



Health Reform and Criminal Justice: Addressing Health Disparities Among the Racial and Ethnic Minority Populations in Jails

A Summary Report

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Introduction

Racial and ethnic minorities historically have encountered substantial and persistent disparities in health care. Given the anticipated growth of minority populations, and the passage of health reform through the Patient Protection and Affordable Care Act of 2010 (ACA), it is more important and more feasible than ever to address these disparities.

To do this successfully, states and counties must also address the unique health care needs of the millions of Americans who interface annually with the criminal justice system. There are three principle categories of justice-involvement: people in jails, people in prison, and people on probation or parole. Each population will interface with the health care system in different ways. This paper focuses on the population in county jails, which is more transient and younger than the population in prison.

All categories of justice-involved individuals have been documented to have disproportionately high rates of chronic disease, mental illness, and substance addiction. Demographically, they tend to be non-white and male, and they are largely uninsured.

Under the ACA, states have new opportunities to extend health coverage to this historically uninsured population through Medicaid expansion and the creation of health insurance exchanges. By offering health care coverage to an estimated 32 million Americans, many of whom will be members of racial and ethnic minorities, health reform will help reduce health disparities.

A great deal of work is underway to prepare for 2014, when Medicaid expansion is implemented and new state or federal insurance exchanges are in place. In order to ensure that health reform fully addresses racial and ethnic disparities, justice-involved populations need to be part of the plan. Unless states and counties work to meet the health care needs of the justice-involved, they cannot make a substantial difference in health disparities.

Perhaps most significantly, many justice-involved individuals will for the first time have access to treatment for mental health and substance abuse problems, conditions at the root of many criminal behaviors. Thus, expanded mental health and addiction treatment for justice-involved individuals could reduce not only health disparities but also crime and recidivism in the community.

Jails can serve as the nexus for connecting a high-need population with specific behavioral health¹ services in the community, so that jail-involved individuals can get the treatment they need, regardless of whether they are in jail or in the community.

¹ Behavioral health services include both mental health and addiction services.

Convening Around Health Reform, Criminal Justice, and Health Disparities

On December 6, 2012, Community Oriented Correctional Health Services (COCHS) and the National Minority Quality Forum, with support from the Robert Wood Johnson Foundation (RWJF), convened *Health Reform and Criminal Justice: Addressing Health Disparities among the Racial and Ethnic Minority Populations in Jails*. The purpose of this invitation-only meeting was to explore various issues related to health disparities at the intersection of health reform and criminal justice.

More than 120 leaders in public safety, community health, health advocacy, philanthropy, and all levels of government participated in the December 6 conference to hear the presentations, learn from each other, and help identify next steps. This report summarizes the discussions from that day.

Nancy Barrand of the Robert Wood Johnson Foundation welcomed the conference attendees, followed by Gary Puckrein, PhD, president and CEO of the National Minority Quality Forum, who gave an introductory presentation on health disparities, and keynote speaker Tonya Robinson, JD, special assistant to President Obama for justice and regulatory policy. During the balance of the day, conference attendees heard and participated in panel discussions organized around four themes:

- Can Medicaid Expansion Mitigate Health Disparities in the Criminal Justice Population?
- Case Study: The California Experience
- Experiences from Other Early Adopter States
- Envisioning the Future

What Do the Data Tell Us?

Gary Puckrein, president and CEO of the National Minority Quality Forum, started the conference with a presentation that illustrated some of the underpinnings of health disparities and shed light on emerging trends that could support improvements in the future.

The National Minority Quality Forum has developed a comprehensive health database that links demographic, environmental, claims, clinical-laboratory, and other data elements into a centralized data warehouse, linked by ZIP Code. The ZIP Code Analysis Project, as it is called, can identify communities with high incidence or prevalence of chronic diseases, evaluates the impact of specific interventions, and monitors changes in health service and status.

According to Puckrein, the primary lesson from this national database can be boiled down to two words: Geography matters. Geographically bound health care markets in the U.S. exhibit stable consumption patterns from one year to the next.

Almost 80 percent of every health care dollar in the U.S. is spent on whites, even though they are only 62 percent of the population. This means that the remaining 38 percent of the population receives only 20 percent of the health care budget, which, on average, is less than half of what the white population receives per capita. Moreover, people without private insurance or Medicaid receive very limited health care on average.

Under health reform, approximately 32 million Americans will gain access to health care coverage, and 43 percent will be minorities. The majority of those new minority consumers will live in 4,500 of the nation's 38,000 ZIP codes. Because most of these consumers have not had continuous health care coverage, they are expected to enter the health care market with a backlog of problems. Yet, across the country, there are only about 500 minority-serving hospitals and 40,000 minority-serving primary care physicians. Quality of care will become a serious issue due to the shortage of minority-serving providers, Puckrein noted.

Puckrein observed that people often fail to recognize that health care is paid for collectively, through either private or government insurance pools derived from individual taxpayers or private purchasers of insurance. Those dollars not only pay for health care delivery but for health care technology and innovation as well. No one individually could afford health care; in fact, not even the 1 percent of the wealthiest Americans could afford a system that served only their own needs. Hence, it is important to realize that the more people who have health care coverage, the better the entire health care system will be for everyone.

With health reform, the consumer base will expand; this should spur even greater investment in innovation and technology. Those improvements, he said, will help all consumers – from the wealthiest “1 percent” to those who are in jail.

Changing demographics, he said, will force a change in direction. Minorities will make up a growing percentage of the U.S. population, meaning that the pressure for change will come from the marketplace itself. Meanwhile, medicine's ability to intervene with disease continues to expand rapidly. New capabilities bring new choices, Puckrein said.

“You can either recreate the 1950s for a segment of the American population ... or you can create a 21st century health care system for all,” Puckrein said. “The numbers will drive the policy.”

But he acknowledged that many of the states that are most aggressive with respect to their incarceration policies are the same states that are opting out of Medicaid expansion. Puckrein called on everyone concerned about health disparities to advocate – and to do so with a message that speaks to a financial imperative. He noted that the health care industry is the largest employer in the United States. It employs more people than the manufacturing or the defense, produces value, and provides jobs that remain local. States that are concerned about their local economies should support health care expansion – including Medicaid expansion.

The Federal Government Perspective

Tonya Robinson, special assistant President Obama for justice and regulatory policy, noted that, on their own, the issues of health reform and criminal justice are each critically important. Together, they make up “one of the more profound interactions for law and public policy,” she said.

Some 2.1 million people are incarcerated in the United States. Each year, more than 700,000 are released from prison, while 9 million cycle through the nation's 3,300 jails. They tend to have higher rates of HIV/AIDS, hepatitis, cancer, diabetes, substance addiction, and mental

illness – and extremely low rates of health insurance. Once released, ex-prisoners return to their children, families, and communities, where most of them have had little or no access to health care.

The end result, Robinson said, is that the burdens of fragmented health care and failed re-entry efforts are felt disproportionately by people of color and the poor. Although the federal government has several programs underway to improve re-entry outcomes, the truth is that a great deal more work remains to be done. As things stand, Robinson said, there are no mechanisms for connecting people discharged from incarceration with reliable, quality care in the community – or empowering them with the tools they need to get that care themselves.

Nevertheless, Robinson saw some cause for optimism. The ACA will be transformative in terms of making health care available to vulnerable populations, including the formerly incarcerated. Medicaid expansion, coupled with the development of electronic health record systems, creates an “impressive opportunity” to create a real continuum of care for former offenders, while the inclusion of mental health parity in the ACA holds the potential to dramatically change the course of recovery for those with behavioral health problems.

The federal government is hoping that relatively small investments will yield substantial returns for improving re-entry outcomes and reducing recidivism. For example, the U.S. Department of Health and Human Services has awarded a \$7 million Health Care Innovation Grant to San Francisco Community College to work with six states and the District of Columbia on a project to improve the health of new releasees. The grantee states will train community health workers in chronic disease management so that they can teach and mentor people who have been recently discharged to manage their diseases and maintain their health.

In another example, the Substance Abuse and Mental Health Services Administration (SAMHSA) has established 30 learning centers across the country to support community health providers with limited business capacity to prepare for the expanded patient population in 2014. SAMHSA is also working with the Treatment Research Institute of Illinois to identify a core set of best practices for community-based organizations around serving patients coming out of jail or prison.

Robinson said she believes that the nation has “taken a significant leap forward in its efforts to provide equitable coverage and expanded coverage, which will rebound to the criminal justice population.” She urged the conference attendees to “think hard and think strategically” about how best to leverage these new opportunities.

Four Panel Discussions

I. Can Medicaid Expansion Mitigate Health Disparities in the Criminal Justice Population?

The first panel of the day focused on some of the realities that jails and community health providers will face in 2014, when Medicaid expansion goes into effect. COCHS CEO Mike DuBose noted that an estimated 42 percent of enrollees in the new state health insurance exchanges will be non-white; for Medicaid, the percentage of non-white newly eligible enrollees is estimated to be 36 percent. Clearly, this represents a significant opportunity to address racial disparities in health by expanding health care access for all low income citizens.

But significant challenges remain. There is little or no infrastructure to support enrollment of Medicaid-eligible individuals while they are in jail, to connect them with treatment in the community, and/or to bill Medicaid for many of those services. Currently, there are not enough community-based behavioral health care providers to meet the needs of the expansion population, and while many small community-based providers are adept at providing culturally competent care, they are funded primarily through SAMHSA block grants and don't have the capacity to bill Medicaid. By 2014, those block grants may end, so that these providers will need to either bill Medicaid directly or partner with other organizations that have experience billing Medicaid.

Meanwhile, most jails continue to operate as islands, separate from their communities, and disconnected from the community health care system. Notably, very few jails have attempted to establish electronic health record systems or join community health information exchanges that would support greater connectivity with community care providers.

How, then, can the safety net community – this includes jails – meet service demands and provide quality, culturally competent care to the expansion community?

Arthur Wallenstein, corrections administrator for Montgomery County, MD, expressed optimism. In addition to the opportunities created by the ACA, he cited the work of the Federal Re-entry Policy Council in bringing greater attention to issues surrounding health care around justice-involved populations. He also noted that the Prison Rape Elimination Act (PREA), signed by President George W. Bush, has a significant health care component. But the real driver, he said, will be jurisdictions' concerns about potential litigation, if failure to enroll inmates in Medicaid is considered deliberate indifference to health care needs under *Estelle v. Gamble*.

Together, Wallenstein argued, these developments are putting jurisdictions under increased pressure to change the way they do business. "The glass is far more than half-way full," he said. He urged conference attendees to step up their advocacy activities at the local level, where the services actually exist and need to be connected.

Vanetta Abdellatif described the situation in Multnomah County, OR, where she directs integrated clinical services for the Health Department, which has responsibility for correctional

health care. The county operates two adult jails and one juvenile detention center that are accredited by the National Commission on Correctional Health Care and the Joint Commission. The jails are funded 100 percent by the county, and that funding, like that in many counties, is being squeezed, she said.

Abdellatif reported that locally in Oregon there is a move to create coordinated care organizations (CCOs) – similar to the accountable care organizations encouraged under the ACA – with a focus on Medicaid. Currently there are two CCOs in the Portland area. She believes that CCOs hold some promise in terms of preventive care for single childless adults. The model will rely heavily on the use of community health workers, global budgets, electronic health record systems, and patient-centered medical homes. It is unclear how all this will play out in jails, which have been slow to adopt metrics for measuring the effects of health interventions. There is a strong desire to bend the cost curve down.

The CCOs are pushing for integration, particularly with respect to electronic health records. In Multnomah County, EPIC is the dominant system, and the emphasis is weighted toward access to information than on confidentiality. The jails just went live with EPIC in October 2012. Although federally qualified health centers (FQHCs) are required to collect data on race and ethnicity, many are uncomfortable doing so and simply guess at their patients' race and ethnicity, instead of asking them directly. However, the data in evidence does show sharp disparities in rates of prenatal care, low birthweight, cardiac-related deaths, access to mental health services, and other areas.

Abdellatif concluded by noting that there is a significant need for care that is culturally competent and consistently high-quality. Medicaid will not pay for the infrastructure needed to support enrollment and education, so those will be significant challenges. Many people who are in jail should not be there, she argued. They are in jail because their mental health problems got out of control, but in a properly coordinated and integrated health care system that emphasizes primary care and prevention, they might not engage in criminal behaviors that lead to arrest and detention.

Kavita Patel, MD, of the Brookings Institution's Engelberg Center for Health Reform, believes that, ultimately, most states will choose to participate in Medicaid expansion. In the meantime, however, hesitation in large states like Florida and Texas is creating a great deal of confusion.

At the community level, the challenge is doing the most with scarce resources and getting newly eligible people enrolled. Communities, she said, will need to collaborate more around solving this problem. Enrolling people in jail is another open question, she said, adding that most people don't even understand what Medicaid is or how to stay in it once enrolled. "The most common scenario," Patel said, "is that people enter Medicaid, have some adjustments, fall out of the program, and have to figure out how to get back, usually through a hospital admission or the emergency room."

Patel said she is encouraged by several developments, including SAMHSA's move away from block grants and Medicaid's new innovation grants, which she said are a mechanism for accessing dollars to work with vulnerable populations. She told conference attendees that confusion around the new health insurance exchanges are actually an opportunity for motivated stakeholders to get involved in these important policy conversations, such as the establishment of essential health benefits that cover mental health.

Quality, she said, will continue to be a major area of concern. Medicare has four decades of experience measuring and understanding quality, but Medicaid has been held to a far lower standard. With Medicaid expansion coming, states are starting to look to Medicare for standards on quality. Hospitals are under pressure to spend less and demonstrate community benefit, yet a comorbid diagnosis of mental illness increases the risk of hospital readmissions twenty-fold.

"You have every reason to partner together," Patel told the conference participants.

II. The California Experience

Ellwood York, former director of pretrial services for the 16th Judicial Circuit of the State of Florida, moderated the second panel focused on the California experience. He noted that the Supreme Court decision in *Estelle v. Gamble* changed jails and prisons forever. Today, he said, there are people who actually seek arrest in order to get health care.

The ACA is ushering another wave of change in correctional health, he said, and California offers a useful case study as an early adopter of health reform.

In June 2010 the state submitted an 1115 Medicaid Demonstration waiver, dubbed the "Bridge to Reform," in response to the ACA that allows counties to expand Medicaid coverage to low-income, uninsured, non-pregnant adults with matching federal funds. By 2016, California's uninsurance rate (7 million people) is projected to fall by more than half.

The waiver funds public hospitals to achieve population-focused improvements in low-income groups with chronic conditions, including mental health and substance abuse, which are common among justice-involved individuals. New Medi-Cal² enrollees must be assigned to a medical home. In addition, Medi-Cal expansion can provide newly released inmates with access to medical treatment, which could help reduce recidivism.

Simultaneously, a new state law makes it easier for low-level offenders to get treatment in the community. AB-109 requires that individuals sentenced to non-serious, non-violent, non-sexual offenses serve their sentences in county jails instead of state prison. To alleviate overcrowding, many of these low-level offenders are being placed under community supervision rather than serving jail time.

² Medicaid in the state of California is called Medi-Cal.

This convergence of Medi-Cal expansion with criminal justice realignment creates an opportunity to reduce both racial health disparities and recidivism rates by creating a continuum of care between the jail and the community. Patrick Duterte, director of health and social services for Solano County, said that the onus is on the counties to do the work to leverage this opportunity.

However, the main impetus for county involvement in health reform implementation is not around reducing disparities – it's financial, said David Muhammad, former chief probation officer for Alameda County, which already bills Medicaid when jail inmates enter residential treatment. He cited a recent invoice from the county to Medicaid of \$805,000 for a month's worth of inmate care provided outside the jail walls.

Muhammad said that all counties are supposed to have a plan for enrolling people into Medi-Cal when they are discharged from incarceration. Alameda County is developing a transition center that will consolidate probation, Medicaid, general assistance, and other services into one place and begin Medicaid enrollment a week or two before discharge. The new personnel who will actually enroll inmates in Alameda County are called "eligibility technicians." One challenge is that the labor union, the S.E.I.U., is fighting the deployment of these new eligibility technicians in prisons and jails.

Duterte said that counties need to take a more "upstream" approach to care for vulnerable populations. Solano County piloted a managed care program that lowered costs and scored high for both quality and satisfaction. "At the county level, we need to figure out a way to make things work outside the walls of the jail," he said. "If you integrate health care, it will save you money."

COCHS President Steven Rosenberg said the role of probation needs to be reconsidered, so that people who are arrested for technical violations are not simply reincarcerated. They need to be managed, similar to what Alameda County is doing. Muhammad said, under that paradigm, the probation officer becomes responsible for developing a re-entry plan for each inmate that is not simply about drug testing but that includes housing, behavioral health, chronic disease management, employment, and forming connections with healthy, positive adults.

Duterte agreed, noting that criminal justice realignment provides an opportunity to broach this conversation, and engage stakeholders to step outside their conventional silos and focus on how to rethink health care delivery as a way to reduce recidivism.

Conversations, however, don't always result in agreement. Rosenberg noted the sheriff in Contra Costa County wanted to use new realignment money to build more jail beds. The community organized itself against that proposal, demanding instead that the money go to health and social services. So far the dispute has not been resolved, and the funding is stuck. "The silos are broken down but there's no agreement," Rosenberg said, adding that the incident illustrates "the tensions that are inherent to county agencies."

III. Experiences from Other Early Adopter States

California is not the only state that has pursued special waiver authority or offered state-only Medicaid expansion. The third discussion panel, moderated by Allison Hamblin, vice president of the Center for Health Care Strategies, included representatives from two other early adoption states, Maryland and New Mexico, as well as a Medicaid managed care trade organization. This panel discussion was moderated by Allison Hamblin, vice-president of the Center for Health Care Strategies.

Carlessia Hussein, RN, DrPH, director of Maryland's Office of Minority Health and Health Disparities, noted that the Maryland Health Improvement and Disparities Reduction Act has a specific charge to reduce racial health disparities. Approximately 72 percent of inmates in the state are African American, she said. Kari Armijo, health care reform manager for New Mexico's Medicaid office, said that most people in the State Coverage Insurance (SCI) program have not had health insurance for at least three years. As a result, there is a great deal of pent-up demand for high-cost, high-acuity services.

Both states are also seeking to expand drug addiction treatment. New Mexico, for example recently added suboxone treatment. However, access is limited because of the need to train primary care doctors on how to provide this treatment.

Targeted enrollment strategies will be important to the success of any expansion program, Armijo said, adding that Medicaid typically has not focused on the re-entry population from corrections, but instead on women and children. She said that state Medicaid administrators will need to change how they interact with correctional facilities so that inmates have access to coverage and services immediately upon discharge. They need to be both enrolled and connected with a provider who can get them the services they need.

Thomas L. Johnson, JD, president and CEO of Medicaid Health Plans of America, noted that, under the Balanced Budget Amendment, health plans cannot market directly to individuals, although they can conduct targeted marketing activities in places that have high concentrations of Medicaid-eligible individuals. Furthermore under the ACA, more stakeholders will become involved in educating newly eligible people on enrollment procedures in Medicaid, which will help, he added.

In Maryland, the new legislation included a provision to establish health enterprise zones – high-priority, low-income ZIP code areas for focused Medicaid outreach and services. Hussein said the state plans to make use of community health workers to reach people in their communities, and it needs to do something similar for the incarcerated population. She noted that although the state plans to track outcomes for people served in the health enterprise zones, it doesn't have the capacity yet to do that separately for people involved with the criminal justice system.

In New Mexico, work is underway to improve the SCI benefit package so that it meets health reform benchmarks. Armijo said that, even though the law includes parity for mental health, it doesn't specify which services must be included. Particular attention is being paid to the establishment of health homes – with a priority on behavioral health homes – by managed care plans. However, Armijo acknowledged that this is new territory for Medicaid programs. Hussein agreed, adding that one of the most pressing challenges is integrating mental health care with physical health care.

Allison Hamblin of the Center for Health Care Strategies remarked that shortages of primary care physicians in many communities are making it difficult for states to achieve their expansion goals. Armijo replied that New Mexico doesn't even have enough providers to serve the currently insured. Meeting the demands of an expanded service population is indeed very challenging, she said. Hussein said that Maryland has more resources to devote to this challenge, and is looking at ways to maximize not only physicians, but other professionals as well, including social workers, community health workers, and translators. It is also considering ways to provide transportation in some areas of the state.

Payment of primary care providers is another issue. Under ACA, payment to primary care providers will increase to 100 percent of Medicare in 2013 – but only for two years. Johnson noted that many health plans pay their participating providers slightly more than the state Medicaid fee, but they need to make sure that the rates they pay are actuarially sound. Plans, he said, are caught in the middle. They are concerned about the provider shortage, and they recognize that it's important to pay providers adequately. On the other hand, they are also under very real pressure from the states to contain Medicaid costs.

Rosenberg asked whether, in a world of capitation and population-based outcomes, managed care plans would be willing to provide certain ancillary services that can support positive outcomes. Thomas replied that plans are “absolutely” open to doing that, but cautioned that there are limits to what managed care plans can do. He believes that payment will become increasingly tied to outcomes, and while pay-for-performance can work very well, states need to hold up their end of the bargain. He cited the experience of Medicaid plans in Pennsylvania that agreed to a performance-based contract with the state. “They delivered the outcomes, but the state didn't pay, and they had to sue to get the payment they were supposed to get,” he said.

Thomas concluded by noting that the ACA does not address all the challenges associated with treating Medicaid populations, and that many aspects of implementation have yet to be determined. Like other speakers, he urged conference participants to continue their advocacy and education efforts to ensure that health reform achieves its potential for vulnerable populations.

IV. Envisioning the Future

Rosenberg opened the final panel discussion, which he moderated, by citing the national war on drugs, initiated under President Nixon, that has resulted in the incarceration of many low-level drug offenders who are disproportionately non-white. He asked: “Is there anything in health reform that will let us think differently about how the war on drugs has resulted in disparities within the criminal justice system?”

Louis E. Baxter, MD, medical director for New Jersey’s Division of Mental Health and Addiction Services, noted that in recent years there has been a shift in thinking with regard to drug addiction, which historically has been viewed more as a matter of “willful misconduct” and bad behavior. Now, however, addiction increasingly is seen as a medical condition, and a chronic disease. As a result, more resources are focusing away from punishment and toward treatment.

Lucy Perez, MD, president and CEO of the Cave Institute, called racism “the elephant in the room.” The war on drugs, she said, has had a pronounced impact on minorities. Research shows that a black male born in 2001 has a 32 percent chance of spending time in prison at some point in his life, a Hispanic male has a 17 percent chance, and a white male has a 6 percent chance.

Racism has manifested itself somewhat differently in health care, noted National Minority Quality Forum CEO Gary Puckrein. “We find permission in a lot of different ways to exclude people from the health care system,” he said. “We’ve persuaded ourselves that health care is a scarce commodity that needs to be rationed, so we exclude people – by race, behavior, or whatever. This becomes a really important collective conversation ... [about] where to allocate our resources and who gets what and who doesn’t.”

Those choices have very real effects, Rosenberg said. “This speaks to the outcome of not providing community-based services and not identifying people who don’t get services. As a result, we have a very expensive criminal justice system that doesn’t in fact protect public safety.”

“We have to acknowledge that racism does make a difference in health disparities,’ Baxter said. “We can’t ignore that.” Although the ACA creates a more equal opportunity for more people, the criminal justice system was designed to punish people – not to treat them. This affects minorities disproportionately.

However, he added, jail offers a great opportunity to diagnose and treat a high-risk population, and addiction treatment, in particular, is highly beneficial for society at large. Every dollar spent on addiction treatment, according to Baxter, returns seven dollars to the economy. “We return people to their families and to the workforce,” he said.

Puckrein said that he is encouraged by shifting demographic changes that giving minority population a stronger political voice. “Those new voices are going to have an impact on health care,” he asserted.

Conclusion

This document offers only the highlights of this dynamic day of exploring health care disparities. The entire proceedings (exclusive of Tonya Robinson’s keynote address) were videotaped and are posted on the COCHS website, www.cochs.org, for anyone to access.

There is a growing perception that criminal justice as it has been oriented, funded, and implemented for the past 40 years may have to change in response to new fiscal conditions. The confluence of this perception with the pending implementation of the ACA could create opportunities to reorient criminal justice and corrections –and the *de facto* racial disparities that have dominated those institutions – while addressing inequities in access to health care in so many minority communities. This promises to be a watershed era, but careful planning and collaboration will be required in order to achieve these benefits. Hopefully this conference has provided the basis for a more nuanced and cooperative approach to these challenges and opportunities.