

THE CHALLENGE OF CORRECTIONAL HEALTH CARE

Balancing cost with quality of care

Correctional facilities are tasked with delivering high-quality health care to a large, complex, and aging population under the pressures of increasing regulation and budget constraints. This paper explores options that may help corrections officials stabilize or reduce costs while maintaining high standards for care.

Caring for incarcerated patients:

- Unique challenges
- The effect of health care reform
- Promising cost-saving strategies
- Treating a growing elderly population



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EXECUTIVE SUMMARY

The correctional health community has faced the challenge of improving health care for the prison population while containing costs for decades.* The prison population is growing rapidly and each jurisdiction at the federal, state, and local level has its own health care policies and procedures. Moreover, the population is getting older due to “tough on crime” policies such as “three strikes” and longer sentences, while the regulatory and economic pressures of providing inmates with high-quality health care are increasingly more demanding.¹

MEDICAID EXPANSION

The Patient Protection and Affordable Care Act (PPACA) provides for the expansion of Medicaid to include all individuals under age 65 with incomes up to 133 percent of the federal poverty level, including single adults and adults without children. A 2012 U.S. Supreme Court ruling gave states the power to decide whether to expand Medicaid, and a recent analysis estimates up to 35 percent of individuals who would be newly eligible under Medicaid expansion have been involved in the criminal justice system at some point.²

Several jurisdictions are currently evaluating how Medicaid expansion will affect inmate populations before, during, and after release.

POTENTIAL SOLUTIONS

Clearly, finding solutions which will improve care and contain costs in the correctional health community are more urgent than ever before.

Correctional reformers and experts have proposed many innovative cost control solutions over the years. Several promising solutions including more efficient claims processing, improved procedures for utilization review, and pharmacy management are among the topics addressed in this paper.

*For the purposes of this white paper, a prison houses inmates who have been convicted, typically felons and those sentenced to a year or more. Prisons are under the jurisdiction of either federal or state authorities.

A UNIQUE CHALLENGE

The United States incarcerates a higher percentage of its population than any other country in the world.* The U.S. imprisoned 753 per 100,000 population in 2008, and the incarceration rate increased 240 percent from 1980 to 2008.³ Moreover, state and local governments, not federal, bear more than 90 percent of the total costs of corrections in the United States.⁴

Prisoners at every level have always been less healthy than the general public. A 2009 report from the National Institutes of Health (NIH) showed that 40 percent of all prisoners reported at least one serious chronic medical condition. Almost one-quarter of the prison population, roughly 490,000 inmates, have a previously diagnosed mental health condition, such as schizophrenia, bipolar disorder, depression, or anxiety.⁵

Incidence of diabetes among federal inmates is 11.1 percent compared with 6.5 percent among similarly aged members of the public. The prevalence of prior myocardial infarction among the populations of the state (5.7 percent) and federal prisons (4.5 percent) compared with 3 percent in the general population.⁷

According to a U.S. Bureau of Justice Statistics report issued in 2012, the rate of state and federal inmates with HIV/AIDS was 146 inmates per 10,000.⁸ The HIV/AIDS rate was 15.0 per 100,000 in the civilian population that year, according to the Centers for Disease Control.⁹

The prison population is also getting older. A Bureau of Justice analysis found that the number of elderly male prisoners, defined as aged 55 and older, jumped by 82 percent from 1999 to 2007.¹⁰

While in prison, elderly inmates tend to show signs of aging faster than elderly Americans outside prison walls, according to a CNN report.¹¹ For this and other reasons, health care costs for elderly prisoners can be up to nine times greater than for younger inmates, according to a Human Rights Watch report cited in the New York Times.¹²

40%

of all prisoners reported at least one serious chronic condition, according to a report from the NIH.

*All statistics refer to U.S. institutions unless otherwise noted.

As a result of these challenges, results from a study by the State Health Care Spending Project found that health care spending on inmates increased in 42 of 44 states from 2001 to 2008. The median increase was 49 percent. In 10 states, health care spending increased by at least 90 percent. A study by Pew found that per-inmate spending increased in all 44 states surveyed, with a median increase of 28 percent.¹³

THE EFFECT OF HEALTH CARE REFORM



The Patient Protection and Affordable Care Act (PPACA) provides for the expansion of Medicaid to include all individuals under age 65 with incomes up to 133 percent of the federal poverty level, including single adults and adults without children. A 2012 U.S. Supreme Court ruling gave states the power to decide whether to expand Medicaid, and a recent analysis estimates up to 35 percent of individuals who would be newly eligible under Medicaid expansion have been involved in the criminal justice system at some point.¹⁴

Medicaid expansion does not affect the so-called “inmate exception,” whereby inmates, both pre- and post-adjudication, are generally ineligible for Medicaid. As a result, an inmate’s Medicaid coverage is suspended or terminated, depending on the state’s policy, upon incarceration.

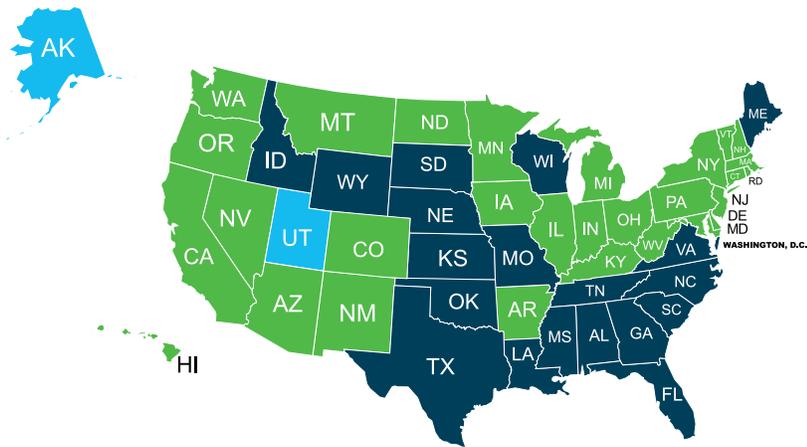
However, guidance letters issued in 1997 and 1998 by the Centers for Medicare and Medicaid Services (CMS) may allow states to shift the cost of Medicaid-eligible inmates to the federal government for inpatient stays outside the correctional facility that exceed 24 hours. In states that have opted to expand Medicaid, the CMS guidance language has the potential to ease the financial burden of outpatient stays for inmates who previously had been ineligible for Medicaid.

A few jail and prison systems already have programs that can serve as models for helping enroll inmates into medical assistance programs upon release.

A UNIQUE CHALLENGE

As stated earlier, the PPACA does not affect the inmate exception rule, but many Medicaid-expansion states are recognizing the advantage of enrolling eligible inmates in Medicaid upon release. Many correctional officials anticipate both a social benefit and long-term cost savings from any effort made to educate inmates about their health care options, and to helping inmates apply for or continue Medicaid benefits after they are released from custody.

Twenty-nine states and the District of Columbia have chosen to expand Medicaid under PPACA. As of April 2014, Cook County Jail in Chicago started more than 13,000 inmate applications. With the help of a counselor from Treatment Alternatives for Safe Communities, new inmates complete an application for Medicaid as part of the intake process.¹⁵



19
states are not expanding Medicaid

30
states are expanding Medicaid including D.C.*

2
states are awaiting federal waiver approval

NOTES: *AR, IA, IN, MI, PA and NH have approved Section 1115 waivers. Coverage under the PA waiver went into effect 1/1/15, but it is transitioning coverage to a state plan amendment.

SOURCE: "Status of State Action on the Medicaid Expansion Decision," KFF State Health Facts, June 2015

San Francisco's Board of Supervisors approved a bill allowing the Sheriff's Office to enroll inmates into Medicaid in June 2014. Sheriff Ross Mirkarimi said he expects to save \$2,500 in medical expenses per year, per inmate while reducing recidivism by roughly 20 percent.¹⁶

Ohio's Department of Rehabilitation and Correction has announced plans to enroll inmates in Medicaid after they have been hospitalized for 24 hours. The state expects to save \$18 million annually through the practice.¹⁷

A few jail and prison systems already have programs, which can serve as models for helping enroll inmates into medical assistance programs upon release. New York City's Department of Health and Mental Hygiene has a state-funded discharge planning staff to handle the screening and pre-enrollment of eligible individuals into Medicaid and other programs. New York is one of a few states that suspend rather than terminate Medicaid benefits upon incarceration, so Medicaid beneficiaries incarcerated less than 30 days can retain their status. Those in custody more than 30 days can generally have their coverage reinstated after their release.

The National Association of Counties suggests several steps that correctional facilities should consider:

- Improve data gathering and sharing.
- Evaluate and improve screening and discharge-planning processes.
- Use outside resources.
 - Salt Lake County, Utah, directly employs state Medicaid eligibility workers by paying the Medicaid administrative rate, as well as by working with other community partners.
- Develop or strengthen partnerships with state and community officials and health care service providers.¹⁸

PROMISING COST-SAVINGS



Utilization review

Innovative care practices, inventive models for payment, and advanced technology for providing medical services and preventing fraud are among the practices proven to be effective at controlling costs. Chief among these solutions is improving practices for utilization review.

Utilization review programs have been shown to reduce or slow the growth of costs in many states by denying services that are not clinically appropriate, approving a lower-cost treatment alternative, and/or preventing unnecessary hospitalization. During one three-year period, the Florida Department of Corrections used utilization review to cut hospital spending from \$11.9 million to \$11.3 million, despite a 20 percent increase in the average daily prison population.¹⁹

Many programs introduced in the name of improved utilization review have already had a considerable effect. The extensive use of nurse practitioners instead of doctors, for example, may adequately meet the medical needs of most prisoners while substantially reducing health care costs for correctional institutions. This is particularly true in states where nurse practitioners are allowed to prescribe medications with as much latitude as physicians.

Efficient claims processing

The use of rigorous claims processing with fraud detection to spot errors and abuse is crucial to controlling costs. Unbundling, upcoding, and other types of errors can cost institutions a significant amount of money. Improving claims processing may seem obvious, but an experienced claims processor can discover fraud and waste that may otherwise go undetected. Combining the expertise of an experienced claims processor with new technological tools and more sophisticated claims systems could help correctional facilities realize significant cost savings.

Efficient claims processing not only helps detect fraud, but it also helps a correctional institution meet payment responsibilities in a timely fashion. Timely payment remittance helps maintain good relationships with local health care providers.

Telemedicine

Several state corrections departments have adopted telemedicine, an interactive remote medical consultation service. Telemedicine allows prison health care professionals to hold a videoconference with outside specialists, eliminating the costs of providing security and transporting a prisoner to an outside medical facility.

Texas and Ohio report savings between \$200 and \$1,000 per consultation through telemedicine.²⁰ Although the average cost of installing telemedicine equipment in a prison unit ranges from \$50,000 to \$75,000, a report by the National Institute of Justice found that the initial equipment costs can be recovered in as little as 15 months. Once the initial investment is recovered, telemedicine can save most prisons as much as \$14,200 every month.

Preferred provider organizations (PPOs)

Some states achieved significant cost savings by using PPOs. Under this type of arrangement, a state corrections department contracts with providers that agree to charge discounted fees or standardized rates, or that will accept per-capita payments for all services provided to an enrollee for a specified time.

Nebraska trimmed \$3.5 million from expected medical costs by negotiating lower rates with hospitals in Lincoln and Omaha.²¹ State corrections departments have also shed costs by contracting with HMOs for comprehensive health care.



Several state corrections departments are using telemedicine to bypass the costs of transporting and providing security to take a prisoner to a hospital.

PROMISING COST-SAVINGS

New models for payment

According to results from a National Institute of Corrections survey of 49 state corrections departments and the Federal Bureau of Prisons, ambulatory and emergency care represents a huge expense for most states. In response, many states launched innovative approaches including:

- fee for service;
- pre-negotiated discounted fee for service;
- capitated rates for specific services (departments make payments in advance for services such as dental or ambulatory care);
- global capitated model (fixed inmate-per-day fee for all health care services);
- making health care providers state corrections' employees.

The survey found that the capitated contract model provided the least expensive ambulatory care service, while the global capitated model delivered the best price for emergency services.²²

Intake health screenings

A 2008 change in standards issued by the National Commission on Correctional Health Care (NCCHC) gave jails and prisons a second option for the screening and initial health assessment of prisoners. Corrections facilities typically conduct an intake screening on new inmates, followed by an "initial" health assessment within seven days (prisons) or 14 days (jails).

Facilities may now skip the follow-up (or "initial") health assessment if they expand the intake screening by gathering more information on inmates. With this new option, the initial health assessment is only necessary for prisoners receiving screenings that indicate clinically significant findings.

This expanded intake screen allows facilities to avoid spending limited resources on assessments of healthy inmates.



Nebraska trimmed \$3.5 million from expected medical costs by negotiating contracts with hospitals in Lincoln and Omaha to avoid paying the highest rates charged.

Facilities must have around-the-clock health staff to choose this option. In addition, the expanded intake screening must include an inquiry into the inmate's medical history and symptoms of chronic disease, a finger stick for inmates with diabetes, and collection of vital signs, including blood pressure.

SAVING ON OFFSITE CARE



According to one estimate, offsite care accounts for 15 to 25 percent of the overall health budget in a jail setting, and 12 to 22 percent in the prison setting.²³ Each clinic trip and hospital stay generates significant costs, particularly in overtime for security details.

Therefore, many institutions are now reducing the need for offsite care by upgrading onsite infirmaries and improving management of chronic care. Some institutions have obtained additional funding to hire infirmary personnel, purchase new equipment, or establish onsite specialty clinics because they've demonstrated that these improvements will reduce officer overtime.

Emergency room (ER) trips also consume valuable resources. Correctional consultant Rick Morse claims that prisons should have no more than 75 to 100 such trips per 1,000 inmates per year, and that at least 40 percent of these trips should result in hospital admission.²⁴ Anything less, he says, indicates poor use of emergency department resources. Assessing patterns can help determine which trips are necessary. A high number of night trips, for example, may indicate that inmates are manipulating the system, which suggests the need for a better assessment process.

A jail should see 130 to 150 hospital days per 1,000 inmates per year, Morse says. In prison, this number should be 125 to 145 days.²⁵ Although these ranges are similar, the patterns behind them differ. Jails typically have more hospital admissions, but a shorter average length of stay. On the other hand, prisons have fewer admissions, but a longer average length of stay.

Offsite care accounts for 15 to 25% of the overall health budget in the jail setting, according to one estimate, and 12 to 22% in the prison setting.

PROMISING COST-SAVINGS

In 2008, the NCCHC revised standards for continuity of care to improve follow up and monitoring of offsite care. These standards now specify that when an inmate returns from an ER visit, the prison physician should see the patient, review the discharge orders, and issue follow-up orders as clinically indicated. If the prison does not have an onsite physician or if a physician is not present at the time of release, designated health staff should contact the physician on call to review the ER findings and obtain orders as appropriate.

The same NCCHC principles of review and follow up apply when an inmate returns from being hospitalized. These revised standards should help improve care and may improve inmates' perception of the quality of care they're receiving.

CONTAINING DRUG COSTS



Pharmaceuticals should account for 9 to 12 percent of a typical jail budget and 14 to 16 percent in a prison.²⁶ Officials have found several ways to control drug and drug administration costs, including:

- negotiating lower fees with providers;
- using a generic formulary that requires approval by senior physicians for non-formulary prescriptions, except in emergencies;
- negotiating with the drug provider to reduce "fill fees," the price a pharmacy charges to fill a prescription;
- starting a keep-on-person program allowing inmates to hold a limited amount of certain medications, reducing the time nurses spend distributing medications;
- reviewing the pharmacy bill every month to ensure accuracy;
- developing reports that track important metrics, such as the number of medications distributed per inmate per month;
- exploring group purchasing opportunities or a centralized pharmacy that serves multiple facilities;
- examining eligibility for 340B pricing.

Pharmaceuticals should account for 9 to 12% of a typical jail budget and roughly 14 to 16% in a prison, according to one expert.

Jails and prisons have demonstrated clear savings on pharmaceuticals with such measures. Since 2003, the University of Rhode Island College of Pharmacy has collaborated with the Rhode Island Department of Corrections (RIDOC) on a pharmacy management program that uses a formulary, waste-reduction strategies, staff education, and treatment protocols. From 2003 to 2009, RIDOC pharmaceutical expenditures per inmate, per year grew at a rate of only 1.5 percent. As a result, the RIDOC saved almost \$5 million during this period.²⁷

ELDERLY INMATE CARE

The increasing number of older inmates has made it more challenging to provide care for this population. Moreover, the per-capita cost of incarcerating elderly inmates has soared. A survey conducted by the Criminal Justice Institute from 1997 to 2001 found that the average annual cost for treating an elderly inmate was \$60,000 to \$70,000, compared with \$27,000 per inmate in the general prison population.²⁸

Officials faced with this expensive and growing concern need new ideas for managing elderly and special-needs inmates. Building or remodeling existing inmate housing units, providing more adaptive devices such as walkers and hearing aids, and expanding programs that permit medical or compassionate release for elderly or terminally ill inmates can also reduce the cost of treating this population.

Many corrections officials try to predict future expenditures on elderly inmates so they can lobby their legislatures for more funds before the situation gets worse. Such appeals are most successful if they are based on specific costs, rather than general inflationary increases. Corrections officials in Utah, for example, have devised an “O55” index that divides cost increases by the percentage increase in the elderly population to identify past costs and predict future values.²⁹

The per-capita cost of incarcerating elderly inmates has soared, according to a report from the Criminal Justice Institute, to an average of \$60,000 to \$70,000 per year.

LONG-TERM CHALLENGE

Finding solutions that improve care and contain costs remains a long-term challenge for anyone concerned about the state of health care in U.S. correctional facilities. The prison population is getting older and sicker, while the requirements for providing inmates with health care are becoming more demanding due to regulatory and economic pressures. Despite these and other concerns, prison systems throughout the country have successfully implemented several cost-saving initiatives, such as:

- identifying potential fraud and abuse during claims processing;
- replacing in-person visits with telemedicine;
- improving procedures for utilization review;
- increasing use of PPOs, HMOs;
- using PBMs and pharmacy management programs;
- expanding infirmaries or building new onsite clinics to reduce offsite care;
- improving payment models for offsite care;
- improving follow up and monitoring of offsite care.

The pressures of the marketplace and the resourcefulness of health care professionals, corrections officials at all levels, and claims processors may lead to solutions to help improve the quality of the inmate health care, while controlling health care spending.

ABOUT AMERIHEALTH ADMINISTRATORS

AmeriHealth Administrators, Inc. has a history of innovation in managing self-funded health plans, and providing business process outsourcing services for insurers and payers. We listen, anticipate, and respond by leveraging technology and carefully crafting strategies, tools, and services to help correctional facilities and their health management companies provide inmates with access to offsite medical care.

By leveraging relationships with the provider community and a decade of experience in the industry, we coordinate external medical resources with correctional institutions and their health management companies to help contain costs without sacrificing quality of care. Services include:

- external care coordination with the facility's health management company;
- efficient claims adjudication with fraud protection safeguards;
- prompt provider payments to help maintain positive relationships;
- customized processes to match the uniqueness of the population;
- concurrent review and discharge planning.

Contact AmeriHealth Administrators at 1-800-984-5933 or visit our web site at ahatpa.com.

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