HealthAffairs

At the Intersection of Health, Health Care and Policy

Cite this article as:
Stephen A. Somers, Elena Nicolella, Allison Hamblin, Shannon M. McMahon, Christian Heiss and Bradley W. Brockmann
Medicaid Expansion: Considerations For States Regarding Newly Eligible Jail-Involved Individuals
Health Affairs, 33, no.3 (2014):455-461

doi: 10.1377/hlthaff.2013.1132

The online version of this article, along with updated information and services, is available at:
http://content.healthaffairs.org/content/33/3/455.full.html

For Reprints, Links & Permissions:
http://healthaffairs.org/1340_reprints.php

E-mail Alerts : http://content.healthaffairs.org/subscriptions/etoc.dtl

To Subscribe: http://content.healthaffairs.org/subscriptions/online.shtml

Health Affairs is published monthly by Project HOPE at 7500 Old Georgetown Road, Suite 600, Bethesda, MD 20814-6133. Copyright © 2014 by Project HOPE - The People-to-People Health Foundation. As provided by United States copyright law (Title 17, U.S. Code), no part of *Health Affairs* may be reproduced, displayed, or transmitted in any form or by any means, electronic or mechanical, including photocopying or by information storage or retrieval systems, without prior written permission from the Publisher. All rights reserved.

Not for commercial use or unauthorized distribution

Downloaded from content.healthaffairs.org by *Health Affairs* on December 1, 2014
by HARRY HEIMAN

By Stephen A. Somers, Elena Nicolella, Allison Hamblin, Shannon M. McMahon, Christian Heiss, and Bradley W. Brockmann

DOI: 10.1377/hlthaff.2013.1132
HEALTH AFFAIRS 33,
NO. 3 (2014): 455–461
©2014 Project HOPE—
The People-to-People Health
Foundation, Inc.

Medicaid Expansion: Considerations For States Regarding Newly Eligible Jail-Involved Individuals

ABSTRACT The expansion of Medicaid eligibility to Americans with incomes up to 138 percent of the federal poverty level should greatly increase access to coverage and services for people recently released from jail and, thus, improve health outcomes and reduce recidivism in this population. The population is disproportionately male, minority, and poor; suffers from high rates of mental and substance abuse disorders; and is expected to make up a substantial portion of the Medicaid expansion population. To ensure connections to needed services after release from jail, states could help inmates determine their eligibility and enroll in Medicaid; take advantage of federal grants to automate systems that determine eligibility; and include a robust array of behavioral health services in Medicaid benefit packages. In most states, new partnerships between Medicaid and corrections agencies at both the state and local levels will be needed to support these activities.

Stephen A. Somers is president and CEO of the Center for Health Care Strategies, in Hamilton, New Jersey.

Elena Nicolella is director of policy and innovation at the Rhode Island Executive Office of Health and Human Services, in Cranston.

Allison Hamblin (ahamblin@chcs.org) is vice president for strategic planning, Center for Health Care Strategies.

Shannon M. McMahon is director of coverage and access, Center for Health Care Strategies.

Christian Heiss is a program officer, Center for Health Care Strategies.

Bradley W. Brockmann is executive director of the Center for Prisoner Health and Human Rights at the Miriam Hospital, in Providence, Rhode Island.

The Affordable Care Act (ACA) expands Medicaid eligibility to include people with incomes of up to 138 percent of the federal poverty level. This expansion could make health insurance newly available to as many as seventeen million Americans.[1] The Supreme Court decision in *National Federation of Independent Business v. Sebelius* made the expansion optional.[2] As of January 2014 twenty-five states and the District of Columbia had declared themselves willing to expand Medicaid.[3] This means that those jurisdictions will receive the federal match of 100 percent of the costs for enrolling newly eligible people in Medicaid in 2014 through 2016.

States' decisions whether or not to expand Medicaid will have significant implications for adults involved in the criminal justice system, particularly the ten million people moving through local jails.[4] Ninety percent of people who enter county jails have no health insurance.[5] Jails are required to provide health care to inmates, usually through contracted providers, with costs borne by the local corrections agencies.

States may not use federal Medicaid funds to provide services for incarcerated people, except for hospital inpatient stays that last longer than twenty-four hours.[6] As a result, states either terminate or suspend Medicaid enrollment for people entering jail. Therefore, the overwhelming majority of individuals released from jail have no health insurance.[5]

Demographic data suggest that there will be a sizable overlap between the Medicaid expansion population and the jail-involved population, which we define as people with a history of arrest in the previous year. Before being arrested, 60 percent of the jail-involved population have incomes less than 138 percent of poverty.[7] As many as one-third could have incomes of 100–400 percent of poverty and thus be eligible for premium subsidies for commercial insurance

Downloaded from content.healthaffairs.org by Health Affairs on December 1, 2014
by HARRY HEIMAN

purchased through the new health insurance exchanges, or Marketplaces. However, most will be eligible for Medicaid by the time they leave jail because their income will likely have disappeared.

State and local officials have a compelling fiscal rationale to support health insurance for jail-involved individuals upon their release into the community, particularly given their disproportionately high rates of mental illness, substance abuse, and other physical comorbidities.[8–10] If left untreated, these conditions can result in exacerbations of disease, avoidable and expensive hospitalizations and institutionalizations, and repeated cycling through the correctional system.[11]

For jail-involved people who remain uninsured, health care costs upon release will likely be borne by state-only programs for uncompensated care, mental health care, and substance abuse treatment. Local costs may rise in the years ahead, since the ACA authorized a substantial decrease in federal funds available for disproportionate-share hospital payments as a result of the emergence of new federally subsidized coverage options. Meanwhile, the costs of recidivism associated with untreated mental health and substance abuse disorders are borne by local governments and by society as a whole. The prospects of replacing these state and local health care expenditures with federal Medicaid funds, and avoiding state and local corrections costs, are strong incentives for states to elect to expand Medicaid.

In this article we examine the opportunity presented by Medicaid expansion to make sure that jailed individuals are enrolled in health coverage and connected to health care services by the time they are released. Meeting that goal should improve health, reduce recidivism, and lower costs to state and local governments.

After outlining state fiscal and benefit-design considerations associated with Medicaid expansion, we describe opportunities provided by the ACA for enrollment in and navigation through the health system for jail-involved people upon release. We conclude with examples of efforts to facilitate Medicaid enrollment and continuity of coverage for this population in Connecticut and Rhode Island.

Overlap Between Jail-Involved And Medicaid Expansion Populations

People with prior jail involvement are expected to represent a substantial subset of the Medicaid expansion population. Members of the jail-involved population are disproportionately young, male, minority, and poor, with low levels of education.[10] These characteristics closely mirror those of the Medicaid expansion population, as identified through national survey data (Exhibit 1). In general, the population newly eligible for Medicaid will be dominated by men under age thirty-five.[12] This is largely because women are more likely than men to be already eligible for or enrolled in Medicaid by virtue of pregnancy or parenthood.

Analyses of individual states shed additional light on the overlap between newly eligible low-income childless adults and jail populations. For example, officials in Washington State expect that the vast majority of the approximately 160,000 adults released annually from Washington jails will be eligible for Medicaid in 2014.[13] Only 20 percent of them had a disability or other factor that qualified them for Medicaid eligibility prior to the implementation of the ACA, and approximately 112,000 had no state-funded health care coverage.[13]

Policy makers expect the majority of this group to meet Medicaid expansion eligibility requirements, which suggests that up to 30 percent of

EXHIBIT 1

Demographic Comparison Of Jail-Involved And Total Medicaid Expansion Populations

Characteristic	Jail-involved[a]	Total Medicaid expansion[b]
Age	44% under age 25	55% under age 35
Sex	88% male	61% male
Race or ethnicity	39% black, 16% Hispanic	53% nonwhite (including 19% black, non-Hispanic; and 26% Hispanic)
Employment	59% earned less than $1,000 per month	45% unemployed[c]
Education	47% did not have a high school diploma	25% did not have a high school diploma
Insurance	90% uninsured	—[d]

SOURCE Authors' analysis; see sources below. [a]Vesey BM. The intersection of public health and public safety in U.S. jails (Note 7 in text). [b]Kaiser Family Foundation. Expanding Medicaid under health reform: a look at adults at or below 133% of poverty (Note 12 in text). [c]Or 60 percent unemployed, according to Haber SG, Khatutsky G, Mitchell JB. Covering uninsured adults through Medicaid: lessons from the Oregon Health Plan. Health Care Financ Rev 2000;22(2):119–35. [d]Not applicable; the data are for an uninsured population.

Downloaded from content.healthaffairs.org by Health Affairs on December 1, 2014
by HARRY HEIMAN

Mental illness and substance use disorders are often prevalent among the jail-involved population.

the 380,000 estimated newly eligible individuals in Washington could be in the jail-involved population—depending on who enrolls in the expanded Medicaid coverage. These estimates are consistent with Washington's experience with the state-funded general assistance program, in which 30 percent of childless adults with very low incomes (up to 38 percent of poverty) had been arrested.[14]

Behavioral Health Needs Of Jail-Involved Populations

Mental illness and substance use disorders are often prevalent among the jail-involved population. In the Washington State general assistance program, claims data indicated that 53 percent of those with prior jail involvement showed signs of needing mental health treatment. Approximately one-third of this group had a diagnosis of serious mental illness, and the balance had anxiety disorders, depression, or other related diagnoses.[14] Data about this population also suggest that 79 percent of jail-involved people need substance abuse treatment, compared with 42 percent of people with no history of jail involvement.

Importantly, these data are for the lowest-income subset of the expansion population (those with incomes of up to 38 percent of poverty), which has historically qualified for Washington State's general assistance program. By nature of their eligibility for this program, this subset's medical, mental illness, and substance abuse needs are likely to be greater on average than those of the overall expansion population.

State Considerations For Benefit Design

Given the anticipated behavioral health care needs of the expansion population, it will be critical for states to ensure access to a broad range of evidence-based mental health and substance abuse treatment services. To date, substance abuse treatment coverage in traditional Medicaid has been highly variable across the country. States often rely on their general funds, block grants from the Substance Abuse and Mental Health Services Administration, and other sources of public funding to support access to care. The ACA requires that states electing to expand Medicaid develop "alternative benefit plans," which enumerate the Medicaid-covered services available to newly eligible beneficiaries under the expansion. Importantly, under federal requirements, these alternative benefit plans must include mental health and substance abuse services that are at parity with comparable medical benefits. Accordingly, most states are looking to expand their offerings of behavioral health treatment services for the expansion population.

Estimating The Financial Impact Of Expansion On State And Local Governments

National analyses predict overall cost savings and improved population health as a result of the Medicaid expansion.[15] States have conducted their own fiscal analyses, which have examined the potential return on investment that Medicaid expansion would bring to various stakeholders and the state's economy as a whole.[16] States have reviewed several categories of impact, including the costs, offsetting state or local government savings, and the impact of the "woodwork" or "welcome mat" effect (which refers to the potential increase in enrollment as the publicity about new coverage options causes individuals previously eligible for coverage to enroll in greater numbers than expected in the absence of this publicity).

For example, a 2013 study commissioned by the Oregon Health Authority estimated that Medicaid expansion would save the state $79 million during the first six years.[17] Although the study did not focus on the jail-involved population, the estimated savings of $79 million includes general fund savings that would result from reductions in spending on state-funded community mental health services (and corresponding increases on the Medicaid side), which are expected to be widely used by the jail-involved population.[13]

A 2012 analysis by Leavitt Partners for the Idaho Department of Health and Welfare estimated that nearly 95 percent of people released from correctional facilities in the state each year are ages 19–64. Given their likely income and employment status, the majority would be newly eligible for Medicaid if Idaho agreed to the ex-

Downloaded from content.healthaffairs.org by Health Affairs on December 1, 2014
by HARRY HEIMAN

pansion[18] (the state has so far declined to do so). The analysis noted that since such a large proportion of the corrections population is likely to be eligible for Medicaid, federal expansion funds could help offset state and local costs for providing health services to these individuals.

In addition, a large portion of Idaho's corrections population has existing mental or physical health conditions, or both, which makes it more likely that these people would require ongoing treatment in the Medicaid program if it were expanded.[18] A subsequent actuarial analysis suggested that Idaho would save $84.6 million across the 2014–24 budget periods if it decided to participate in the Medicaid expansion.[19]

Opportunities To Support Enrollment And Navigation

The continuing implementation of the ACA will create opportunities to connect members of the jail-involved population with health care coverage by the time they are released. It will also support efforts to ensure that people who were previously enrolled in Medicaid are not lost to the system while they are incarcerated.

Federal law allows states to suspend Medicaid eligibility for people while they are incarcerated instead of terminating that eligibility. However, few states have taken advantage of this opportunity to keep coverage available for inmates upon their release. This is primarily because of limitations in state Medicaid eligibility information systems and to ensure that Medicaid does not make inappropriate payments to managed care organizations for people who are unable to access services because they are incarcerated.

The ACA includes a number of changes to Medicaid eligibility and enrollment policies, including the use of the Modified Adjusted Gross Income to determine individual and household income and the use of streamlined and simplified enrollment procedures for coverage through Medicaid, the Marketplaces, and other health and human services programs. These changes have forced states to upgrade their existing information technology infrastructures.

In April 2013 the Centers for Medicare and Medicaid Services advised states that increased federal funding will be available to support new systems to determine Medicaid eligibility and maintain records related to it.[20] With this funding and a new federal data hub for the electronic verification of applicants' financial and nonfinancial information,[21] states could automate and simplify eligibility determination processes for jail-involved people and connect them with coverage through Medicaid or the Marketplaces.

As noted above, federal law has long allowed states to suspend rather than terminate eligibility for Medicaid for incarcerated people, although information system barriers have contributed to states' inability to exercise this option. System upgrades could reduce these barriers, allowing states to maintain an open eligibility record for people while they are in jail. This would make it easier to connect them to coverage upon their release.

Federal law has long allowed states to suspend rather than terminate eligibility for Medicaid for incarcerated people.

Through Medicaid section 1115 waivers, states can also implement twelve-month continuous eligibility for adults, limiting the number of times a person's eligibility status is scrutinized—for example, because of a change in income or incarceration—in a given year.[22] The ACA also allows incarcerated people who have not been sentenced to enroll in or maintain their coverage through Qualified Health Plans in the health insurance Marketplaces. These strategies can help maintain enrollment among high-need individuals in the transient jail-involved population.

In cases where automated eligibility and enrollment processes are not available, or in states that have chosen not to implement continuous eligibility during incarceration, the ACA includes provisions to facilitate enrollment in Medicaid and the Marketplaces. For instance, the act awards grants to navigators to provide education about the marketplaces and the choices of health plans available there, and help individuals select the appropriate plan for their circumstances.

In addition, states should consider adopting training and certification requirements for existing Medicaid outreach programs that promote out-stationing—that is, locating outreach workers at corrections facilities—or maintain other means of in-person contact with this population.

Early Observations From The Field

A number of states have recognized the value of integrating Medicaid outreach and enrollment

Downloaded from content.healthaffairs.org by *Health Affairs* on December 1, 2014
by HARRY HEIMAN

Medicaid officials need to forge new partnerships with corrections officials at the state and local levels.

activities for jail-involved individuals with discharge planning. The policy question underscoring these state efforts is how to use Medicaid dollars to ensure continuity of care for people upon their release from custody. Below we highlight examples of activities in Connecticut and Rhode Island.

CONNECTICUT Connecticut's Department of Social Services is using a shortened Medicaid application form for inmates with identified medical or behavioral health needs to expedite the process of determining their eligibility and enrolling them. In 2005 the state began an initiative in its jails to identify incarcerated people with serious mental illnesses who would need services immediately after their release.[23] With funding from the state's Department of Mental Health and Addictions Services, these people received assistance in applying for Medicaid and securing eligibility determinations prior to release. Within two years the state had expanded the program to include all inmates in prison and jail and parolees who had been high users of health and mental health services while incarcerated (Colleen Gallagher, director of quality assurance, health and addiction services, Connecticut Department of Correction, personal communication, January 3, 2014).

Department of Correction officials began working with officials in the Department of Social Services and the Department of Mental Health and Addictions Services to create an expedited, centralized application process (Gallagher, personal communication). Key elements included discharge planners, employed by correctional health providers and based in correctional facilities, who assisted inmates in completing Medicaid applications prior to their release; reentry counselors, who offered classes for inmates on filling out applications; entitlement specialists, based at the Department of Social Services, who determined eligibility for Medicaid; a short-form application, representing a more limited array of public benefits than those available through the standard state application; and access for the Department of Social Services to daily electronic feeds from the Department of Correction to identify people about to be discharged, so that benefits could be "switched on" in a timely manner.

Because of the expedited application process, 60 percent of people who routinely sought health care services in correctional facilities completed an application for Medicaid. The number of applications rose from a few hundred in 2006 to more than four thousand in 2013 (Gallagher, personal communication, January 17, 2014). Given the success of the initiative, the state continues to build upon this effort, adding additional reentry counselors in correctional facilities and expanding the population targeted for application assistance.

RHODE ISLAND To prepare for Medicaid expansion, Rhode Island designed and implemented a new eligibility and enrollment system that supports both its Executive Office of Health and Human Services, the agency that administers Medicaid for the state, and HealthSource RI, the new state-based Marketplace. The new system incorporates features that would facilitate coverage and continuity of care for vulnerable populations, including the jail-involved. The new system also provides stakeholders at various state agencies with better information through improved data sharing and access, together with appropriate privacy safeguards. In addition, the Rhode Island Department of Corrections is working with the Bureau of Justice Affairs in the US Department of Justice to develop and pilot best practices for correctional facilities to handle inmates' protected health information.

Extensive collaboration among the state's Department of Corrections, Medicaid agency, and HealthSource RI has helped facilitate inmates' enrollment in appropriate post-release coverage. Cross-agency discussions seek to enable the Department of Corrections to assist inmates in establishing their eligibility and in enrolling three to six months before being released.

To facilitate the identity verification requirements of the new system, the Medicaid agency and HealthSource RI agreed that former inmates can submit the thirty-day photo ID issued by the Department of Corrections as valid identification for enrollment. The Medicaid agency and HealthSource RI also agreed that the release letter provided to each inmate at release will be valid proof of income for enrollment.

Rhode Island is still clarifying its policy for incarcerated people enrolled in Qualified Health Plans who have not been sentenced. Under the ACA, these people remain eligible for health plan

Downloaded from content.healthaffairs.org by Health Affairs on December 1, 2014
by HARRY HEIMAN

coverage as long as they qualify for it. However, the savings that this provision could represent to a jail facility come with potential costs.

For example, a jail can only charge a Qualified Health Plan for medical services offered to a detainee if the jail is an approved provider for that plan. Health plans mandate compliance with the complex privacy and security provisions of the Health Insurance Portability and Accountability (HIPAA) Act of 1996, and that compliance would require the state's unified prison and jail system to use dedicated staff or consultants' time.

Conclusion

States pursuing Medicaid expansion have an unprecedented opportunity to provide jail-involved people with health insurance and access to health care services. Given the high prevalence of mental health and substance abuse treatment needs among this population, timely enrollment and access to services after release have the potential to greatly improve the outlook for these very vulnerable people. Enrolling jail-involved people in Medicaid or connecting them to Qualified Health Plans through the health insurance Marketplaces during or immediately following incarceration could increase access to high-quality care, reduce reliance on emergency departments and other costly acute care settings, improve health status, and reduce rates of recidivism by addressing root causes of incarceration.

To take full advantage of this opportunity, Medicaid officials need to forge new partnerships with corrections officials at the state and local levels. With full implementation of the ACA in 2014, the year ahead is a good time to build the organizational and system-level bridges that would enable the full access to coverage and services intended under the new law. ■

Support for preparation of this article was provided by Community Oriented Correctional Health Services (COCHS) through a grant from Robert Wood Johnson Foundation (RWJF). Elena Nicolella is an employee of the State of Rhode Island. The views expressed here are solely those of the authors and do not necessarily reflect those of COCHS, RWJF, or the State of Rhode Island. The authors acknowledge Anjana Pandey for her assistance in the preparation of an early version of this article, Colleen Gallagher for background on the Connecticut Pre-Release Enrollment initiative, and three anonymous reviewers for their helpful comments.

NOTES

1 Congressional Budget Office. Updated estimates for the insurance coverage provisions of the Affordable Care Act [Internet]. Washington (DC): CBO; 2012 Mar [cited 2014 Jan 17]. Available from: http://www.cbo.gov/sites/default/files/cbofiles/attachments/03-13-Coverage%20Estimates.pdf

2 National Federation of Independent Business v. Sebelius, 567 U.S., 2012 WL 2427810 (2012 Jun 28).

3 Advisory Board. Where the states stand on Medicaid expansion [Internet]. Washington (DC): Advisory Board; 2014 Jan 9 [cited 2014 Jan 17]. Available from: http://www.advisory.com/Daily-Briefing/Resources/Primers/MedicaidMap

4 Solomon AL, Osborne JWL, LoBuglio SF, Mellow J, Mukamal DA. Life after lockup: improving reentry from jail to the community [Internet]. Washington (DC): Urban Institute, Justice Policy Center; 2008 May [cited 2014 Jan 14]. Available from: http://www.jjay.cuny.edu/final_life_after_lockup.pdf

5 Wang EA, White MC, Jamison R, Goldenson J, Estes M, Tulsky JP. Discharge planning and continuity of health care: findings from the San Francisco County Jail. Am J Public Health. 2008;98(12):2182–4.

6 42 CFR sec. 435.1009 (2006).

7 James DJ. Profile of jail inmates, 2002 [Internet]. Washington (DC): Department of Justice, Bureau of Justice Statistics; 2004 Jul [cited 2014 Jan 14]. Available from: http://www.bjs.gov/content/pub/pdf/pji02.pdf

8 Torrey EF. Jails and prisons—America's new mental hospitals. Am J Public Health. 1995;85(12):1611–3.

9 Karberg JC, James DJ. Substance dependence, abuse, and treatment of jail inmates, 2002 [Internet]. Washington (DC): Department of Justice, Bureau of Justice Statistics; 2005 Jul [cited 2014 Jan 14]. Available from: http://www.bjs.gov/content/pub/pdf/sdatji02.pdf

10 Veysey BM (Rutgers—The State University of New Jersey, Newark, NJ). The intersection of public health and public safety in U.S. jails: implications and opportunities of federal health care reform [Internet]. Oakland (CA): Community Oriented Correctional Health Services; 2011 Jan [cited 2014 Jan 14]. (Issue Paper). Available from: http://www.cochs.org/files/Rutgers%20Final.pdf

11 Shah MF, Mancuso D, Yakup S, Felver BEM. The persistent benefits of providing chemical dependency treatment to low-income adults [Internet]. Olympia (WA): Department of Social and Health Services, Research and Data Analysis Division; 2009 Nov [cited 2014 Jan 14]. (RDA Report No. 4.79). Available from: http://publications.rda.dshs.wa.gov/1397/313/

12 Kaiser Family Foundation. Expanding Medicaid under health reform: a look at adults at or below 133% of poverty [Internet]. Menlo Park (CA): KFF; 2010 Apr [cited 2014 Jan 14]. Available from: http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8052-02.pdf

13 Mancuso D, Felver BEM. Health care reform, Medicaid expansion and access to alcohol/drug treatment: opportunities for disability prevention [Internet]. Olympia (WA): Department of Social and Health Services, Research and Data Analysis Division; 2010 Oct [cited 2014 Jan 14]. (RDA Report No. 4.84). Available from: http://publications.rda.dshs.wa.gov/1418/364/

14 Hamblin A, Somers SA, Neese-Todd S, Mahadevan R. Medicaid and criminal justice: the need for cross-system collaboration post health care reform [Internet]. Oakland (CA): Community Oriented Correctional Health Services; 2011 Jan [cited 2014 Jan 14]. (Issue Paper). Available from: http://www.cochs.org/files/CHCS_Final.pdf

15 Angeles J. How health reform's Medicaid expansion will impact state

Downloaded from content.healthaffairs.org by *Health Affairs* on December 1, 2014
by HARRY HEIMAN

budgets [Internet]. Washington (DC): Center on Budget and Policy Priorities; [revised 2012 Jul 25; cited 2014 Jan 21]. Available from: http://www.cbpp.org/files/7-12-12health.pdf

16 Manatt Health Solutions, Center for Health Care Strategies, State Health Access Data Assistance Center. Medicaid expansion: framing and planning a financial impact analysis [Internet]. Princeton (NJ): State Health Reform Assistance Network; 2012 Sep [cited 2014 Jan 14]. (Issue Brief). Available from: http://www.statenetwork.org/wp-content/uploads/2012/09/State-Network-Medicaid-Expansion-Framing-and-Planning-a-Financial-Impact-Analysis.pdf

17 State Health Access Data Assistance Center, Oregon Health Sciences University Center for Health Systems Effectiveness, Manatt Health Solutions. Estimated financial effects of expanding Oregon's Medicaid Program under the Affordable Care Act (2014–2020) [Internet]. Minneapolis (MN): State Health Access Data Assistance Center; 2013 Feb [cited 2014 Jan 14]. Available from: http://www.oregon.gov/oha/Documents/MedicaidExpansion-Estimated FinancialEffects.pdf

18 Leavitt Partners. Idaho's newly eligible Medicaid population: demographic and health condition information [Internet]. Salt Lake City (UT): Leavitt Partners; 2012 Sep 18 [cited 2014 Jan 14]. Available from: http://www.healthandwelfare.idaho.gov/Portals/0/Medical/Medicaid CHIP/0918%20Idaho%20Medicaid%20Leavitt%20Report.pdf

19 Milliman. Idaho Medicaid expansion population and cost forecast [Internet]. Vienna (VA): Milliman; 2013 Mar 18 [cited 2014 Jan 14]. Available from: http://healthandwelfare.idaho.gov/Portals/0/Medical/More Information/Milliman%20Idaho%20Medicaid%20Expansion%20Presentation%2020130318.pdf

20 Centers for Medicare and Medicaid Services. Affordable Care Act: state resources FAQ [Internet]. Baltimore (MD): CMS; 2013 Apr 25 [cited 2014 Jan 14]. Available from: http://www.medicaid.gov/state-resource-center/FAQ-medicaid-and-chip-affordable-care-act-implementation/downloads/Affordable-Care-Act-FAQ-enhanced-funding-for-medicaid.pdf

21 Centers for Medicare and Medicaid Services. Medicaid program; eligibility changes under the Affordable Care Act of 2010. Final rule; interim final rule. Fed Regist. 2012;77(57):17144–217.

22 Centers for Medicare and Medicaid Services. Facilitating Medicaid and CHIP enrollment and renewal in 2014 [Internet]. Baltimore (MD): CMS; 2013 May 17 [cited 2014 Jan 14]. Available from: http://www.medicaid.gov/federal-policy-guidance/downloads/sho-13-003.pdf

23 Morrissey J, Cuddeback G, Domino M, Frisman L. State prisons, mentally ill offenders, and expedited Medicaid restoration [Internet]. Paper presented at: Sixth Academic and Health Policy Conference on Correctional Health; 2013 Mar 22; Chicago, IL [cited 2014 Jan 21]. Available from: http://www.correctionalhealthconference.com/sites/correctionalhealthconference.com/files/Expedited%20Medicaid%20Restoration_Joseph%20Morrisey.pptx

Downloaded from content.healthaffairs.org by *Health Affairs* on December 1, 2014
by HARRY HEIMAN