

The Patient Protection and Affordable Care Act What Are the Facts, and Where

By Viola Riggins

The Patient Protection and Affordable Care Act (PPACA), also known as the Affordable Care Act or Obamacare, has split the nation on the issue of health care reform. The mere mention of the act can cause emotions to run high for the majority of Americans one way or the other. PPACA defines its role as being established “to help Americans who found themselves uninsured and unwanted in the health insurance market find a health care home.” This act includes an opportunity for every American to be provided with appropriate insurance coverage to protect these individuals from financial ruin if they become ill and in need of care: “PPACA puts consumers back in charge of their health care. Under the law, a new ‘Patient’s Bill of Rights’ gives the American people the stability and flexibility they need to make informed choices about their health.”¹ Regardless of where we stand on the issue, the act is scheduled to take effect Jan. 1, 2014. To that end, we must not allow ourselves to be ignorant of what the PPACA stands for and what is required of us as correctional health care professionals.

As corrections professionals, we understand how to care for inmates who lack the resources to meet their own needs, especially as it relates to health care services in the community. Correctional health authorities nationwide have struggled for years to negotiate contracts and services for inmates when the community at large has viewed this population as undesirable. This is largely due to both the heavy level of services that they consume, and the community’s attitude about mingling offenders with citizens in community waiting rooms.

This raises several important questions: How does this act really affect the incarcerated population? How do we define “inmate” and “inmate patient” within the health insurance arena, and what rights and requirements do inmates have to access and comply with PPACA? Are they covered under the “Patient’s Bill of Rights?” The American Correctional Association’s Coalition on Correctional Health Authorities (CCHA) formed a working group to evaluate the data, understand the language of this

extensive law and then provide an unbiased look into how the new mandate may affect the incarcerated population. The CCHA-PPACA working group has spent many hours assisting secretaries and directors of corrections in understanding and developing a plan for managing this new act. The following provides an outline of that work.

PPACA — What Does It Mean?

PPACA is a U.S. federal statute signed into law on March 23, 2010. President Obama stated, “This act represents the most significant government expansion and regulatory overhaul of the U.S. health care system since the passage of Medicare and Medicaid in 1965.”² PPACA is aimed at increasing the rate of health insurance coverage for Americans and reducing the overall cost of health care. It provides a number of mechanisms — including mandates, subsidies and tax credits — to employers and individuals to increase the coverage rate. Additional reforms aim to improve health care outcomes and streamline the delivery of health care.

In the beginning of the planning phases of PPACA, the Congressional Budget Office projected that the act will lower both future deficits and Medicare spending. However, as of May 2013, their estimates determined that the overall cost of PPACA will result in a \$40 billion dollar cost to the American public after 12 years.³

On June 28, 2012, the U.S. Supreme Court upheld the constitutionality of most of PPACA in *National Federation of Independent Business v. Sebelius*. This very pragmatic and close ruling (a 5-4 vote) upheld the requirement that certain individuals pay a financial penalty for not obtaining health insurance, and that this penalty may reasonably be characterized as a tax. However, the court rejected the mandate in the law that would have expanded Medicaid. In a 7-2 vote, it ruled that the law exceeded its constitutional authority to require Medicaid expansion at the risk of losing existing federal payments.⁴

and Affordable Care Act: *Where Do We Go From Here?*

Legislation

PPACA legislation was written to provide comprehensive health insurance reform that will:

- Expand coverage;
- Hold insurance companies accountable;
- Lower health care costs to certain individuals;
- Guarantee more choices; and
- Enhance the quality of care for all Americans.

PPACA actually refers to two separate pieces of legislation: PPACA (Public Law 111-148) and the Health Care and Education Reconciliation Act of 2010 (Public Law 111-152). Together, these two pieces of legislation “expand Medicaid coverage to millions of low-income Americans and makes numerous improvements to both Medicaid and the Children’s Health Insurance Program (CHIP).”⁵

Centers for Medicare and Medicaid Services’ Implementation Priorities

Since the law was enacted in March 2010, the Centers for Medicare and Medicaid Services (CMS) have worked with states to identify key implementation priorities and provide guidance to prepare for significant changes to Medicaid. CMS provided forms of guidance and federal support for state efforts to develop new eligibility systems and to upgrade existing eligibility systems. In March 2012, CMS released two final rules defining the eligibility and enrollment policies needed to achieve coverage for individuals who will be eligible for Medicaid beginning in 2014, as well as eligibility and enrollment for the new affordable insurance exchanges. The insurance exchanges are considered the marketplace for individuals to buy insurance based on their income eligibility, through national and some state sponsored websites if the state chooses to participate in the marketplace exchange. As of January 2013, the insurance exchanges

were formally labeled the “Health Insurance Marketplace.” The Health Insurance Marketplace officially opened to the public Oct. 1, 2013.⁶

PPACA creates a minimum Medicaid income eligibility level across the U.S., that includes all people who meet income eligibility requirements. It no longer excludes adults ages 18-64. The PPACA also:

- Provides navigator grants — the grants allow for new jobs and training in each community on how to navigate the Health Insurance Marketplace;⁷
- Establishes a patient-centered medical home (PCMH) for each individual through the insurance system, requiring the primary care physicians to have resources to treat and/or refer the patient to services within their network;⁸
- Creates a simplified, single application form for all Medicaid services; and
- “Creates websites for those with questions and concerns to be able to research solutions on how to navigate and purchase health care.”⁹

PPACA Provisions

PPACA established a new office within CMS to coordinate care for individuals who are eligible for both Medicaid and Medicare (“dual eligibility”). If the state chooses to increase their Medicaid participation in full accordance with PPACA, the state will receive 100-percent federal matching funds for any service provided to an individual who previously was not eligible for Medicaid. The act was designed to promote transparency among Medicaid policies and programs, including federal Medicaid waivers. Health insurance exchanges will commence operation in each state, offering a “marketplace” where individuals and small businesses can compare policies and premiums, and buy insurance (with a government subsidy, if eligible).

The law expands Medicaid eligibility to include all individuals and families with incomes up to 133 percent of the poverty level.

The act has a shared responsibility requirement (an individual mandate) that all individuals not covered by an employer-sponsored health plan, Medicaid, Medicare or other public insurance programs, must secure an approved private insurance policy or pay a penalty — unless the applicable individual is a member of a recognized religious sect exempted by the Internal Revenue Service, or waived in cases of financial hardship. The act also includes numerous provisions designed to increase program integrity in Medicaid, such as: “Terminating providers from Medicaid that have been terminated in other programs, suspending Medicaid payments based on pending investigations or credible allegations of fraud, and preventing inappropriate payment or claims under Medicaid.”¹⁰

Under PPACA, low-income individuals and families above 100 percent, but less than 400 percent of the federal poverty level will receive federal subsidies on a sliding scale if they choose to purchase insurance via the marketplace exchange. Those between 133 and 150 percent poverty level would be subsidized so that their premium cost would be 3 to 4 percent of their income. The law expands Medicaid eligibility to include all individuals and families with incomes up to 133 percent of the poverty level.

However, in *National Federation of Independent Business v. Sebelius*, the Supreme Court allowed states to opt out of the Medicaid expansion, and some states have stated their intention to do so. States that choose to reject the Medicaid expansion can set their own Medicaid eligibility thresholds. Because expanded federal subsidies are not available to those states choosing not to expand their Medicaid enrollment, individuals purchasing insurance plans through the Health Insurance Marketplace are eligible for subsidies up to the amount their state’s plan allows.

Minimum standards for health insurance policies will be established, and annual and lifetime coverage caps will be banned. In addition, “Firms employing 50 or more people but not offering health insurance will also pay a shared responsibility requirement if the government has had to subsidize an employee’s health care.”¹¹ This portion of PPACA has been delayed and will take effect in 2016, rather than 2014 as originally intended.

PPACA Provisions by Effective Date

PPACA is divided into 10 titles and contains provisions that became effective immediately, 90 days after enactment and six months after enactment, as well as provisions that will be phased-in through 2020. The past, present and future provisions as outlined in PPACA are listed below.¹²

Effective at enactment — March 23, 2010. The U.S. Food and Drug Administration (FDA) is now authorized to approve generic versions of biological drugs and to grant biologic drug purchases, even for manufacturers that hold 12 years of exclusive use before generics can be developed. A nonprofit organization, the Patient Centered Outcomes Research Institute, was established independently from the government to undertake comparative research. Its 19-member board includes patients, doctors, hospitals, drugmakers, device manufacturers, insurers, employers, government officials and health experts. Other provisions include:

- The Medicaid drug rebates for brand name drugs was increased to 23.1 percent;
- A task force was created to evaluate and promote community preventive services. This task force will develop, update and disseminate evidence-based recommendations on the use of clinical and community prevention services;
- The Indian Health Care Improvement Act was reauthorized and amended;
- Chain restaurants/food vendors with 20 or more locations are now required to display the caloric content of their food; and
- States can apply for a state plan amendment to expand family planning eligibility to the same eligibility as pregnancy-related care (above and beyond Medicaid-level eligibility), through a state option rather than having to apply for a federal waiver.

Effective June 21, 2010. Adults with pre-existing conditions became eligible to join a temporary high-risk pool, requiring insurance companies that accepted the high-risk pool to no longer deny payment on services due to pre-existing conditions. As of January 2014, this temporary high-risk pool will be transitioned into the health care exchange and insurance companies will no longer be allowed to deny payment due to pre-existing conditions.

Effective July 1, 2010. The president established, within the U.S. Department of Health and Human Services (HHS), the National Prevention, Health Promotion and Public Health Council to help begin to develop a national prevention and health promotion strategy. A 10-percent sales tax on indoor tanning also took effect.

Effective Sept. 23, 2010. Provisions effective as of this date included:

- Insurers are prohibited from imposing lifetime dollar limits on essential benefits, such as hospital stays, in new policies issued;
- Dependents (children) are now permitted to remain on their parents’ insurance plan until their 26th birthday and regulations implemented under PPACA include dependents who no longer live with their

parents, are not a dependent on a parent's tax return, are no longer a student or are married;

- Insurers are prohibited from excluding pre-existing medical conditions;
- All new insurance plans must now cover preventive care and medical screenings. Insurers are prohibited from charging copayments, coinsurance or deductibles for these services;
- Individuals affected by the Medicare Part D coverage gap receive a \$250 rebate, and 50 percent of the gap was eliminated in 2011. The gap will be eliminated by 2020;
- Insurers' abilities to enforce annual spending caps are restricted, and will be completely prohibited by 2014;
- Insurers are prohibited from dropping policyholders when they get sick;
- Insurers are required to reveal details about administrative and executive expenditures;
- Insurers are required to implement an appeals process for coverage determination and claims on all plans;
- Enhanced methods of fraud detection were implemented through Medicaid oversight programs;
- Medicare was expanded to small, rural hospitals and facilities;
- Medicare patients with chronic illnesses must now be monitored/evaluated on a three-month basis for coverage of the medications to treat such illnesses;
- Companies that provide early retiree benefits for individuals ages 55-64 are eligible to participate in a temporary program that reduces premium costs;
- A new website installed by the secretary of HHS will provide consumer insurance information for individuals and small businesses in all states;
- A credit program was created to stimulate private investment in new therapies for disease treatment and prevention; and
- All new insurance plans must now cover childhood immunizations and adult vaccinations recommended by the Center for Disease Control's Advisory Committee on Immunization Practices without charging copayments, coinsurance or deductibles when provided by an in-network provider.

Effective Jan. 1, 2011. As of this date, insurers must spend 80 percent (for individual or small group insurers) or 85 percent (for large group insurers) of premium dollars on health costs and claims. This leaves only 20 or 15 percent, respectively, for administrative costs and profits, subject to various waivers and exemptions. If an insurer fails to meet this requirement, there is no penalty, but a rebate must be issued to the policy holder. This policy is known as the medical loss ratio. Flexible spending accounts, health reimbursement accounts and health savings accounts cannot be used to pay for over-the-counter drugs purchased without a prescription (insulin is the exception).

Effective Sept. 1, 2011. As of this date, all health insurance companies are now required to inform the public when they want to increase health insurance rates for individual or small group policies by an average of 10 percent or more. This policy is known as rate review.

Effective Jan. 1, 2012. Employers must now disclose the value of the benefits they provided beginning in 2012 for each employee's health insurance coverage on the employee's annual W-2 form.

Effective Aug. 1, 2012. As of this date, all new plans must now cover certain preventive services, such as mammograms and colonoscopies, without charging a deductible, copay or coinsurance. Women's preventive services are covered without cost sharing, including: well-woman visits (human papillomavirus testing); DNA testing for women ages 30 and older; sexually transmitted disease counseling, HIV screening and counseling; FDA-approved contraceptive methods and contraceptive counseling; breastfeeding issues; and domestic violence counseling. This is also known as the contraceptive mandate.

Effective Oct. 1, 2012. CMS began the Readmissions Reduction Program, which requires CMS to reduce payments to inpatient hospitals with excessive readmissions.

Effective Jan. 1, 2013. Income from self-employment and wages of single individuals in excess of \$200,000 annually are now subject to an additional tax of 0.9 percent. The threshold amount is \$250,000 for a married couple filing jointly. An additional Medicare tax of 3.8 percent will apply to unearned income. Also beginning Jan. 1, 2013, the limit on pretax contributions to health care flexible spending accounts was capped at \$2,500 per year. Most medical devices are subject to a 2.3 percent excise tax collected at the time of purchase. Insurance companies are required to use simpler, more standardized paperwork, with the intention of helping consumers make "apples-to-apples" comparisons between the prices and benefits of different health plans.

Effective Aug. 1, 2013. As of this date, religious organizations that were given an extra year to implement the contraceptive mandate must comply. Certain nonexempt, nongrandfathered group health plans established and maintained by nonprofit organizations with religious objections to covering contraceptive services may take advantage of an additional one-year enforcement safe harbor until Aug. 1, 2014.

Effective Oct. 1, 2013. Those looking to buy an individual health insurance policy can enroll in subsidized plans offered through state-based exchanges. Any person can purchase health care from the marketplace exchange. If the state the person lives in is participating in state-based and developed marketplace exchanges, the person can choose to purchase either from the national marketplace exchange, or the state marketplace exchange. Those with state marketplace exchanges will also allow for reduced insurance cost based on the income eligibility rule for their state.

Effective Jan. 1, 2014. As of this date, the following provisions will be effective:

- Out-of-pocket premium payments under PPACA will be maximized according to family size and federal poverty level;
- Insurers will be prohibited from discriminating against or charging higher rates for any individuals based on gender or pre-existing medical conditions;

- Insurers will be prohibited from establishing annual spending caps;
- Individuals who are not covered by an insurance policy will be charged an annual penalty of \$95, or up to 1 percent of income over the filing minimum, whichever is greater. This will rise to a minimum of \$695 (\$2,085 for families), or 2.5 percent of income over the filing minimum, by 2016;
- Exemptions to the mandatory coverage provision and penalty will be permitted for religious reasons, for members of health care sharing ministries, or for those individuals whose least expensive policy would exceed 8 percent of their income;
- In participating states, Medicaid eligibility will be expanded. All individuals with income up to 133 percent of the poverty line qualify for coverage, including adults without dependent children;
- PPACA as it was originally written in March 2010 intended to withhold Medicaid funding from states declining to participate in the expansion. However, on June 28, 2012, the U.S. Supreme Court ruled that this withdrawal of funding was unconstitutionally coercive, and that individual states had the right to opt out of the Medicaid expansion without losing pre-existing Medicaid funding from the federal government;
- As of Sept. 17, 2013, 15 states announced that they would decline to participate in the Medicaid expansion, and seven more were leaning toward declining as well;¹³
- Health insurance exchanges will be established, and subsidies for insurance premiums will be given to individuals who buy a plan from an exchange and have a household income between 133 percent and 400 percent of the poverty line. To qualify for the subsidy, the beneficiaries cannot be eligible for other acceptable coverage;
- Section 2708 will become effective, prohibiting patient eligibility waiting periods in excess of 90 days for group health plan coverage;
- Plans will still be allowed to impose eligibility requirements based on factors other than the lapse of time. For example, a health plan can restrict eligibility to employees who work at a particular location or who are in an eligible job classification;
- Two years of tax credits will be offered to qualified small businesses. To receive the full benefit of a 50-percent premium subsidy, the small business must have an average payroll per full-time equivalent employee (FTE) of no more than \$50,000 and have no more than 25 FTEs;
- For employer-sponsored plans, a \$2,000 maximum annual deductible will be established for any plan covering a single individual, or a \$4,000 maximum annual deductible for any other plan;
- To finance part of the new spending, spending and coverage cuts will be made to Medicare Advantage — a current Medicare health plan offered by private companies in the form of health management organizations that contract with Medicare to provide Part A and Part B Medicare benefits;¹⁴
- The growth of Medicare provider payments will be slowed (in part through the creation of a new Independent Payment Advisory Board);
- Members of Congress and their staff will only be offered health care plans through the exchange or plans otherwise established by the act;
- Health insurance companies will become subject to a new excise tax based on their market share. The rate will gradually rise between 2014 and 2018, and thereafter will increase at the rate of inflation;
- The qualifying medical expenses deduction for “schedule A” tax filings will increase from 7.5 percent to 10 percent of adjusted gross income;
- Consumer operated and oriented plans — member-governed and nonprofit insurers entitled to a five-year federal loan — will be permitted to start providing health care coverage; and
- Health Resources and Services Administration (HRSA) collaboration and compliance with health record codification, transportation encryption and electronic interface with community providers is required no later than Jan. 1, 2014.

Effective Oct. 1, 2014. Federal payments to disproportionate share hospitals treating large numbers of indigent patients are to be reduced, and will subsequently be allowed to rise based on the percent of the population that is uninsured in each state.

Effective Jan. 1, 2015. CMS will begin using the Medicare fee schedule to give larger payments to physicians who provide high-quality care compared with cost. A \$2,000 per-employee penalty will be imposed on employers with more than 50 employees who do not offer health insurance to their full-time workers (as amended by the reconciliation bill). “Full-time” is currently defined as an employee who works, on average, at least 30 hours per week. However, this portion of the bill is being highly debated and may be set for amendment.

Effective Oct. 1, 2015. As of this date, states will be allowed to shift children eligible for care under the CHIP to health care plans sold on their exchanges — as long as HHS approves.

Effective Jan. 1, 2016. As of this date, states will be permitted to form health care choice compacts and insurers will be allowed to sell policies in any state participating in the compact.

Effective Jan. 1, 2017. As of this date, a state may apply to HHS for a “waiver for state innovation” — provided that the state passes legislation implementing an alternative health care plan meeting certain criteria. A state receiving the waiver would be exempt from some of the central requirements of PPACA, including the individual mandate; the creation by the state of an insurance exchange; and the penalty for certain employers not providing coverage. The state would also receive compensation equal to the aggregate amount of any federal subsidies and tax credits for which its residents and employers would have been eligible under the PPACA plan, but which cannot be paid out due to the structure of the state plan. To qualify for the waiver, the state plan must provide insurance at least as comprehensive and affordable as that required by PPACA;

must cover at least as many residents as the PPACA plan would; and cannot increase the federal deficit. The coverage must continue to meet the consumer protection requirements of PPACA, such as the prohibition on increasing premiums because of pre-existing conditions (Vermont and Montana are seeking waivers at this time). States will be able to allow large employers and multiemployer health plans to purchase coverage through the exchange.

Two federally-regulated, Multi-State Plan (MSP) insurers — with one being nonprofit and the other being forbidden from providing coverage for abortion services — will be available to all states. They will have to abide by the same federal regulations as required by individual states' qualified health plans available on the exchanges, and must provide the same identical cover privileges and premiums in all states. MSPs will be phased in nationally — being available in 60 percent of all states by 2014; 70 percent by 2015; 85 percent by 2016; and with full national coverage by 2017.

Effective Jan. 1, 2018. As of this date, all existing health insurance plans must cover approved preventive care and checkups without copayment. A 40-percent excise tax on high-cost (Cadillac) insurance plans will be introduced. The tax is on insurance premiums in excess of \$27,500 (family plans) and \$10,200 (individual plans), and it will be increased to \$30,950 (family) and \$11,850 (individual) for retirees and employees in high-risk professions.

Effective Jan. 1, 2019. Medicaid will extend coverage to former foster care youths who were in foster care for at least six months and are under 26 years old.

Effective Jan. 1, 2020. The Medicare Part D coverage gap will be completely phased-out and closed.¹⁵

Areas That May Affect Corrections

The following are areas that are not specific to corrections, but have a large impact on how services are provided to the inmate population. Correctional health care authorities are making great strides in many states on the issues surrounding the PPACA and the HRSA Electronic Health Record Guidelines coming into effect Jan. 1, 2014, including:

- Grants for homelessness and housing placement assistance and information are available;
- Grants for marketplace exchange navigator information, and training are available;
- Grants are available from the Substance Abuse and Mental Health Services Administration to assist with mental health issues involved in this new law;¹⁶
- Understanding the requirement to place an individual in a “medical home” as described in PPACA will be crucial to successful discharge planning for the offenders releasing into the community;
- Understanding Electronic Health Record Portability Rules is essential to the Health Insurance Portability and Accountability Act (HIPAA) compliance that becomes effective Jan. 1, 2014;
- New information on how to obtain community-based health records is available;

- Health Insurance Marketplace exchanges and the rules on how and when to enroll are now available;
- States are defining their roles in addressing the current Medicaid rules, any expansion of the Medicaid program for your state, and how to comply with PPACA. This information is available through your state's insurance commissioner and your state's Medicaid director; and
- Information about insurance coverage for those individuals awaiting sentencing is available to assist you in determining if insurance coverage is applicable to the offender, and under what payment source should the health care costs of the offender be billed.

How to Develop an Implementation Plan in Corrections

The CCHA-PPACA working group is committed to providing the latest information on PPACA and how it impacts correctional systems and the offender population. In order to develop an implementation plan for your correctional organization, it is important to update/introduce any communications related to corrections; the general rules it requires; and how the CCHA-PPACA working group plans to support its members in meeting any necessary correctional based requirements as reforms continue to develop. These communications should be conceptual descriptions of the new laws that are emerging; explain the changes and what they mean to corrections; be timed to allow members to “get used to” the ideas; encourage professionals to discuss them inside their organizations; and build awareness and interest before it is time for implementation. They should also include updates on how state exchanges are developing; how legal challenges and budgeting issues are unfolding, and what that means to corrections; and how Medicaid expansion is unfolding between now and the end of calendar year 2014. In order to provide this information, it is important to review the elements of health care reform that will impact corrections, such as:

- Juvenile coverage up to age 26 on the parental policy;
- Jails' and prisons' abilities to access private health insurance for presentenced inmates;
- Design of state's marketplace exchanges and integration with corrections, including: corrections census data, single electronic application and enrollment in the marketplace exchange before parole/release;
- Subsidized individual coverage;
- Other regulations controlling ancillary services such as pharmaceuticals;
- Inpatient admissions that will be eligible for federal match for states regardless of expansion; and
- Continuity of care at release/parole: payment avenues (in private, government and blended systems) for juvenile and adult offenders being transitioned to and from other insurers.

Other ways to develop an implementation plan include:

- Establish your group's priorities/staging of health care reform requirements;
- Establish your group's priorities/staging within the PPACA/Medicaid reimbursement issues;
- Articulate and quantify the need for counties, inmates and health systems to collect federal matching funds for inmate hospital admissions regardless of the need for expansion;
- Develop clear, defensible guidance on key policy questions behind the challenges coming from hospitals such as higher Medicaid enrollments on our caseloads and lower payment reimbursement from corrections to community hospitals;
- Develop a template for issues to address with your Medicaid agency in collecting a federal match for eligible inmate hospitalizations;
- Provide guidance in contracting for health care services to ensure that the vendor or prison/jail cannot be construed as insurance; and
- Recommend steps to engage county and city jails in a unified approach to the requirements of PPACA/Medicaid and linkages to communities, for both pretrial and adjudicated offenders.

Areas That Correctional Health Care Authorities Should Investigate

The following are aspects of health care reform correctional health care authorities should closely monitor:

- Insurance companies may accept insurance inclusion of incarcerated inmates after sentencing. Check to see if the laws or regulations in your state allow individual insurance companies to cover incarcerated individuals;
- Establish rules regarding newly-incarcerated inmates with insurance rights. In most states, inmates do not have the responsibility, nor the right, to choose their providers — even with health insurance coverage;
- Review the insurance regulations in your state. Some states may prohibit health plans from rescinding coverage of an enrollee. Some states, however, do allow insurance companies to suspend coverage if the inmate maintains premiums;
- Review with your state insurance commissioner the rights of adult children under the age of 26. Check to see if your state allows insurance coverage and access for incarcerated youths for ambulatory off-site service coverage;
- Determine who in your state will be the “payer of last resort.” Will this responsibility fall to the state?;
- For those states and counties with private vendors, discuss with your vendor how they plan to deal with the issues of Medicaid lump-sum payments. PPACA requires Medicaid to look at lump-sum payments, and how they would affect private vendor health care negotiations with inpatient hospital contracts;

- Ensure your correctional agency is involved in the Keyes (Medicaid compliance and oversight) program;
- PPACA calls for juveniles under age 18 being discharged from correctional facilities to have a “health care power of attorney” as part of transitioning planning;
- Review the advantages and disadvantages of placing inmates needing one-on-one full-time care into nursing care facilities;
- Ensure your physicians are required to identify standards and outcome measures described in PPACA. Correctional agencies should identify those standards similar to hospital outcome measures and adopt them when possible;
- Understand and review PPACA's impact on mental health services;
- Pretrial detainees are covered by personal insurance as allowed by HRSA;
- Educate the offender on the rule that 30 days after discharge from incarceration, an individual must have proof of insurance to prevent the possibility of tax penalty;
- There may be planning grants for reentry services to develop home health services upon release. Make sure that the appropriate parties are aware of them;
- Be aware of the \$58.7 million in grants for health care education and navigator grants;
- The National Health Services' loan repayment has reduced the number of sites qualifying within corrections, but PPACA states' growth is expected. Check in your state to see how your agency can qualify;¹⁷
- PPACA requires hospitals and physician practices to develop a risk score for the elderly and frail. Corrections should adopt a similar practice, as some states already have developed this score;
- Have a strong understanding of electronic health records: HRSA requires each diagnosis match international diagnostic codes for all health records in the very near future. What date is the deadline for requirements in your state? If applicable, when are the international health care language codification manuals ICD-9 and ICD-10 required to be part of correctional health care records?;¹⁸
- Explore shared decision-making resource centers for patient decision aides and medical treatment options in your state through collaboration with other state agencies;
- PPACA has grants to develop and implement quality improvement and patient safety education;¹⁹
- Patient Navigator grants for navigating the exchange system — correctional sites are using these now;²⁰
- Grants for reduction in chronic disease rate programs and strategies are available;²¹
- Grants for adult and youth vaccine programs state that purchase plans for high-risk populations are now available;²²
- Research Title V Health Care Workforce program to assist with the stabilization of your staffing needs. Enhance health care workforce education and training grants for health activities in education and training;²³

- Workforce improvements, such as expanding primary care residency programs, are now part of PPACA. Encourage your state to participate;
- As of 2012, there are increased requirements for background checks on direct patient access employees of long-term care facilities and providers;
- Correctional facilities utilizing Medicaid coverage for adult and youth services must comply with the PPACA rules including the responsibility to audit and monitor private vendor activities related to patient claims; and
- PPACA expands the 340B pharmacy program for children and underserved communities. Review your agency's rules to see if your facility is eligible to participate.

Improving Enrollment Efforts Upon Release

Identify people who are already eligible. States have extensive information readily available about the number of uninsured individuals and families because of their connections to other public programs. This includes parents of children enrolled in CHIP; adults participating in programs such as the Supplemental Nutrition Assistance Program, formerly known as food stamps; and individuals who are receiving support through state-funded mental or behavioral health programs, assistance for the homeless or other state or local means-tested programs. This information can be used to make outreach, application and eligibility determination processes easier for both the consumer and the state.

Mine existing databases. Identify and enroll uninsured residents who are in custody and need outside services, as well as those who are ready to discharge when they are eligible for coverage programs. For example, the majority of young adults who were formerly in state foster care systems will automatically become eligible for coverage. Beginning on Jan. 1, 2014, many former foster youths will be eligible for Medicaid until they reach the age of 26. States should use their existing foster care data to proactively reach out to and enroll as many of these eligible youths as possible.

Streamline the enrollment process. Under PPACA, people seeking health coverage will no longer need to submit different applications to different agencies for different health coverage programs. Instead, Medicaid and CHIP agencies and the health insurance marketplaces must coordinate behind the scenes to make the process easier for consumers. There are a number of steps state corrections departments can take to better coordinate and simplify this process, such as developing a memorandum of understanding with the state Medicaid office that allows for corrections staff to participate in the enrollment process for the offender.

Eliminate unnecessary handoffs and encourage real-time enrollment. Integrate eligibility information technology systems to the greatest extent possible, and treat any Medicaid eligibility assessments conducted by the new health insurance marketplaces as final eligibility determinations. Even states that are not building their own

2012-2013 Probation and Parole Directory



The 2012-2013 *Probation and Parole Directory* features newly updated information on adult and juvenile probation and parole commissions, boards, and local offices, plus state, district, and satellite offices and their programs. Contact details for key administrative personnel will be presented, along with statistical tables detailing distribution of probation and parole personnel, client caseloads, and average salaries for probation and parole offices across the country. (ISBN 978-1-56991-278-2)

Item # 640

Nonmembers \$100

ACA Members \$80

To place an order, please call customer service at (800) 222-5646, ext. 0129, or visit our website at www.aca.org/store/bookstore.

marketplaces have the option to accept Medicaid eligibility determinations completed by the federal marketplace as final determinations.

Conclusion

Since the passing of PPACA, ACA's CCHA working group has striven to clarify the act's impact on the corrections field. As legislation develops to manage PPACA, updates will be necessary to keep the corrections field well-informed about changes and requirements. CCHA has been a vital resource for information and guidance where possible on this subject to date. It will continue to keep corrections professionals informed as this act progresses.

ENDNOTES

¹ U.S. Department of Health and Human Services. July 1, 2010 (updated Aug. 21, 2012). Washington, D.C.: Author. Retrieved from www.hhs.gov/healthcare.

² Samora, J.B. and C.M. Hettrich. 2010. *Where the candidates stand on health care*. Rosemont, Ill.: The American Academy of Orthopedic Surgeons. Retrieved from www.Aaos.org/news/aaosnow/oct12/advocacy2.asp.

³ Banthin, J. and S. Masi. 2013. *CBO's estimate of the net budgetary impact of the affordable care act's coverage provisions has not changed much over time*. Washington, D.C.: Congressional Budget Office. Retrieved from www.cbo.gov/publication/44176.

⁴ Liptak, A. June 28, 2012. Supreme court upholds health care law, 5-4, in victory of Obama. *The New York Times*. Retrieved from www.nytime.com/2012/06/29/us/supreme-court-lets-health-law-largely-stand.html?

⁵ Child Welfare Information Gateway. 2010. *Patient protection and affordable care act, P.L. 111-148, children's bureau guidance on provision of law*. Washington, D.C.: U.S. Department of Health and Human Services, Administration for Children and Families. Retrieved from https://www.childwelfare.gov/systemwide/laws_policies/federal/index.cfm?event=federalLegislation.viewLegis&id=141.

⁶ U.S. Department of Health and Human Services. 2013. *The health insurance marketplace is coming soon, web portal to health insurance marketplace*. Washington, D.C.: Author. Retrieved from www.healthcare.gov.

⁷ Office of Population Affairs. *Affordable care act*. Washington, D.C.: U.S. Department of Health and Human Services. Retrieved from hhs.gov/opa/affordable-care-act/index.html.

⁸ Wise, C.G., J.J. Alexander, L.A. Green, G.R. Cohen, C.R. Koster. 2011. Journey toward a patient-centered medical home: Readiness for change in primary care practices. *The Milbank Quarterly*, 89(3):399-424.

⁹ Office of Population Affairs.

¹⁰ Rosen, M.A. 2011. *Hospital review, reducing healthcare fraud and abuse: Making sense of PPACA's provisions and CMS' final recommended guidelines*. Nashville, Tenn.: Provider Trust, LLC.

¹¹ Geisel, J. 2013. *Business insurance, senate bill will delay PPACA employer mandate for two years*. Retrieved from www.businessinsurance.com/article/20130723/NEWS03/130729952.

¹² U.S. Department of Health and Human Services. 2012. *Key features of the affordable care act by year*. Retrieved from www.hhs.gov/healthcare, approval code OMB#0990-0379, expiration date June 3, 2014.

ObamaCare Facts. *Health care reform timeline by dates, 2010-2022*. Retrieved from <http://www.obamacarefacts.com/>.

¹³ The Daily Briefing, The Advisory Board Company. Sept. 17, 2013. *Beyond the pledges: Where the states stand on Medicaid*. Retrieved from advisory.com/daily-Briefing/Resources/Primers/MedicaidMap.

¹⁴ Centers for Medicare and Medicaid Services. 2013. *Medicare advantage plans*. Baltimore: Author. Retrieved from www.medicare.gov.

¹⁵ Medicare Rights Center. Feb. 28, 2013. *Health reform and Medicare: Closing the doughnut hole*. Retrieved from <http://www.medicarerights.org/policy/priorities/health-reform-and-medicare-closing-the-doughnut-hole/>.

¹⁶ Substance Abuse and Mental Health Services Administration. *Health reform basics mental health parity and addiction equity act*. Retrieved from <http://beta.samhsa.gov/health-reform/health-reform-basics>.

¹⁷ National Health Services Corps. Sept. 20, 2013. *The corps experience, NHSC loan repayment program*. Retrieved from <http://nhsc.hrsa.gov>.

¹⁸ Health Resources and Services Administration. *Health information technology and quality improvement, meaningful use*. Retrieved Sept. 14, 2013, from www.hrsa.gov/healthit/toolbox/healthITadoptiontoolbox/meaningfuluse.

¹⁹ Office of Population Affairs.

²⁰ Ibid.

²¹ Ibid.

²² Ibid.

²³ The White House. *Putting Americans in control of their health, title V, health care workforce*. Retrieved Sept. 20, 2013, from www.whitehouse.gov.

Viola Riggin is chair of the Coalition on Correctional Health Authorities-Patient Protection Affordable Care Act (CCHA-PPACA) working group. She would like to thank the following members of the CCHA-PPACA working group for their contributions to this article: Elizabeth Gondles, Ph.D., health care advisor to the president, Office of Correctional Health Care, American Correctional Association; Wendy Kelley, JD, co-chair, deputy director for health and correctional programs, Arkansas Department of Corrections; and James C. Welch, RN, HNB-BC, CCHA, co-chair, chief of the Bureau of Correctional Healthcare Services, Delaware Department of Correction.

All content and images are copyrighted by ACA, 2013, and may not be reprinted, altered, copied, transmitted or used in any way without written permission.