Suzanne Fields, a SAMHSA senior advisor on health care financing. The federal government is working with states on other options, including treating patients under programs paid for with other federal money.

Fields said federal health officials are also meeting with insurance plans and trade groups to provide information and help them ease the transition to the new system of expanded benefits.

In the past, many people didn't have access to substance abuse treatment because they were uninsured or their policies didn't cover it. The majority of states also did not include substance abuse benefits or only offered bare-bones coverage through Medicaid.

"These are services that have not been covered or haven't been covered very well," said Dan Belnap, senior health policy analyst at Legal Action Center, a nonprofit advocacy group based in New York. "There is a lot of ground to make up."

In addition to the protections under the Affordable Care Act, long-awaited rules for another federal law -- the Mental Health Parity and Addiction Equity Act -- were released late last year requiring that coverage for substance abuse and mental health treatment not be more restrictive than other medical coverage. For example, insurance companies can't have different rules for co-payments or visit limits for substance abuse or other behavioral issues than for medical issues.

The expansion of coverage and services is also expected to lower health care spending. Illicit drug use in the U.S. costs more than $190 billion, including from lost productivity and on health care expenditures, according to estimates from the federal government.

Still, some of the reforms have sometimes been slow to take root.

For example, despite the new coverage and protections, treatment centers said they are continuing to fight with insurance plans over how long they can keep patients in care. The law does not specify length or intensity of treatment.

"This is disease in which continued treatment is essential," said David Rosenbloom, a professor at Boston University School of Public Health. "If the new law is implemented by managed care companies with short leashes, they will undo its potential efficacy."

Les Sperling, chief executive officer of the Central Kansas Foundation, said there is significant pressure by insurance companies to shorten the length of time people are in residential care. "There is that natural tension between a payer and a provider that continues," he said.

At the Impact Drug and Alcohol Treatment Center in Pasadena, Calif., administrators said they constantly are trying to persuade insurance plans to pay for longer stays. "We have to paint a picture for the insurance companies of this sick person who needs a lot more help," said Mark Paquet, admissions director.

Take 19-year-old Jessica Schabel from Yucaipa, Calif., who is covered through her parents' plan. Her insurance benefits ran out after 30 days but administrators could not get the treatment extended. The facility paid for her to stay an additional 30 days.

Outside in the garden, where she sat down to eat a hamburger, Schabel explained that she dropped out of high school and has been arrested numerous times. She started using heroin and methamphetamine when she was 15, a habit Schabel said she supported by selling drugs.

"For people who have used for years, it takes a long time to break that habit," she said.

Providing care for patients dealing with substance abuse has long been a priority, but plans are now doing what's necessary to meet the new requirements, said Clare Krusing, spokeswoman for America's Health Insurance Plans. Plans are basing their coverage decisions on what the evidence shows is "proven to be safe and effective for a particular patient given a particular condition," she said.

Even with all of the unanswered questions and obstacles, the new benefits are a relief for those covered under Obamacare, said Tom Delegatto, executive director of business development for Gateway Foundation in Illinois.

"Nobody is jumping for joy when they have to go into substance abuse treatment," he said. "But they are grateful to have the ability to pay for it. ... They have an opportunity they did not have before."

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Department of Health Care Services (DHCS)
Organized Delivery System Waiver for the Drug Medi-Cal (DMC) Program

January 10, 2014

The Department of Health Care Services (DHCS) will request a waiver from the Centers for Medicare and Medicaid Services (CMS) to operate the Drug Medi-Cal Program (DMC) as an organized delivery system. The waiver will give state and county officials more authority to select quality providers to meet drug treatment needs. This will strike an appropriate balance between ensuring access to these vital services while also ensuring that drug treatment services are being provided consistent with program goals.

Realignment of the DMC Program: The DMC program provides substance use disorder treatment services to Medi-Cal beneficiaries. Funding for the program was realigned to the counties as part of 2011 Public Safety Realignment, but the delivery system remained unchanged.

Reasons DHCS is Seeking a Waiver: The need to fully realign this program takes on more importance given a number of developments and experiences:

- *Integration through Coordination:* The need to maximize services for the beneficiary, with integration through improved coordination of substance use disorder treatment with county mental health and public safety systems and primary care.
- *Building Upon the Mental Health System:* The opportunity to build upon the experience and positive results California has achieved in state administered and county operated Medi-Cal Specialty Mental Health program. In 54 of the 58 counties, mental health and substance use disorder programs are consolidated in the same department.
- *Medi-Cal Eligibility and Benefit Expansion:* The expansion of eligibility for and substance use benefits in the Medi-Cal program under the Affordable Care Act and enacted in the 2013-14 Budget Act. This will result in tens of thousands of additional potential Medi-Cal beneficiaries seeking enhanced substance use disorder treatment.
- *Improving Drug Medi-Cal:* Need to improve the DMC program, in light of recent significant program integrity issues.

Medicaid Waiver as Vehicle: Federal law allows states seeking to improve the performance of Medicaid programs to seek permission from the federal government to deliver those programs in innovative ways in their state. The process for making the change involves seeking a *waiver* of federal Medicaid law.

Access: The state is committed to striking a balance between ensuring the greatest degree of access for Medi-Cal beneficiaries, while also maintaining integrity and incenting performance in those programs.

Benefits of a Waiver: There are numerous anticipated benefits for a DMC waiver:

- The waiver will support coordination and integration across systems to the benefit of the beneficiary, with the goal of more appropriate use of health care, such as reduced emergency rooms and hospital inpatient visits.
- A waiver is consistent with the State's recent reforms in transitioning populations and services to organized delivery systems. In particular, the structure will build upon the existing organized delivery system in the Medi-Cal Specialty Mental Health program.
- This will result in increasing the monitoring of provider delivery of services to DMC beneficiaries, with the goal of improving the quality of substance use disorder treatment services beneficiaries receive.
- This model will strengthen county oversight of network adequacy, service access, and standardized practices in provider selection which will:
    - Improve information available regarding provider performance;
    - Help avoid provider fraud and the inappropriate use of public funds.
- This structure will create an organized substance use disorder delivery system that can better coordinate with county public safety systems, improving the coordination of mental health and substance use disorder services to better support offenders in their re-entry back into the community.

County Opt-in Model: The waiver will only be operational in counties that elect to opt into this organized delivery system for DMC. DHCS will work with counties to move forward with implementation, particularly in light of 2011 Realignment, which provided counties with the financial and administrative responsibilities for DMC services. Given the spectrum of county infrastructure and resources, DHCS does expect some counties to implement sooner than others. However, DHCS encourages all counties to implement this new model.

Requirements for Counties Opting In: Counties that opt into this waiver will be required to:

- Implement selective provider contracting. This allows local control over the providers that participate in the program and the number of contracts the county oversees.
- Provide or arrange for all DMC benefits. A county could not exclude any benefits, including Narcotic Treatment Programs, which provide methadone.
- Monitor the providers based on performance criteria, with timely and appropriate action when county or beneficiary concerns are noted.
- Assure beneficiary access to DMC service providers, an adequate provider network for the anticipated population, and standardized practices in provider selection by the county.

- Use a single-point of access for beneficiary assessment to determine medical necessity and provide appropriate service referrals. Provide access for beneficiaries who require emergency or urgent services.
- Collect and maintain data regarding the accessibility and quality of services, and timely reporting of data to DHCS.
- Ensure timely termination of contracts with non-compliant providers, and appropriate placement of affected beneficiaries.
- Partner with DHCS on the licensing and certification of providers, including conducting on-site review of providers.
- Ensure a collaborative relationship with DHCS to protect program integrity and beneficiary access.

Experience with Specialty Mental Health Waiver: DHCS expects that this waiver will improve quality of care, access to services, and program integrity similar to the experience with the Medi-Cal Specialty Mental Health waiver. That waiver:

- Helps promote a higher quality of provider and increases beneficiary protections. It does this through selective provider contracting based on uniform and federally-approved performance standards (such as Hedis Measures) and oversight requirements.
- Provides increased administrative authority for counties to select and maintain the highest-quality service providers in all regions of counties.
- Provides for a single-point of beneficiary assessment to determine medical necessity and provide appropriate service referrals.
- Allows for better monitoring oversight by the county and the state through annual external and triennial audits which ensures that providers are meeting expected standards and regulations.

Stakeholder Engagement: As the next step, DHCS will sponsor a conference call on January 21, 2014 at 4PM, and convene stakeholders beginning later that month to provide input and review of the waiver proposal DHCS will submit to CMS. Stakeholder input is critical, and will be considered by DHCS.

In particular, DHCS will request consultation on the:

- Access and monitoring requirements under the waiver.
- Safeguards and protections for beneficiaries to receive urgent access to services.
- A provider selection appeal or dispute resolution process.

Stakeholder Participants: Representatives will include, but are not limited to:

- County Representatives
  - California State Association of Counties (CSAC)

- California Mental Health Directors Association (CMHDA)
- County Alcohol and Drug Administrators Association of California (CADPAAC)

- Providers
  - California Association of Alcohol and Drug Program Executives (CAADPE)
  - California Society of Addiction Medicine (CSAM)
  - California Opioid Maintenance Providers (COMP)
- Consumers, Family Members and Advocates
- Legislative Staff

Where: DHCS in Sacramento, and via webinars and teleconferences (will vary)

Anticipated Stakeholder Process:

1. Conference Call: Kick Off January 21, 2014 at 4PM
Call-in: 1-888-673-9783 Passcode: 8269475
Objective: Review stakeholder process, workgroups and identify participants.

2. Workgroup Meetings: Meetings will begin in February 2014 until completion of the waiver
Objective: Recommend essential elements of DMC program components and make recommendations for waiver revisions.

3. Post-Workgroup Progress Updates: Meetings will begin in March 2014 until completion of the workgroups
Objective: Following workgroup meetings, all interested parties will be provided with progress updates, with the opportunity for input.

4. Webinar: Stakeholder Workgroup Outcomes
Objective: Share workgroup recommendations, solicit broader stakeholder input, share timeline and prepare waiver.

JUSTICE CENTER
THE COUNCIL OF STATE GOVERNMENTS
Collaborative Approaches to Public Safety

December 2013

Medicaid and Financing Health Care for Individuals Involved with the Criminal Justice System

People in prisons and jails often have complex and costly health care needs, and states and local governments currently pay almost the entirety of these individuals' health care costs. In addition, it is estimated that as many as 70[1] to 90[2] percent of the approximately 10 million[3] individuals released from prison or jail each year are uninsured. Lack of health insurance is associated with increased morbidity and mortality,[4] and the high rate of uninsurance among individuals involved with the criminal justice system is compounded by rates of mental illness, substance use disorders, infectious disease, and chronic health conditions that are as much as seven times higher than rates in the general population.[5]

When an individual returns to the community after incarceration, disruptions in the continuity of medical care have been shown to increase rates of reincarceration and lead to poorer and more costly health outcomes.[6] Research shows that the first few weeks after release from incarceration are the most critical in terms of connecting people to treatment. Reentry into the community is a vulnerable time, marked by difficulties adjusting, increased drug use, and a 12-fold increase in the risk of death in the first two weeks after release.[7] For many, the failure to provide a link to healthcare coverage and services upon release results in needless, potentially months-long gaps in their access to health care. If they access care at all, these individuals often rely upon hospital emergency room services, shifting much of the cost burden to hospitals and state, county, and city agencies.[8]

This failure to link individuals involved with the criminal justice system to health coverage and services upon release from incarceration is especially costly to state and local governments. Total state and local spending on uncompensated health care for the uninsured reached $17.2 billion in 2008.[9] Individuals involved with the criminal justice system, who make up as much as one-third of the uninsured population in the United States, can be expected to account for a significant portion of this spending.[10] Furthermore, elevated recidivism rates, which are associated with a lack of access to health care for individuals with mental illnesses or substance use disorders, contribute to the burden of state and local corrections spending.[11]

The appropriate use of federal Medicaid dollars to help pay for health care provided to this population can save states and localities money, in addition to minimizing health and public safety concerns associated with reentry following incarceration. However, opportunities to maximize and maintain Medicaid enrollment for eligible individuals in this population, and especially to make use of Medicaid to finance certain types of care provided to those who are incarcerated, have been largely underutilized by states.

Historically, adults who do not have dependent children or do not meet disability criteria have not been eligible for Medicaid, which has limited the extent to which the program has funded services for people involved with the criminal justice system. Under the Affordable Care Act (ACA), a significant portion of the justice-involved population will gain eligibility for Medicaid coverage for the first time. Some will qualify for federally subsidized health insurance plans offered through the state health

insurance marketplaces, but the majority will be newly eligible for Medicaid under the law's expansion of the Medicaid program. States that make full use of opportunities to enroll eligible individuals in their criminal justice systems in Medicaid and appropriately leverage the program to finance eligible care can realize considerable cost savings by diverting more individuals to treatment—which is significantly less costly than incarceration—and by reducing reliance on state-funded health care services for the uninsured.

There are also opportunities to achieve budget savings for certain health care services provided to those who are incarcerated. Although the Medicaid "inmate exclusion"—which refers to language in the Social Security Act barring the use of federal Medicaid funding to pay for health care services for "inmates of a public institution"[12]—limits the ability of states and localities to draw on Medicaid funding for inmate health care, certain exceptions to this provision can generate important cost savings. Medicaid payment for services provided in correctional settings is restricted by the inmate exclusion, but federal law does grant states the authority to use Medicaid to finance inpatient health care services for incarcerated individuals when provided by a licensed medical facility in the community, i.e., one that is not under the authority of the corrections agency. Only a few states have yet opted to take advantage of this opportunity. However, with the expansion of Medicaid under the ACA, an opportunity exists for states to better leverage Medicaid to help finance inmates' inpatient medical care.

This paper will provide an overview of federal Medicaid law related to people involved with the criminal justice system; discuss policy options available to improve continuity of coverage while ensuring federal funds are spent appropriately; provide state examples of best practices; and give recommendations for state and local governments.

Federal Medicaid Rules on Coverage of Criminal Justice Populations

A significant portion of states' criminal justice populations, including prison and jail populations, are eligible for Medicaid, and the numbers will increase significantly in 2014 in those states participating in the Medicaid expansion authorized by the ACA. Although federal law restricts the use of Medicaid to finance health care provided to beneficiaries while they are incarcerated, the ability to finance qualifying inpatient medical care is an important exception. In addition, Medicaid can serve as a valuable source of coverage for health care services for individuals who are mandated to treatment, on probation or parole, or who are returning to the community following incarceration. States that effectively utilize Medicaid to finance care provided to eligible justice-involved individuals can realize significant cost savings. Furthermore, criminal justice systems that identify and enroll eligible individuals in Medicaid at all points of justice system involvement, including in jails and prisons, can greatly improve access to needed health services for this population.

While there is a Constitutional requirement under the Eighth Amendment to provide health care services to individuals who are incarcerated, federal law prohibits states from using federal Medicaid funds to pay for care provided to incarcerated individuals in most circumstances, even if they are eligible and enrolled in the program.[17] Specifically, section 1905 of the Social Security Act prohibits "payments with respect to care or services for any individual who is an inmate of a public institution (except as a patient in a medical institution)."[18] This provision, known as the inmate exclusion provision, pertains to all individuals involuntarily confined in state or federal prisons, jails, detention facilities, or other penal facilities.

The inmate exclusion provision applies only to the availability of federal financial participation, i.e. it does not restrict the ability of states to utilize state dollars to pay for inmate health care services. In practice, the exclusion results in most health care provided in jails and prisons being financed by the state or local corrections agency, rather than by the state Medicaid program. However, the inmate exclusion provision does not change whether an individual is *eligible* for Medicaid and does not require termination of Medicaid enrollment during incarceration.[19] In fact, under federal Medicaid law, an individual incarcerated in a public institution may remain enrolled in Medicaid if the appropriate eligibility criteria are met. States have been encouraged by CMS to suspend rather than terminate an individual's Medicaid enrollment during incarceration, allowing

Medicaid

Jointly financed and administered by states and the federal government, Medicaid is the primary source of health care coverage for more than 50 million low-income parents, children, and pregnant women. Beginning in 2014, millions of additional individuals, including many low-income, childless adults will gain eligibility for coverage for the first time as a result of the passage of the ACA. State participation in the expansion of Medicaid eligibility is optional, and eligibility criteria will continue to vary by state.

Each state has a distinct Medicaid program that operates within broad guidelines defined by federal law.[13] States document the design of their Medicaid programs and outline the benefits that are available to Medicaid beneficiaries and the amount, duration, and scope of those benefits in their State Plans, which are submitted to and reviewed by the federal Centers for Medicare and Medicaid Services (CMS).[14] While there is considerable variation in Medicaid programs and benefits among states, and sometimes even among various categories of enrollees within a state, the comprehensiveness of Medicaid coverage generally compares favorably with commercial health insurance. Through a combination of low overhead costs and below average provider reimbursement rates, Medicaid is also typically more cost-effective than other sources of health care coverage.[15] This is particularly true in comparison with health care spending by corrections systems, which typically do not have the same negotiating power and cannot obtain similarly favorable rates for health care services.

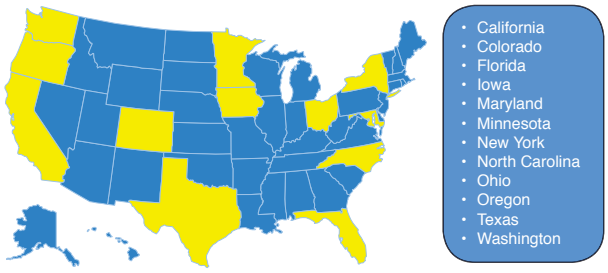
The costs of the Medicaid program are shared by states and the federal government. The federal share varies by state based on the state's average personal income compared to the national average. For most services, the federal government pays a state between a floor of 50 percent and about 74 percent of service costs, leaving the state responsible for the remainder. For newly eligible enrollees under the ACA, the federal share will be at least 90 percent from 2014 forward. This federal share of Medicaid costs is called the Federal Medical Assistance Percentage, or FMAP. In addition, the state's costs for administering the Medicaid program are generally matched dollar for dollar by the federal government, with some administrative activities matched at a higher rate.[16]

Medicaid to be billed for certain, limited types of health care services that are permitted to be reimbursed during incarceration. An additional benefit of suspension is that individuals can more easily access Medicaid services following release, which can be critical to a successful transition during the reentry process.

However, states and localities often misinterpret the exclusion to require the termination of Medicaid enrollment, and some states' information technology systems are simply unable to accommodate a suspension of Medicaid enrollment. As a result, the vast majority of states currently forgo the opportunity to utilize Medicaid as a funding source for inpatient healthcare services. By enabling the suspension of enrollment in Medicaid, states can make more effective use of Medicaid and ensure that it is leveraged appropriately both during incarceration and upon release to link people to appropriate services.

States Suspending Medicaid

Suspension of Medicaid Benefits upon Incarceration: At least 12 states have laws or administrative policies to suspend Medicaid enrollment of inmates.



Allowable Uses of Medicaid for Incarcerated Persons

The inmate exclusion provision expressly allows the use of federal Medicaid funding to finance care provided to an eligible incarcerated individual when that individual is "a patient in a medical institution."[20] The Department of Health and Human Services has clarified that this allows federal funds to be used when the incarcerated individual is admitted as an inpatient in a hospital, nursing facility, juvenile psychiatric facility, or intermediate care facility for at least 24 hours.[21] Because community-based inpatient care can represent a sizeable portion of the

cost of care provided to individuals in prisons and jails, there is the potential for considerable cost savings to a state that is able to effectively use Medicaid funding to finance some of these services. For example, North Carolina has reported that it saved $10 million in the first year of billing Medicaid for eligible inpatient services, while California saved about $31 million by doing so in FY 2013.[22]

To qualify for federal financial participation, the individual must be admitted for at least 24 hours and the facility must be community-based and separate from the corrections system.[24] Once the individual has been admitted in the appropriate inpatient setting for at least 24 hours, all medically necessary Medicaid covered services provided to that individual while admitted can be billed by the provider to Medicaid. At least 14 states—Arkansas, California, Colorado, Delaware, Louisiana, Michigan, Mississippi, Nebraska, New York,[25] North Carolina,[26] Oklahoma, Pennsylvania, Vermont,[27] and Washington—currently bill Medicaid for at least some eligible inpatient health services provided to incarcerated individuals, and additional states are exploring this option.[28]

The potential savings available to state budgets are spurring efforts by additional states to bill Medicaid for allowable inpatient medical services, as well as to expand the scope of this practice in states already doing so in a limited fashion. For example, in a study of prison expenditures on health care services in New York between April 2008 and March 2010, it was found that the New York Department of Corrections and Community Supervision contracted with community-based healthcare providers for certain emergency, inpatient, and outpatient services for its incarcerated population, at a cost of approximately $230 million. Approximately $89 million of this money, or 38 percent of the costs for community-based care over the two-year period, was for inpatient services that were potentially reimbursable by Medicaid. To date, New York has implemented policies to seek federal Medicaid reimbursement retroactively for its jail population in limited instances, and it is currently making policy changes to allow the state to draw on federal funds in all allowable circumstances.[29] New York's efforts, as well as recent efforts to bill Medicaid for inmate inpatient care in North Carolina and Colorado, are discussed in more detail later in this report.

While underutilized, this opportunity to use Medicaid to finance inpatient care for individuals in prisons and jails has long existed. However, the ACA's Medicaid expansion and enhanced federal funding will likely make this practice much more attractive to states that choose to expand their Medicaid program beginning in 2014. The resulting increase in the number of eligible inmates and the higher federal matching rate in those states will likely incentivize the implementation of policy changes to make use of federal Medicaid funding for their incarcerated populations' inpatient medical care.

Understanding Medicaid Enrollment, Suspension, and Termination

Medicaid termination—This term refers to the removal of an individual from the Medicaid rolls as a result of incarceration, without regard to whether or not an individual remains eligible for the program. If terminated, an individual would need to submit a new application for the Medicaid program. Depending upon the type of application, a new eligibility determination may take as long as 45 to 90 days under federal guidelines.[23]

Medicaid suspension—This option allows an incarcerated individual to remain on the Medicaid rolls in a suspended status, which reflects that the individual continues to meet eligibility criteria but that health care services (apart from qualifying inpatient medical care) cannot be financed using federal Medicaid dollars.

Medicaid redetermination—Federal policy requires that an individual's eligibility for Medicaid be redetermined at least every 12 months. Federal rules also state that for those who are eligible based on Modified Adjusted Gross Income (MAGI) criteria, eligibility may not be redetermined more frequently than every 12 months.

States Billing for Inpatient Care

Billing Medicaid for Inmate Inpatient Care: At least 14 states bill Medicaid for at least some eligible inmate inpatient care.

- Arkansas
- California
- Colorado
- Delaware
- Louisiana
- Michigan
- Mississippi
- Nebraska
- New York
- North Carolina
- Oklahoma
- Pennsylvania
- Vermont
- Washington

The ACA's Medicaid Expansion: Opportunities to Increase Health Coverage for Individuals Involved with the Criminal Justice System

In the vast majority of states, Medicaid eligibility guidelines have excluded childless adults from coverage, regardless of their income or poverty level. A few states have used waivers and other mechanisms to extend coverage to this population, but most states have limited Medicaid eligibility to those who meet categorical eligibility criteria, such as low-income pregnant women, individuals disabled by medical conditions, children, and parents of dependent children. As a result, low-income, childless adults make up a substantial portion of the uninsured in this country. Recognizing the high proportion of uninsured individuals in this population, Congress significantly expanded Medicaid coverage under the ACA to include adults at or below 133 percent of the federal poverty level (FPL), or $15,282 annual income for an individual and $25,975 for a family of three, at a projected cost to the federal government of about $434 billion through 2019.[30]

Under the ACA, up to 15.1 million previously uninsured, low-income adults ages 19 to 64 may become Medicaid eligible,[31] and the expansion will have important implications for the criminal justice system. Estimates indicate that approximately 35 percent of people gaining Medicaid eligibility under the ACA will have a history of criminal justice system involvement.[32] Furthermore, there are approximately 4.5 million adults in the United States that are currently eligible for Medicaid but are not enrolled, who may have more opportunities to be enrolled into coverage when the major provisions of ACA take effect on January 1, 2014.[33]

Increased Federal Funding for the Newly Medicaid Eligible Population

States that expand Medicaid eligibility as outlined under the ACA will receive a significantly increased FMAP to do so, meaning that the reimbursement available from the federal Medicaid program will be significantly enhanced. In fact, federal reimbursement for health care services for all newly eligible adults who gain coverage under the ACA (known as the "expansion population") will equal 100 percent for the years 2014-2016, and reimbursement will continue to be significantly increased after full federal funding expires. Beginning in 2017, states will receive 95 percent FMAP for the expansion population, and the rate will be reduced slightly each year through 2020, at which point it will remain permanently at 90 percent.[34]

A number of "expansion states" used waivers to expand Medicaid to childless adults making at least 100 percent FPL prior to the passage of the ACA. These states will have few or no individuals who qualify as "newly eligible" under the law, but new federal matching provisions aimed specifically at these states will still provide an opportunity for significant savings on health care expenditures. These expansion states will begin receiving enhanced FMAP for those individuals that were eligible on March 23, 2010 and would otherwise have been newly eligible under the ACA.[35] The expansion state FMAP will vary by state, but will be at least 75 percent in 2014 and will gradually increase annually until all states receive a permanent 90 percent FMAP for this population by 2020.[36]

As a result of the expansion of Medicaid to childless adults and higher income parents and the greatly enhanced funding available from the federal government for this newly eligible population, states that implement policies to maximize and maintain enrollment for their justice-involved populations will see the potential for even more considerable cost savings than these opportunities have presented in the past. For example, Kentucky currently covers the full cost of providing health care for its incarcerated population, but the Governor's FY 2013 budget estimated a $4

million savings could be realized for the state in FY 2013-2014 as a result of the ACA's expansion of Medicaid eligibility to state inmates with income levels up to 133 percent FPL.[37]

Opportunities to Maximize Medicaid Enrollment

The major provisions of the ACA, including the major coverage expansion provisions and the enhanced FMAP for newly-Medicaid eligible adults, take effect in January 2014. In preparation for the enormous changes coming to the health care system, federal, state, and local governments have been redesigning eligibility systems, defining Medicaid benefits packages for the expansion population, developing enrollment strategies, and implementing countless other policy and practice reforms. As states consider how they can maximize the Medicaid program to enhance access to health care services for individuals while reducing state and local spending, it may be helpful to review states' existing efforts to leverage the Medicaid program to provide health care to individuals involved with the criminal justice system.

State Approaches to Utilizing Medicaid for Healthcare Services for People Involved with the Criminal Justice System

This section details examples of best practices and ongoing systems changes to bill Medicaid for allowable services provided to incarcerated populations in three states: North Carolina, New York, and Colorado. These states were chosen for more in-depth analysis of their Medicaid policies due to their recent and ongoing efforts to implement effective practices related to Medicaid eligibility and enrollment for their incarcerated populations. Each of the states profiled has chosen to implement a different set of policy options to maximize Medicaid coverage for this population, and they are at varying stages of implementation. Policy and programmatic issues explored include the use of Medicaid funds to bill for inpatient medical care for jail and prison inmates and suspension versus termination of Medicaid status upon incarceration.

Of the three states, only North Carolina has adopted and widely implemented policies to bill Medicaid for community-based, inpatient medical care provided to those who are incarcerated. It also requires suspension of enrollment under an August 2008 directive to county directors of social services,[44] however, it appears that in practice, many counties may not be following this directive,[45] potentially limiting the impact of recent policy changes by the state to bill Medicaid for eligible services provided to its incarcerated population. New York suspends Medicaid enrollment when an eligible individual is incarcerated, bills Medicaid retroactively for inpatient care in some circumstances, and is currently undertaking policy and practice changes to make full use of Medicaid for both its prison and jail populations. Finally, Colorado passed legislation to suspend, rather than terminate Medicaid enrollment for its incarcerated population in 2008, and this legislation is still in the process of being implemented.

North Carolina

North Carolina has recently implemented policies to make use of Medicaid for eligible services provided to Medicaid-enrolled individuals incarcerated in the state's jails and prisons. A state law was passed in 2010 requiring the Departments of Corrections and Health and Human Services to develop protocols for utilizing Medicaid to pay for care provided to those in the state that would be receiving Medicaid if not for their incarceration.[46] Since February 2011, under the State Plan, North Carolina has been requiring hospitals and other inpatient providers to bill Medicaid for services provided to Medicaid-enrolled incarcerated individuals. By requiring these community-based health care providers to bill Medicaid directly for services provided to incarcerated individuals—as these providers do for all Medicaid beneficiaries they serve—the corrections system can avoid certain administrative burdens and can generate greater efficiencies and reduced costs.

A report in 2010 by North Carolina's State Auditor found that during the two-year period from 2008 to 2009, the state Department of Corrections paid about $159.8 million for health care, about $26.5 million of which was for inpatient medical care that was provided to likely Medicaid-eligible incarcerated individuals. The report

Special benefits considerations for the Medicaid expansion population

All newly-eligible Medicaid beneficiaries will be enrolled in an "alternative benefits plan" (also known as a "benchmark plan"), which may be based on certain private health insurance plans or be any coverage approved by the Secretary of HHS, including a state's traditional coverage under the State Plan.[38] In addition, coverage must include the ACA's ten categories of Essential Health Benefits (EHBs).[39] Among the mandatory EHB coverage categories for Medicaid alternative benefit plans is coverage of services for mental health and substance use disorders, which must be covered at parity with medical/surgical benefits.[40] The inclusion of substance use disorder treatment services as an EHB to be provided at parity is especially significant, as there has been wide variation in coverage of substance use disorder services across state Medicaid programs, if these services have been covered at all.[41] Given that the justice-involved population is estimated to make up a significant proportion of the newly eligible and taking into account the higher than average prevalence of substance use and mental health disorders in this population, the requirement that plans covering the expansion population include these benefits represents a significant opportunity to improve access to mental health and substance use disorder services.

These protections are important to ensure that newly eligible adults, including those with involvement in the criminal justice system, receive adequate coverage. However, states will continue to have significant discretion in outlining the services covered within these mandatory benefit categories, and some states may use the flexibility available to them to offer the expansion population a package of benefits that is potentially less robust that what Medicaid traditionally covers. To protect the coverage of vulnerable populations, the ACA specifies that certain categories of individuals, including the "medically frail," are exempt from mandatory enrollment in the alternative benefit plan.[42] Those who qualify as medically frail include individuals with a wide range of disabilities and limitations, including individuals with chronic substance use disorders and adults with serious mental illness.[43] These individuals will want to evaluate both the alternative benefit plan and traditional Medicaid to determine which set of benefits best meets their needs.

estimated that by using Medicaid to pay for hospital and other inpatient care for its eligible prison and jail population, North Carolina could have realized a two-year savings of $23 million. According to the auditor, this approximately 87-percent savings on inpatient care for Medicaid-eligible individuals would have resulted both from the ability to bill Medicaid for eligible services thereby drawing down federal funding, as well as from the lower provider rates negotiated by Medicaid as compared to the prices paid by the Department of Corrections.[47]

The State Auditor's report also noted that the Medicaid expansion under the ACA would result in considerable additional savings for the state, should it choose to participate in the Medicaid expansion. While the report did not attempt to quantify the potential savings to the state under the ACA, if North Carolina expands Medicaid eligibility to nearly everyone in the state at or below 133 percent FPL, state spending on health care services for justice-involved individuals would fall significantly.[48]

New York

New York is one of the few states that suspends Medicaid enrollment when someone is incarcerated, and it is the only state to suspend Medicaid indefinitely, rather than only until a new eligibility determination is required.[49] It is also one of only a handful of states to have provided Medicaid coverage to childless adults up to 100 percent FPL prior to the passage of the ACA in 2010. These policies put New York in a unique position to utilize Medicaid to pay for care provided to its incarcerated population; however the state is just recently beginning to undertake an effort to maximize Medicaid enrollment and reimbursement policies for care provided to people involved with the criminal justice system.

New York removed restrictions in state law that prohibited claiming federal Medicaid funds for care provided to incarcerated individuals beginning in 2001, and it started suspending rather than terminating Medicaid enrollment for incarcerated individuals in 2008.[50] However, state practices have resulted in the receipt of just a portion of potentially available federal Medicaid funds for qualifying services provided to incarcerated individuals. Under current New York policy, reimbursement from the federal government is only sought for services provided to individuals incarcerated in local jails. Moreover, reimbursement for care provided to individuals in local jails is only sought in limited situations compared to the broader range of eligible situations that federal law permits.[51] As a result, the state is only receiving a small portion of the federal reimbursement that might be available.

Still, to date, local governments in New York have received more than $4.5 million in reimbursement from the federal government for inpatient medical services provided to Medicaid eligible inmates.[52] To claim this reimbursement, the state submits claims to the federal government on behalf of the local jurisdiction for the amount that would have been billed by the inpatient treatment facility. The local jurisdiction then receives reimbursement for the federal share of the Medicaid costs. The local jurisdiction remains responsible for what the state's share of costs would have been, as well as any difference between Medicaid rates and the rate paid by the jail for those inpatient services.[53]

New York's approach is more administratively complicated than approaches in which states require the treating medical facility to bill Medicaid directly, and it fails to capture available federal funds that could be used to reimburse providers for allowable inpatient medical services provided to state prisoners. New York is working to change its policy to allow the state to access federal Medicaid funds for care provided to its incarcerated population in all allowable circumstances, i.e., for inmates of both jails and prisons, as well as to require health care providers to bill Medicaid directly rather than submitting for retroactive reimbursement.[54] According to a December 2012 report by the Office of the State Comptroller, New York could save $20 million annually if it used Medicaid to finance allowable inpatient services provided to all eligible incarcerated individuals.[55]

New York's practice of suspending Medicaid enrollment indefinitely when an individual is incarcerated, which relies on a state law providing that time incarcerated shall not count toward the required redetermination period,[56] as well as its status as a Medicaid expansion state, makes it strongly positioned to access federal Medicaid funding for its incarcerated population and may potentially make it a model for other states to follow.

Colorado

In 2008, the Colorado state legislature passed a law to require that "persons who are eligible for Medicaid just prior to their confinement in a jail, juvenile commitment facility, Department of Corrections facility, or Department of Human Services facility shall have their Medicaid benefits suspended, rather than terminated, during the period of their confinement."[57] This legislation is in the process of being implemented, and in the years since the passage of the state law a detailed correspondence between the state and the federal Department of Health and Human Services has developed that may be useful for other states considering similar policy changes (see appendix).[58] For example, the correspondence clarifies that:

- As long as the individual continues to be eligible for Medicaid and is residing as an inpatient in a medical facility, federal policy and regulations do not place a time limit on federal Medicaid funding availability for those individuals under the exception to the inmate exclusion provision;[59]
- If the correctional authority limits an individual's ability to leave a correctional facility on a permanent basis, such as a requirement that the individual return to the facility at night, that would be considered incarceration under the federal standard;[60]
- The state would not have to amend its Medicaid State Plan in order to establish suspension of Medicaid for incarcerated individuals, and would therefore not need approval from the federal Centers for Medicare & Medicaid Services (CMS) to institute the change.[61]

The Colorado Department of Health Care Policy and Financing continues to communicate with CMS

and other states as it moves forward to implement Medicaid suspension policies for those in its prison and jail system. Colorado's ongoing clarifications on the appropriate use of federal Medicaid funds to finance inpatient medical care for eligible, incarcerated individuals have been critical to the state's efforts to utilize Medicaid funding and can serve as a valuable source of information for other states.

Opportunities and Recommendations for State Policymakers

While opportunities to make more effective use of Medicaid have always been available, with the passage of the Affordable Care Act and the expansion of Medicaid, states have an important opportunity to reevaluate whether their use of Medicaid to finance care for eligible, justice-involved populations is making efficient use of state and federal resources. Below are recommendations for states to consider implementing in order to better meet the health needs of incarcerated and reentering individuals.

1. Discontinue automatic Medicaid terminations

The federal government has repeatedly encouraged states to ensure that incarcerated individuals eligible for Medicaid are returned to the Medicaid rolls upon release, so that coverage is immediately available.[62] However, just a few states have implemented this recommendation. It appears that only New York suspends Medicaid enrollment indefinitely, allowing individuals who are incarcerated for longer periods or those who are incarcerated during their annual redetermination date to remain enrolled. Other states, including California,[63] Florida,[64] Iowa,[65] Maryland, Minnesota, North Carolina,[66] Ohio,[67] Oregon,[68] Texas, and Washington, do not automatically terminate Medicaid but suspend it for a certain period of time, typically until the enrollee's scheduled eligibility redetermination period.[69] Additional states have policies in place to enroll eligible individuals in Medicaid as part of discharge planning.[70] States that suspend Medicaid can more easily ensure that enrollment is reinstated when incarcerated individuals are released and that formerly incarcerated individuals can immediately access health care without gaps in coverage. An indefinite suspension approach as exemplified by New York would likely enable states to make the most effective use of federal funding, as there would be no lapses in Medicaid enrollment for incarcerated individuals that continue to meet eligibility criteria. Policy options include:

- End the automatic termination of Medicaid for individuals when they are incarcerated by indefinitely suspending Medicaid enrollment and facilitating reactivation when needed.

  or

- Suspend Medicaid up to the enrollee's annual eligibility redetermination date, minimizing disruptions in Medicaid enrollment for those incarcerated for short periods of time. Combined with discharge planning that includes Medicaid eligibility screenings, states could use this more limited approach to reenroll eligible individuals when they are released. However, this limited approach may continue to result in disruptions in enrollment that would likely make it more difficult for states to draw down available federal funding for care provided to incarcerated individuals.
- Upgrade claims systems and other computer systems to track suspended enrollment. States are currently upgrading their Medicaid systems to prepare for the implementation of the ACA, with enhanced federal funding for certain administrative activities.[71] This may provide states that have previously chosen not to implement Medicaid suspension policies due to difficulties upgrading eligibility and claims systems with an opportunity to revisit their disenrollment policies.
- Regardless of Medicaid suspension or termination policies, ensure that all individuals released from incarceration who are eligible for Medicaid are enrolled and eligible to receive health care services upon release.

2. Make effective use of federal Medicaid funding for inpatient services

Federal officials have repeatedly informed states that the Medicaid inmate exclusion provision does not apply to inpatient medical services provided in certain facilities under federal law. States that have designed their Medicaid eligibility and enrollment systems in a way

that makes use of federal funding for these services, or studied potential savings associated with doing so, have shown that considerable reductions in state and local spending can be achieved by using federal funding to help finance these services. In addition, these analyses have also frequently demonstrated that additional savings can be captured as a result of the more favorable provider rates negotiated by Medicaid, as compared with the rates paid by the local or state corrections agency. As many more incarcerated individuals become Medicaid eligible in 2014 at the enhanced federal matching rate, states prepared to use Medicaid to finance inpatient care will see substantial savings.

- States should ensure that processes are in place to determine an inmate's Medicaid eligibility and enrollment status at entry into the criminal justice system.
- States should implement policies to require community-based hospitals, nursing homes, juvenile psychiatric facilities, and intermediate care facilities to bill Medicaid for eligible inpatient services provided to incarcerated individuals.

3. Screen individuals involved with the criminal justice system for Medicaid eligibility at every opportunity

While much of the discussion in this report focuses on untapped opportunities to leverage Medicaid for incarcerated populations, states can ensure greater access to health coverage and services and achieve efficiencies in state and local spending by ensuring that all individuals involved in the criminal justice system are screened for Medicaid eligibility. The ACA requires the use of a single, streamlined application to evaluate eligibility for both Medicaid and federally subsidized health coverage offered by the health insurance Marketplace, meaning that the submission of a single application will be sufficient to ensure that an individual's eligibility for enrollment in either type of health care coverage is considered. In addition, the Medicaid alternative benefits package required by the ACA, including coverage of mental health and substance use disorder services, provides new opportunities to expand appropriate diversion to treatment and to ensure access to necessary health care services upon release for people involved with the criminal justice system. As discussed earlier, opportunities to utilize Medicaid to fund health care services for incarcerated individuals are limited by the inmate exclusion, but are still quite financially significant. To ensure that these opportunities are fully captured, states should screen individuals involved with the criminal justice system for Medicaid eligibility at every opportunity, including during incarceration. Contrary to common perceptions among individuals charged with reentry planning, there is no federal prohibition against screening individuals for Medicaid eligibility during incarceration. In fact, federal law requires that Medicaid applicants be allowed to have individuals accompany, assist, and represent them in the application or eligibility redetermination processes if they choose.[72] HHS has clarified that "corrections department employees and others working on behalf of incarcerated individuals are not precluded from serving as an authorized representative of incarcerated individuals for purposes of submitting an application on such individual's behalf."[73] States could implement policies to screen everyone for Medicaid eligibility in all of their prisons and jails, and immediately suspend coverage when an incarcerated individual is found eligible.

Administrative costs incurred by states for staffing, training, and performing Medicaid eligibility determinations are split evenly by the states and the federal government, and a federal administrative matching rate of 90 percent is temporarily available to states for the costs of upgrading eligibility and enrollment systems to prepare for the coverage expansions under the ACA.[74] By maximizing enrollment of its incarcerated population, a state could also maximize the use of available federal Medicaid funds and ensure that all eligible individuals leaving prisons and jails are enrolled in Medicaid and able to access services. HHS has made clear that corrections department employees and others working on behalf of individuals incarcerated in prisons and jails may serve as authorized representatives for the purposes of submitting an application for Medicaid coverage, and that these administrative activities are likely eligible for federal matching funds.

To ensure that the state budget efficiencies and expanded Medicaid coverage are achieved:

- States should implement policies to screen all individuals in their prisons and jails for Medicaid eligibility, and suspend enrollment for those found eligible. By maximizing their incarcerated populations' Medicaid coverage, states can make full use of Medicaid to finance inpatient health care for this population and ensure that all eligible individuals being released from prison or jail have Medicaid coverage.
- States should develop strategies to screen and enroll Medicaid-eligible individuals at all points of justice-system involvement and maximize the use of federal administrative matching funds to support enrollment staff and processes. A large percentage of those who are on probation, parole, or at other points in the criminal justice system may be eligible for Medicaid, and states should work to ensure that those who are eligible are enrolled and able to access needed health services.
- Given the significant overlap in justice-involved and Medicaid-eligible populations, criminal justice and Medicaid agencies should work closely to identify and address enrollment challenges and coverage issues unique to the criminal justice population.

4. Ensure that Medicaid coverage for the newly eligible offers an adequate scope of services

Finally, increased enrollment in Medicaid will be of limited value in enhancing coverage and access to health care services for people involved with the criminal justice system who are living in the community, if the Medicaid alternative benefit plans covering the newly eligible population do not include an adequate scope of services. The high rates of chronic and communicable disease in the justice-involved population point to a compelling need for access to comprehensive coverage, especially with regard to mental health and substance use disorder services. While the ACA requires that coverage for all ten categories of essential health benefits be included in these plans, including the provision of mental health and substance use disorder coverage at parity, it does not address scope of services. To ensure that individuals can access necessary health care services:

- Criminal justice and Medicaid agencies should work as a team to ensure that the scope of services included in the state's Medicaid alternative benefit plan are adequate to meet the needs of the justice-involved population. Essential services include, but are not necessarily limited to: integrated treatment for co-occurring mental and addictive disorders, cognitive behavioral interventions to address factors associated with illegal activity, and intensive case management.

Conclusion

The Affordable Care Act has provided a new focus on enrolling those who are eligible for health care coverage but who remain uninsured, as well as those who will gain coverage for the first time under the law. These system changes are ongoing and will take years to fully implement, however criminal justice systems, health departments, and state and local officials can now identify and review existing and new opportunities to utilize Medicaid to meet the health needs of people involved with the criminal justice system.

The expansion of Medicaid under the ACA provides an opportunity for states to review their health coverage policies for their criminal justice populations. HHS has made clear that states can and should ensure that Medicaid enrollment is suspended while an eligible individual is incarcerated and that they should implement policies to immediately return an eligible individual to the Medicaid rolls at release. In addition, federal law gives states flexibility to use Medicaid for certain inpatient medical services provided to their Medicaid eligible incarcerated populations. This flexibility is underutilized and states that suspend, rather than terminate, and reinstate Medicaid eligibility when an incarcerated individual receives community-based inpatient care could see considerable cost-savings.

Many more people who are involved with the criminal justice system will soon be eligible for Medicaid at an enhanced federal match, and states have an unprecedented opportunity to improve health outcomes, maintain continuity of care, and reduce their health care costs for the criminal justice population by implementing policies to maximize Medicaid coverage and reimbursements. To effectively meet these challenges, policymakers from criminal justice and Medicaid agencies should regularly communicate and partner to improve relevant systems, processes, and policies affecting their Medicaid-eligible criminal justice population.

Resources

The following resources may be helpful to state officials working to implement changes in Medicaid eligibility and enrollment policies for criminal justice populations.

Implications of The Affordable Care Act on People Involved with the Criminal Justice System (2013)
A brief providing 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.

County Jails and the Affordable Care Act: Enrolling Eligible Individuals in Health Coverage (March 2012)
A report by the National Association of Counties detailing issues and challenges local jails and human services agencies may face determining eligibility and enrolling those in county jails into health coverage gained under the Affordable Care Act.

How Will the Medicaid Expansion for Adults Impact Eligibility and Coverage? (July 2012)
An issue brief prepared by the Kaiser Family Foundation that provides an overview of Medicaid eligibility for adults and implications of the ACA for adult Medicaid coverage.

Frequently Asked Questions: Implications of the Federal Health Legislation on Justice-Involved Populations (2011)
A set of FAQs from the Council of State Governments Justice Center detailing the impact of health coverage and other provisions in the ACA for those in criminal justice system.

Medicaid Expansion and the Local Criminal Justice System (2011)
An article published in American Jails describing the implications of the Medicaid expansion for local correctional systems.

Facilitating Medicaid Enrollment for People with Serious Mental Illnesses Leaving Jail or Prison: Key Questions for Policymakers Committed to Improving Health and Safety (2011)
A brief providing elected officials and corrections and mental health directors with guidance related to enrolling eligible individuals with serious mental illness in Medicaid and other programs.

Establishing and Maintaining Medicaid Eligibility upon Release from Public Institutions (2010)
A report by the Substance Abuse and Mental Health Services Administration discussing opportunities and challenges for increasing Medicaid coverage among those being released from correctional institutions and other public institutions.

Policy Basics: Introduction to Medicaid (2008)
A short report by the Center on Budget and Policy Priorities providing an overview of Medicaid eligibility, benefits, and financing.

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[41] Allison C. Colker, "Treatment of Alcohol and Other Substance Use Disorders: What Legislators Need to Know" (paper presented at National Conference of State Legislatures, Washington, January 2004).
[42] §2001 of the Patient Protection and Affordable Care Act. As defined in §1937(2)(A) of the Social Security Act, those exempt from enrollment in a Medicaid alternative plan include individuals in the following categories: those who are blind or disabled, terminally ill hospice patients, eligibility due to institutionalization, medically frail and special needs individuals, and children in foster care receiving welfare services and children receiving foster care or adoption assistance.
[43] §440.315(f), Public Health, Title 42, Code of Federal Regulations [42 CFR 440.315(f)] defines medically frail individuals as children with serious emotional disturbances, individuals with disabling mental disorders, individuals with serious and complex medical conditions, individuals with physical and/or mental disabilities that significantly prevent them from performing one or more activities of daily living, adults with serious mental illness, individuals with a disability determination based on Social Security criteria, and individuals with a chronic substance use disorder.
[44] William W. Lawrence, Jr., to County Directors of Social Services, "DMA Administrative Letter No: 09-08, Medicaid Suspension" (Raleigh: North Carolina

Department of Health and Human Services, August 27, 2008) available at info.dhhs.state.nc.us/olm/manuals/dma/abd/adm/MA_AL09-08.htm.

[45] Wood, *Performance Audit: Department of Correction Inmate Medicaid Eligibility, August 2010.*

[46] §19.8, North Carolina Session Law 2010-31, "An Act to Modify the Current Operations and Capitol Improvements Appropriations Act of 2009 and for Other Purposes."

[47] Wood, *Performance Audit: Department of Correction Inmate Medicaid Eligibility, August 2010.*

[48] On February 12, 2013, North Carolina Governor Pat McCrory announced that the state would not participate in the ACA's Medicaid expansion. The U.S. Department of Health and Human Services has said that there is no deadline for states to expand Medicaid, and a state can opt-in at any time.

[49] Substance Abuse and Mental Health Services Administration, *Establishing and Maintaining Medicaid Eligibility upon Release from Public Institutions—(SMA) 10-4545* (Washington: U.S. Department of Health and Human Services, 2010); New York State Department of Health, "Maintaining Medicaid Eligibility for Incarcerated Individuals," *Medicaid Reference Guide* (New York State Department of Health, updated January 2012), 545-546, available at health.ny.gov/health_care/medicaid/reference/mrg/january2012/pages545-546.pdf; New York State Department of Health, "Administrative Directive to Commissioners of Social Services: Maintaining Medicaid Eligibility for Incarcerated Individuals," (Albany: New York State Department of Health, April 21, 2008), available at health.ny.gov/health_care/medicaid/publications/docs/adm/08adm-3.pdf.

[50] Kathryn Kuhmerker to Local District Commissioners, "Retroactive Federal Financial Participation (FFP) Reimbursement for Inpatient Medical Costs for Involuntarily Confined Individuals" (Albany: Department of Health, State of New York, May 3, 2001) available at wnylc.net/pb/docs/01OMMLCM4.PDF.

[51] Betty Rice to Local District Commissioners, Medicaid Directors, Temporary Assistance Directors, and CNS Coordinators, "Revenue Reimbursement Project: Retroactive FFP Claiming of Certain Inpatient Medical Claims for Inmates of Correctional Facilities" (Albany: Office of Medicaid Management, February 15, 2005), available at health.ny.gov/health_care/medicaid/publications/docs/gis/05ma008.pdf. This memo directs that local jurisdictions in New York only seek reimbursement if the incarcerated patient was enrolled in Medicaid at the time of incarceration, if a Medicaid application was previously submitted and denied due to the individual's incarcerated status, or if the inpatient services were provided to an otherwise eligible individual in the three months prior to the date in which the local jurisdiction submitted the reimbursement forms to the state (§435.91, Public Health, Title 42, Code of Federal Regulations [42 CFR 435.914] states that Medicaid coverage may start retroactively for up to three months prior to the month of application).

[52] New York State Office of the State Comptroller, *Payments for Inmate Health Care Services: Department of Corrections and Community Supervision.*

[53] Rice, "Revenue Reimbursement Project: Retroactive FFP Claiming of Certain Inpatient Medical Claims for Inmates of Correctional Facilities."

[54] Jason A. Helgerson, "13ADM-02: Medicaid Payment of Inpatient Hospital Claims for Incarcerated Individuals and Individuals Age 21-64 Who Are Admitted to a Psychiatric Center" (Albany: New York State Department of Health, July 9, 2013), available at health.ny.gov/health_care/medicaid/publications/adm/13adm2.htm.

[55] New York State Office of the State Comptroller, *Payments for Inmate Health Care Services: Department of Corrections and Community Supervision.*

[56] §3661(a), New York State Social Services Law provides that: "Notwithstanding any other provision of law, in the event that a person who is an inmate of a state or local correctional facility, as defined in section two of the correction law, was in receipt of medical assistance pursuant to this title immediately prior to being admitted to such facility, such person shall remain eligible for medical assistance while an inmate, except that no medical assistance shall be furnished pursuant to this title for any care, services, or supplies provided during such time as the person is an inmate; provided, however, that nothing herein shall be deemed as preventing the provision of medical assistance for inpatient hospital services furnished to an inmate at a hospital outside of the premises of such correctional facility, to the extent that federal financial participation is available for the costs of such services. Upon release from such facility, such person shall continue to be eligible for receipt of medical assistance furnished pursuant to this title until such time as the person is determined to no longer be eligible for receipt of such assistance. To the extent permitted by federal law, the time during which such person is an inmate shall not be included in any calculation of when the person must recertify his or her eligibility for medical assistance in accordance with this article."

[57] "An Act Concerning Suspension of Medicaid Benefits for Persons Confined Pursuant to a Court Order and Making an Appropriation Therefor," Senate Bill 08-006, Colorado State Legislature, 2008.

[58] The letters between state representatives and HHS are available on the website of the Colorado Department of Health Care Policy and Financing, available at colorado.gov/cs/Satellite/HCPF/HCPF/1247146939485.

[59] Richard C. Allen to Joan Henneberry, Question 1.

[60] *Ibid.,* Question 2.

[61] *Ibid.,* Question 9.

[62] Donna E. Shalala to Honorable Charles L. Rangel (Washington: Department of Health and Human Services, April 6, 2000); Tommy G. Thompson to Honorable Charles L. Rangel (Washington: Department of Health and Human Services, October 1, 2001).

[63] §4011.11, California Penal Code, California Statutes.

[64] §409.9025, "Eligibility While an Inmate," Title 30, Social Welfare, Florida Statutes.

[65] §249A.38, "Inmates of Public Institutions—Suspension or Termination of Medical Assistance," Iowa Statutes.

[66] Lawrence, "DMA Administrative Letter No: 09-08, Medicaid Suspension."

[67] Ohio Department of Rehabilitation and Correction, "Reinstatement of Medicaid for Public Institution Recipients: 07-ORD-14" (Columbus: Ohio Department of Rehabilitation and Correction, November 10, 2009) available at drc.ohio.gov/web/drc_policies/documents/07-ORD-14.pdf.

[68] §411.439, "Suspension of Medical Assistances of Persons with Serious Mental Illness Under Certain Circumstances," Volume 10, Oregon Revised Statutes.

[69] Substance Abuse and Mental Health Services Administration, *Establishing and Maintaining Medicaid Eligibility upon Release from Public Institutions- (SMA) 10-4545.*

[70] National Association of Counties, "County Jails and the Affordable Care Act: Enrolling Eligible Individuals in Health Coverage" (Washington: National Association of Counties, March 2012), available at naco.org/programs/csd/Documents/Health%20Reform%20Implementation/County-Jails-HealthCare_WebVersion.pdf.

[71] Centers for Medicare & Medicaid Services, "Medicaid Program: Federal Funding for Eligibility Determination and Enrollment Activities (76 FR 21949)" (Washington: Federal Register, April 19, 2011).

[72] §435.908, "Assistance with Application," Public Health, Title 42, Code of Federal Regulations [42 CFR 435.908].

[73] Centers for Medicare & Medicaid Services, "Medicaid Program: Eligibility Changes Under the Affordable Care Act of 2010 (77 FR 17143)" (Washington: Federal Register, March 23, 2012).

[74] Centers for Medicare & Medicaid Services, "Medicaid Program: Federal Funding for Eligibility Determination and Enrollment Activities (76 FR 21949)."

Appendix

1. Letter on "Clarification of Medicaid Coverage Policy for Inmates of a Public Institution." Health Care Financing Administration [now called the Centers for Medicare & Medicaid Services], Washington, DC, December 1997.

2. Letter on Medicaid Eligibility of Inmates in the New York City Jail System. Secretary of Health and Human Services, Washington, DC, April 2000.

3. Letter on Medicaid Eligibility of Inmates upon Release from Prison. Secretary of Health and Human Services, Washington, DC, October 2001.

4. Letter on "Suspension of Medicaid Eligibility for Incarcerated Persons." Centers for Medicare & Medicaid Services, Washington, DC, December 2008.

5. Letter on Federal Medicaid Policy for Medicaid Eligible Individuals that Become Incarcerated and Subsequently Need Medical Care. Centers for Medicare & Medicaid Services, Washington, DC, August 2010.

1.

DEPARTMENT OF HEALTH & HUMAN SERVICES — Health Care Financing Administration

7500 SECURITY BOULEVARD
BALTIMORE MD 21244-1850

DEC 12 1997

FROM: Director
Disabled and Elderly Health Programs Group
Center for Medicaid and State Operations

SUBJECT: Clarification of Medicaid Coverage Policy for Inmates of a Public Institution

TO: All Associate Regional Administrators
Division for Medicaid and State Operations

The purpose of this memorandum is to clarify current Medicaid coverage policy for inmates of a public institution. Recently, central office staff have become aware of a number of inconsistencies in various regional office directives on this subject which have been sent to States. Moreover, the growing influx of inquiries from the internet has prompted us to expand and, in some cases, refine our coverage policy in this area. Therefore, in the interest of insuring consistent and uniform application of Medicaid policy on inmates of a public institutution, we believe that this communication is necessary

Statute and Parameters

Section 1905(a)(A) of the Social Security Act specifically excludes Federal Financial Participation (FFP) for medical care provided to inmates of a public institution, except when the inmate is a patient in a medical institution. The first distinction that should be made is that the statute refers only to FFP not being available. It does not specify, nor imply, that Medicaid eligibility is precluded for those individuals who are inmates of a public institution. Accordingly, inmates of a public institution may be eligible for Medicaid if the appropriate eligibility criteria are met.

The next significant distinction is that under current Medicaid coverage policy for inmates there is no difference in the application of this policy to juveniles than the application to adults. For purposes of excluding FFP, for example, a juvenile awaiting trial in a detention center is no different than an adult in a maximum security prison. For application of the statute, both are considered inmates of a public institution.

Criteria for Prohibition of FFP

When determining whether FFP is prohibited under the above noted statute, two criteria must be met. First, the individual must be an inmate; and second, the facility in which the individual is residing must be a public institution. An individual is an inmate when serving time for a criminal offense or confined involuntarily in State or Federal prisons, jails, detention facilities, or other penal facilities. An individual who is voluntarily residing in a public institution would not be

considered an inmate, and the statutory prohibition of FFP would not apply. Likewise, an individual, who is voluntarily residing in a public educational or vocational training institution for purposes of securing education or vocational training or who is voluntarily residing in a public institution while other living arrangements appropriate to the individual's needs are being made, would not be considered an inmate. It is important to note that the exception to inmate status – based on 'while other living arrangements appropriate to the individual's needs are being made' does not apply when the individual is involuntarily residing in a public institution awaiting criminal proceedings, penal dispositions, or other involuntary detainment determinations. Moreover, the duration of time that an individual is residing in the public institution awaiting these arrangements does not determine inmate status.

Regarding the second criteria necessary for determining whether FFP is prohibited, a facility is a public institution when it is under the responsibility of a governmental unit, or over which a governmental unit exercises administrative control. This control can exist when a facility is actually an organizational part of a governmental unit or when a governmental unit exercises final administrative control, including ownership and control of the physical facilities and grounds used to house inmates. Administrative control can also exist when a governmental unit is responsible for the ongoing daily activities of a facility, for example, when facility staff members are government employees or when a governmental unit, board, or officer has final authority to hire and fire employees.

Privatization of Prisons

Some States have contracted with a private health care entity to provide medical care in the public institution to its inmates. We have determined that FFP would not be available for the medical services provided in this situation. We believe that the inmates are not receiving services as a patient in a medical institution. Rather, they are continuing to receive medical care in a public institution because governmental control continues to exist when the private entity is a contractual agent of a governmental unit.

Some States are also considering the feasibility of selling,or transferring ownership rights of the prison's medical un including the housing facility and the immediate grounds) to a private health care entity, thereby potentially establishing the unit as a medical institution for which FFP may be available on the greater grounds of the public institution. We do not believe this arrangement is within the intent of the exception specified in the statute. We adhere to the policy that FFP is unavailable for any medical care provided on the greater premises of the prison grounds where security is ultimately maintained by the governmental unit.

Exception to Prohibition of FFP

As noted in the above cited statute, an exception to the prohibition of FFP is permitted when an inmate becomes a patient in a medical institution. This occurs when the inmate is admitted as an inpatient in a hospital, nursing facility, juvenile psychiatric facility, or intermediate care facility. Accordingly, FFP is available for any Medicaid covered services provided to an 'inmate' while an inpatient in these facilities provided the services are included under a State's Medicaid plan and

the inmate is Medicaid-eligible. We would note that in those cases where an inmate becomes an inpatient of a long-term care facility, other criteria such as meeting level of care and plan of care assessments would certainly have to be met in order for FFP to be available.

FFP, however, is not available for services provided at any of the above noted medical institutions including clinics and physician offices when provided to the inmate on an outpatient basis. Nor is FFP available for medical care provided to an inmate taken to a prison hospital or dispensary. In these specific situations the inmate would not be considered a patient in a medical institution.

Policy Application

As a result of a significant number of recent inquiries from the internet and regional offices, we have provided policy guidance involving issues where inmates receiving medical care in various settings and under unique situations. The following examples will help in determining whether FFP is available or not. Please keep in mind that these are broad and general examples and extenuating circumstances may exist which could effect this determination.

Examples when FFP is available:

1. Infants living with the inmate in the public institution
2. Paroled individuals
3. Individuals on probation
4. Individuals on home release except during those times when reporting to a prison for overnight stay
5. Individuals living voluntarily in a detention center, jail, or county penal facility after their case has been adjudicated and other living arrangements are being made for them (e g , transfer to a community residence)
6. Inmates who become inpatients of a hospital, nursing facility juvenile psychiatric facility or intermediate care facility for the mentally retarded (Note: subject to meeting other requirements of the Medicaid program)

Examples when FFP is unavailable:

1. Individuals (including juveniles) who are being held involuntarily in detention centers awaiting trial
2. Inmates involuntarily residing at a wilderness camp under governmental control
3. Inmates involuntarily residing in half-way houses under governmental control
4. Inmates receiving care as an outpatient
5. Inmates receiving care on premises of prison, jail, detention center, or other penal setting

If there are any questions concerning this communication, please contact Thomas Shenk or Verna Tyler on 410 786-3295 or 410 786-8518, respectively.

Robert A. Streimer

2.

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

APR 6 2000

The Honorable Charles B. Rangel
House of Representatives
Washington, D.C. 20515-3215

Dear Mr. Rangel

Thank you for your letter requesting clarification of Federal law regarding the eligibility of detainees/inmates in the New York City jail system. You asked if Federal policy requires or allows States to suspend (or end) Medicaid eligibility for inmates entering the New York City Jail System at Rikers Island. You also asked about Federal policy on reinstating Medicaid eligibility upon release of such an inmate. I regret the delay in this response.

Since Federal Financial Participation is not available for services rendered to a Medicaid-eligible individual during the period of incarceration (see section 1905(a) of the Social Security Act), Federal policy permits (but does not require) States to use administrative measures that include temporarily suspending an eligible individual from payment status during the period of incarceration to help ensure that no Medicaid claims are filed. In addition, for inmates with longer periods of incarceration, a State can periodically redetermine eligibility as required by 42 CFR 435.916, but use simplified procedures to do so. Regardless of the simplified procedures used, a State must ensure that the incarcerated individual is returned to the rolls immediately upon release, unless the State has determined that the individual is no longer eligible for some other reason.

I have asked Ms. Judy Berek, the Health Care Financing Administration's Regional Administrator for the New York area, to contact the State and ensure that Federal policy is understood and implemented correctly.

I appreciate your bringing this matter to our attention.

Sincerely,

Donna E. Shalala

3.

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

OCT 0 1 2001

The Honorable Charles L. Rangel
House of Representatives
Washington, DC 20515

Dear Mr. Rangel:

Thank you for your letter inquiring about the Department's policy on the Medicaid eligibility of inmates when they are released from prison.

I share your concern about the ability of inmates who entered jail enrolled in Medicaid to retain Medicaid coverage. The letter correctly describes the Department's policy, which is aimed at preventing the kinds of situations you describe. The September 14, 2000, letter stated that States may not terminate incarcerated individuals from Medicaid until a redetermination has been conducted, including an ex-parte review.

In addition, unless a state determines that an individual is no longer eligible for Medicaid, states must ensure that incarcerated individuals are returned to the Medicaid eligibility rolls immediately upon release, thus allowing individuals to go directly to a Medicaid provider and demonstrate his/her Medicaid eligibility. Please be assured that this is CMS current policy and there are plans to disseminate it to all states.

This policy is clearly advantageous for those whose incarceration is relatively brief. If they are released during a normal period of eligibility and before the State's usual, periodic redetermination of eligibility takes place, then our policy should ensure immediate resumption of Medicare coverage upon their release.

Please feel free to call me if you have any further questions or concerns.

Sincerely,

Tommy G. Thompson

4.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
1600 Broadway, Suite 700
Denver, CO 80202-4967

2008 DEC 8 PM 2 21

CENTERS for MEDICARE & MEDICAID SERVICES

Region VIII

RECEIVED

December 2, 2008

Joan Henneberry
Executive Director
Colorado Department of Health Care Policy and Financing
1570 Grant Street
Denver, CO 80203-1818

Re: Suspension of Medicaid Eligibility for Incarcerated Persons

This is in response to your letter dated July 31, 2008 requesting clarification on Federal Medicaid policy for Medicaid eligible individuals that become incarcerated. Please note that federal financial participation at the administrative match rate is available for States that want to implement suspension status for Medicaid eligible individuals that become incarcerated. We researched your questions and consulted with CMS Central Office to provide the following responses (in bold). The responses are based 42 CFR 435.110 and Health Care Financing Administration Letter dated December 12, 1997. Please note that this is the current policy and is subject to change based on appropriate regulatory processes by CMS.

1. Under the above *(inserted in State's letter)* definition of an inmate, would an individual be considered an inmate if they are in an inpatient hospital setting that is a locked acute forensic medicine inpatient care unit specifically designed for those incarcerated, awaiting criminal proceedings, or awaiting penal dispositions?

   An individual would be considered an inmate if he or she is residing in this setting involuntary because the setting is acting on behalf of a law enforcement public institution for incarceration. Therefore there is no Federal Financial Participation (FFP) available.

   An individual may be under arrest or even under investigation (not charged with any crime) by a local sheriff's department or that state patrol, but are confined involuntarily in the inpatient hospital setting. Would such an individual be considered an inmate even if they were not in a locked acute forensic medicine inpatient care unit specifically designed for those incarcerated but instead in an inpatient hospital room designed for normal, daily use?

   If the individual is in a hospital that is separate from the prison system and the individual becomes and inpatient of that hospital, then the individual is not considered to be an inmate of a public institution.

   If an individual is incarcerated in a state prison or county jail and then transferred to the inpatient hospital setting, is the individual still considered an inmate under 42 CFR § 435.1010 and ineligible for FFP?

If the setting is a hospital accredited as such and not created for the purposes of law enforcement and incarceration (which is separate from the law enforcement system), then the individual is not considered and inmate. FFP would be available.

If an individual is incarcerated in a state prison or county jail and then transferred to a nursing facility setting, is the individual considered an inmate under 42 CFR § 435.1010 and ineligible for FFP? Does the response change if the inmate is hospitalized or in the nursing facility for an indefinite amount of time? For example, the individual requires a ventilator and remaining in a state prison or county jail is no longer medically feasible.

If the inmate becomes an inpatient of a nursing facility or a hospital, FFP is available for that individual under the exception of the inmate provision. This continues as long as the individual is an inpatient of the medical facility. Federal policy and regulations do not place a time limit for FFP availability as long as individual continues to be eligible for Medicaid and residing as an inpatient in the medical facility.

2. Under the above definition of an inmate, would an individual required to reside in privately-owned center (such as a halfway house) that is not an organizational part of any governmental unit, nor does any such unit exercise final administrative control over the private facility, considered an inmate under 42 CFR § 435.1010 and ineligible for FFP? For example, the state's Community Corrections programs provide services for persons convicted of less severe felony offenses who are diverted from prison by the courts and services for persons who are being transitioned back to the community from prison. In addition, individuals in Community Corrections programs may have been released from a state prison or county jail, but have yet to be released on parole and are required to return to the privately-owned center nightly. We further note that the state does not exert any significant indicia of control over the Community Corrections facilities. Employees are private employees, each facility has a large degree of discretion in setting its own administrative and disciplinary policies and procedures, and the facilities retain the power to remand residents back to prison in a variety of situations.

   If facilities under the State's Community Corrections programs are limiting the individual's ability to leave the facility on permanent basis, such as the requirement for the individual to return to the center at night, CMS interprets these facilities as institutions for incarceration. While the State provides information that the centers are separate from any governmental unit, we would like additional clarification for the facility's legal basis to restrict an individual's ability to leave the facility. From the information we have, we conclude that Colorado Community Corrections programs are an integral part of the State's criminal justice system and act on the behalf of an overburden traditional prison system.

   If so, if the individual is transferred to the inpatient hospital setting during their stay in such a facility, is the individual still consider an inmate and should benefits remain to be suspended?

   See response to question #1: if the individual becomes an inpatient of a hospital, then FFP is allowed as long as he or she is an inpatient of the hospital and eligible for Medicaid.

3. Under the above definition of an inmate, would an individual only needing temporary detoxification services be considered an inmate if they are in held in a locked facility that provides non-medical, clinically managed detoxification from alcohol and drugs in a clean and safe environment? All individuals are provided sleeping accommodations and well-balanced meals during their stay. The individual is normally held in these facilities until their blood alcohol level is negligible. Even though these services are not normally billable to Medicaid, the Department requests clarification to understand if these individuals are inmates and would qualify to have their benefits suspended during their stay.

   It depends on whether the facility is acting on behalf of a public institution for incarceration and it carries out law enforcement duties. Please provide additional information about these facilities: location, organizational structure, funding, etc. Please clarify whether individuals go to these facilities voluntarily or whether they are placed in these facilities by law enforcement personnel.

   If so, if the individual is transferred to the inpatient hospital setting during their stay in such a non-medical, clinically managed facility, does the individual remain an inmate and should benefits remain suspended?
   Depends on nature of facility. Please provide additional information per previous response.

   Since many of the individuals covered under Medicaid, qualify due to their status of having children in the household, the Department has the following questions to operationalize the suspension of Medicaid eligibility.

4. If one member of the household becomes incarcerated, does that action alone trigger a "change in circumstance" under 42 CFR § 435.916?

   Yes, this would be a change is circumstance that must be reported and for which eligibility must be re-determined pursuant to 42 CFR 435.916 (change in household composition and change in residency for member of the household).

   a. If so, must the Department re-determine eligibility for the entire household and exclude the incarcerated individual from the household's application? Such an action would likely render the incarcerated individual ineligible for Medicaid. Further, if the individual incarcerated is the only child in the household, the re-determination would likely also cause the parents or other adult members of the household to become ineligible.

   Per previous response, State must re-determine eligibility and remove incarcerated individual from household application because individual is no longer living in the same household. This could have an impact on the eligibility of other household members.

   b. If not, is it acceptable to suspend the Medicaid benefits of the incarcerated individual without changing the Medicaid eligibility status of the remaining members of the household?
   No, per previous response.

c. Does the answer change if the member of the household that is incarcerated is considered head-of-household? Currently all Medicaid households must have a "head-of-household" that resides at the residence. All correspondence is mailed to the head-of-household.

Federal regulations do not establish that there must be a "head of household" in order for individuals to be eligible for Medicaid. Pursuant to 42 CFR 435.401, the State may not impose eligibility requirements that are more restrictive than the AFDC or SSI programs. Please clarify whether it is a requirement in Colorado Medicaid to have a "head-of household" for purposes of Medicaid eligibility.

d. Does the answer change if the member of the household that is incarcerated is earning income and that income is no longer available to the household?

Yes, this would change financial circumstances for the members remaining in the household and eligibility must be re-determined.

e. If the Medicaid eligibility of an inmate is suspended upon incarceration, should it be "unsuspended" as a procedural matter if the inmate is transferred to an inpatient hospital setting (as referred to in Question 1)?

This is a State decision as federal law and regulations do not specify provisions on the process used to suspend Medicaid eligibility. The fact that a Medicaid eligible client becomes incarcerated does not make them ineligible for Medicaid, but FFP is not available while they are incarcerated.

If the eligibility is "unsuspended," will the inmate's nominal household revert back to his or her household prior to incarceration?

No, because they are no longer living in the household.

If the nominal household does not revert back and the inmate previously was Medicaid-eligible as a result of residing in a household with qualifying children, how can the inmate retain eligibility?

If the only basis for eligibility for the inmate was being a caretaker relative under section 1931 of the Act, the individual would not be eligible for Medicaid.

5. For disabled adults receiving Social Security Income (SSI), the Department operates Medicaid under a Section 1634 agreement with the Social Security Administration (SSA). As such, individuals are automatically enrolled or disenrolled from Medicaid depending solely in the information received from the SSA.
The SSA has the ability to transmit to the Department when an individual's SSI benefits are suspended. Currently, the Department terminates Medicaid eligibility for these individuals. Once SSA lifts the suspension of SSI, Medicaid is automatically reinstated. Would it be appropriate for the Department to suspend Medicaid eligibility in accordance with the SSI suspension instead of terminating Medicaid eligibility?

If the Department receives information that an SSI individual is incarcerated but their SSI benefits continue, would it be appropriate to suspend Medicaid eligibility?

Because Colorado only covers individuals receiving SSI payments pursuant to section 1634 of the Act and 42 CFR 435.120, but not the "eligible but not receiving" group in 42 CFR 435.210, if the individual stops receiving SSI payments when he or she becomes incarcerated, this individual can no longer be eligible for Colorado Medicaid.

If the Department has suspended Medicaid eligibility for an inmate on SSI, would it be appropriate for the Department to maintain the suspension of Medicaid eligibility after SSI benefits have been terminated? SSI benefits are normally terminated after an individual has been incarcerated for over a year.
Upon the conclusion of the incarceration, can the Department "un-suspend" (*i.e.*, reinstate) an individual's Medicaid eligibility if that individual had his or her SSI benefits terminated or suspended by SSA solely due to incarceration without the reinstatement of SSI benefits by SSA?

If SSA terminates SSI benefits, Medicaid must do the same because the only reason for those individuals to be eligible for Medicaid was due to the receipt of SSI payments.

6. Depending on the facility, inmates may spend various lengths of time involuntarily confined. In state prisons the average stay is well over a year, while in county jails the stay may only be for a few days. Is there any specific length of time that Medicaid eligibility may be suspended for inmates?

Federal statute or regulations do not specify time limitations for suspending Medicaid eligibility.

a. If not, is it appropriate to indefinitely suspend Medicaid eligibility?
If so, and the individual is a member of a household, can the individual remain part of that household indefinitely during the incarceration period?

Per response to question #5, an incarcerated individual is no longer a member of a household because they are no longer living there.

If so, and an eligibility redetermination required upon the conclusion of the incarceration period? The Department is concerned about those individuals who are incarcerated for several years and may not return to the same household under which Medicaid eligibility was originally established.

b. Medicaid eligibility is re-determined annually. Can Medicaid eligibility be suspended beyond the individual's re-determination date? Is an annual redetermination required if the individual is still an inmate?

If the individual continues to be eligible for Colorado Medicaid when they become incarcerated, the State must do annual re-determination of eligibility pursuant to 42 CFR 435.916.

c. Can the Medicaid agency specify a length of time beyond which Medicaid eligibility can be suspended? For example, Medicaid eligibility may be suspended while an individual is incarcerated up to one year but not beyond the individual's Medicaid re-determination date. **Federal statute or regulations do not specify time limitations for suspending Medicaid eligibility.**

7. Would it be appropriate to set a policy for the suspension of Medicaid eligibility that treated Medicaid individuals differently?

   No, this would violate comparability requirements in section 1902(a)(10(B) of the Act.

   If so, could that policy be set to treat SSI-disabled individuals different from AFDC adults? For example, SSI-disabled individuals would not be eligible to have their Medicaid eligibility suspended, but AFDC adults could.
   If so, could that policy be set to treat adult individuals differently from children? For example, adults would not be eligible to have their Medicaid eligibility suspended but children would be, and that policy would be enforced even when adults and children are in the same household (such as with AFDC households).
   If so, could the policy be different based on the individual's status in the household? For example, anyone designated as head-of-household would not be eligible to have their Medicaid eligibility suspended, but other adults and children in the household would be.
   Suspension of Medicaid Eligibility for Incarcerated Persons July 31, 2008 Page 5

   No, this would violate comparability requirements in section 1902(a)(10(B) of the Act.

8. What would be the process for suspending Medicaid eligibility for those individuals who have submitted a Medicaid application but have not received an eligibility determination prior to incarceration? Under this scenario, Medicaid eligibility could be backdated to the period prior to the incarceration, but then suspended once the incarceration began. Would such an action be acceptable?

   If the individual meets eligibility criteria when the application is processed, they would be eligible for Medicaid even though he or she later becomes incarcerated. No FFP can be claimed as long as they are inmates of the public institution.

9. To implement a suspension of Medicaid eligibility would the Department need to modify the State Plan? Is there any notification to, or approval from, CMS that is needed prior to implementation?

   The State would not have to amend its Medicaid State Plan in order to establish suspension of Medicaid eligibility for incarcerated individuals. This is not part of the State Plan. The State would not need CMS approval prior to implementation.

10. Does CMS have any information regarding other states that have successfully implemented a policy to suspend Medicaid eligibility that they could share with the Department? If so, the Department would appreciate any assistance CMS could provide in contracting those states.

New York and Pennsylvania have implemented suspension status for Medicaid eligible individuals that become incarcerated.

11. Does CMS have any additional guidance on the issue of inmate eligibility other than the December 12, 1997 letter that can be provided?

    Not at this time.

12. Is it possible to apply the same suspension of eligibility to State Children's Health Insurance Program ("SCHIP") individuals? If so, would any of the above responses to Medicaid eligibility be significantly different?

    Section 2110(b)(2) of the Social Security Act excludes children that are inmates of public institutions from the SCHIP program, therefore similar suspension policies would apply.

Please contact Diane Dunstan if you have questions regarding this letter. She can be reached at (303) 844-7040 or at Diane.Dunstan@cms.hhs.gov .

Sincerely,

Richard C. Allen
Associate Regional Administrator
Division of Medicaid & Children's Health Operations

Cc: Chris Underwood

5.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
1600 Broadway, Suite 700
Denver, CO 80202-4967

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Region VIII

August 16, 2010

Joan Henneberry
Executive Director
Colorado Department of Health Care Policy and Financing
1570 Grant Street
Denver, CO 80203-1818

Dear Ms. Henneberry:

This is in response to your letter dated December 23, 2009, requesting clarification on Federal Medicaid policy for Medicaid eligible individuals that become incarcerated and then subsequently need medical care. We apologize for the delay in responding.

Specifically, you are asking if services provided to the inmates who are receiving care from the Correctional Care Medical Facility of Denver Health Medical Center, is eligible for Federal Financial Participation (FFP). In your letter you describe the Correctional Care Medical Facility of Denver Health Medical Center as a unit that is designed exclusively to treat inpatient referrals from the Denver County detention facility but is a part of and operates under the accredited inpatient hospital license of the Denver Health Medical Center.

Please be advised the costs of care, treatment and services described above and in your letter dated December 23, 2009, is entitled to FFP. The basis for this technical assistance is based on 42 CFR 435.1009 and 42 CFR 435.1010 and the State Medicaid letter dated April 10, 1998. While Federal law at 1905(a)(A) of the Social Security Act prohibits FFP for medical care or services for inmates in a public institution there is the exclusion when the inmate who is otherwise Medicaid eligible receives medical care in a medical institution.

The situation you describe in your letter is inmates on occasion are admitted into this special unit of the Denver Health Medical Center for inpatient care. Denver Health Medical Center is a licensed, accredited inpatient hospital and otherwise meets the definition of a medical institution as defined at 435.1010(b)(2)(b). The inmates in question are expected to remain in Denver Health Medical Center for a period of 24 hours or longer. Denver Health Medical Center is an accredited and licensed hospital and not created for the purposes of law enforcement and incarceration (which is separate from the law enforcement system) and is not under the authority of any correctional unit. As long as these conditions are met FFP is available.

Additionally, if the inmate becomes an inpatient of a nursing facility or a hospital, FFP is available for that individual under the exception of the inmate provision. This continues as long as the individual is an inpatient of the medical facility. Federal policy and regulations do not place a time limit for FFP availability as long as the individual continues to be eligible for Medicaid and residing as an inpatient in the medical facility.

If you have any questions please contact Diane Dunstan-Murphy of my staff at (303) 844-7040 or via email at Diane.Dunstan-Murphy@cms.hhs.gov.

Sincerely,

Richard C. Allen
Associate Regional Administrator
Division of Medicaid & Children's Health Operations

cc: Chris Underwood

Acknowledgments

The Council of State Governments Justice Center thanks the Legal Action Center for their work in developing this policy brief. Contributors to this report include Dan Belnap, Senior Health Policy Analyst, Legal Action Center; Gabrielle de la Gueronniere, Director for National Policy, Legal Action Center; and Paul Samuels, Director/President, Legal Action Center.

JUSTICE CENTER
THE COUNCIL OF STATE GOVERNMENTS

The Council of State Governments Justice Center is a national nonprofit organization that serves policymakers at the local, state, and federal levels from all branches of government. It provides practical, nonpartisan advice and evidence-based, consensus-driven strategies to increase public safety and strengthen communities. To learn more about the Council of State Governments Justice Center, please visit **csgjusticecenter.org**.

LEGAL ACTION CENTER

The Legal Action Center (LAC) is the only nonprofit law and policy organization in the United States whose mission is to advocate for sound substance use, criminal justice, and HIV/AIDS public policies and to fight discrimination against and protect the privacy of people with these backgrounds. Since 1973, LAC has worked to improve our nation's public policies to promote drug and alcohol prevention, treatment and recovery, and smarter criminal justice and HIV policies. LAC is committed to helping people reclaim their lives, maintain their dignity, and participate fully in society as productive, responsible citizens. To learn more LAC, please visit **lac.org**.

the NATIONAL REENTRY RESOURCE CENTER
A project of the CSG Justice Center

Established by the Second Chance Act, the National Reentry Resource Center (NRRC) provides education, training, and technical assistance to states, tribes, territories, local governments, community-based service providers, non-profit organizations, and corrections institutions involved with prisoner reentry. The NRRC's mission is to advance the reentry field by disseminating information to and from policymakers, practitioners, and researchers and by promoting evidence-based principles and best practices. The NRRC is administered by the U.S. Department of Justice's Bureau of Justice Assistance and is a project of the Council of State Governments Justice Center, in cooperation with the Urban Institute, the Association of State Correctional Administrators, the American Probation and Parole Association, and other key partner organizations. To learn more about the NRRC, please visit **csgjusticecenter.org/nrrc**.

BJA
Bureau of Justice Assistance
U.S. Department of Justice

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Ten Ways Court Systems Can Help Make Connections to New Health Insurance Opportunities

As millions of Americans become eligible for new, affordable health insurance options in 2014, court systems can play a vital role in making sure people learn about health coverage and get help applying. By helping people apply for health insurance, court systems can help large numbers of people with mental illness, substance use disorders and other chronic conditions gain access to primary and behavioral health care. Improving their access to health care services can help protect public health and safety.

Depending on the state, many more people may qualify for Medicaid, the Children's Health Insurance Program (CHIP) or coverage through the Health Insurance Marketplace. Many people who do not have health insurance will now be able to get it, and many may also qualify for help that makes coverage easier to afford. Open enrollment for health coverage through the Marketplace runs from October 1, 2013 to March 31, 2014. People can apply for Medicaid and CHIP at any time. Some special rules apply to people who are incarcerated.

Here's how court systems can contribute to the outreach and enrollment effort:

Share Basic Information

1. **Educate court personnel on the new health insurance opportunities.** Encourage them to include information about Medicaid, CHIP and coverage through the Health Insurance Marketplace when they talk with justice-involved individuals and their families. Knowing the basics about new health insurance opportunities, and the individual's responsibility to get covered, ensures these professionals are providing the best service. Training materials and videos can be found at **Marketplace.cms.gov**.
2. **Help staff become familiar with eligibility and enrollment rules, including special rules that may apply.** For example, individuals who are detained pending disposition of charges may enroll and receive coverage through the Marketplace. Those detained following disposition of charges are not eligible to enroll in coverage offered through the Marketplace, but may apply prior to release or during a 60-day window following reentry into the community. Detainees may apply for Medicaid and CHIP at any point. However, if determined eligible for Medicaid, eligibility must be suspended while incarcerated, and health care services cannot be covered by Medicaid until release, except for off-site inpatient medical care lasting 24 hours or more. An applicant cannot be determined eligible for CHIP while incarcerated.

3. **Reach out to people held pending disposition of charges, those released on bond and probationers living in the community.** Highlight what coverage options are available, as well as when, where and how to apply. Help them understand the new requirement to obtain health insurance coverage. Explain how individuals can get more information and direct them to available application support services.

4. **Display consumer materials explaining the basics of Medicaid, CHIP and coverage through the Marketplace and how to apply.** Key locations include common areas and probationer waiting rooms. Families of individuals involved in court proceedings may be eligible for coverage as well.

5. **Provide education materials to public defenders, law firms, and other key personnel.** Build on the relationship that these groups have with their clients to share information about health insurance enrollment and the new requirement to obtain health insurance coverage.

Help People Under Supervision Apply for Coverage

6. **Find out how your system's administrative process can accommodate the health coverage application process.** Determine whether any security, administrative, or structural changes need to be made to provide access to applications and foster effective collaboration with the Marketplace and Medicaid agency. For example, are there any court rules or procedures pertaining to individuals using computers or the internet in certain buildings or areas?

7. **Assist people in applying for health coverage.** People released on bond, those under pre-trial supervision and probationers are all eligible to apply for coverage without restrictions. Applications may be submitted online, by phone, by mail and in-person. If possible, make computer terminals and phones available and assign trained staff to provide needed help to individuals with the application process.

8. **Provide access to health insurance marketplace applications.** Provide computer terminals, paper applications, or telephones to help facilitate enrollment for individuals. Applications and other information could be available in pre-trail waiting areas and other locations.

9. **Engage key community agencies in providing application assistance.** Organizations that work with people involved in the court system can augment the help that court staff may be able to offer. A list of local community agencies that are certified application counselors that provide application assistance can be found on **Localhelp.HealthCare.gov**.

Promote Promising Practices

10. **Share ideas and successful experiences.** Document your approach to outreach and enrollment, barriers you encountered and your accomplishments. Other court systems can benefit greatly from your good work and leadership.

For More Information

For more information: Visit **HealthCare.gov** or **CuidadoDeSalud.gov**, or call the Health Insurance Marketplace Call Center at 1-800-318-2596. TTY users should call 1-855-889-4325. Visit **Marketplace.cms.gov** for Marketplace widgets and badges and other partner materials.