



Engaging with the Affordable Care Act: Implications and Recommendations for Adult Drug Court Professionals

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The Patient Protection and Affordable Care Act (hereafter ACA) will affect your adult Drug Court operations and participants whether you work in a state that elected to expand Medicaid and open a state-run health care marketplace under the ACA or are in one that has left Medicaid unchanged and elected to rely on the federal exchange.¹ The ACA seeks to expand insurance coverage to millions more Americans through the individual insurance mandate, market reforms, tax credits and subsidies, and the expansion of Medicaid. Implementation of the ACA, in conjunction with the Mental Health Parity and Addiction Equity Act of 2008 (hereafter the Parity Act), will alter the landscape of how Drug Courts and participants access and pay for treatment. This bulletin outlines some of the key provisions of the ACA and provides guidance to state administrators and Drug Court team members about where to find information, the most critical questions to ask, and recommendations for action. The ACA is in its early stages of implementation, and states are still working to interpret and put it into practice. Drug Court practitioners are well positioned to help inform local and state-wide implementation of the ACA. This document seeks to empower those involved in adult Drug Courts to become educated about the potential effects of the ACA on adult Drug Court operations and participants and to act effectively. Implementation of the ACA is a work in progress and, as such, this is the first in a series of advisories about the act and its implications.

¹ This bulletin focuses on the effect of the ACA on adult Drug Courts, but the act will affect other treatment courts—DWI, family, mental health, veterans, and juvenile—similarly. For more information regarding how the ACA will affect these courts, contact your Single State Agency.

A Brief Primer on the ACA

On March 23, 2010, Congress enacted the ACA to begin addressing many problems in the U.S. health care system, such as rising health care costs, limited access to care, and the large number of uninsured Americans. The intent of the ACA is to provide millions more Americans with health care coverage by eliminating certain insurance industry practices that created barriers to coverage for many individuals, such as those with preexisting medical conditions, and by expanding Medicaid and providing subsidies to make coverage more affordable for everyone.

Health Insurance Marketplaces

Health insurance marketplaces were created for Americans in the individual and small group markets to pool risk and purchase quality insurance coverage with premium and cost-sharing subsidies to make coverage more affordable for those who qualify based on their income. The Centers for Medicare and Medicaid Services (CMS) built the federally facilitated Health Insurance Marketplace, which operates in the thirty-three states that chose not to build their own marketplace. Sixteen states and the District of Columbia have state-run marketplaces. Of the thirty-three states with federally facilitated marketplaces, seven states have state-federal partnership exchanges in which the state manages the plan and consumer assistance responsibilities, and the federal government is responsible for all other exchange duties. Utah is the only state that is running a state-based small-business marketplace while the federal government is running the individual marketplace (Kaiser Family Foundation, 2013).

The Health Insurance Marketplace is the official Web site for buying health or dental insurance. It allows individuals, families, and small

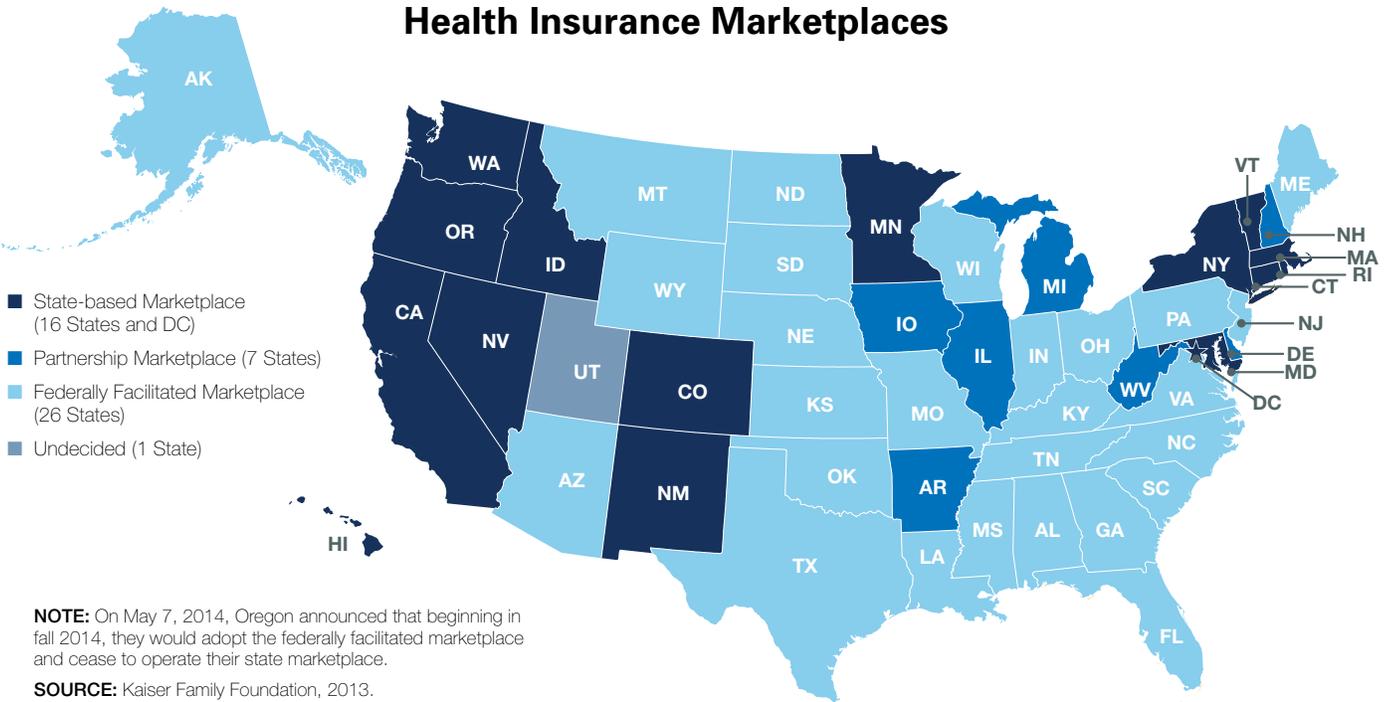
businesses under fifty employees to compare and select from competing health plans. Factors affecting premiums are limited to age, family size, geography, and tobacco use. The four different types of plans—bronze, silver, gold, and platinum—differ by *actuarial value*, meaning they vary in terms of premiums, deductibles, co-pays, and coinsurance. For example, an individual with a bronze plan could have lower monthly premiums but higher deductibles than an individual with a platinum plan. The premium tax credits and insurance subsidies to defray the cost of coverage are also available by applying on the marketplace.

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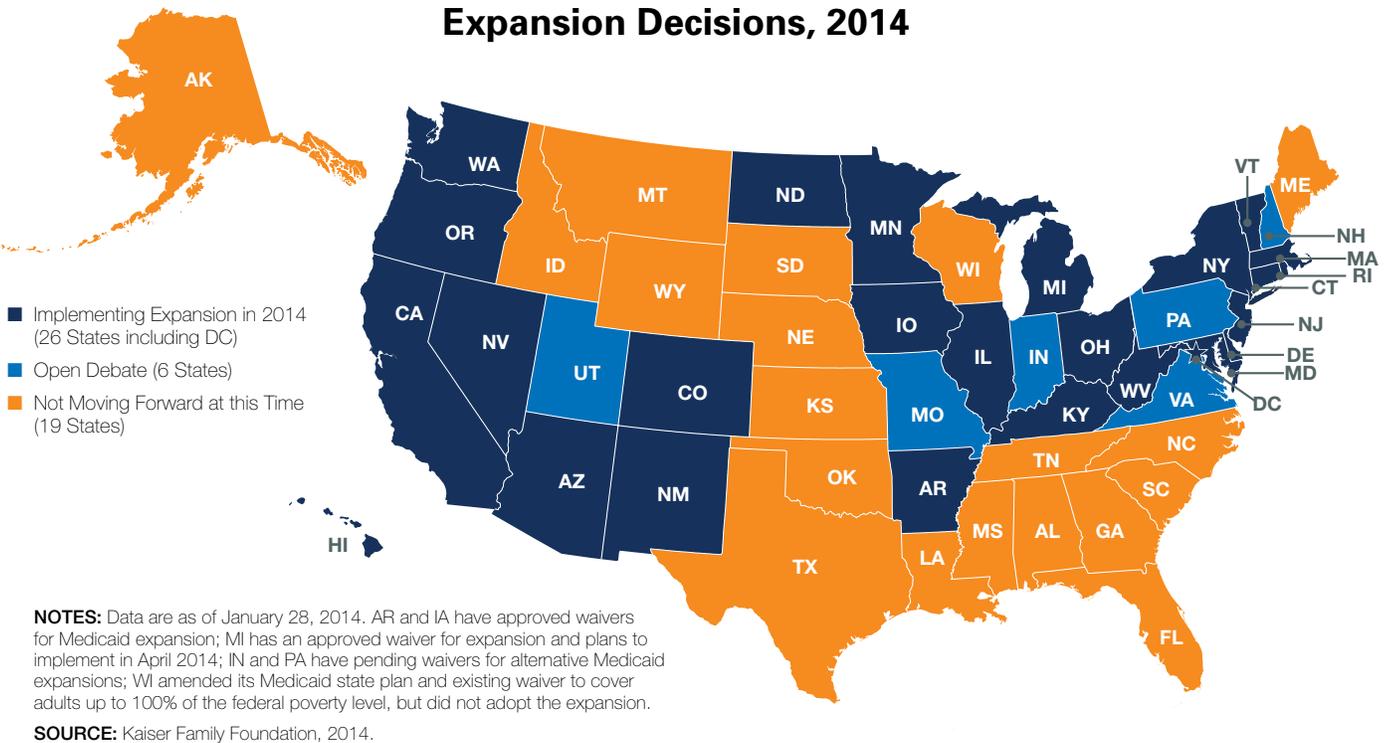
People applying for health insurance through the marketplace can seek help from navigators or certified application counselors (CACs). Navigators are funded through state and federal grant programs to provide outreach and education to raise awareness about the marketplace and to help enroll individuals. CACs educate and help enroll people in appropriate coverage through electronic or paper applications. They also help determine if an individual may qualify for insurance affordability programs (such as premium tax credits), cost sharing reductions, Medicaid, or CHIP (Children's Health Insurance Program). CACs may include trained volunteer groups from community health centers or other health care providers, hospitals, or social service agencies. Many communities are working to colocate navigators or CACs where the uninsured are likely located, including jails, hospitals,

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States Decisions For Creating Health Insurance Marketplaces



Current Status of State Medicaid Expansion Decisions, 2014



shelters, and community clinics. Navigators and CACs are not agents or brokers for insurance companies and must meet requirements to avoid conflicts of interest. They are certified through comprehensive federal training unless the state has a state-based marketplace and elects for state training and certification (Medicare & Medicaid Services, n.d.).

The Ten Essential Health Benefits

The ACA legislates that all health care plans must provide coverage that includes the Ten Essential Health Benefits.

- 1. Ambulatory patient services**
- 2. Emergency services**
- 3. Hospitalization**
- 4. Maternity and newborn care**
- 5. Mental health and substance use disorder services, including behavioral health treatment**
- 6. Prescription drugs**
- 7. Rehabilitative and habilitative services and devices**
- 8. Laboratory services**
- 9. Preventive and wellness services and chronic disease management**
- 10. Pediatric services, including oral and vision care**

The ACA also introduced several other key protections for individuals covered by an individual market or small group insurer. One of the most important of these includes making it illegal for health insurance providers to discriminate based on preexisting conditions such as cancer, diabetes, or a heart condition.

Prior to the ACA, Medicaid provided health coverage for certain groups, or categories, of low-income people, including children and adolescents, parents and caretaker relatives,

pregnant women, the elderly, and people with disabilities. Although Medicaid coverage has varied across all states, many low-income individuals, particularly men, were not eligible for Medicaid because they were not part of a covered category. This ineligible group tends to be the population most often served by adult criminal Drug Courts.

When the ACA was passed, it required all states to expand Medicaid coverage for adults age 18 to 65 with incomes up to 138% of the federal poverty level. However, the U.S. Supreme Court later ruled that Medicaid expansion would be voluntary for states (Klees, Wolfe, & Curtis, 2012). Individuals in those states with expanded Medicaid eligibility have access to Medicaid coverage if they meet income and other requirements. States that have not expanded Medicaid may have a gap in coverage commonly referred to as the *Medicaid expansion gap*. Individuals who are not members of a specific Medicaid-covered category and who do not have incomes high enough to qualify for tax credits and subsidies to purchase insurance coverage on the exchange fall into this gap. Even if your state has this gap, federal subsidies can help individuals pay for coverage if their income falls between 100% and 400% of the federal poverty level.

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Medicaid Expansion

Medicaid and Medicaid expansion are important because Medicaid was designed to provide for the health care needs of low-income individuals. Coverage of benefits in Medicaid is determined by the state division of medical assistance (or its equivalent) in its state plan, within the framework required by federal law. Exactly who and what

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income categories will be covered by Medicaid or the Medicaid expansion provided through the ACA, often referred to as an alternative benefit plan, will differ from state to state and may even differ by jurisdiction. Generally, Medicaid expansion is intended to cover those who would not normally qualify for Medicaid because the individual's income falls above Medicaid cutoff levels (but below the income level that qualifies for premium tax credits or subsidies) or because of the individual's group, or categorical, status (e.g., childless adults). Under Medicaid expansion, states will cover nondisabled, childless adults and parents under age 65 to at least 138% of the federal poverty level.

The connection between poverty and poor health outcomes is well documented (Braveman & Egerter, 2013). Those involved in the criminal justice system tend to be low income and have complex medical, mental health, and substance use/abuse/dependence treatment needs (Rich et al., 2014). Those states that expanded Medicaid will likely experience improvement in access to care for their Drug Court participants, many of whom will be eligible for Medicaid for the first time.

The expansion in health care coverage for adult Drug Court participants will change how Drug Courts access and pay for services. Increased coverage will provide opportunities to use treatment funds, previously needed to fund core treatment services, for enhanced or expanded care. Your Drug Court might use these funds to pay treatment providers to participate in staffings, expand the number of participants you serve, provide enhanced complimentary care (e.g., exercise programs, meditation, or dietary consultations), offer medications not on the formulary, provide access to recovery management programs, or any number of other uses that could benefit your Drug Court participants.

Non-Medicaid Expansion

If your Drug Court operates in a non-Medicaid expansion state, the ACA and its provisions will still affect your court operations and population. Medicaid coverage, as defined by your state, is still in place for those who meet

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eligibility criteria. The most significant difference is that nondisabled adults who are below 100% of the federal poverty level continue to be ineligible for Medicaid and have incomes that are too low to qualify for the premium tax credits and cost-sharing subsidies available on the exchange, putting this population into the expansion gap. Often, adult Drug Court participants are not covered by Medicaid, are without employer health insurance, and fall into the gap. Nationally, Drug Courts have met this population's treatment needs through some combination of participant self-pay, negotiated treatment contracts, grant or community funding, and state substance abuse block grant funding. Drug Courts in nonexpansion states will need to continue to use other funding sources to pay for core treatment when Medicaid is not available.

Mental Health and Substance Use/Abuse/Dependency Treatment and Parity

Inclusion of mental health and substance use/abuse/dependency treatment as an essential benefit is one of the most important aspects of ACA for Drug Courts. The ACA extended the requirements of the 2008 Parity Act to all health care plans. Parity means that the substance use/abuse/dependency and mental health treatment benefits covered by the plan be no more restrictive than other covered medical health care benefits. The ACA expands federal mental health and addiction treatment parity requirements to three main types of health plans:

- Individual market plans and nongrandfathered small group plans sold outside the marketplace
- Medicaid alternative benefit plans, including the Medicaid coverage that is required for the Medicaid expansion population
- Plans offered through the marketplace (Sarata, 2012).

The Parity Act already covers large group plans and Medicaid-managed care plans, and CHIP reauthorization in 2009 extended the parity requirements to CHIP plans.

The intent of the Parity Act was to increase access and reduce discriminatory practices for mental health and substance use/abuse/dependence treatment. Of particular interest to Drug Court practitioners is how mental health, substance use/abuse/dependence and medical- and surgical-health parity will continue to be negotiated and fully implemented at the state and local levels.

With the ACA's coverage expansions comes a renewed focus on *medical necessity*. Most Drug Courts are familiar with this concept that requires treatment decisions (e.g., level and duration of care) be determined based on what is medically appropriate for the individual and his or her diagnoses. In Drug Courts, following the American Society of Addiction Medicine (ASAM) recommended levels of care or other established guidelines for drug treatment is important to ensuring that providers are reimbursed for delivered services. Likewise, following medical best practices, such as concurrent treatment of mental health and substance use/abuse/dependency and use of medication-assisted therapies, is also important. Frequently however, what treatment providers consider medically necessary and what payers (insurance companies) consider medically necessary differ. This will continue to be a challenge for Drug Court practitioners and participants. This is part of the

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ongoing education and negotiation process and one reason that treatment courts will need other sources of funding (e.g., the Substance Abuse Prevention and Treatment Block Grant) to pay for services that are not covered.

Key Agencies Working to Implement the ACA

Enactment of the ACA in each state may be quite different, but some of the most critical offices overseeing its implementation include the state's insurance commissioner, the state agency in charge of managing Medicaid (often called the division of medical assistance or services), and the Single State Agency (which oversees substance use/abuse/dependence treatment). Knowing who is making the decisions about coverage is critical because over the next year or two, states will be interpreting and resolving the legal and practical ramifications of the ACA and Parity Act as the ACA is fully implemented at the state and local levels. The offices that manage Medicaid define which services and medications they cover and for how long. The state insurance commissioner oversees certain private insurance coverage and ensures compliance with state insurance laws.² Insurance companies submit their proposed benefit plans to the commissioner who ensures the plans meet state laws and benefit requirements. Broad or narrow interpretation may affect what services and medications are included in plans. For example, how parity is interpreted and enforced could affect which, if any, medication-assisted therapy drugs are covered in your state. The Single State Agency should be involved in discussions with both the Medicaid agency and the insurance commissioner to make recommendations about what each of the insurance plans should cover and how the requirements of the Parity Act are met.

² The federal government is responsible for all Employee Retirement Income Security Act plans and for most of the oversight of plans in nonpartnership federally facilitated marketplaces. Insurance commissioner oversight of plans in state-based marketplaces varies by state.

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Finally, some states will be introduced to one or more managed care organizations or health maintenance organizations as the ACA is implemented. Health maintenance organizations have been around since the 1970s and reviews of their efficacy and patient care have varied. They differ from traditional health care plans because they generally require individuals to work with a particular set of providers and to select a primary care physician. A number of states use managed care organizations to manage their Medicaid plans in hopes that this will improve patient care and reduce costs.

Challenges and Cautions for All Drug Courts

The dramatic changes in insurance coverage in all states under the ACA require that state and local Drug Court practitioners become educated and actively engaged in the dialogues, processes, and decisions associated with mental health, substance use/abuse/dependence, and primary health care treatment. The level of change and potential for involvement will differ depending on where your Drug Court is located.

Medical Necessity

As noted earlier, focusing on medical necessity should improve access to and the quality of treatment Drug Court participants receive but doing so is likely to pose new challenges for Drug Court practitioners and treatment providers as everyone adjusts to the new ways Drug Courts will access and finance treatment. Your Drug Court may need to increase use of validated screening and assessment instruments and rely more on treatment professionals' recommendations for care. Drug Court best practices emphasize appropriate targeting of participants by criminal offense and treatment needs

and discourage criminal justice personnel from dictating primary medical, mental health, and substance use/abuse/dependence treatment. Understanding both the clinical assessments of medical necessity and the payer's assessment of medical necessity will improve how your Drug Court operates and accesses appropriate care for your participants.

Residential Treatment

Treatment providers must design their services to provide the level of care requirement as dictated by medical necessity and as defined by the payers. In some cases, Drug Courts may struggle to access in-patient care for some high-risk addicted individuals because their drug of addiction is not one that requires medical detoxification (e.g., alcohol and benzodiazepines require medically supervised detoxification, opioids do not). The ability to demonstrate to payers that residential care is clinically appropriate and medically necessary can be challenging. Drug Courts will have to work with the state Medicaid authority, insurance commissioner, and health insurance plan providers to ensure Drug Court participants remain eligible for and have access to residential services.

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One specific issue related to billing for in-patient care under Medicaid is a regulation dating back to mental health reform in 1965. The Institutions for Mental Disease exclusion in the Social Security Act prohibits Medicaid billing for residential services in facilities that are larger than sixteen beds. Because of this regulation, most states have historically used state and federal non-Medicaid dollars to purchase residential services from agencies that are larger than sixteen beds.

Medicaid Billing

Medicaid billing is complex. Many of the smaller treatment providers, often contracted to work with local Drug Courts, may find it difficult to meet the licensure and administrative records provisions required for Medicaid. Also, many smaller providers may struggle with the reimbursement lag associated with Medicaid or the loss of clients from the Drug Courts if they do not qualify. This could result in fewer treatment providers in your jurisdiction and the potential loss of known and trusted treatment partners. The Substance Abuse and Mental Health Services Administration (SAMHSA) is providing additional outreach and support to providers to help them meet conditions for Medicaid billing.

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More Provider Choice

Expansion of Medicaid and the ACA health insurance reforms allow more people to become eligible for health coverage and seek treatment. Your Drug Court may face new challenges as new providers move into your jurisdiction seeking to treat your Drug Court participants. Some potential Drug Court treatment providers may have less experience or expertise in treating court-involved, addicted individuals. Other providers may be new to your area but be highly qualified to treat adult Drug Court participants. Under Medicaid, individuals are guaranteed provider choice. Your Drug Court may need to develop a set of guidelines to help participants access the providers in their plans' networks that are the

most experienced and best qualified to meet their treatment needs. Changes in which providers will be treating your participants will result in a need for your court to develop protocols for including these new providers in your treatment court and staffings. This expansion in treatment providers will most likely occur in urban areas.

Less Provider Choice

The ACA has initiated changes regarding what kind of health care coverage should be provided, how it should be provided, and how it will be reimbursed. As stated, your jurisdiction could see an expansion of qualified treatment providers, but you may also find your Drug Court's choices are reduced. Established partners may not be included in the networks of the new exchange plans or qualify to bill Medicaid. The ACA reform includes network adequacy standards in anticipation of possible network contraction. Each state must ensure that the resulting network has a sufficient number of accessible in-network primary and specialty care providers. Rural Drug Courts, which generally had few treatment choices before ACA, may be disproportionately affected by network contractions. In many states, the federally qualified health centers are filling these provider gaps or are considering expanding behavioral health care services to meet the needs of their largely rural populations.

Changes to the State Substance Abuse Prevention and Treatment Block Grant

SAMHSA block grant funds are noncompetitive grant dollars provided to all states based on a formula determined by Congress that takes into account population and other factors. States typically use these funds to provide substance use/abuse/dependence treatment to high-needs populations such as justice-involved populations

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and others who may not otherwise have access to substance use/abuse/dependence treatment coverage. In states that have expanded Medicaid coverage, many of the people previously receiving health care through block grants now receive coverage through Medicaid. In this case, states would have funds that they may reappropriate to other treatment. In those states that have not elected to expand Medicaid or for individuals and services that remain uncovered in expansion states, these block grant funds continue to provide a critical source of funding for core substance use/abuse/dependence treatment in high-needs populations.

Treatment Provider Participation in Staffings

The new *Adult Drug Court Best Practice Standards (Standards)* recommends that adult Drug Courts work with only one or two highly qualified treatment providers and that treatment professionals from those agencies participate in the Drug Court staffings and hearings (NADCP, 2013). In the case of courts with many highly qualified providers, the *Standards* recommends a coordinated process of gathering and sharing information between the treatment providers and Drug Court team. Changes in treatment provider networks and in how treatment is reimbursed may make doing this difficult for local Drug Courts. Changes in court operations, personnel, and payment structures may be necessary to meet this standard.

Inclusion of mental health and substance use disorder services in the Ten Essential Health Benefits in conjunction with the Parity Act have the potential to dramatically affect how mental health and substance use/abuse/dependence treatment is covered.

Defining and Achieving Parity

Mental health and addiction treatment parity has been a goal for many years, but its realization finally became feasible with the passage of the 2008 Parity Act. Inclusion of mental health and substance use disorder services in the Ten Essential Health Benefits in conjunction with the Parity Act have the potential to dramatically affect how mental health and substance use/abuse/dependence treatment is covered. Key to coverage, however, is how parity is defined and enforced. This is an area in which state Drug Court administrators should take particular care to remain informed and involved.

Defining Coverage

New insurance plans, new providers, new laws, and new opportunities for change will keep your state's division of medical assistance, insurance commissioner, and courts busy over the next few years interpreting what should be covered by health care plans. Understanding which insurance providers are working in your jurisdiction and what services, medications, and health care providers they propose to include in their coverage could mean the difference between your Drug Court participants accessing optimal or minimal treatment.

Drug Courts in states with a more unified statewide approach and those administered by the state's mental health and substance abuse treatment agency are at a distinct advantage during this process of change. Drug Courts operating in states with unified systems have fewer structures to navigate and will experience greater consistency among jurisdictions. Also, Drug Courts overseen by the state's behavioral health care agency are more likely to be actively involved as treatment definitions are authorized for the state. Regardless of how Drug Courts are administered in your state, Drug Court professionals must learn the basic federal and state health coverage requirements and work closely with the relevant state officials to ensure that Drug Court participants can access all appropriate services for their mental health and substance use/abuse/dependence treatment needs.

The Top Ten Things You Can Do

Drug Court practitioners are known for being on the forefront of meeting the complex needs of justice-involved individuals. The ACA provides another opportunity for Drug Court professionals to meet those needs and improve the quality of care provided. However, to fully leverage the potential of the ACA, your Drug Court professionals will need to be educated and involved, especially over the next year or two as your state interprets and implements the ACA. Here are ten recommendations for how you and your Drug Court can become educated and shape how justice-involved populations access and experience treatment.

10. Maximize the number of justice-involved individuals receiving Medicaid or insurance coverage.

Justice-involved individuals, such as those served by Drug Courts, are among the least likely to have health care coverage, most likely to have high physical and mental health and substance use/abuse/dependence treatment needs, and least likely to seek out health care coverage. Whether you are in a Medicaid expansion state or not, more people with insurance coverage (either through Medicaid or the marketplace) could, over time, increase the qualified health care providers in your area and improve access to care for your participants. Many organizations (see Resources at the end of this fact sheet) are helping agencies working with criminal justice populations (e.g., law enforcement, shelters, hospitals, prisons, and Drug Courts) develop protocols for helping justice-involved populations enroll in health care coverage.

What you can do

- Talk with others in your state or jurisdiction about what they are doing to increase the number of justice-involved individuals enrolled in health care coverage.
- Consider how you or your Drug Court can contribute.

9. Ensure continued access to high-quality treatment.

The shifts in treatment definitions and payment structures may change which treatment providers your Drug Court participants can access.

What you can do

- Strengthen existing relationships with the highly qualified treatment providers.
- Build new relationships with all treatment and health plan providers operating in your area and serving your Drug Court participants.
- Support your treatment providers as they navigate the many changes and regulations associated with the ACA and Parity Act.

Learn how Medicaid and health insurance companies operate, what they require before they pay for services, and how working with insurance and Medicaid will affect your Drug Court's operations.

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8. Communicate with your Medicaid office, insurance commissioner, and others in your state implementing and overseeing health reform.

Since the enactment of the ACA will change treatment coverage and treatment providers in your jurisdiction, you need to stay involved with the officials implementing and overseeing health reform.

What you can do

- Educate these officials about what Drug Courts do, the health care needs of the population you serve, and the kinds of treatment coverage that best serves this high-need, high-cost population.
- Engage officials in dialogue about how the Ten Essential Health Benefits, Parity Act, and nondiscrimination aspects of the ACA are being interpreted and implemented in your county and state.
- You or someone from your Drug Court needs to review state-level documents to determine who is covered by Medicaid and Medicaid expansion and share the results with your Drug Court team.

7. Understand medical necessity and how it affects Drug Court operations.

With increased insurance coverage and Medicaid expansions, more Drug Court participants will have health care coverage. Learn how Medicaid and health insurance companies operate, what they require before they pay for services, and how working with insurance and Medicaid will affect your Drug Court's operations.

What you can do

- Create or update treatment plans with the full continuum of treatment as recommended in the Adult Drug Court Best Practice Standards.
- Learn how your typical Drug Court treatment plan might meet or be challenged to meet clinical definitions of medical necessity and how these are likely to intersect or diverge from

Medicaid or insurance company definitions of medical necessity.

- Talk with Medicaid, insurance plan administrators, and your treatment providers about how your Drug Court treatment providers can be paid by Medicaid and insurance companies for services provided.

6. Communicate with your Single State Agency.

Drug Courts will be significantly affected by all changes in the state's definitions, regulations, and coverage of substance use/abuse/dependence and mental health treatment. The agency with the primary responsibility for overseeing these changes is the Single State Agency.

What you can do

- Maintain active communication with officials at your Single State Agency about your Drug Court's needs and the kinds of treatment coverage that best serves your participants.
- Discuss with your Single State Agency how the ACA (and resultant Medicaid and insurance changes) affect or could affect your Drug Court operations and participants.

5. Determine how your state's substance abuse prevention and mental health block grants may be affected.

The ACA and the Parity Act may change how Substance Abuse Prevention and Treatment Block Grants and Community Mental Health Services Block Grants are allocated and utilized within your state.

What you can do

- Talk with officials in your state's substance abuse and mental health care agency.
- Find out how the state's SAMHSA block grant funds are currently designated. What changes, if any, are planned because of the implementation of the ACA?

4. Understand what the Parity Act means in your state or jurisdiction.

Most commercial health plans and some Medicaid plans must comply with mental health and substance use/abuse/dependence parity right now. Although federal regulation defines this, individual states and jurisdictions are still in the process of interpreting these regulations in light of their state insurance and Medicaid frameworks. The implications of parity for your Drug Court are critical to how your Drug Court will operate and how your participants will access services in the future.

What you can do

- Get informed about parity by talking with and monitoring updates provided by your Single State Agency and others in your state and nationally that are working on parity.
- Talk to those who are involved in making decisions about how Drug Courts operate and the health care needs of the population you serve.
- Invite officials to observe your Drug Court to see how Drug Courts are a perfect example of why mental health and substance use/abuse/dependence treatment parity is so important.

3. Understand that the ACA and the Parity Act bring both opportunities and challenges for adult Drug Courts.

This will continue to be a period of significant change in how health care is accessed and paid for and how different health care services are defined and funded.

What you can do

- Get engaged. You are a stakeholder in this process.
- Meet with your Drug Court team to identify what opportunities and challenges might be specific to your jurisdiction.
- Make a plan to get ahead of the challenges and leverage the opportunities.

2. Get Educated.

You will need to make a special effort to stay current over the next year or two as states interpret and implement the ACA within their own systems. Many resources are available to help you self-educate. The resources included on the National Drug Court Resource Center (NDCRC) Web site give you a starting point (see Resources).

What you can do

- Learn everything you can about what the ACA is (and is not).
- Find out how implementation of the ACA in your state affects your Drug Court operations and participants.
- Participate in the many opportunities to learn more about the ACA and criminal justice populations through the available literature, Web resources, webinars, and trainings provided by federal, state, and nonprofit groups.
- Talk to your treatment partners and other agencies serving your Drug Court population about how they are preparing for and adjusting to the ACA.

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1. Be an educator.

If you inform your community, your partners, and the agencies and institutions interacting with and affecting your Drug Court, you will be more likely to engage them and enlist them in your Drug Court's efforts to help participants achieve successful outcomes.

What you can do

- Share what you have learned with your Drug Court Team.
- Talk to both traditional and nontraditional partners about how Drug Courts operate, the population you serve, and the Drug Court participants' complex treatment needs.
- Help shape access to care for your Drug Court population by informing those who are making decisions about ACA interpretation and implementation of what your Drug Court does, what it needs, and how it helps the community.

Resources

For more information and to access key resources for your state and about ACA implementation and how it will affect criminal justice populations, visit the NDCRC ACA resource link at: <http://www.ndcrc.org/ACA>.

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NADCP

**National Association of
Drug Court Professionals**

About NADCP

It takes innovation, teamwork and strong judicial leadership to achieve success when addressing drug-using offenders in a community. That's why since 1994 the National Association of Drug Court Professionals (NADCP) has worked tirelessly at the national, state and local level to create and enhance Drug Courts, which use a combination of accountability and treatment to compel and support drug-using offenders to change their lives.

Now an international movement, Drug Courts are the shining example of what works in the justice system. Today, there are over 2,800 Drug Courts operating in the U.S., and another thirteen countries have implemented the model. Drug Courts are widely applied to adult criminal cases, juvenile delinquency and truancy cases, and family court cases involving parents at risk of losing custody of their children due to substance abuse.

Drug Court improves communities by successfully getting offenders clean and sober and stopping drug-related crime, reuniting broken families, intervening with juveniles before they embark on a debilitating life of addiction and crime, and reducing impaired driving.

In the 25 years since the first Drug Court was founded in Miami/Dade County, Florida, more research has been published on the effects of Drug Courts than on virtually all other criminal justice programs combined. The scientific community has put Drug Courts under a microscope and concluded that Drug Courts significantly reduce drug abuse and crime and do so at far less expense than any other justice strategy.

Such success has empowered NADCP to champion new generations of the Drug Court model. These include Veterans Treatment Courts, Reentry Courts, and Mental Health Courts, among others. Veterans Treatment Courts, for example, link critical services and provide the structure needed for veterans who are involved in the justice system due to substance abuse or mental illness to resume life after combat. Reentry Courts assist individuals leaving our nation's jails and prisons to succeed on probation or parole and avoid a recurrence of drug abuse and crime. And Mental Health Courts monitor those with mental illness who find their way into the justice system, many times only because of their illness.

Today, the award-winning NADCP is the premier national membership, training, and advocacy organization for the Drug Court model, representing over 27,000 multi-disciplinary justice professionals and community leaders. NADCP hosts the largest annual training conference on drugs and crime in the nation and provides 130 training and technical assistance events each year through its professional service branches, the **National Drug Court Institute**, the **National Center for DWI Courts** and **Justice for Vets: The National Veterans Treatment Court Clearinghouse**. NADCP publishes numerous scholastic and practitioner publications critical to the growth and fidelity of the Drug Court model and works tirelessly in the media, on Capitol Hill, and in state legislatures to improve the response of the American justice system to substance-abusing and mentally ill offenders through policy, legislation, and appropriations.

For more information please visit us on the Web:

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