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

Peter Coolsen is court administrator for the Circuit Court of Cook County, Criminal Division, Chicago, IL. Contact him at peter.coolsen@cookcountyil.gov.

Maureen McDonnell is director for Business and Health Care Strategy Development at TASC, Inc. TASC works on building alternate supervision, diversion, and reentry programs that link people under justice supervision who have substance use and psychiatric disorders with community services and supervision.

RESOURCES

1. Public Law 111-148, The Patient Protection and Affordable Care Act, Government Printing Office at http://www.gpo.gov/fdsys/pkg/PLAW-111publ148/pdf/PLAW-111publ148.pdf.

2. Applications for ACA-based Medicaid expansion will be based on residency and income only, unlike the complex and lengthy disability-based Medicaid applications that many justice and health agencies are familiar with today.

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.

4. Wang EA, White MC, Jamison R, Goldenson J, Estes M and Tulsky JP. "Discharge Planning and Continuity of Health Care: Findings From the San Francisco County Jail." *American Journal of Public Health*, 98(12):2182-84, 2008.

5. DePietro B, Eggleston A, Osher F, Justice Center, The Council of State Governments, Frequently Asked Questions: Implications of the Federal Health Legislation on Justice-Involved Populations, 2011, http://reentrypolicy.org/jc_publications/faqs-implications-of-the-federal-legislation-on-justice-involved-populations/FAQs_Federal_Health_Legislation_on_Justice_Involved_Populations_REV.pdf. U.S. citizens and legal residents are covered under the provisions of ACA. Undocumented residents are not eligible for expanded insurance under ACA. Kaiser Commission, *Summary of New Health Reform Law*, April 15, 2011, http://www.kff.org/healthreform/upload/8061.pdf.

6. Kaiser Commission, IBID.

7. Congressional Budget Office (CBO), Letter to Speaker Pelosi from CBO director Douglas W. Elmendorf. March 20, 2010, http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/113xx/doc11379/amendreconprop.pdf.

8. *National Federation of Independent Businesses et al. v. Sebelius*, 567 U.S. _____, 132 S.Ct.2566 (2012)..

9. The National Health Law Program, Prepared for the American Public Health Association, The Supreme Court's ACA Decision & Its Implications for Medicaid, July 27, 2012.

10. Wang, Op Cit.

11. The National Center on Addiction and Substance Abuse (CASA) at Columbia University. *Behind Bars II: Substance Abuse and America's Prison Population* (New York: Columbia University, February 2010).

12. Steadman H, Osher F, Robbins PC, Case B and Samuels S, *Estimates on the Prevalence of Adults with Serious* Mental Illnesses in Jails, Psychiatric Services 60 (June 2009): 761–65.

13. Urban Institute, *Life After Lockup: Improving Reentry from Jail to the Community*, New York, May 2008.

14. McDonnell M, Brookes LG, Lurigio A, Baille D, "Realizing the Potential of National Health Care Reform to Reduce Criminal Justice Expenditures and Recidivism Among Jail Populations," Presented at the COCHS Conference, November 2010, Washington, DC.

15. Mancuso D and Felver BEM. *Providing Chemical Dependence Treatment to Low-income Adults Results in Significant Public Safety Benefits*. Olympia, WA: Washington State Department of Social and Health Services Research and Data Analysis Division, 2009.

16. Justice Policy Institute, *Substance Abuse Treatment and Public Safety*, January 2008. http://www.justicepolicy.org/uploads/justicepolicy/documents/08_01_rep_drugtx_ac-ps.pdf.

17. Kirby P, Ferguson W, Lawthers A, Post-Release MassHealth Utilization, Center for Health and Policy Research, University of Massachusetts Medical School.

18. Veterans who currently receive comprehensive health benefits through the Veterans Administration have access to care through this system, and may not see additional benefit from expanded coverage through health care reform. For those veterans without comprehensive VA benefits, national health reform may create greater access to insurance and, therefore, to health care. Veterans courts may see an expansion of available benefits for this population.

19. Almquist L, Dodd E, 2009. *Mental Health Courts: A Guide to Research-Informed Policy and Practice.* Council of State Governments, Justice Center, New York, p. 2.

20. Dvorak A, "Northwest suburban mental health agencies say they're hurt by state cuts." August 27, 2012, *Daily Herald*, Arlington Heights, Illinois.

21. Telephone interview in November, 2011 with Terre Marshall, PhD., director of Mental Health Services, Cermak Health Services, Cook County Jail.

22. This information was provided by Terre Marshall, director of Mental Health Services, Cermak Health Services, Cook County Health and Hospital System, at a meeting on health care reform, October 10, 2012.

23. Marcus, Matthew M.D., director of Forensic Clinical Services, Circuit Court of Cook County, Internal Report, October 2012.

24. These states/territories expanded coverage to all or some low-income adults, regardless of disability, before July 2011: Arizona, Indiana, New York, Pennsylvania, Vermont, Washington, Wisconsin, and the District of Columbia. Kaiser Commission, *Expanding Medicaid to Low-Income Childless Adults under Health Reform: Key Lessons from State Experiences*, July 2011, http://www.kff.org/medicaid/upload/8087.pdf. Additional states expanded Medicaid coverage early under ACA: Connecticut, Minnesota, California, New Jersey. Illinois advanced a proposal to expand Medicaid coverage under this option as well. "State Pushes Cook County Medicaid Plan," *State Journal Register*, January 31, 2012. http://www.sj-r.com/breaking/x370663192/State-pushes-Cook-County-Medicaid-plan.