

A CONTINUING EDUCATION FORUM



JOINT TRAINING PARTNERSHIP

Health Care Reform and County Criminal Justice Systems

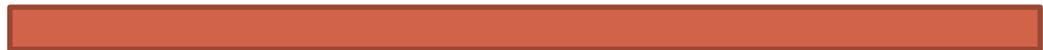
*An introduction to health care reform and the
opportunities and challenges for county criminal
justice systems*

COURSE MATERIALS

April 5, 2013



Presented by the Crime and Justice
Institute in collaboration with
California State Association of
Counties, California State Sheriffs'
Association, and the Chief
Probation Officers of California.





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Health Care Reform and County Criminal Justice Systems

**An introduction to health care reform and the
opportunities and challenges for county criminal justice systems**

April 5, 2013

Healthcare Reform and County Criminal Justice Systems – the first in a series – provides an overview on how the upcoming changes in the California healthcare system will impact local criminal justice systems. Speakers discuss the relationship between healthcare and the criminal justice population, and compare healthcare today with anticipated healthcare in the years to come under the Affordable Care Act. Speakers highlight efforts counties can take today to further maximize existing resources and address the healthcare needs of the criminal justice population. Question and answer periods are included to encourage open dialogue and information sharing.

Agenda

Times are approximate

- | | |
|-------|---|
| 10:00 | <p>Welcome and Introductions</p> <ul style="list-style-type: none"> ◆ Diane Cummins, Special Advisor to the Governor on Realignment, and Bill Chiat, Dean, CSAC Institute, provide an overview of the day and highlight the importance of the topic |
| 10:15 | <p>Public Health and Public Safety: The critical intersection of healthcare and recidivism</p> <ul style="list-style-type: none"> ◆ Topics include the healthcare needs of the criminal justice population, types of services that can meet these needs, challenges this population faces in accessing healthcare and related policy implications. ◆ Steve Rosenberg, President, Community-Oriented Correctional Health Services (COCHS) |
| 11:15 | <p>Healthcare for Today and Tomorrow: A comparison between how healthcare works today and how it will work in 2014 and beyond.</p> <ul style="list-style-type: none"> ◆ Topics include the current Medi-Cal program, eligibility and enrollment, and the intersection with the local criminal justice system; and what to expect as we enter 2014 including the California Health Benefit Exchange (Covered California), the Medi-Cal expansion, and the eligibility for coverage. ◆ Len Finocchio, Associate Director, Department of Health Care Services; and David Panush, External Relations Director, Covered California |
| 12:45 | <p>Lunch (provided)</p> |
| 1:30 | <p>Laying out a framework: An overview of what counties can be doing today to leverage existing resources and to prepare for 2014.</p> <ul style="list-style-type: none"> ◆ Panel discussion to include current strategies to leverage existing resources to address rising offender healthcare costs, steps to take to prepare for healthcare reform in 2014, where to go for more information and resources. ◆ Cathy Senderling, Deputy Director, California Welfare Directors Association, TBD County Representative, and Paul Beddoe, Associate Legislative Director – Health, National Association of Counties |
| 3:30 | <p>Summary and Closing</p> |



Presented by the Crime and Justice Institute in collaboration with California State Association of Counties, California State Sheriffs' Association, and the Chief Probation Officers of California.



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Health Care Reform and County Criminal Justice Systems COURSE FACULTY

Diane M. Cummins

Diane Cummins currently serves as the Special Advisor to the Governor on State and Local Realignment. She officially retired in 2008 after a distinguished 31-year career in California government, but has been brought back to advise the Governor in an area of her particular expertise.

Ms. Cummins was appointed Chief Fiscal Policy Advisor to the President pro tem of the State Senate in January, 1999. In that capacity, Ms. Cummins served as the primary staff for the Senate on fiscal matters related to the State Budget, major initiatives and legislation. She was the primary staff person representing the pro tem in budget negotiations with the Governor's Office and the Assembly. Ms. Cummins also advised the President pro tem on issues related to revenue and taxation policy and issues in the Human Services program area. Prior to her appointment in the Senate, Ms. Cummins served as the Chief Deputy Director, Budgets in the Department of Finance where she acted as a key advisor to the Governor and was the Governor's primary contact with the Legislature in budget matters. During her 21-year tenure in the Department of Finance, Ms. Cummins was a key staff person on several major policy initiatives, including 1991 Realignment, the 1997 state assumption of trial court funding, the 1997 state welfare reform effort which resulted in the state CalWORKs program and Foster Care Reform.

William Chiat

Bill Chiat (pronounced 'shy-at') is Dean of the California State Association of Counties Institute for Excellence in County Government. His expertise spans 33 years in local government

with executive positions in state, county and city governments, including County Executive Officer of Napa County. Bill also served as Executive Director of the Arizona Governor's Office for Excellence in Government. From 2004 until October 2012 Bill was Executive Director of the California Association of Local Agency Formation Commissions. He provides organizational development, continuing education and facilitation services to local governments throughout the West through his consultancy practice, Alta Mesa Group LLC.

Bill has a B.S. from the University of Minnesota and a M.S. from the University of Michigan. He is a graduate of the Senior Executives in State and Local Government Program from Harvard's Kennedy School of Government. He has research and taught numerous courses in public agency leadership, structure, governance and operations.

Steve Rosenberg

President, Community-Oriented Correctional Health Services (COCHS)

Steve Rosenberg has more than 30 years of experience providing technical assistance and directing projects that increase access to health care for the most vulnerable populations in our nation. He founded Community Oriented Correctional Health Services (COCHS) in 2006 to develop a public health approach to serving the population of people who cycle through jails, and to connect them to community-based health care. Mr. Rosenberg is a specialist in health care policy and finance with expertise in Medicaid and correctional health.

Community Oriented Correctional Health Services (COCHS) is a non-profit organization that works to build partnerships between jails

and community health care providers. Its goal is to establish medical homes for offenders in their communities. The organization's objectives include supporting changes in public policy and practice that promote access to health preventive and treatment services both in jail and in partner community institutions; insuring that local health care systems are in place to treat jail-involved populations; improving the ability of jails to connect offenders with health care; and, developing health care delivery systems that are financially viable and sustainable.

Leonard J. Finocchio, Dr.P.H.

Associate Director, California Department of Health Care Services

Dr. Finocchio is responsible for implementation of Medicaid provisions of the Affordable Care Act. He coordinates the work on eligibility, benefits, managed care, information technology and legislative analysis. He also serves as liaison with California Health Benefit Exchange on eligibility and enrollment, information technology and legislative affairs. Previously Dr. Finocchio was a Senior Program Officer with California Healthcare Foundation. He holds a Doctorate of Public Health from the University of Michigan Pew Doctoral Program in Health Policy and an MPH from the University of California, Los Angeles.

David Panush

Director, External Affairs, Covered California

As the Director of External Affairs, David provides executive leadership for the ongoing legislative and regulatory policy and related activities for the Exchange. Panush previously was the Health Policy Advisor to California Senate President Pro Tempore Darrell Steinberg. He has been a key policy consultant in the Office of the President Pro Tempore since 1986, and has advised the past five State Senate leaders on a variety of policy and fiscal issues.

Cathy Senderling

Cathy Senderling is the Deputy Executive Director for the County Welfare Directors Association of California. In that role she works with the Association's Executive Director and the human services directors in all 58 of California's counties to promote legislative, budget and policy changes that improve health and human services programs and the delivery of those services. Prior to joining CWDA in August 2000, Cathy served as the California Senate Budget Committee Consultant for social services programs and a Fiscal and Policy Analyst for the California Legislative Analyst's Office. She has a Bachelor of Journalism degree from the University of Missouri at Columbia and a Master's degree from the Heinz School of Public Policy and Management in Pittsburgh, PA.

Paul V. Beddoe, Ph.D.

Associate Legislative Director – Health, National Association of Counties

Paul Beddoe joined the National Association of Counties as an Associate Legislative Director in November 2000. He manages NACo's health policy development and advocacy. Prior to joining NACo, he served as a Policy Analyst for the Idaho Association of Counties in Boise from 1998, coordinating advocacy on a range of county issues before the Idaho legislature and state and federal agencies. Raised in Boise, he earned a bachelor's degree from the Master's College in Santa Clarita, California, and a doctorate from Scotland's University of St. Andrews. While working for Idaho's counties, he taught part-time as an adjunct professor of history at Boise State University. His misspent youth included an extended stint teaching English as a second language in Athens, Greece.

Public Health and Public Safety: Explaining the Critical Intersection of Healthcare and Recidivism

Public Health and Public Safety: Explaining the Critical Intersection of Healthcare and Recidivism

Prepared for
The Joint Training Partnership
Forum on Health Care Reform and County Criminal Justice Systems
April 2013



COMMUNITY ORIENTED CORRECTIONAL HEALTH SERVICES
Linking Community Health and Public Safety



COMMUNITY ORIENTED CORRECTIONAL HEALTH SERVICES
Linking Community Health and Public Safety

Health Reform: Public Health, Public Safety

- The Patient Protection and Affordable Care Act (“Health Reform”) creates new opportunities for individuals who seek health care, but also creates new opportunities for local jurisdictions that are responsible for the public health and safety of their residents.
- Eligibility for Medi-Cal and Covered California insurance coverage will be expanded under Health Reform to qualified adults, many of whom may be jail-involved.

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COMMUNITY ORIENTED CORRECTIONAL HEALTH SERVICES
Linking Community Health and Public Safety

Health Reform: Public Health, Public Safety

The COCHS Approach: Jails and Community Health

- Public safety and public health systems are intertwined.
- The health of the jail population is similarly intertwined with the health of the community outside of jail.
- Connecting health care in jails to health care in the community preserves the investment counties make in their vulnerable criminal justice-involved populations.

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Public Health and Public Safety: Explaining the Critical Intersection of Healthcare and Recidivism



Health Reform: Public Health, Public Safety

Presentation Overview

1. Who's in jail and what are their health care needs?
2. Why does Health Reform matter to the jail-involved population?
3. What are the related policy implications?

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Health Reform: Public Health, Public Safety

- Jail inmates are disproportionately young, male, persons of color, and poor.
- They have high rates of health problems (chronic and infectious disease, injuries), psychiatric disorders, and substance use disorders.
- 80% of detainees with a chronic medical condition have not received treatment in the community prior to arrest.

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Jails as Behavioral Health Care Providers

- Jails have become *de facto* behavioral health providers in many communities, a role for which they are not adequately equipped to meet the need.
 - A 2009 study estimated current prevalence rates of serious mental illness among adult jail inmates to be 15% for males and 31% for females.
 - Among jail detainees with a diagnosed mental illness, 75% of women and 72% of men have a co-occurring substance use disorder.

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Public Health and Public Safety: Explaining the Critical Intersection of Healthcare and Recidivism



Jails as Behavioral Health Care Providers

The ADAM II 2011 Report

- Over 60% of arrestees in all sites tested positive for at least one drug in their system, and fewer reported having received outpatient drug or alcohol treatment in the prior year—less than 10% in 8 of the 10 sites.
- 13 - 38% of arrestees tested positive for multiple substances.
- 13 - 30% of arrestees said they had been arrested two or more times in the prior year.

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Health Reform: Public Health, Public Safety

- Few people in jail or prison today are enrolled in Medicaid because they have not been eligible as single, childless adults.
- Currently, 90% of detainees have no health insurance upon release from jail.

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Health Reform: Public Health, Public Safety

- Nationally, only about 4% of jail admissions result in sentences to prison.
- OR, in other terms...
- 96% of jail detainees and inmates return *directly* to the community from jail, along with their often untreated health conditions.

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Public Health and Public Safety: Explaining the Critical Intersection of Healthcare and Recidivism



Massachusetts Uninsured

- According to a recent NASADAD study, less than 3% of Massachusetts residents are uninsured, but the uninsured residents “are likely to have elevated rates of chronic SUDs.”
- In fact, approximately 22% of the admissions for publicly funded SAT in MA in 2009 were uninsured. The uninsured population was disproportionately low-income and young adult, Black, and Hispanic, characteristics that mirror the demographics of the jail-involved population.

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Washington State: “The Mancuso Effect” Reduced Crime / Improved Health & Safety

- When chemical dependency treatment was offered to very low income adults—a population very similar to the jail population—research found:
 - improved physical and mental health and significant cost savings in health care
 - reduced crime and recidivism, and correlated savings to crime victims and criminal justice systems

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Washington State: “The Mancuso Effect” Reduced Crime / Improved Health & Safety

- The next two slides illustrate the savings reported by Dr. David Mancuso, Senior Research Supervisor, Department of Social and Health Services.
 - Mancuso, D, Felver, B. *Bending the Health Care Cost Curve by Expanding Alcohol/Drug Treatment*, Washington State DSHS Research and Data Analysis Division, RDA Report 4.81 (Sept 2010).
 - Mancuso, D, Felver, B. *Providing chemical dependency treatment to low-income adults results in significant public safety benefits*, Washington State DSHS Research and Data Analysis Division, Report 11.130 (Feb 2009).
 - Mancuso, D, Felver, B. *Health Care Reform, Medicaid Expansion and Access to Alcohol/Drug Treatment: Opportunities for Disability Prevention*, DSHS, RDA Report 4.84 (Oct 2004).

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Public Health and Public Safety: Explaining the Critical Intersection of Healthcare and Recidivism



Projected Statewide Medi-Cal Eligibility in 2014 for Jailed Individuals: Male, Aged 18-24 (May 2012, pre-AB 109)

- Approximately **69%** of jail-involved male individuals between the ages of 18 and 24 in the state of California may be eligible for Medi-Cal benefits in 2014.

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Health Reform: Public Health, Public Safety

- The LAO recently reported that, “As the 2011 realignment continues to be implemented, the number of offenders sentenced to county jail and county probation likely will increase significantly.”

California's Criminal Justice System: A Primer. Prepared by Mac Taylor, California Legislative Analyst's Office, January 2013: <http://www.cdcr.ca.gov/Reports/docs/External-Reports/criminal-justice-primer-011713.pdf>

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Why Health Reform Matters

Health Reform:

1. Expands eligibility for Medi-Cal to some of our most vulnerable citizens for the first time.
2. Includes coverage for behavioral health care (mental health and substance abuse treatment) at parity with physical health care.

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Public Health and Public Safety: Explaining the Critical Intersection of Healthcare and Recidivism



Why Health Reform Matters, cont'd

3. Allows “qualified individuals” to enroll in a qualified health plan and participate in a health insurance exchange while incarcerated in a correctional institution *pending disposition of charges*. This same provision may be extended to Medi-Cal.
4. Promotes the use of health information technology (HIT).

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1. The Expansion of Medi-Cal Eligibility

- Medi-Cal will be available to a new category of citizens: those people with income up to 138% FPL, regardless of health status, age, gender, or parental status.
- COCHS estimates that about 2/3 of the jail-involved population will be eligible for Medi-Cal under the expansion, creating access to health care for many individuals for the first time.
- Eligibility will not be precluded if an individual is incarcerated.

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2. Behavioral & Physical Health Care Parity

- California has yet to determine its benefit package for behavioral health.
- Under Health Reform, coverage for mental health and substance abuse services is supposed to be provided “at parity”—to the same degree that physical healthcare services are delivered.

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Public Health and Public Safety: Explaining the Critical Intersection of Healthcare and Recidivism



Behavioral & Physical Health Care Parity, cont'd

- Without access to care, many jail-involved individuals will be repeat users of emergency room services and inpatient psychiatric services in the community, and jail health services as “frequent flyers.”
- From a fiscal perspective, it will be in the interest of the state and counties to offer effective behavioral health treatment to Medi-Cal and Covered California beneficiaries.

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3. Health Plan Coverage for Offenders Pending Disposition of Charges

- Health Reform requires each state to create or participate in a health insurance exchange for qualified individuals and small businesses to buy subsidized health insurance.
- Californians with income from 138–400% FPL will be able to purchase plans through Covered California, the health benefit exchange offering premium support beginning in 2014.

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Health Plan Coverage for Offenders Pending Disposition of Charges, cont'd

- Federal legislation regarding Health Insurance Exchanges specifies that: “[a]n individual shall not be treated as a qualified individual if, at the time of enrollment, the individual is incarcerated, *other than incarceration pending the disposition of charges.*”
- This means that, subject to the requirements of health plans, jail health care providers may be reimbursed for qualified services they deliver to Covered California beneficiaries who are *incarcerated while pending disposition of charges.*

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Public Health and Public Safety: ***Explaining the Critical Intersection of Healthcare and Recidivism***



Health Reform: Public Health, Public Safety

- Nationally, the average stay in jail for a sentenced inmate is about 3 months, although on any given day, 62% of detainees have not been sentenced.
- In California, in 2011, approximately 70% of the county jail population was unsentenced, pending disposition by the court.

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4. Health Reform Promotes the Use of Health Information Technology

- Correctional authorities may increase continuity and coordination of care between jail and community providers through health information technology.
- Electronic health records (EHRs) can facilitate health care transitions, save staff time, contribute to patient safety, and offset the costs of some of the new, expanded roles for correctional facilities by reducing medical record staffing requirements.

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Health Reform Promotes the Use of Health Information Technology, cont'd

- Health Reform legislation provides incentives to health care providers to adopt and use EHR systems in "stages."
- Medi-Cal providers eventually will have to meet a requirement to use EHR systems to submit claims for reimbursement for delivering qualified services.
- Jail health care providers will have to adopt these same standards to participate in Medi-Cal.

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Covered California: Understanding Health Benefits

Covered California Overview

David Panush
Director, External Affairs
Covered California

April 5, 2013
California State Association of Counties
Healthcare Reform and the County Criminal Justice Systems



Covered California Governance Independent Public Entity with Qualified Board

Board Members:

Diana Dooley, Board Chair and Secretary of the California Health and Human Services Agency, which provides a range of health care services, social services, mental health services, alcohol and drug treatment services, income assistance and public health services to Californians

Kim Belshé, Executive Director of First 5 LA (Los Angeles), former Senior Policy Advisor of the Public Policy Institute of California, former Secretary of California Health and Human Services Agency, and former Director of the California Department of Health Services

Paul Fearer, Senior Executive Vice President and Director of Human Resources of UnionBankCalCorporation and its primary subsidiary, Union Bank N.A., Board Chair of Pacific Business Group on Health, and former board chair of Pacific Health Advantage

Robert Ross, M.D., President and Chief Executive Officer of The California Endowment, previous director of the San Diego County Health and Human Services Agency from 1993 to 2000, and previous Commissioner of Public Health for the City of Philadelphia from 1990 to 1993

Susan Kennedy, Nationally-recognized policy consultant, former Deputy Chief of Staff and Cabinet Secretary to Governor Gray Davis, former Chief of Staff to Governor Arnold Schwarzenegger, former Communications Director for U.S. Senator Dianne Feinstein, and former Executive Director of the California Democratic Party



Covered California Vision & Mission

Vision

- Improve the health of all Californians
- Access affordable care
- Provide high quality care.

Mission

- Increase insured Californians
- Improve health care quality
- Lower costs
- Innovative, competitive marketplace
- Choice & value



Covered California: Understanding Health Benefits

Key Dates

- **Fall 2013**
Pre Enrollment begins
- **January 1, 2014**
Coverage begins
- **January 1, 2015**
Federal funding ends



Major Activities 2013 - 2014

- **Qualified Health Plans (QHPs).** Evaluate, select, certify and contract with QHP issuers to provide coverage through the individual and SHOP exchanges.
- **Marketing, Outreach, Education.** Refine and implement marketing, outreach, and public education program leading to the first open enrollment period in 2013 and 2014.
- **California Health Eligibility, Enrollment & Retention System (CalHEERS).** Refine, test and bring online.
- **Small Business Health Options Program (SHOP).** Establish to serve small employers and their employees.



Subsidies Available to help with Cost

A "sliding scale" subsidy will be provided based on income for individuals and families earning between 138 and 400 percent of the federal poverty level. The size of the subsidy depends on both the income and family size of eligible individuals.

The table below illustrates the tax credit subsidy for a family of four at several income levels.

Assumes: 2014 projected income of a 45 year-old policyholder and the family buys a plan that has a 70 percent actuarial value (the policyholder would be responsible for 30 percent of all covered benefits, the health insurer would be responsible for the remaining 70 percent). Does not include cost-sharing which is also available.

Percent of FPL	Annual Income	Unsubsidized Annual Premium	Annual Tax Credit	Annual Premium after Tax Credit	Unsubsidized Monthly Premium	Monthly Premium Credit	Monthly Premium after Credit
150%	\$35,137	\$14,245	\$12,840	\$1,405	\$1,187	\$1,070	\$117
200%	\$46,850	\$14,245	\$11,294	\$2,952	\$1,187	\$941	\$246
300%	\$70,275	\$14,245	\$7,569	\$6,676	\$1,187	\$631	\$556
399%	\$93,700	\$14,245	\$5,344	\$8,901	\$1,187	\$445	\$742



Covered California: Understanding Health Benefits

Essential Health Benefits

The Patient Protection Affordable Care Act requires health plans and health insurers that offer coverage in the small group or individual market, inside and outside of the Exchange, to cover specified categories of benefits.

These Essential Health Benefits categories are:

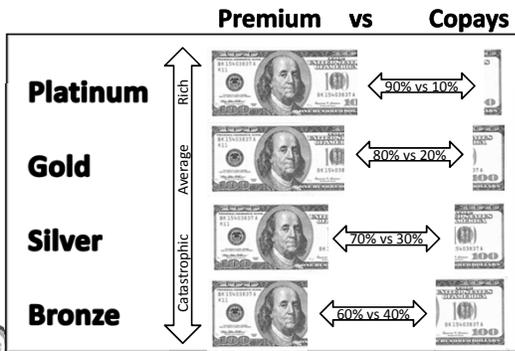
- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder services, including behavioral health treatment
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services, including oral and vision care

With the signing of SB 951 and AB 1453, state law has established the Kaiser Small Group HMO 30 as the EHB benchmark plan in California.



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Consumers Trade Off Up Front Affordability with expected Out-of-Pocket Costs



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Making Care More Affordable

<p>PREMIUM 2.6 million Californians eligible for subsidized care pay a % of their income; Federal government pays balance</p>	<p>OUT-OF-POCKET COST Standardized benefits limit out of pocket costs based on sliding scale; Most copays are not subject to deductibles</p>	<p>AFFORDABLE CARE True transparency on up front and out of pockets costs.</p>
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Covered California: Understanding Health Benefits

2014 Standard Plans for Individuals – Key Benefits

	Platinum	Gold	Silver	Bronze
COPAYS IN THE GREEN SECTIONS ARE NOT SUBJECT TO ANNUAL DEDUCTIBLE AND COUNT TOWARD THE ANNUAL OUT-OF-POCKET MAXIMUM			CATEGORIES IN BLUE ARE SUBJECT TO DEDUCTIBLES	
Preventive Care Copay	No Cost – 1 Ann Visit	No Cost – 1 Ann Visit	No Cost – 1 Ann Visit	No Cost – 1 Ann Visit
Primary Care Visit Copay	\$20	\$30	\$45	\$60 for 3 Visits
Specialty Care Visit Copay	\$40	\$50	\$65	\$70
Urgent Care Visit Copay	\$40	\$60	\$90	\$120
Emergency Room Copay	\$150	\$250	\$250	\$300
Lab Testing Copay	\$25	\$30	\$45	30%
X-Ray Copay	\$40	\$50	\$65	30%
Generic Medication Copay	\$5 or less	\$20 or less	\$25 or less	\$25 or less
High cost and infrequent services like Hospital Care, Outpatient Surgery, and Imaging (MRI, CT, Pet Scans).	HMO Outpatient Surgery – \$250; Hospital – \$250 per day up to 5 days PPO 10%	HMO Outpatient Surgery – \$600; Hospital – \$600 per day up to 5 days PPO 20%	HMO Outpatient Surgery – \$600; Hospital – \$600 per day up to 5 days PPO 20%	30% of Your Plan's Negotiated Rate
Brand Medications may be subject to an Annual Deductible before you Pay the Copay	None	None	\$250 Drug Deductible then you pay the Copay Amount	No Separate Drug Deductible
Preferred Brand Copay After Deductible is Paid	\$15	\$50	\$50	\$50
ANNUAL MAXIMUM OUT-OF-POCKET COST TO YOU	\$4,000 for you and \$8,000 for your family	\$6,400 for you and \$12,800 for your family	6,400 for you and \$12,800 for your family	6,400 for you and \$12,800 for your family

Covered California's 2014 Sliding Scale Plans – Family of 4

Annual Income	\$23,550 - \$35,325	\$35,325 - \$47,100	\$47,100 - \$58,875	\$58,875 - \$94,200
Monthly Consumer Cost (Minimum and Maximum)	\$39 - \$118	\$118 - \$247	\$247 - \$395	\$395 - \$746
COPAYS IN THE GREEN SECTIONS ARE NOT SUBJECT TO ANY DEDUCTIBLE AND COUNT TOWARD THE ANNUAL OUT-OF-POCKET MAXIMUM			BENEFITS IN BLUE ARE SUBJECT TO EITHER A MEDICAL DEDUCTIBLE, DRUG DEDUCTIBLE OR BOTH	
Deductible (if Any)	No Deductible	No Deductible	\$1500 Medical Deductible	\$2000 Medical Deductible
Preventive Care Copay	No Cost – 1 Annual Visit	No Cost – 1 Annual Visit	No Cost – 1 Annual Visit	No Cost – 1 Annual Visit
Primary Care Visit Copay	\$3	\$15	\$40	\$45
Specialty Care Visit Copay	\$5	\$20	\$50	\$65
Urgent Care Visit Copay	\$6	\$30	\$80	\$90
Lab Testing Copay	\$3	\$15	\$40	\$45
X-Ray Copay	\$5	\$20	\$60	\$65
Generic Medication	\$3	\$5	\$20	\$25
Emergency Room Copay	\$25	\$75	\$250	\$250
High cost and infrequent services like Hospital Care, Outpatient Surgery, and Imaging (MRI, CT, Pet Scans)	HMO Outpatient Surgery – \$250; Hospital – \$250 per day up to 5 days PPO 10%	HMO Outpatient Surgery – \$600; Hospital – \$600 per day up to 5 days PPO 20%	20% or Your Plan's Negotiated Rate	30% or Your Plan's Negotiated Rate
Brand Medications May be subject to Annual Drug Deductible before the Copay	No Deductible on Brand Drugs	\$50 Brand Drug Deductible then you pay the Copay Amount	\$250 Brand Drug Deductible then you pay the Copay Amount	\$350 Brand Drug Deductible then you pay the Copay Amount
Preferred Brand Copay After Drug Deductible	\$5	\$18	\$30	\$50
MAXIMUM OUT-OF-POCKET FOR ONE	\$2,250	\$2,250	\$5,200	\$6,400
MAXIMUM OUT-OF-POCKET FOR FAMILY	\$4,500	\$4,500	\$10,400	\$12,800

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Covered California Plan Affordability: Family of 4 with Annual Income of \$23 - 35K

Prevention

1 Free Annual Prevention visit

Office Visits \$6 or less

Selected Benefits



Premium:
\$39 - \$118 / mos

Contribution

No Deductible

Max Out of Pocket \$4,500

Generic Rx \$3

Urgent Care \$6

Lab X-Ray \$10 or less

E.R. \$25

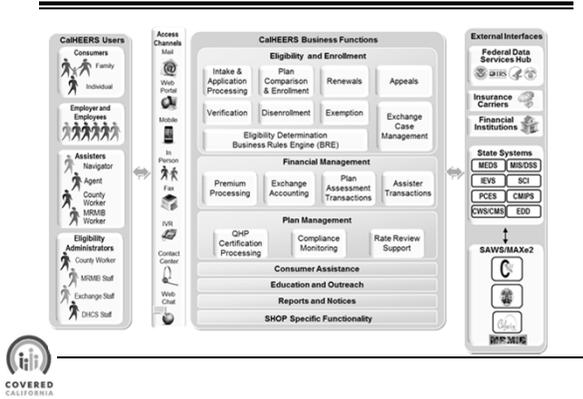


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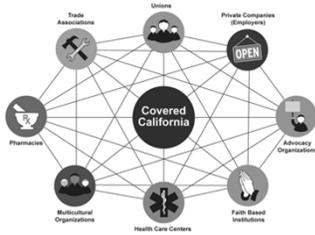
Covered California: Understanding Health Benefits

CalHEERS Business Function Overview



Community Mobilization

- Providing a stakeholder engagement framework for our Community Based grants and In-person Assisters program to reach strategic points of entry where people "live, work, shop, and play."



Community Mobilization

- Extending paid media through grassroots public relations, media relations and community outreach.
 - Community-based grants program, funded at \$43M over 2013-2014
 - Mobilizing and Educating key influencers
 - Launching key milestone events
 - Establishing market driven partnerships
 - Managing educational outreach and enrollment



Covered California: Understanding Health Benefits

In-person Assistance & Navigator Programs

- Assistance delivered through trusted and known channels will be critical to building a culture of coverage to ensure as many consumers as possible enroll in and retain affordable health insurance.
- The need for assistance will be high during the early years, with some estimates ranging from 50% to 75% of applicants needing assistance to enroll.
- The in-person assisters and navigators will be trained, certified and registered with the Exchange in order to enroll consumers in Covered California products and programs.



Paid Media

- Paid media is designed to reach broad and targeted audiences in urban and rural markets across the state.
- Will target all multicultural channels and allow messages in 13 threshold languages.
- Paid media has a “halo” effect on all aspects of the outreach and education program, improving performance in those areas.



Customer Service Center

- The Service Center will respond to general inquiries, provide assistance with enrollment, support retention and help those who enroll in Covered California
- Estimate 850 staff for the period from initial implementation in 2013 through December 31, 2014
- A significant share of staff will be hired as permanent intermittent staff to accommodate fluctuations in demand between open enrollment periods and other times of the year
- Current plans call for staff to be located in 3 separate facilities:
 - The main facility will be in Sacramento
 - A secondary facility targeted for southern/central California
 - A third facility will be located at a County-based site





Counties and Medi-Cal for Inmates: Current Rules – Future Considerations

Counties and Medi-Cal for Inmates: Current Rules/Future Considerations

Cathy Senderling-McDonald, CWDA
Presentation to CSAC Institute
April 5, 2013

Overview of Presentation

- Current Medi-Cal rules for county inmates
- Medical Probation and Compassionate Release
- Juvenile Requirements
- Affordable Care Act changes
- Implications for counties
- Questions?

Current Medi-Cal Enrollment Rules

Counties and Medi-Cal for Inmates: Current Rules – Future Considerations

Current Rules

- Whether someone is Medi-Cal *eligible* is a different question from whether the service rendered to them can be *claimed*
 - Governed by both federal and state rules
 - Federal rules more flexible on eligibility, less so on claiming
- Eligibility = can they be actively enrolled into Medi-Cal or have eligibility suspended (rather than terminated) while they are incarcerated?
- Claiming = can county (or another provider) claim federal reimbursement for services rendered during incarceration?

Eligibility Rules: County Inmates

- Counties may enroll both adult and juvenile inmates into Medi-Cal while they are incarcerated
 - Process piggy backs off of existing eligibility processes
 - Processed by county human services agency eligibility worker
- Complicating factor: While CDCR has been granted authority to act on behalf of state inmates to complete and sign the Medi-Cal application, county jail staff do not have this automatic statutory authority.
 - Title 22 California Code of Regulations (CCR) Section 50163 provides that the applicant or the spouse of the applicant must sign the Statement of Facts, with some exceptions
 - Authorized representative may be designated by the individual

Basic Medi-Cal Eligibility Process

- Inmate signs authorized representative form giving jail staff the ability to act on their behalf
 - Staff at the hospital or other county health facility may help the inmate complete the Medi-Cal application once this consent is given
- County jail submits application to county human services
- County human services determines eligibility for Medi-Cal
 - Applicants determined eligible for Medi-Cal are given an appropriate aid code and eligibility is shown in MEDS and respective county eligibility system(s)
 - Inmate applicants found eligible for Medi-Cal will not receive a Benefits Identification Card (BIC). The county jail facility should instead be given the eligibility information that is necessary for administration of the program



Counties and Medi-Cal for Inmates: Current Rules – Future Considerations

Jail Staff Responsibilities

- Identify county inmates admitted for covered inpatient services off the grounds of the correctional facility
- Obtain Authorized Representative form from the inmate
- Work with inmate to complete and sign off Medi-Cal paperwork
- Forward completed Medi-Cal applications and documentation to county eligibility workers
- Forward medical records, if a disability determination packet is needed
- Receive eligibility information from county eligibility workers regarding an inmate's Medi-Cal determination
- Inform the county when the inmate is released, paroled, or transferred

Eligibility Worker Responsibilities

- Determines Medi-Cal eligibility for county inmates
- Performs annual redeterminations and ongoing case maintenance
- Performs SB 87 eligibility redeterminations for county inmates who are released
- Provides infants born to pregnant county beneficiaries with deemed eligibility and processes/forwards disability determination packets to the Disability Determination Services Division-State Programs (DDSD-SP), if required

How Is Eligibility Determined?

- All income and property for an inmate must be counted (or exempted) in accordance with current Medi-Cal rules.
- No income or property is exempt for an inmate applicant solely because the individual is an inmate.
- Inmates must also meet linkage requirements (such as having a disability) which will remain in place until 2014, in order to be found Medi-Cal eligible.
 - May necessitate submission of a disability packet to CDSS for review and determination (can be lengthy process)



Counties and Medi-Cal for Inmates: Current Rules – Future Considerations

Potential LIHP Eligibility

- Counties may also assess for LIHP eligibility if inmate is not Medi-Cal eligible (most likely due to lack of linkage)
- LIHP eligibility may be assessed by either county human services department or county health department depending on how the county has structured its LIHP eligibility system

Complicating Factors

- Voluntary completion of the Medi-Cal or LIHP application by the inmate can be a difficult process for determining eligibility for the Medi-Cal and LIHP programs
- In order to establish Medi-Cal or LIHP eligibility for a county inmate, the inmate must provide all of the information necessary to determine eligibility
- Current Medi-Cal rules are extremely complex and it can take some time to process applications
- Disability evaluations can take many weeks, if not months, to be processed by CDSS

Claiming Rules: County Inmates

- Assembly Bill (AB) 1628 (Chapter 729, Statutes of 2010) and Senate Bill (SB 92) (Chapter 36, Statutes of 2011) authorize the California Department of Corrections and Rehabilitation (CDCR) and the Department of Health Care Services (DHCS) to draw down federal funds for:
 - Medi-Cal-covered **inpatient hospital services**
 - provided to eligible State and County adult and juvenile inmates
 - **off the grounds** of the correctional facility
- Key: Only **inpatient** hospital services provided **off the grounds** of the facility are covered by federal Medicaid
 - Would not cover someone going off grounds to a hospital for treatment that does not result in admission to that hospital

Counties and Medi-Cal for Inmates: Current Rules – Future Considerations

County Claiming Process

- County pays hospital for inpatient services at contracted rate
- County submits claims through DHCS Fiscal Intermediary (FI) via data exchange*
- DHCS FI adjudicates claim to determine Medi-Cal rate and payment data*
- DHCS generates invoice & forwards invoice to DHCS Accounting*
- DHCS Accounting claims federal funds based on Medi-Cal rate and authorizes the State Controller's Office (SCO) to issue check for federal reimbursement to County*
- DHCS claims FFP (claimable) 50/50 (FFP back to County)*

*County claiming process is in review, per DHCS

County Inmate Aid Codes

- **Aid Code F3 Medi-Cal no SOC* for County Inmates.**
Medi-Cal-covered inpatient hospital services only, for eligible inmates in correctional facilities who receive those services off the grounds of the correctional facility.
- **Aid Code G3 Medi-Cal with SOC for County Inmates.**
Medi-Cal-covered inpatient hospital services only, for eligible inmates in correctional facilities who receive those services off the grounds of the correctional facility.
- **Aid Code F4 Medi-Cal no SOC for undocumented County Inmates.** Restricted - Hospital inpatient emergency (Title XIX) and pregnancy-related (Title XXI) services, for eligible inmates who, while in a county correctional facility, receive those services off the grounds of the correctional facility.
- **Aid Code G4 Medi-Cal with SOC for undocumented County Inmates.** Restricted - Hospital inpatient emergency and pregnancy-related services, for eligible inmates who, while in a county correctional facility, receive those services off the grounds of the correctional facility.

*SOC = "Share of Cost"

Medical Probation/
Compassionate Release



Counties and Medi-Cal for Inmates: Current Rules – Future Considerations

County Option Created in State Law

- SB 1462 (Chapter 837, Statutes of 2012) authorizes a county sheriff, or designee, to compassionately release or request the court resentence a prisoner from a county jail to medical probation, if the prisoner:
 - does not pose a threat to public safety.
 - has a life expectancy of six months or less.
 - is physically incapacitated, or needs long term care.
- Counties are required to pay the non-federal share of Medi-Cal expenditures for a medical probationer or county inmate compassionately released for the period of time the offender would have otherwise been incarcerated.
- If the county determines that the former inmate can provide for their own medical care once compassionately released or granted medical probation, the county is not be required to pay the former inmate’s medical expenses.

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Eligibility for Compassionate Release

County Sheriffs are authorized to release a prisoner from a county correctional facility on compassionate release if:

- The sheriff in consultation with a physician determines that the inmate has a **life expectancy of six (6) months or less**.
- The sheriff determines the prisoner would not reasonably pose a threat to public safety.
- The sheriff notifies the presiding judge of the superior court of his or her intention to release the prisoner.
- A placement option for the prisoner is secured and a CWD or other applicable county agency examines the prisoner’s eligibility for Medi-Cal or other medical coverage.

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Eligibility for Medical Probation

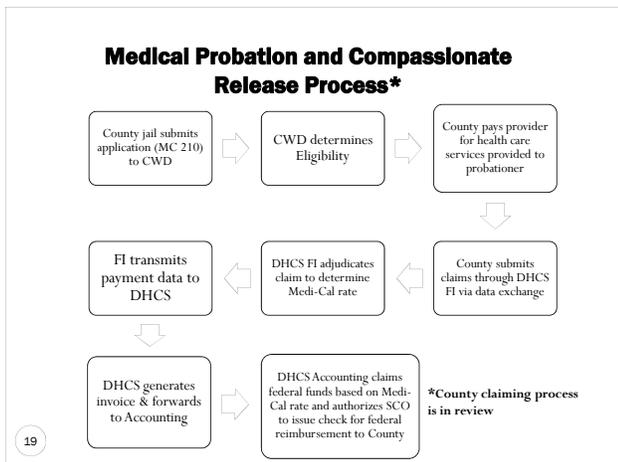
County Sheriffs are authorized to **request** medical probation if:

- A prisoner is physically incapacitated with a medical condition that renders the prisoner permanently unable to perform activities of basic daily living, requiring 24-hour care, if that incapacitation did not exist at the time of sentencing.
- A prisoner would require acute long-term inpatient rehabilitation services.
- A placement option for the prisoner is secured and applicable county agency determines the prisoner’s eligibility for Medi-Cal or other medical coverage.
- If at any time the court determines, based on a medical examination, that the probationer’s medical condition has improved to the extent that the probationer no longer qualifies for medical probation, the court may return the probationer to the custody of the sheriff.

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Counties and Medi-Cal for Inmates: Current Rules – Future Considerations



Juvenile Inmates

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SB 1147 Requirements

- Senate Bill (SB) 1147 (Chapter 546, Statutes of 2008) required county human services departments to suspend Medi-Cal eligibility for up to one year for minors incarcerated in juvenile detention facilities
- Effective January 1, 2010, SB 1147 requires restoration of Medi-Cal benefits on the day an eligible juvenile is no longer an inmate of a public institution.
- The requirements of SB 1147 apply to juveniles who:
 - Are Medi-Cal beneficiaries at the time of incarceration
 - Comply with all annual redetermination requirements during their period of incarceration
 - Remain otherwise eligible for Medi-Cal during their period of incarceration;
 - Are no longer considered an inmate of a public institution within one year of their incarceration date
 - Are eligible on the day they are released.

Counties and Medi-Cal for Inmates: Current Rules – Future Considerations

SB 1469 Requirements

- Prior to the passage of SB 1147, SB 1469 (Chapter 657 Statutes of 2006) required DHCS to develop a Medi-Cal application process so that juveniles who are incarcerated in specified county detention facilities for 30 days or longer can establish Medi-Cal eligibility immediately upon release if they are determined eligible
- Per SB 1469, a county detention facility is required to notify the county human services agency when juveniles are to be released
 - Under SB 1147, counties can use that information to add eligible juveniles back into family Medi-Cal cases or update MEDS with the suspension stop date
- The two processes required by SB 1469 and SB 1147 are intended to work together to make Medi-Cal more accessible to newly released juveniles who are Medi-Cal eligible

AB 396 Option for Counties

- Assembly Bill (AB 396) (Mitchell, Chapter 394, Statutes of 2011) authorizes DHCS to develop a process to allow counties and CDCR, Division of Juvenile Facilities (DJF), to receive any available FFP for acute inpatient hospital services and inpatient **psychiatric services** provided to Medi-Cal eligible juvenile inmates admitted into a hospital off the grounds of the correctional facility.
- This process must be coordinated, to the extent possible, with the processes implemented for adult inmate claiming and can only be implemented for counties that elect voluntarily to provide the nonfederal share of expenditures for health care services provided to eligible juvenile inmates.
- AB 396 took effect on January 1, 2012.

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State Juvenile Inmate Aid Codes

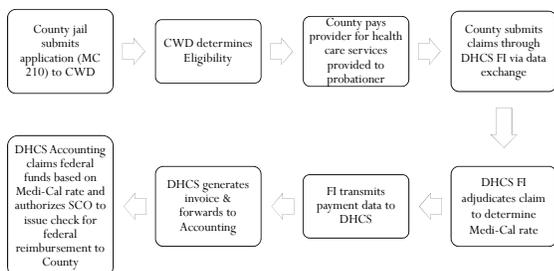
- **Aid Code G1**--Title XIX, Medi-Cal no share-of-cost (SOC) for State Juvenile Inmates. Medi-Cal benefits limited to covered inpatient hospital and inpatient mental health services only, for juvenile inmates in state correctional facilities who receive those services off the grounds of the correctional facility.
- **Aid Code G2**--Title XIX/Title XXI, Medi-Cal no SOC for **undocumented** State Juvenile Inmates. Medi-Cal benefits limited to covered inpatient hospital emergency and inpatient mental health emergency (Title XIX) and inpatient pregnancy-related (Title XXI) services only, for juvenile inmates in state correctional facilities who receive those services off the grounds of the correctional facility.

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Counties and Medi-Cal for Inmates: Current Rules – Future Considerations

County Juvenile Inmate Process*



*County claiming process is in review

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County Juvenile Inmate Aid Codes

- **Aid Code G5**--Title XIX, Medi-Cal no SOC for County Juvenile Inmates. Medi-Cal benefits limited to covered inpatient hospital or inpatient mental health services only, for juvenile inmates in county correctional facilities who receive those services off the grounds of the correctional facility.
- **Aid Code G6**--Title XIX/Title XXI, Medi-Cal no SOC for undocumented County Juvenile Inmates. Medi-Cal benefits limited to covered inpatient hospital emergency, inpatient mental health emergency (Title XIX) and inpatient pregnancy-related (Title XXI) services only, for juvenile inmates in county correctional facilities who receive those services off the grounds of the correctional facility.
- **Aid Code G7**--Title XIX, Medi-Cal SOC for County Juvenile Inmates. Medi-Cal benefits limited to covered inpatient hospital or inpatient mental health services only, for juvenile inmates in county correctional facilities who receive those services off the grounds of the correctional facility.
- **Aid Code G8**--Title XIX/Title XXI, Medi-Cal SOC for undocumented County Juvenile Inmates. Benefits limited to inpatient hospital inpatient mental health emergency (Title XIX) and inpatient pregnancy-related (Title XXI) services only, for juvenile inmates in county correctional facilities who receive those services off the grounds of the correctional facility.

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Adult and Juvenile County Inmates

Similarities

- County is responsible for non-federal share of medical expenditures
- County inmate must receive covered inpatient services off the grounds of the correctional facility
- County inmate must meet all Medi-Cal eligibility requirements such as, linkage, deprivation, alien/citizenship/national status, income, and property

Differences

- In addition to inpatient hospital health care services, juvenile inmates receive coverage of inpatient mental health services received off the grounds of the correctional facility
- The juvenile inmate program is only available for individuals up to age 21

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Counties and Medi-Cal for Inmates: Current Rules – Future Considerations

Affordable Care Act Changes

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Changes in ACA

- ACA makes changes to *eligibility*, but little change to *claiming*
- *Eligibility* will become somewhat easier
 - Will allow childless non-disabled adults to receive Medi-Cal
 - LIHP population will transition into Medi-Cal
 - Based on income reported to IRS
 - No asset test
- For *claiming* purposes:
 - Newly eligible inmates will be eligible for 100% federal funds
 - Still limited to inpatient hospital stays (for adults/juveniles) and inpatient mental health (for juveniles)

2014 ACA aid codes for county adult inmates

- **Aid Code N7**--Title XIX, Medi-Cal no SOC for County Adult Inmates. Medi-Cal benefits limited to covered inpatient hospital services only, for adult inmates aged 19 through 64 years of age in county correctional facilities who receive those services off the grounds of the correctional facility.
- **Aid Code N8**--Title XIX/Title XXI, Medi-Cal no SOC for **undocumented** County Adult Inmates. Medi-Cal benefits limited to covered inpatient hospital emergency, and inpatient pregnancy-related (Title XXI) services only, for adult inmates aged 19 through 64 years of age in county correctional facilities who receive those services off the grounds of the correctional facility.

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Counties and Medi-Cal for Inmates: Current Rules – Future Considerations

Implications for Counties

- AB 109/Realignment overlaps
 - Behooves county to enroll all eligible inmates while incarcerated or as they are being released
 - Will help with re-entry to community
 - Will draw down 100% county funds for newly eligible childless adults and LIHP transitioned eligibles starting in 2014
 - Can help ensure continuation of county safety net providers
- Still limited as far as coverage while incarcerated
 - But will help offset county costs when major illness occurs
- Start now to build communication with human services
 - May also find eligibility for CalWORKs, CalFresh (SB 283)

Questions?

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Health Care Reform and County Criminal Justice Systems ONLINE RESOURCE

A variety of resource materials have been recommend by the faculty and are available for you to review and download at a special website created for this class. Listed below are some of the materials you will find. To download these and other materials, including copies of today's presentations, lease visit:

<http://tinyurl.com/cjhealthcare>

Medicaid Coverage for Individuals in Jail Pending Disposition: Opportunities for Improved Health and Health Care at Lower Costs

Marsha Regenstein, PhD and Jade Christie Maples, Department of Health Policy, School of Public Health and Public Services, George Washington University. November 2012.

Who's in Jail? This background fact sheet details who in fact populates our nation's jails. It includes demographic information as well as the health status of those incarcerated.

Medicaid and Criminal Justice: The Need for Cross-System Collaboration Post Health Care Reform

Allison Hamblin, Stephen A. Somers, Sheree Neese-Todd and Roopa Mahadevan of the Center for Health Care Strategies, Inc.

Medicaid Expansion and The Local Criminal Justice System

Michael DuBose for AMERICANJails MAGazine, November-December 2011

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This session examines cost-effective opportunities for interrupting the cycle of offending through treatment options. Speakers explore the mutual benefits of public health and public safety as well as the fiscal implications of providing a system of care inside and outside of the secure facilities. A review of lessons learned from the evidence, innovative strategies for targeting treatment needs, and the impact of managed care plans forms a foundation for open dialogue and information sharing. Concrete strategies for collaboration among managed care and the criminal justice system are provided. Highlights include:

- * *Targeting the treatment needs of the population*
- * *Increasing participant enrollment and engagement in managed care programs and benefits*
- * *Case studies and practice examples of success in economical treatment of justice populations*



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Who Should Attend

Senior managers and staff responsible for policy development and management of health care services and eligibility in county corrections systems

- ♦ Probation Department
- ♦ Sheriff and Sheriff Custody
- ♦ Corrections
- ♦ County Administrator and Analysts
- ♦ Not-for-profit partners in health care provision

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Registration Fees

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*Discount registration available for two or more participants registered together.

NO REGISTRATION AT THE DOOR

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Presented by the Crime and Justice Institute in collaboration with California State Association of Counties, California State Sheriffs' Association, and the Chief Probation Officers of California.