Health Care Reform
What's Next for Corrections?

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The ACA creates new opportunities and challenges; addressing them will be complicated and involve many stakeholders

President Obama's reelection and the Supreme Court's ruling this past summer have solidified the Patient Protection and Affordable Care Act ("Obamacare" or "the ACA") as the law of the land. A few states continue challenges to parts of the ACA but most of its key provisions will soon apply to all Americans. The ACA provides several new options for inmate health care and also will likely lead to new challenges for prisons and jails in providing constitutionally sound health care to inmates. This article provides an overview of key elements of the ACA that relate to corrections, insight into their implications and actions that prisons and jails should consider.

Coverage Objective

The fundamental objective of the ACA is to provide affordable health insurance to the uninsured, who are primarily adults employed in low-wage jobs or unemployed. More than 30 million Americans will be eligible for insurance coverage beginning in 2014, through insurance market reforms, federal subsidies for insurance purchased through state-based health insurance exchanges and expansion of the Medicaid program. A sizable portion of the population newly eligible for coverage will be adults involved with the justice system. About 20 million people will remain uninsured after the ACA is implemented—most will be undocumented aliens or people who opt to pay a penalty rather than purchase coverage.

Insurance Market Reform

Effective January 2014, all commercial insurance plans will be prohibited from denying coverage to a person based on preexisting health conditions. Insurance carriers must cover any applicant and cannot terminate coverage based on illness. Lifetime limits on benefits are prohibited. These changes assure coverage for all inmates for any condition at release or parole.

Health Insurance Exchanges

The ACA requires every state to have a Web-based health benefit exchange in operation by January 2014. Each state may operate its own exchange, operate it in partnership with the federal government or delegate operation fully to the federal government. In any case, the exchange will allow individuals and employees of small businesses to shop for insurance through a user-friendly portal. All exchanges will offer four standardized levels of coverage with several plans available in each level. Plans within each level will be easy to compare for cost, quality and provider network.

Exchanges are intended to spark competition among insurance carriers and result in more numerous and affordable insurance options.

New Medicaid applications will also be made through the exchanges, which must use a single enrollment form for all plans and Medicaid. The exchange will interface with the IRS, Social Security Administration and other state and federal sources necessary to determine eligibility electronically in a simple, seamless process.

To assure that health insurance is affordable, the ACA provides premium subsidies for individuals and families. The federal government will pay graduated subsidies to persons with incomes at 100% to 400% of the federal poverty level. In 2012, the income range for individuals is $11,170 to $44,680 and for a family of four it is $23,050 to $92,200. These subsidies are intended to assure that health insurance premiums account for no more than 9.5% of a family's wages. Subsidies are available only for insurance plans purchased from an exchange.

According to the ACA, individuals are not qualified to enroll in a health plan through an exchange "if, at the time of enrollment, the individual is incarcerated, other than incarceration pending the disposition of charges." This provision implies that a detainee who is enrolled in an exchange plan and in a pretrial status or otherwise awaiting disposition should be covered by that insurance plan during incarceration. A large portion of the nation's jail population is awaiting disposition of charges, and this provision may offer a new option for health care services provided to those detainees. Jails may be able to bill insurance plans for prescription drugs, physical exams, mental health services and other on- and off-site care. However, such arrangements will be challenging to establish and administer and must account for plan-specific provider networks, prior authorizations and many other factors.

Medicaid Expansion

States and the federal government share the cost of the Medicaid program. Each state receives federal matching funds for Medicaid services, and today the match rate ranges from 50% to 74%. For every $10 a state spends, the federal government matches $5.00 to $7.40.

Today, eligibility for Medicaid is determined by category and income. Pregnant women, children and adults age 65 or older who meet their state's income and asset tests are eligible. In most states, childless adults are eligible only if they have a disabling condition that will prevent them from working for a year or more. Other low-income adults are not eligible, except in a few states that have implemented federally approved waivers. Today, about 3% to 5% of state prison inmates are Medicaid eligible.

Effective January 2014, Medicaid eligibility for persons not covered by current categories will be based exclusively on income. All U.S. citizens with incomes at or below 133% of the federal poverty level can be eligible for Medicaid. Application and eligibility determination will be simplified and expedited: Applicants will use a simple form created by the exchange, and income and citizenship will be verified by the exchange. In 2014, nearly all prison inmates and many jail inmates will be Medicaid eligible.

In addition, the federal matching rate for new Medicaid expansion population will be 100%—the federal government will bear the full cost of the Medicaid expansion population for the first few years and 90% thereafter.

The Supreme Court has given states the option of deciding whether or not to participate in the Medicaid expansion, without penalty to their current Medicaid programs. Several states are deeply committed to the expansion; a few are highly opposed. Most states are expected to participate since nearly the entire cost is borne by the federal government and there are other significant financial implications in opting out of the Medicaid expansion.

In states that expand Medicaid per the ACA, nearly all persons who are incarcerated will be eligible for Medicaid or subsidized coverage at release or parole, creating a seamless continuum of coverage for this population for the first time. The Medicaid expansion has two major implications for corrections: matching funds for inpatient hospitalizations, and opportunities for continuity of care at release or parole.

Medicaid and Inpatient Hospitalizations

Medicare and many commercial insurance plans do not provide health care benefits to incarcerated persons. Federal Medicaid rules, however, currently allow federal matching funds for inpatient hospitalizations and skilled nursing home admissions when an inmate is enrolled in Medicaid, the hospital stay is longer than 24 hours and the hospital is one that serves the general public (even if the inmate is in a locked unit guarded by the jail or prison). No other services are eligible for Medicaid matching funds. This provision is confusing and widely misunderstood, but prisons, jails and Medicaid agencies that work through its complexities can significantly bolster their budgets. In addition, the correctional organization or county, rather than Medicaid, can pay the nonfederal share of the hospitalization so that the state Medicaid budget does not grow but the state or county cost for inpatient care is offset by federal matching funds.

As noted, today about 3% to 5% of a prison population is eligible for Medicaid; these inmates may account for 10% to 50% of inpatient hospital care. In 2014, when nearly all inmates will be Medicaid eligible, nearly all inpatient hospitalizations will be eligible for federal matching funds at 100%.

About a dozen state departments of correction and a few large jails are collecting Medicaid federal matching funds for some or all eligible inmate hospitalizations. Other corrections organizations have not pursued Medicaid matching funds because the volume of eligible admissions has been relatively small and establishing a process is complex. Beginning in 2014, the volume of hospitalizations eligible for federal match at 100% becomes very large and Medicaid enrollment becomes simpler. All prisons and jails, whether currently collecting federal match or not, should work with the state exchange and Medicaid to establish a standard process to enroll inmates in Medicaid, keep them enrolled and collect available federal funds for hospitalizations.

Medicaid and Continuity of Care

The ACA offers important new opportunities for improving continuity of care for inmates being released or paroled. Enrolling inmates in Medicaid will be a simple process using the state's health benefit exchange and a simple application.

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Many eligibility determinations will occur in real time and will no longer depend on lengthy, labor-intensive disability determinations.

Inmates with mental illness, HIV/AIDS, hepatitis and other chronic or serious conditions will have a continuous source of primary and specialty care and prescription drugs at release. This provision will afford an opportunity for correctional institutions and community-based providers to ensure continuity of care. Access to health care following incarceration is a known deterrent to reoffending, so this new opportunity can enhance health and public safety and also reduce incarceration costs for recidivism.

Prisons and jails should be aware that eligibility for Medicaid does not necessarily equate to a source of care in the community. Seamless access to free-world health care is contingent on several factors:

- The inmate must be enrolled in Medicaid or an exchange plan effective on the date of release. Someone must assist the inmate to enroll via the Web-based exchange prior to release or parole.
- The inmate must be established with a community provider. For inmates with active health conditions, a "warm handoff" in which the inmate has an appointment with a community primary care provider is ideal. Someone must establish contact with the insurance carrier or Medicaid system and coordinate postrelease care with the corrections plan of care.

These are new functions for prisons and jails. They will require new resources and planning, and developing processes will take time.

Medicaid managed care organizations, federally qualified health centers and local primary care practices are potential partners in developing these processes. Depending on the state Medicaid plan, all may have significant financial risk for new Medicaid beneficiaries who are ex-offenders and therefore have a strong interest in preventing unnecessary emergency room visits and hospitalizations. "Warm handoffs" and aligning parole officers with an ex-offender's primary care provider can prevent these unnecessary expenses.

Impending Health Care Workforce Shortages

The ACA's health insurance coverage expansions will create new demand for primary care, mental health services, substance abuse treatment and prescription drugs for 30 million people, far exceeding today's health care workforce capacity. Corrections organizations should expect increased challenges in recruiting and retaining nurses, primary care providers, pharmacists, psychiatrists and mental health providers. Challenges will likely emerge by mid-2014 and worsen thereafter. Unfilled positions can significantly reduce inmate access to necessary care and create significant risk for inmates and correctional facilities. Staffing requirements in vendor contracts do not protect prisons and jails—widespread workforce shortages will hinder vendor recruitment but the consequences of poor care will fall on corrections.

Prisons and jails should immediately begin to redesign health care practices to assure that medical providers are fully occupied, clinicians do not spend unnecessary time on paperwork or nonclinical interactions and custody is fully engaged in assuring that inmate "no-shows" are minimized. Examples of such redesign efforts include the following:

- Expand clinic hours to 10- or 12-hour shifts
- Eliminate physician approval for shoes, low bunks and other accommodations
- Upgrade scheduling systems to integrate mental health, dental and medical appointments, "compress" multiple inmate appointments and manage prescription drug renewal
- Require primary care providers to manage psychotropic medications for stable inmates, with psychiatrists in a consultative role
- Expand telemedicine so that in-house psychiatrists and primary care providers see inmates in rural locations
- Eliminate provider appointments and pharmacy fills for over-the-counter medications

Changes of this scope require support from all sectors of corrections and from the highest leadership in custody and health care. They will take time and effort, and should begin immediately in order to be operational when workforce shortages emerge.

Preparing for the Affordable Care Act

The ACA creates several new opportunities and challenges for correctional health care and addressing them will be complicated and involve many stakeholders. January 2014 is just around the corner, so prisons and jails should begin to prepare immediately. All prisons and jails should take the following steps, at a minimum:

- Educate custody and health care leaders at the highest level of the organization about the ACA and the decisions prisons and jails must make
- Engage with the state's exchange effort to build seamless and ongoing enrollment of inmates into Medicaid or exchange plans as inmates move between jails, prisons and the community
- Decide whether to directly assist inmates in enrolling in coverage on the exchange and, based on that decision, build appropriate processes
- Develop or expand processes to collect federal matching funds for inpatient hospitalizations of inmates enrolled in Medicaid
- Build relationships and discharge planning processes with community providers, especially Medicaid managed care organizations
- Assure that vendor contracts can be modified to address changes that arise as a result of the ACA. This could include revisiting payments if hospital costs are covered by Medicaid, new duties in discharge planning, etc.
- Begin to revise on-site clinical practices so that all providers are operating at "the top of their licenses," productivity is increased and scheduling is optimized.

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