Health Care Reform, Behavioral Health, and the Criminal Justice Population

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Abstract

The 2010 Patient Protection and Affordable Care Act (ACA) has a number of important features for individuals who are involved with the criminal justice system. Among the most important changes is the expansion of Medicaid to more adults. The current study estimates that 10% of the total Medicaid expansion could include individuals who have experienced recent incarceration. The ACA also emphasizes the importance of mental health and substance abuse benefits, potentially changing the landscape of behavioral health treatment providers willing to serve criminal justice populations. Finally, it seeks to promote coordinated care delivery. New care delivery and appropriate funding models are needed to address the behavioral health and other chronic conditions experienced by those in criminal justice and to coordinate care within the complex structure of the justice system itself.

Overview

The 2010 Patient Protection and Affordable Care Act (ACA), health care reform, has a number of features that make it particularly salient for individuals who have had contact with the criminal justice system. First, it closes significant gaps in insurance coverage for younger adult men who have the highest rates of justice involvement and are among the most likely to be uninsured today; second, it emphasizes the importance of mental health and substance abuse benefits; and third, it seeks to promote coordinated care delivery. To understand the potential for the ACA to improve care for justice-involved individuals, it helps to understand the ways in which individuals have contact with the justice system, the size of the justice population, and their age, behavioral health, and health services profiles. This study provides evidence on the context and the behavioral health needs of the justice population. It discusses potential impacts of health reform, including state decisions, some of which have yet to be made. Challenges and recent models of care behavioral health care delivery tailored for the justice-involved population are also addressed.

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Background

The criminal justice population, broadly defined, includes individuals who are in the community under probation or parole supervision, those who are in jail, and those who are in state or federal prison serving longer sentences. Based on 2011 administrative data, an estimated 4.8 million individuals are on probation or parole at any given time and approximately 1.6 million are serving time in prison with sentences that are typically longer than 1 year.[1] Another 735,000 inmates are in local jails and are serving sentences typically of a year or less.[2] Household survey data confirm the large number of adults who have recent incarceration experience, i.e., within the past year. Data from the 2006 to 2010 National Survey of Family Growth show that among adult men living in the community, 4.1 million reported having been in jail or prison in the past 12 months. This question was not asked of women in the survey, but other data show that women make up 12% of jail inmates[3] and 7% of prison inmates.[1]

Because prison inmates typically serve longer sentences than jail inmates, prisons tend to offer a broader set of on-site health services to inmates. As inmates transition into the community and seek benefits, job training, and behavioral health services, prisons also tend to rely on more formalized step-down programs and halfway houses than jails. Much larger than the prison population, the jail-affected population includes over 4 million inmates who are released each year. Jails vary significantly in size and in the health services provided on-site to inmates, ranging from medical and behavioral health services in large urban facilities to a narrower range of services in smaller community jails. Jails are heterogeneous in their capacity to provide general medical and behavioral health services and they vary in their capacity to link and coordinate care with community providers when individuals reenter the community.

Health Insurance for Justice Populations under the ACA

The most significant change under the ACA for the justice-involved population is the expansion of health insurance coverage. Currently, the primary source of health insurance for adult males in the general population is insurance offered by employers to full-time employees and their dependents.[4] Only a small fraction of adult males purchase insurance on their own. By its very nature, the criminal justice system disrupts ties to employment. And, where work is delayed during reentry or where it is part-time, temporary, or low pay, employer-provided coverage may not be available. Among low-income adults in general, 40% have no insurance today, with percentages ranging from 12% in Massachusetts to 58% in Texas.[5] According to the 2006–2010 National Survey of Family Growth (NSFG), 51% of adult males who report being incarcerated in the past 12 months also lacked health insurance at some point in the past 12 months, compared to 29% of males who were not incarcerated. Among both groups, private health insurance was the most commonly reported type of coverage (40% of adult males who report incarceration compared to 67% for other adult males) followed by Medicaid or other state-sponsored coverage (17% of males who report incarceration compared to 6% for other adult males).

Under the ACA health insurance coverage is anticipated to expand significantly as most US residents will be required to obtain health insurance by January 1, 2014. Before the Supreme Court decision on the constitutionality of the ACA, the Congressional Budget Office (CBO) estimated that there would be roughly 30 million newly insured individuals. Assuming all states would expand their Medicaid programs, the CBO estimated 17 million newly covered eligible Medicaid beneficiaries and 23 million individuals covered by private health insurance made available through newly formed health insurance exchanges.[6] However, the Supreme Court decision in *National Federation of Independent Business v. Sebelius, 132 S. Ct. 2566* (2012) held that states could choose whether or not to expand eligibility for coverage under their Medicaid program pursuant to the ACA. Without any specific knowledge of which states might expand Medicaid, the

CBO scaled back its Medicaid expansion estimate to 10 million new beneficiaries.[7] The net estimate was that more individuals would purchase coverage through health insurance exchanges with federal subsidies, but more would also remain uninsured.

Medicaid eligibility expansion Medicaid is a shared federal-state program to provide health insurance coverage for low-income children and for adults who meet specific criteria. The federal government sets minimum thresholds for Medicaid eligibility but states can choose to exceed these within defined limits. Medicaid covers low-income adults who have disabilities and are receiving Supplemental Security Income (SSI). It also covers parents of dependent children who have low family incomes, roughly 40% of the federal poverty level. There is no federal requirement that states cover childless adults under Medicaid and most do not. In 2012, nine states fully covered poor childless adults, while 17 states provided partial coverage.[8] Among these states, seven had reached enrollment targets and, therefore, had closed enrollment.

The Medicaid expansion is potentially significant for justice-involved populations that tend to have lower-than-average incomes and where earnings drop to zero during incarceration. Although Medicaid has paid a relatively small role in providing health coverage to adult males in the past, its potential role grows dramatically under the ACA. Under the ACA's Medicaid expansion, states may include nondisabled adults up to 138% of the federal poverty level. Further, states are given a strong financial incentive to expand their Medicaid programs. Specifically, under the ACA, the federal government will pay 100% of the expansion cost initially and this share will drop gradually to 90% by 2020. This federal matching rate is higher for the Medicaid expansion group than for traditional Medicaid beneficiaries.

The impact of the Medicaid expansion is difficult to project precisely because few national, community surveys query recent incarceration and income. However, based on data from the 2006 to 2010 National Survey of Family Growth (NSFG), among adult males under age 65 who report having been in jail or prison in the past 12 months, 1.47 million or 35.9% report incomes below 138% of the federal poverty level, which will be the new Medicaid eligibility threshold. This likely overstates actual eligibility among men because not all former inmates will have lived in the USA sufficiently long to qualify for benefits despite low incomes. On this basis, as many as 7% of low income individuals would not qualify for Medicaid.[9] At the same time, the NSFG's 12-month incarceration question excludes women; therefore, the estimate should be adjusted upward accordingly. Women represent roughly 10% of the incarcerated population across prisons and jails.[1,3] As a result of combining estimates for men and women, 1.6 million adults who experienced jail or prison in the past 12 months are estimated to meet the income eligibility criteria under the Medicaid expansion (Table 1). This corresponds to roughly one in nine beneficiaries newly eligible for Medicaid.

The 1.6 million estimate represents the potential population, meaning the eligible population if all states were to expand their Medicaid programs to 138% of poverty. State reluctance to expand Medicaid may reduce this estimate by half or more. To date, not all states have made firm decisions as to whether they will expand their Medicaid programs by 2014. As of July 2013, 24 states were moving forward with Medicaid expansion, 21 were not, and in 6, the debate was still ongoing.[10]

State decisions around Medicaid Several financial factors are important for state decisions around expanding Medicaid. First, states can only receive the enhanced federal Medicaid payment amount if they expand their programs to cover individuals up to 138% of poverty. In contrast, states that elect partial expansions, up to some lower income level for example, will receive their traditional federal match rate, which is lower, from 50% to 73% depending on the state.[11] States that delay a full expansion remain eligible for enhanced federal matching even after 2014, but it must be a full expansion. Another factor is the potential for state savings from health care services provided to justice populations, costs that would otherwise be borne by state and local governments. State

Table 1
Individuals incarcerated in the past 12 months: estimated income eligibility for medicaid and insurance tax subsidies

	Number	Percent (%)
Medicaid income eligible (up to 138% FPL)#	1,637,487	35.9
Income eligible for insurance tax credits (139%–400% FPL)*#	2,022,614	44.3
Ineligible (greater then 400% FPL)**	907,353	19.9
Total	4,567,453	100.0

Author tabulations from the 2006 to 2010 National Survey of Family Growth

FPL federal poverty level

#Assumes males represent 90% of individuals incarcerated in the past 12 months and that 7% of low-income released offenders do not meet residency requirement for eligibility

*Offenders not financially eligible for Medicaid but eligible for tax credits, ignoring potential employer coverage

**Includes those estimated to not meet residency requirements for Medicaid eligibility or federal subsidies

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corrections departments spent 20% of their budgets on medical expenditures. The amount for medical services per inmate in 2010 ranged from $2,200 in Illinois to $11,986 in California with a national average of $5,697.[12] Jails also can incur high medical costs. For example, among the seven largest county jail systems in Florida, the average cost per inmate was $4,970 in 2009.[13]

Expanding Medicaid, however, does not mean that Medicaid will pay for all health services for Medicaid beneficiaries who are incarcerated. Beneficiaries who are eligible for Medicaid have their benefits suspended when they are incarcerated. Medicaid has strict rules that exclude care to inmates of public institutions under which, for example, outpatient services to inmates are not funded. Federal Medicaid matching funds only are available if an inmate is admitted to a medical institution, such as a hospital or nursing facility.[14] These facilities may not be on the premises of the jail, prison, or penal setting. States also cannot claim payments to safety net hospitals for care to inmates as part of their Medicaid disproportionate share programs. The rationale is that "the State is obligated to cover [inmates] basic economic needs (food, housing, and medical care) because failure to do so would be in violation of the eighth amendment of the Constitution".[14] Halfway houses represent a further complication for Medicaid coverage. Individuals in halfway houses, if they are under the auspices of the Department of Corrections, are still considered inmates despite living in the community, with the result that their behavioral health services are not eligible for federal Medicaid payments.

Nonetheless, some states have estimated substantial savings from inmates who would be newly eligible for Medicaid under a state expansion. Further, a number of states are moving to contain prison populations and increase community supervision.[15,16] For example, states have shortened sentences, expanded special courts, and other programs that treat drug and alcohol offenders they have shortened the length of probation for drug and property crimes making it less likely that individuals will violate parole and return to jail and they have increased funding to local corrections agencies for community supervision. These efforts will result in more justice-involved individuals living outside of institutions and, therefore, meeting Medicaid eligibility criteria. Other changes, such as expanding in-prison or in-jail treatment, will not affect Medicaid expenditures. In the longer run, states may reconfigure how inpatient services are delivered inside and outside of jails and prisons in order to maximize Medicaid funds under the expansion.

Delaware provides an illustration of how Medicaid can be adapted for the criminal justice population. Delaware is one of six states that have a unified correctional system, meaning it has no local jails. Inmates are not eligible for Medicaid during incarceration, but names are maintained on active lists. Furthermore, once an inmate is transferred to a hospital for at least 24 h of inpatient care, Medicaid will cover their care as long as the individual meets US residency requirements. Prior to release, inmates are assisted with Medicaid application forms and are assisted with medication and follow-up appointments for mental health and substance abuse treatment. Such activities have even greater potential impact under a Medicaid expansion.

Private health coverage through new insurance exchanges Starting in 2014, individuals who are not eligible for Medicaid can obtain insurance through new state health insurance exchanges or through their employers. Notably, the requirement to purchase coverage does not apply to individuals or families with incomes below the tax filing threshold (i.e., $9,750 for individuals and $19,500 for married couples in 2012). Incarceration may lead individuals who experience a reduction in their incomes to more closely weigh the perceived benefits of coverage against the premium cost. Exchanges will be the mechanism through which many low- and moderate-income individuals will receive premium and cost-sharing subsidies to make private health coverage more affordable, and where employees of small businesses will be able to purchase coverage. Tax credits for coverage purchased through an exchange will be available to people with incomes below 400% of the federal poverty level. With subsidies, individuals will pay up to 2% of their income toward health insurance if they are below 133% of the federal poverty level and up to 9.5% of income if they are between 250% and 400% of the poverty threshold. Furthermore, individuals and families who have incomes below 250% of poverty and who seek plans through health insurance exchanges will also be eligible for subsidies toward cost-sharing (i.e., co-payments and deductibles). Based on the NSFG, with adjustment for the lack of female respondents in portions of the survey, as many as 2 million (44%) individuals incarcerated in the past year would be eligible for premium subsidies (Table 1). This does not take into account that people who have coverage through their employer generally would not be eligible for tax credits. On the other hand, the proportion would be higher in states without Medicaid expansions.

Similar to the Medicaid provisions, individuals who are incarcerated are not eligible for exchange coverage. However, unlike Medicaid, the ACA exempts individuals who are incarcerated "pending the disposition of charges," i.e., individuals who are pre-trial detainees. This makes it more likely that their coverage will be maintained as they move through brief detention, but the provision is administratively complex. For example, some individuals may be charged later in their corrections episode but their time in pre-trial detention may be counted as time served. Consequently, reconciling when an inmate qualifies as a pre-trial detainee could be more cumbersome than it currently is under Medicaid.

Separately, the exchanges are required to engage in consumer information and outreach and must coordinate with Medicaid programs. From the perspective of the justice system, a robust outreach and collaboration with probation and parole entities would be highly desirable.

The health of the criminal justice population

Among the greatest needs of jail and prison inmates is treatment of mental health and substance abuse disorders. Over 12% of federal prison inmates and over 25% of state prison and jail inmates report at least one previously diagnosed mental health condition.[17] There are significant differences across a range of mental disorders between individuals with incarceration histories and those without histories.[18] The largest differential is with respect to substance use disorder. High substance use partly reflects sentencing policies, such as

mandatory minimum penalties for drug offenses. Nearly half (48%) of inmates in federal prison were serving time for drug offenses in 2011, compared to slightly more than a third (35%) who were incarcerated for public-order crimes.[1]

In addition to alcohol and substance use, HIV is another important risk behavior for justice populations.[19,20] Table 2 shows responses from the 2006 to 2010 NSFG related to questions on alcohol, substance, and HIV risk behaviors. As noted, this data source has the advantage of asking male respondents about both incarceration and risk behaviors and of providing insights into the community population with recent incarceration experience. Only 36% of respondents who were incarcerated in the past year did not endorse on any of these three behavioral risks. HIV risk behaviors, alone and in combination with alcohol or substance use, were endorsed by 11% of respondents with incarceration experience. Questions related to at-risk drinking and binge drinking and use of other substances (marijuana, crack, cocaine, crystal/meth, or injection of non-prescription drugs), show that 53% of individuals engaged in at-risk alcohol or substance use or both. The rate among those potentially eligible for Medicaid was lower, approximately 46% (data not shown).

Other sources find that trauma and sexual victimization rates in jail are higher than reported in community,[21] further indicating potential interventions needs. In addition to these mental health needs, inmates have been found to have higher rates of hypertension, asthma, and arthritis that are higher than the general population even after controlling for race, education, and other socioeconomic differences.[22] They are also at high risk of death after release from prison—for instance from overdose, cardiovascular disease, and homicide—relative to population averages, particularly in the first 2 weeks after release.[23] These patterns highlight the high overall need for services, and for services that occur in a timely manner.

Behavioral health delivery and the justice population

Today, community behavioral health providers deliver a significant amount of care to the criminal justice population. According to the 2010 Treatment Episode Data Set (TEDS), which captures admissions to alcohol or drug treatment in facilities, 37% of all referrals to substance abuse providers were from the criminal justice system, highlighting the prominence of the criminal justice population in today's substance abuse treatment landscape (Fig. 1). Referrals within the criminal justice system can come from a diverse set of actors including police, probation officers, and judges, and referrals might be for pre-trial or post-trial detainees. Of the criminal justice referrals with further information in TEDS, 35% were from probation or parole, 29% from courts,

Table 2

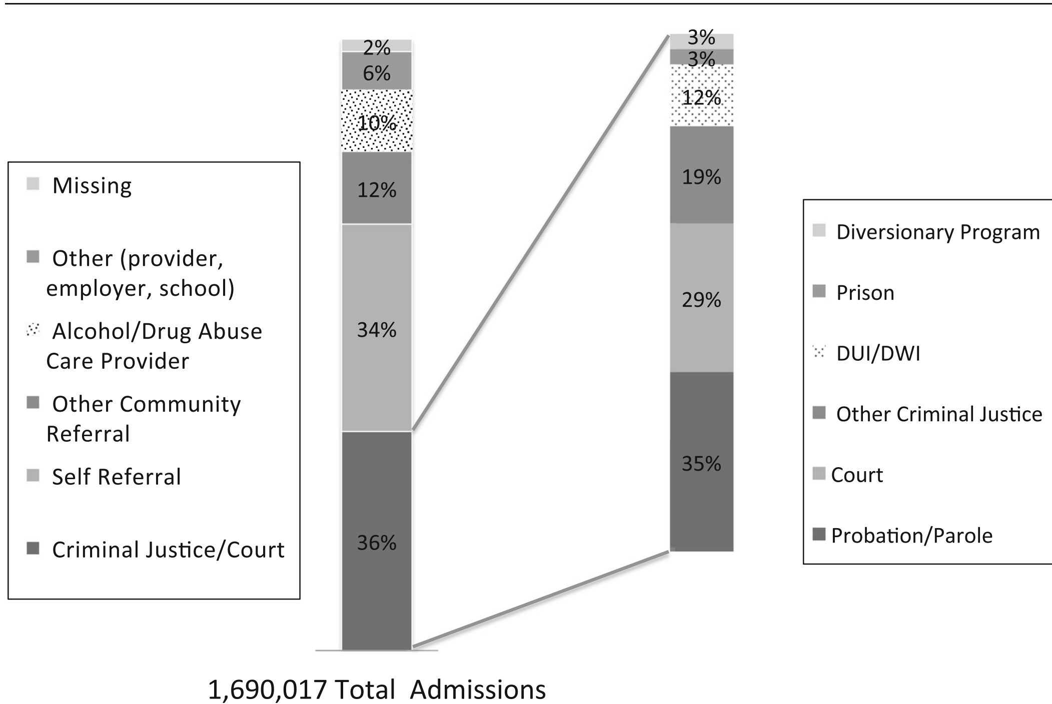
Men incarcerated in the past 12 months: risk behaviors for alcohol abuse, drug abuse, and HIV

Risk	Number	Percent (%)
No reported risk	1,489,264	36.2
Alcohol abuse risk only	849,344	20.7
Drug abuse risk only	482,540	11.7
Alcohol and drug abuse risk	847,148	20.6
HIV risk	148,388	3.6
Alcohol abuse and HIV risk	64,808	1.6
Drug abuse and HIV risk	117,443	2.9
All 3 risk behaviors	111,771	2.7
Total	4,110,706	100.0

Author tabulations from the 2006 to 2010 National Survey of Family Growth

Figure 1

Admissions to substance abuse treatment providers, by Referral Source. Source: Treatment Episode Data Set, 2010



12% from DUI programs, and only 3% were from prisons. This indicates that prisons currently play a very small role as a direct referral source for outpatient, community-based services, although former prisoners may be accessing services as parolees.

Separately, the 2011 National Survey of Substance Abuse Treatment Services (N-SSATS) finds that approximately 90% of mental health and substance abuse providers accept criminal justice clients into treatment. Specialized programming for the criminal justice population plays a larger role for providers that treat substance abuse than providers that treat mental illness alone. The 2011 N-SSATS shows that 30% of providers that offer both mental health and substance abuse services have specialized programming for the justice population, compared to 26% of providers that offer only substance abuse treatment and 17% that offer only mental health treatment.

Nonetheless, offender surveys have found that substance treatment services are underutilized and the quality of community treatment is frequently low.[24] Substance abuse treatments also have been found to be poorly integrated with other medical care and gaps have been noted in HIV-related services.[25–27] Lack of insurance coverage, staff training, and patient acceptance have been cited as barriers to the integration of care such as HIV into substance abuse treatment programs.[28]

Generally speaking, the substance abuse delivery system is characterized by many small providers that frequently are understaffed. One third of addiction treatment settings do not contract with a physician or have one on staff; moreover, fewer than one half employ masters-level counselors or above.[29] Only 13% of providers of substance abuse treatment offer pharmacotherapies; pharmacotherapies are more common if the provider offers both mental health and substance abuse services, according to N-SSATS data.

Mental health delivery presents a somewhat different picture. Two of its important features are the prominent role of non-specialty mental health providers and the diversity of service providers. Almost two thirds of physician office visits for a mental health disorder are to primary care physicians and a third are to psychiatrists.[30] This underscores the role of primary care in mental health services delivery to the general adult population. Other non-specialty settings involved in mental health include community correctional facilities, such as halfway houses, pre-release or work release centers, among which 47% reported mental health screening and 35% reported therapy/counseling.[31] In addition to these providers, there are approximately 1,100 community health centers nationally, of which 77% provide mental health treatment and counseling but only 51% provide substance abuse treatment and counseling.[30] Community health centers provided almost three times as many mental health encounters as substance abuse encounters in 2007, a gap that has widened significantly since 1998.[32]

The potential influx of Medicaid-eligible individuals with criminal justice involvement will represent a large change for existing treatment providers. According to N-SSATS, only 27% of facilities accept Medicaid and this does not differ by whether or not they offer criminal justice programming. It is highly likely that a significant Medicaid expansion that includes low-income adults will mean that more providers become willing to accept Medicaid payment. Exactly how many are likely to participate is difficult to predict. Medicaid fee levels are lower than those of other payers in most states, but as long as fees cover the marginal cost of providing care to patients, providers should be willing to serve at least some Medicaid patients.[33] Other research on provider participation in Medicaid finds that administrative hassles create a strong deterrent to provider participation as do difficulties working with Medicaid beneficiaries, even after controlling for provider fee levels.[34,35] These studies have not focused necessarily on behavioral health treatment providers.

Insurance benefits and behavioral health under the ACA

The mental health and substance abuse treatment system has tended to be less robust than other parts of health care delivery system, in part because coverage from insurance and Medicaid has been comparatively lacking. In the individual health insurance market today, for example, 34% of enrollees do not have coverage for substance abuse services and 18% of enrollees do not have coverage for mental health services,[36] although coverage for these services is more common in large plans.[37] More funding will result from the ACA's private insurance and Medicaid expansions, but also from new requirements that certain types of insurance must include behavioral health services.

Under health care reform, the newly insured population, whether through Medicaid or new small or individual insurance market plans, will have insurance that covers essential health benefits. As defined by the ACA and subsequent regulations, these essential health benefits include mental health and substance abuse disorder treatment, as well as preventive and wellness services and chronic disease management. Furthermore, these services must be covered at parity with medical and surgical benefits. For many years behavioral health and medical benefits were not on equal footing, with behavioral health being subject to higher co-payments, greater deductibles, and coverage limits than general medical care. The federal Mental Health Parity and Addiction Equity Act of 2008 required that mental health and substance abuse care be covered like other medical care, at least in large-group health insurance plans. However, the law did not require that health insurance include any behavioral health benefits, only that they be equivalent if offered. Research has found parity legislation increased the use of behavioral health services by removing significant financial barriers.[38–40] The health reform law extends parity beyond large groups to include small groups and individual coverage and requires that both mental health and substance abuse services be covered.

Medicaid benefits for expansion populations Under the ACA, states will have choices around the benefits that will be covered for their newly Medicaid-eligible populations. Today, Medicaid covers extensive mental health services and services, such as targeted case management, components of supported employment, and assertive community treatment, and wrap-around services that are important for people with complex chronic conditions. By comparison, coverage for substance abuse treatment under Medicaid is frequently limited in amount and by type of provider.[41] Under the ACA, states can choose to offer the same full Medicaid benefits or more limited benchmark plans for any newly covered populations. However, Medicaid benchmark plans must offer essential health benefits, including mental health and substance abuse treatment. Parity provisions also apply to these benefits. Ultimately, the specific coverage will depend on state benefits or benchmark plans, leading to persistent state variation.

Health benefits under exchanges Insurance plans that participate in the state health exchanges will be required to offer the federally defined essential health benefits package. Moreover, parity provisions will apply. However, the benefits need not be offered across states with identical coverage limits or cost-sharing. Each state will define essential health benefits by following one of the following benchmark plans: one of the three largest products in the small group market in the state; one of the three largest state employee health plans; one of the three largest health plans offered to federal or state employees, or the Health Maintenance Organization with the largest commercial enrollment in the state. States may require additional benefits and the scope of benefits may vary across plans. Benefits must be offered at four levels of value, making comparisons across plans easier. The coverage requirement that minimally meets the insurance mandate is significantly less generous, and with a lower premium, than what most people have today.

Ultimately, an increase in funding for behavioral health services is expected under health care reform, stemming from private insurance and Medicaid coverage combined with newly defined essential health benefits. As a result, more funding for behavioral health will be tied to private insurance and Medicaid coverage than in the past. Providers of behavioral health services to justice-involved populations will need to adapt to an environment where fewer funds are tied to state and federal grants. This means greater adoption of financial information and billing systems, professional credentialing to meet insurers' network requirements, and the ability to track the amount and quality of care delivered.

Primary care and the ACA

The ACA places a strong emphasis on care provided in primary care settings which has somewhat uncertain implications for the criminal justice population. In anticipation of greater demand for health care as a result of greater insurance coverage, the ACA requires states to raise their Medicaid fees to primary care providers in 2013 and 2014. The increase is estimated to result in fees that are 73% higher on average than in 2012.[42] It is not known how many more primary care providers will choose to participate in Medicaid as a result. Further, we have little information on what role primary care plays in the delivery of behavioral health services to the justice-involved. However, research has found that in the general population, there has been an increase in mental health care provided by primary care physicians. This shift has been attributed to greater insurance coverage for mental health through Medicaid, insurance parity, and technology changes along with innovations in pharmaceuticals and screening tools for common mental disorders.[43] As a corollary, some anticipate that in the wake of the ACA, care delivery for substance abuse will also shift to the non-specialty substance abuse service system,[29] including primary care. In addition to raising Medicaid fees to primary care providers, the ACA emphasizes and rewards care coordination and

chronic disease management through primary care medical homes. These models could be adapted to address the unique needs of the justice-involved.

Care coordination and chronic disease management

Expanded insurance coverage alone is unlikely to address the full range of behavioral health challenges faced in the justice system or the complexities of managing chronic general health and behavioral health conditions. Several provisions in the ACA related to care coordination are encouraging.

The ACA promotes new care delivery models for individuals with chronic conditions, including medical or health homes models. These models have enormous potential. Primary care medical homes receive financial support specifically to manage chronic conditions and coordinate care across a range of care settings. A related program under Medicaid, called health homes, relies on specialty-based providers to take on the full range of patients' primary and specialty care needs. A number of professional groups have outlined basic features of medical homes or developed accreditation standards. Many of the suggested care process improvements for medical homes focus on improving transitions from inpatient to ambulatory settings and articulate roles for both the inpatient and the outpatient setting in order to improve safety and reduce readmissions (see for instance Sokol and Wynia, 2013).[44] These recommendations span comprehensive health assessment, medication management, and patient activation among other components and could benefit justice-involved individuals with complex chronic conditions. For criminal justice populations, these medical homes should not only focus on general medical care transitions, they also should have strong ties to mental health and substance abuse treatment providers.

Yet, the reality for justice-involved population is that even maintaining medications can involve a primary care provider in the community, a behavioral health specialist, a jail upon arrest, a prison upon sentencing, a halfway house or probation supervision upon release, each playing a role in care delivery.[45] Ideally, medical homes would coordinate with corrections and probation departments not only around continuity of medications and treatment from prison to community, but also around benefit enrollment, and have a basic understanding of probation terms and court orders.

The Veterans Administration (VA) has made in-roads in this area.[46] The Veterans Justice Outreach program offers outreach and case management to veterans when they are initially detained, have court contact, or are involved in drug treatment court. The Healthcare for Reentry Veterans Program offers outreach to veterans incarcerated in state and federal prison and referrals and short-term case management upon reentry. Procedures are developed whereby staff can enter facilities to meet with veterans and connections have been made to veterans in over 1,000 prisons nationwide. Staff in these programs, including mental health social workers, psychologists, and addictions clinicians, function as program coordinators and clinical service providers and frequently have correctional system experience. The operationalization of the program depends on the local context. At various transition or "intercept points" in the correctional system, staff identify veterans and their needs, link them to care, and assist with access barriers. Longer term case management is offered to those involved in treatment court. Separately, three states are participating in VA projects under which information is shared on jail and prison inmates who are veterans in order to further assist case managers from VA Medical Centers who reach into the facilities, help transmit health information care, and coordinate care upon reentry. Similar information exchange would need to take place for medical home providers to track inmates through the various points in the corrections process, coordinate care, and maintain continuity of care. Significant investment will be required for up-front planning and operationalizing of procedures. Ongoing funding will be needed to support the additional burden that these coordination activities impose on medical home providers.

Implications for Behavioral Health

The ACA has the potential to improve behavioral health care for offenders in several ways: (1) Medicaid will be expanded significantly for childless adults who have income below 138% of the federal poverty level; (2) insurance exchanges will be created through which individuals can receive federal subsidies to purchase private coverage; (3) insurance coverage will be more likely to cover mental health and substance abuse services, and (4) numerous initiatives are created to address fragmented care for individuals with chronic conditions.

The Medicaid expansion under the ACA will provide among the greatest improvements for justice-involved individuals, making it more likely that they will seek needed behavioral health treatment. More than a third of this population is likely to qualify for Medicaid in states that elect to expand coverage. In all, nearly 10% of the total Medicaid expansion could include individuals who have experienced recent incarceration.

Previous experience with mental health care shows that mental health delivery benefitted from a combination of expanded Medicaid coverage for people with disabilities and expanded private coverage through mental health parity. This bodes well for behavioral health services under the ACA and in particular for substance abuse services. Both Medicaid expansion benefits and exchange health plans will be required to offer mental health and substance abuse services, both with parity. This coverage should lead to greater insurance-based financing for behavioral health care. In light of high rates of mental health and substance abuse disorders, this is a potentially very important development for offenders.

In contrast, in states that do not expand Medicaid, traditional behavioral health treatment facilities that treat the criminal justice population could be particularly hard hit. In such states, at a time when states are scaling back their prison populations and turning to community alternatives, there will be less financial support to bolster a treatment system that is fragmented, and where low-income individuals frequently cannot find care when it is needed

While expanding coverage under Medicaid would likely provide the greatest improvement, other relatively modest changes to Medicaid could also be meaningful. One example is to assure that Medicaid benefits are placed under suspension status during incarceration but not terminated.[47] This option has been available to states for some time and significantly facilitates reenrollment. Further, the VA has issued a policy change with respect to veterans in halfway houses. Unlike Medicaid, veterans are now eligible for VA benefits upon release from jail or prison whether or not they are released to halfway houses. Possibly, Medicaid will revisit its policy with respect to halfway houses. Under the ACA preparing documentation or actively processing Medicaid applications may also become more likely in prisons. Many jails, by comparison, are not likely to actively engage in enrollment and outreach as turnover is very high; the average weekly turnover in jails is over 60%.[3]

Another possibility is to improve enrollment among those who are eligible once they are in the community. Actively assisting inmates, either pre-release or post-release, to enroll in health plans will remove financial barriers to treatment. While application for Medicaid and exchange coverage is intended to be substantially simpler under the ACA, inmates frequently lack necessary identification documents and require verification of incarceration dates to determine eligibility. Historically, only 50% to 75% of individuals who are eligible for Medicaid have enrolled.[48] As a larger number of justice-involved individuals become eligible for Medicaid, outreach will require new forms of collaboration between criminal justice, Medicaid, exchanges, and behavioral health providers.[9]

The landscape of behavioral treatment providers is likely to shift under the ACA, particularly for those who serve the criminal justice population. Many are likely to professionalize, join provider networks, and adopt information systems that allow them to track enrollee expenditures and quality of care and bill insurance plans for services. Some may further partner with medical homes or

become health homes, in order to be eligible for incentives to coordinate and manage chronic care. Whether these incentive payments will be substantial enough to address the full set of health challenges for the justice population is not known. At the same time, some substance abuse delivery may shift to primary care settings.

Finally, the high health care needs and complex social conditions of the justice-involved could pose new challenges for health plans. Outreach and enrollment, including behavioral health treatment sites, are key steps under reform. The VA provides examples of outreach models designed for justice populations. The VA also incorporates care coordination across criminal justice transitions, lending important lessons for medical home initiatives. Evidence-based treatment models are needed that take into account newly available funding and which incorporate the multiple medical and justice transitions experienced by those who are justice-involved. Developing medical and health home models that can address offenders' complex health and behavioral health could be beneficial to both public health and safety.

Conflict of Interest The authors report no conflicts of interest.

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