New Faces in the Expansion Population: Parolees and Ex-Offenders

The Challenges and Opportunities of Covering this Special (and Large) Population

Donna Strugar-Fritsch
Principal
March 25, 2013

HEALTH MANAGEMENT ASSOCIATES

Objectives

- Understand the scale of parolees and ex-offenders in Medicaid expansion and Exchange populations
- Discuss the unique health characteristics of this population
- Review requirements of Medicaid and Exchange plans to cover services delivered to enrollees while in jail and prison
- Describe new opportunities to manage health care utilization and cost, reduce recidivism, and achieve better health outcomes for this newly insured population
- Explore roles and opportunities for states, health plans, providers, prisons, and jails in assuring continuity of care following release or parole

A Few Notes to Start…

- HMA experience in correctional health care
- Presentation aimed at providers, health plans, and Medicaid
- Much of the information may be new
- Questions at the end
- Definitions

Prison Characteristics

- System, run by state or federal govt
  - Single set of policies and operations, many facilities
- Sentenced inmates, most have come from jail
- Incarceration at least a year
- Population stable

Jail Characteristics

- In every county, large city
- Usually run by Sheriff or Dept. Public Safety
- Up to 60% inmates are pre-adjudicated – awaiting trial/disposition of charges
- Rapid churning of large numbers < 24 hours
- Detainees may be actively psychotic
- Detainees may need acute detox
- Sentenced inmates stay up to a year*

Definitions

- Ex-offender, released prisoner: has fulfilled sentence, no longer under correctional supervision
- Parolee: released before fulfilling full sentence, under conditions of parole; responsible to parole officer (who can be an ally in accessing health care)

The Scale of Inmates in ACA Coverage Expansions

- 750,000 inmates released from prison each year
- 9 million people circulate through jails each year
- 93 – 98% of today's inmates will be released or paroled
- Nearly all will be Medicaid-eligible in states that opt for Medicaid expansion
  - Full Medicaid expansion estimated at 17 million

The Scale of Inmates in Expansions

- If we assume that 1/3 of 9 million people detained in jails spend 2 weeks or more in jail, for purposes of this discussion, people released or paroled from jail and prison = **3.75 million a year, or 22% of the Medicaid expansion population**
- A major metropolitan area estimates 1 in 3 of the expansion population will come from the justice system
- Where Medicaid is not expanded, Exchanges will subsidize coverage for persons 100% - 400% FPL. Many ex-offenders will qualify with family members.

Offender Populations Can Be Very Local Issue for Health Plans and Providers

Expect that *all* Medicaid and Exchange plans will have some experience with ex-offenders, but for those *located near a prison or large jail*, the impact may be very significant

- Are you near a prison or large jail?
- Medicaid and Exchange Plans – how do enrollees choose a plan?

Unique Health Characteristics of Offenders

Conservatively, 11% of inmates have serious and persistent mental illness and an additional 7% - 9% have mental illness of less severity. Also extremely high incidence of Substance Use Disorders

- Women have even higher levels, most have been abused
- MN DOC 2012 women – 70% dependent on at least 1 substance, 7.9% SUD
- SAMHSA "Past Year Arrest" Adults 2012 Of 69,000, 14% used illicit drugs, another 14% had SUD, 26% had mental illness

Unique Health Characteristics of Offenders

- Higher rates of hypertension, asthma, and arthritis than general population; generally high levels of unmanaged chronic conditions
- High burden of stress-related disease, many prisons consider inmates age 50 to be "elderly" for health care purposes
- 13% – 54% have hepatitis C
- 7% have positive TB test
- 1.5% have HIV/AIDS
- Following release/parole, high rates of death from heart disease, suicide, drug overdose

Inmate Health Care Services

- Prisons and jails are constitutionally required to provide health care in order to avoid violating the 8th Amendment. Landmark 1976 lawsuit *Estelle v. Gamble* established that inmates have the right to be free of "deliberate indifference to their serious health care needs."
- Per *Estelle v. Gamble*, inmates have the right to:
  - access emergency and routine care
  - a professional medical judgment
  - care that is ordered

Inmate Health Care Services

- All detainees are triaged at intake and immediate referrals are made for infectious disease, chronic illness, mental health, substance abuse
- Complete physical, mental, dental exam within 14 days is mandatory under accreditation standards and most state regulations

Inmate Health Care Services

- Every prison has:
  - Primary care clinic staffed with doctors, mid-levels, and nurses
  - Urgent/emergent capacity, daily sick-call with triage within 24 hrs
  - Access to off-site emergency and specialty and tertiary care
  - Access to full panel of prescription drugs
  - Full range of mental health services, including social worker/therapists, psychologists, psychiatry, and full panel of psychotropic medications
- Many provide full range of age and gender-appropriate primary care including preventive services
- All engage in significant efforts to manage chronic disease
- Every treated inmate has a medical record, plan of care, and complete history. Many facilities have Electronic Medical Records.

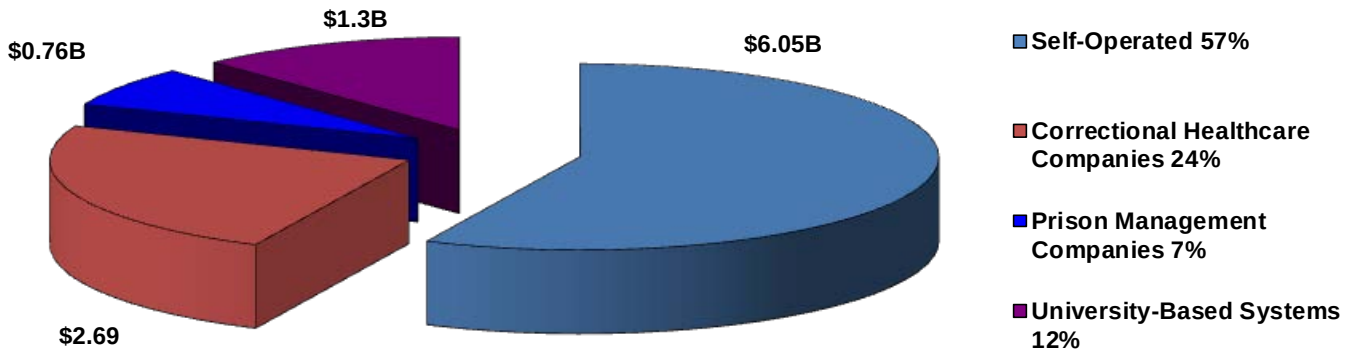
Inmate Health Care Services

- Jails in medium-large counties and cities have the same, with additional detox services.
- Smaller jails differ widely.
- Correctional health care services may be provided by state or county staff, public health department staff, university medical staff, correctional health vendors, or any combination of these.

$10.8 billion spent on inmate health care 2011

INMATE HEALTHCARE MARKETPLACE

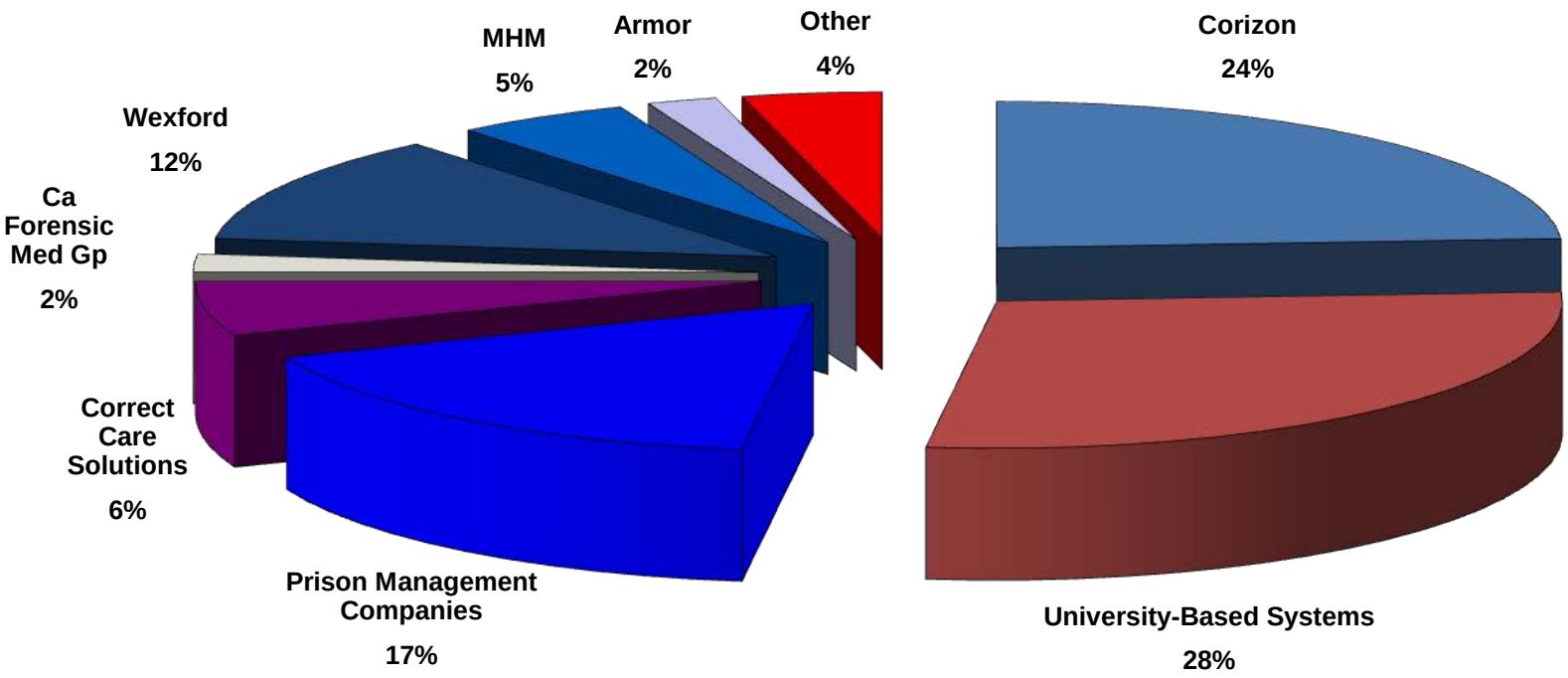
Total Spending - $10.8B



Outsourced - $4.75B / Self-Operated - $6.05B

Source: ASGR (MAR-2011)

OUTSOURCED INMATE HEALTHCARE MARKET OVERVIEW



Source: ASGR (2010)

Inmate Health Care Services

The inmate with chronic or infectious disease or mental illness is usually stable when released from prison and often stable when released from jail.

Effects of Access to Health Care at Release/Parole

- Access to health care following release/parole is well-documented to reduce recidivism
- 2012 Muskegon, MI project linked 2,000 parolees/ex-offenders to medical home. Recidivism decreased from 44% to 26%.
- Significant public safety, and public cost issue
- Also significant public health issue, in continuity of treatment for infectious diseases like TB, sexually transmitted diseases, hepatitis

Affordable Care Act and Inmates

- In 2014, inmates with serious or chronic illness can move into primary care and behavioral health coverage at release/parole, many for the first time ever
- Opportunity for significant improvements in continuity of care; treatment plans and medications for chronic/infectious/mental illness can be **seamless.**

Ex-Offenders can pose serious risk to health plans

- Have little or no reliable experience with the "free world" health care system
- Have little or no income, are often homeless, and have problems accessing reliable transportation
- Likely to use Emergency Rooms
- Ex-offenders with serious mental illness are at high risk for stopping psychotropic medication when the amount provided at release (if any, typically 5 – 30 days supply) runs out
- Following release/parole, extremely high rates of death from heart disease, suicide, drug overdose

Maximize Benefit, Minimize Risk

- It is in the public's interest for ex-offenders to be enrolled in Medicaid/Exchange plans at release/parole
- Early identification is essential for all parties
- It is in the Health Plan's interest to engage the new member immediately at release
  - Discharge planning with prison/jail
  - Communication between providers
  - "Warm hand-off," "In-reach"
  - Intensive case management: medical home, meds, transportation
  - Engage parole officers

Challenges

- Who will enroll inmates?
  - Prison/jail? Navigator? Hospital?
- Exchanges must accommodate enrollment from prison/jail (Exchange and Medicaid). **Can Exchange capture status of enrollee as incarcerated**?
- No one is responsible for these activities today
  - New and unfunded roles for prisons/jails/vendor
- Relationships between health plans and prisons/jails are scant, poorly developed
- Issues not on radar screen of health plans, prison/jail, Medicaid, Exchange
- Time is short

What Should You Do?

Medicaid

- Make sure leadership understands the scale
- Be sure Medicaid can enroll and suspend people during incarceration, through the Exchange or other means
- Provide direction/leadership to plans and providers to develop working relationships with prisons and jails
- Assure that application can capture status of enrollee as incarcerated

What Should You Do?

Health Plans/Providers, especially in service areas near prisons and large jails

- Make sure leadership understands the scale
- Develop relationships with prisons and jail providers and administrators
- Understand their discharge/release practices
- Assure that application can capture status of enrollee as incarcerated
- Develop prison/jail in-reach practices for sick inmates
- Assign (specialized) case managers
- Develop warm hand-offs and medical record exchange
- Engage parole officers where practical

What Should You Do?

Prisons/Jails

- Make sure leadership understands the scale
- Recognize that you have something the health plans want and need – medical history, clinical information, and access to the new plan member
- Find out which Medicaid plans/providers will enroll your inmates
- Assure that application can capture status of enrollee as incarcerated
- Invite medical leadership to tour health facilities, discuss formularies, protocols, discharge practices

What Should You Do?

Prisons/Jails

- Decide who/where enrollment will occur
- Develop release protocols for sick inmates that allow for discharge planning (jails: no more midnight releases)
- Integrate discharge planning functions for physical and mental health, assign them

Medicaid FFP for Inpatient Hospitalizations

- Medicaid excludes FFP for services provided to incarcerated enrollees. However, since 1997, federal rules allow FFP for inpatient hospitalizations of > 24 hrs because person is considered not incarcerated during that time.
- Some states and jails have accessed FFP in a variety of ways, but today only 3-5% inmates qualify for Medicaid.
- In 2014, nearly all inpatient admissions will be eligible for FFP.

Medicaid FFP for Inpatient Hospitalizations

- Many states are considering this FFP in deciding on the Medicaid expansion, many cities and counties counting on budgetary relief
- Serious questions:
  - How will Medicaid health plans operationalize?
  - How will hospitals address?
  - How should prisons and jails proceed?

Exchange Plans and Pre-Trial Detainees

Typically, commercial plans exclude coverage to incarcerated persons. However, ACA Section 1312 (f)(1)

(A) IN GENERAL.—The term ''qualified individual'' means, with respect to an Exchange, an individual who —

(i) is seeking to enroll in a qualified health plan in the individual market offered through the Exchange; and

(ii) resides in the State that established the Exchange (except with respect to territorial agreements under section 1312(f)).

(B) INCARCERATED INDIVIDUALS EXCLUDED.—An individual shall not be treated as a qualified individual if, at the time of enrollment, the individual is incarcerated, **other than incarceration pending the disposition of charges.**

About 60% of jail detainees are pending disposition of charges

Exchange Plans and Pre-Trial Detainees

HMA has evaluated this language and we believe that, short of action by HHS Secretary Sebelius, **Exchange plans must cover medically necessary services provided to pre-trial detainees.**

- Commercial plans are generally not aware of this provision and neither plans nor jails know how to address it.
- What would be covered: medications, diagnostics, treatment, prevention, chronic care?
- In-jail care, or just off-site?
- Who is a network provider?
- How would authorization and reimbursement/ compensation occur?

Exchange Plans and Pre-Trial Detainees

- Don't expect wholesale implementation on 1/1/14
- Will be a bigger issue in states that do not implement Medicaid expansion, because more detainees will be eligible for subsidized Exchange coverage
- Exchanges, Exchange plans, and jails should be prepared to consider the issue.

Summary

- Ex-offenders and parolees will comprise a large portion of Medicaid and subsidized Exchange populations in every state and large city
- The population presents clinical, financial and administrative risks and opportunities for communities at large, states, health plans, and exchanges
- Much of this information is new and there are many unknowns, but the challenges and opportunities are real

Summary

- Cross-over of public safety (reduced re-offending), health and financial issues
- Natural partnerships between DOCs, prison wardens, sheriffs, MCOs, Exchange plans, public health, safety net providers, city and county financial leaders, Medicaid
- Many of these relationships don't exist today, will require strong leadership and vision, detailed follow-through

Summary

- Opportunities build on what managed care and public health already do well, just starts behind bars
- On managed care side, no real call for changes in case mix or risk adjustments or carve outs, medical and psychosocial conditions and similar to ABD populations; the jail or prison is the new twist
- Developing strategies will take time – don't wait to get started

– QUESTIONS AND DISCUSSION