Medicaid and CHIP
MAC
Learning Collaboratives

The Coverage Learning Collaborative

Medicaid and Justice-Involved Populations: Strategies to Increase Coverage and Care Coordination

August 17, 2017
3:00 pm – 4:30 pm (ET)

Agenda

- Setting the Stage
- Maintaining Continued Coverage of Medicaid Beneficiaries
- Enrolling Eligible Individuals in Medicaid
- Connecting Individuals to Care Coordination Upon Re-Entry
- Discussion

Setting the Stage

Setting the Stage

On February 19, 2015, CMS facilitated a Learning Collaborative that reviewed Medicaid eligibility rules and enrollment strategies for justice-involved populations

- On April 28, 2016, CMS released a State Health Official letter with Q&As on how states can facilitate access to Medicaid for eligible individuals before and after time in a correctional institution
- On May 3, 2016, CMS released additional guidance on the provision of Medicaid services to justice-involved populations in skilled nursing facilities, nursing facilities and intermediate care facilities

Building off the growing momentum in states to address the opioid crisis and reduce recidivism, CMS is facilitating this Learning Collaborative to share best practice strategies to increase Medicaid enrollment and care coordination

Source: Medicaid and CHIP Learning Collaboratives, "Medicaid Eligibility and Enrollment for Justice Involved Populations," Coverage Learning Collaborative, (February 19, 2015); SHO #16-007, "To Facilitate successful re-entry for individuals transitioning from incarceration to their communities," (April 28, 2016); CMS, "Updated Guidance to Surveyors on Federal Requirements for Providing Services to Justice Involved Individuals," (May 3, 2016)

Snapshot of Justice-Involved Population: High Need, High Cost

56% of state prisoners and **64%** of jail inmates are affected by a **mental health problem**

Two out of every three inmates meet the medical criteria for substance abuse disorder

Compared to the general population, individuals in jails and prisons suffer:

- **4x** the rate of active TB
- **9x** the rate of Hepatitis C
- **8x** the rate of HIV infection
- **3x** the rate of serious mental illness
- **4x** the rate of substance abuse disorders

Sources: ASPE Issue Brief, "The Importance of Medicaid Coverage for Criminal Justice Involved Individuals Reentering Their Communities," (April 2016). https://aspe.hhs.gov/sites/default/files/pdf/201476/MedicaidJustice.pdf; US Department of Justice, Office of Justice Programs, "Mental Health Problems of Prison and Jail Inmates: Bureau of Justice Statistics Special Report No. NCJ 213600," (2006). National Center on Addiction and Substance Abuse at Columbia University, "Behind Bars II: Substance Abuse and America's Prison Population," (February 2010).Prisoner Reentry: What are the Public Health Challenges? RAND Research Brief. RAND, Santa Monica, CA, May 2003.; Steadman, H. et al. Prevalence of serious mental illness among jail inmates. Psychiatric Services 2009 60: 761-65.; Jennifer C. Karberg and Doris J. James. Substance Dependence, Abuse, and Treatment of Jail Inmates, 2002. Special Report, Bureau of Justice Statistics, U.S. Department of Justice, Washington, DC, July 2005. 1. *Correctional Populations in the United States, 2012*, U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics (2012).; 2. *Behind Bars II: Substance Abuse and America's Prison Population*, The National Center on Addiction and Substance Abuse (CASA) (2010).

Convergence of Medicaid and Criminal Justice Systems

Opportunities

Covering Inmates' Inpatient Hospitalizations

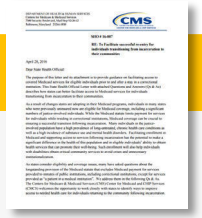
- Medicaid covers inpatient costs of prisoners who would otherwise be eligible for Medicaid.
- *Expansion states:* many prisoners are Medicaid eligible, resulting in savings to state corrections budgets related to inpatient care. (For example, Colorado, Michigan and Ohio have reported savings of $5 to $13 million a year.)
- *Non-expansion states*: reported savings from inpatient hospitalizations for disabled individuals, pregnant women and young adults

Improving Care and Reducing Re-Incarceration

- Washington saw 16% fewer detentions in the year after release when inmates were enrolled in Medicaid
- A three-year pilot program for newly-released inmates:
  - 2 of 83 patients on a prescription medication for their substance use disorder used illegal drugs or alcohol
- An eight-week study of opioid dependent inmates:
  - 38% of persons receiving medication relapsed, compared to 88% of persons receiving no treatment.

Sources: Robert Wood Johnson Foundation, "Medicaid Expansion and Criminal Justice Costs: Pre Expansion Studies and Emerging Practices Point Towards Opportunities for States," November 2015; Community Oriented Correction Health Services, "Medicaid Coverage for Jail Inmates' Inpatient Hospitalizations," (March/April 2015); Robert Wood Johnson Foundation, "States Expanding Medicaid See Significant Budget Savings and Revenue Gains," (April 2015); Pew Charitable Trusts, "Managing Prison Health Care Spending," (October 2013); Addition, "Opioid treatment at release from jail using extended-release naltrexone: A pilot proof-of-concept randomized effectiveness trial," (2015).

CMS Guidance: "To Facilitate Successful Re-Entry for Individuals Transitioning from Incarceration to their Communities"



Key Takeaways

- **Medicaid FFP is not available for an inmate in a public institution, with limited exceptions.**
- **Clarifies definition of inmate:** Individual of any age who is "**in custody** and **held involuntarily** through operation of law enforcement authorities **in a public institution**, other than a child care institution, publicly operated community residence that serves no more than 16 residents, or a public educational or vocational training institution for purposes of securing educational or vocational training."
- Incarceration does not preclude an inmate from being determined **Medicaid eligible**.

Medicaid FFP is available for individuals:

- On parole, probation or released to the community pending trial;
- Living in a halfway house (unless individual does not have "freedom of movement and association");
- Living in a public institution voluntarily; and
- On home confinement.

Medicaid FFP is *not* available for individuals living in:

- State or federal prisons, local jails, or detention facilities
- Federal Residential Re-entry Centers; and
- Residential mental health and substance use disorder treatment facilities for inmates.

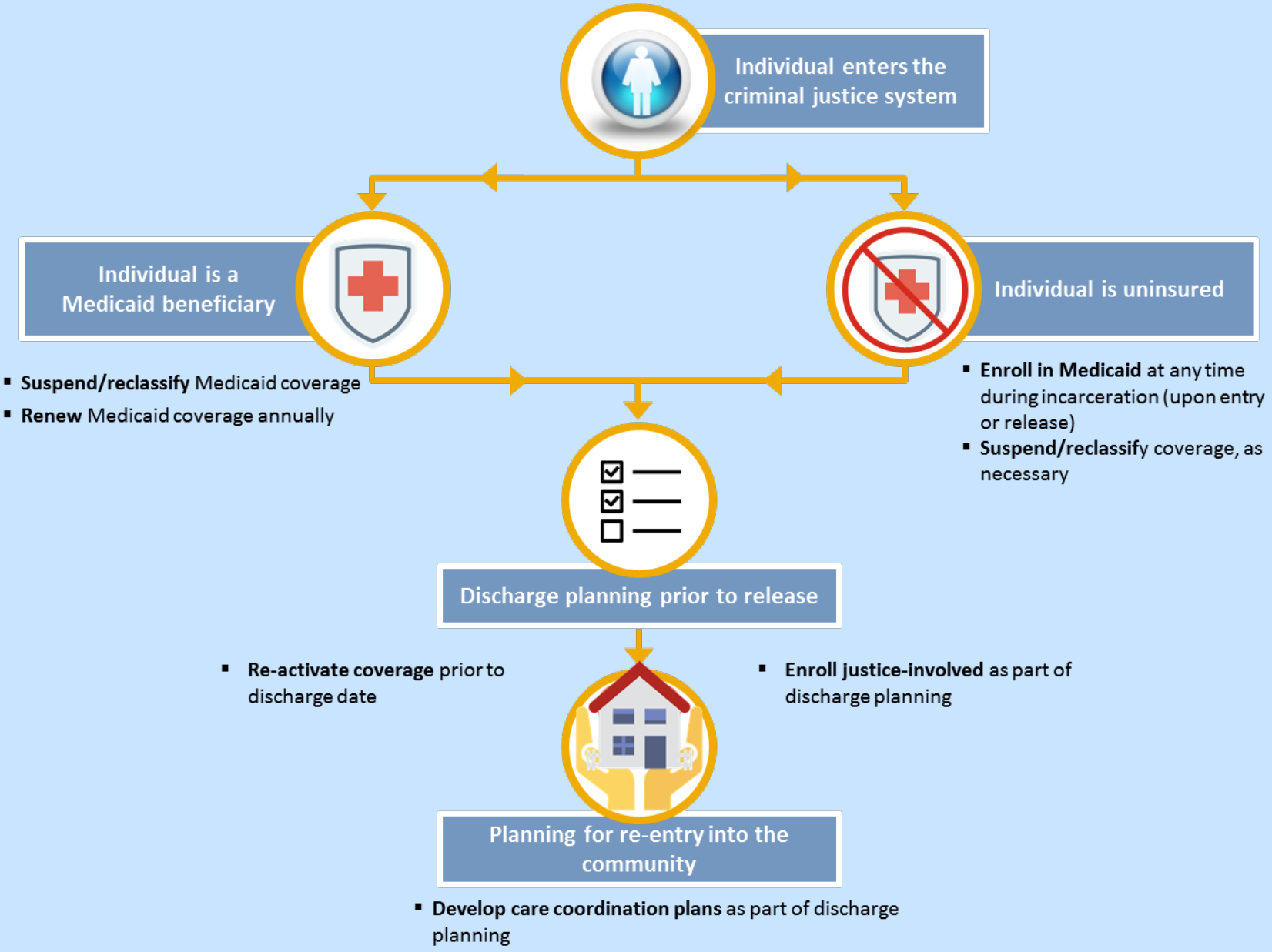
Source: SHO # 16-007, "To Facilitate Successful Re-entry for Individuals Transitioning from Incarceration to their Communities," available at https://www.medicaid.gov/federal-policy-guidance/downloads/sho16007.pdf (April 28, 2016).

States' Challenges to Connecting Justice Involve Populations to Medicaid

Despite states' interest in increasing enrollment of justice-involved populations in Medicaid, many report persistent operational challenges:

- ✓ Exchanging data across prisons/jails and state Medicaid Agencies
- ✓ Coordinating within MMIS and eligibility and enrollment systems to suspend/reclassify status
- ✓ Lifting suspension/reclassification status upon discharge
- ✓ Renewing coverage annually while an inmate is incarcerated
- ✓ Identifying resources and staff available to conduct enrollment in correctional facilities
- ✓ Effectuating coverage that is dependent on fluid discharge dates
- ✓ Submitting applications from jails/prisons due to technical limitations
- ✓ Changing placements as inmates move from one jail/prison to another

Justice-Involved Lifecycle: Multiple Points of Opportunity to Connect to Medicaid Coverage and Care



Strategies for Improving Connections to Coverage and Care

Strategies for Discussion

Individual is a Medicaid beneficiary upon incarceration

1. Implement Suspension/Reclassification
2. Conduct Annual Renewal

Individual is uninsured upon incarceration

3. Assign Application Counselors for Onsite Enrollment at Jails/Prisons
4. Establish Enrollment Processes at Discharge

Planning for re-entry into the community

5. Enroll in Health Homes
6. Employ Medicaid Managed Care Organizations

Maintaining Continued Coverage of Medicaid Beneficiaries

Strategies: Suspension/Reclassification and Renewal

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2. Conduct Annual Renewal

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Suspension/Reclassification Overview

States are prohibited from receiving federal Medicaid payments for treatment of health care costs during incarceration, except for allowable inpatient expenses.

States have taken various approaches to ensuring Medicaid claims are not made improperly:

- 16 states + DC suspend/reclassify Medicaid for the duration of incarceration
- 15 states suspend/reclassify Medicaid for a specific period of time (e.g., 30 days or one year)
- 19 states terminate Medicaid altogether

Benefits of Suspension/Reclassification	Challenges of Suspension/Reclassification
• Requires less time to reactivate coverage than to initiate a new eligibility determination • Allows corrections agencies to bill Medicaid for allowable inpatient expenses	• Requires extensive coordination between Justice and Medicaid agencies • Requires system changes, which may be complex • Changes in incarceration status can occur with little notice, making timely reactivation challenging (more acutely challenging in jails)

Sources: Families USA, "Medicaid Suspension Policies for Incarcerated People: 50 State Map," (July 2016); Bureau of Justice Administration, "Critical Connections: Getting People Leaving Prison and Jail the Mental Health and Substance Use Treatment They Need," (January 2017).

Differences Between Suspension and Reclassification

	Process	What happens when an inmate is hospitalized for more than 24 hours?
Suspension	▪ Individual continues to be enrolled in Medicaid ▪ No benefits are covered under this status	Justice agency coordinates with State Medicaid agency to have Medicaid reinstated for the purpose of covering hospitalization
Reclassification	▪ Individual continues to be enrolled in Medicaid ▪ Eligibility category in the MMIS system is reclassified ▪ Only inpatient hospitalizations are covered (e.g., similar to establishing separate benefit package for pregnant women or children)	Hospital bills Medicaid with no additional action needed

Sources: Families USA, "Medicaid Suspension Policies for Incarcerated People: 50 State Map," (July 2016); Bureau of Justice Administration, "Critical Connections: Getting People Leaving Prison and Jail the Mental Health and Substance Use Treatment They Need," (January 2017).

Implement Suspension/Reclassification Processes

Implementation Approach

Justice agency manually or automatically notifies Medicaid agency of incarceration

Medicaid agency runs data match between justice roster and MMIS system to flag incarcerated Medicaid beneficiaries

Medicaid Agency modifies E&E and/or MMIS systems to suspend/reclassify

Medicaid agency generates return file sent to justice agency (with name, suspended/reinstated status, renewal date, and managed care plan, if applicable)

Justice agency notifies Medicaid agency of release

Medicaid agency updates E&E and/or MMIS systems to restore full Medicaid benefits upon release

Suspension/Reclassification Approach and Mechanics

Implementation Approach

Justice agency manually or automatically notifies Medicaid agency of incarceration

↓

Medicaid agency runs data match between justice roster and MMIS system to flag incarcerated Medicaid beneficiaries

↓

Medicaid Agency modifies E&E and/or MMIS systems to suspend/reclassify

↓

Medicaid agency generates return file sent to justice agency (with name, suspended/ reinstated status, renewal date, and managed care plan, if applicable)

↓

Justice agency notifies Medicaid agency of release

↓

Medicaid agency updates E&E and/or MMIS systems to restore full Medicaid benefits upon release

Implementation Mechanics

Send data feed at least once daily (e.g. everyday at 5:00 pm) from Justice to Medicaid agency

Implement suspension/reclassification once an inmate is institutionalized in a prison/jail for more than 24 hours

- Suspend coverage for however long individual is expected to remain incarcerated (suspension end date would be discharge date
- Implement annual renewal processes for individuals who remain in suspension/reclassification status
- Discontinue Medicaid managed care capitation payments, if applicable

Medicaid agency sends data feed to Justice agency at least once daily (e.g. everyday at 5:00 pm)

Ensure data feed includes advanced notice of discharge date (e.g. 30 days prior) or establish manual file transfer process in advance of release to allow Medicaid to reactivate promptly upon beneficiary's release

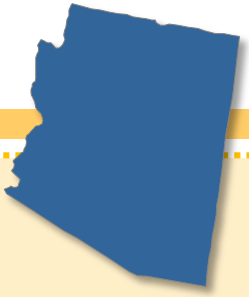
Operationalizing Suspension/Reclassification Strategy

Additional Considerations

- **Justice Agency Involvement:** Requires willingness, commitment and coordination with justice agencies
  - ✓ Coordinating a data exchange with local jails/prisons/facilities may be more challenging when the facilities are not operated by the state
  - ✓ State may want to pilot flat-file data exchanges with a smaller number of high-population jails
- **Unauthorized Billing:** Medicaid agencies need to establish administrative safeguards to prevent unauthorized billing for services while an inmate is incarcerated.
- **Level of IT Investment:** States could implement either secure manual flat file feeds (i.e., excel file) or automated, electronic feeds.
- **Financing:**
  - ✓ Building new electronic interface between justice and Medicaid IT systems that support enrollment, eligibility status adjustment, and renewal qualify for 90% federal match (with pre-authorization from CMS)
  - ✓ Certain eligibility determination-related costs are eligible for 75% FFP (for on-going costs of operating approved eligibility determination systems that meet the seven conditions and standards)
- **Needed policies:** State Medicaid and justice agencies may want to enter into a data use agreement with policies that safeguard privacy and data security

CMS-2392-F, "Medicaid Program; Mechanized Claims Processing and Information Retrieval Systems (90/10)," (December 4, 2015); SMD # 16-009, "Mechanized Claims Processing and Information Retrieval Systems—APD Requirements," (June 27, 2016); Affordable Care Act: State Resources FAQ, "Enhanced Funding for Mechanized Eligibility Systems Operation and Maintenance," (April 25, 2013).

Spotlight on Arizona



- In 2005, the Arizona Health Care Cost Containment System (AHCCCS), the state's Medicaid program, partnered with Pima County to pilot the state's initial Medicaid suspension project
- Project now covers 95% of all justice-involved individuals in the State
- Medicaid agency established technical specs and requirements (e.g. form fields and mechanisms) for an **excel data file transfer** that it requests from jails/prisons:
  - Participating jails/prisons send a file of bookings and releases to AHCCCS at least once daily to identify cases to be placed in suspension status and those that need the suspension status lifted due to release.
  - The Pima County jail runs a data transfer to Medicaid 3 to 4 times a day to capture frequent turnover of inmates and prevent gaps in coverage. They limit their data feed to individuals who have been in the facility for at least 24 hours.
- AHCCCS suspends enrollment for detainees in State prisons that are sentenced to less than 12 months; enrollment is terminated if detainees receive a sentence of more than 12 months
- All State prison detainees are provided a pre-release Medicaid application
  - Over 75% of releasing prison detainees have applied for Medicaid 30 days prior to release; the remainder are not eligible or decline an application
  - State has a 95% application approval rate

Urban Institute, "Information Sharing Between Medicaid and Corrections Systems to Enroll the Justice-Involved Population: Arizona and Washington," (February 3, 2017).

Medicaid Renewal Processes Overview

Sufficient to Determine Continued Eligibility

- Federal regulations require state Medicaid agencies to attempt to renew eligibility **based on available information** (in the account, if reliable, and through data sources)
  - If available information indicates no change or a change that still results in Medicaid/CHIP eligibility, the agency must renew **without requiring further beneficiary action**
  - Consumer must be notified of **determination and the basis**. No action is required by the beneficiary unless information relied upon by the agency is wrong

Insufficient to Determine Continued Eligibility

- If the agency can not renew based on available information, **a pre-populated renewal form** must be sent to the beneficiary
- The beneficiary must be given **a minimum of 30 days** from the renewal date form to provide information, sign and return

Renewal Benefits	Renewal Challenges
• Requires less time to reactivate coverage than to initiate a new eligibility determination • Allows corrections agencies to bill Medicaid for allowable inpatient expenses	• Justice-involved may not receive notices and pre-populated forms if mailed to the community • Delays in receiving mail at jails/prisons may impact renewal timelines • Renewing households greater than 1

Sources: 42 CFR 435.916; 42 CFR 457.343: Medicaid and CHIP Coverage Learning Collaboratives, "Medicaid/CHIP Renewals: State Practices, Lessons Learned and Opportunities," (August 13, 2015).

Conduct Annual Renewal

Implementation Approach

Medicaid agencies with beneficiaries in a suspension/reclassification status can:

- ✓ Renew eligibility for individuals, without requiring additional action, based exclusively on available data sources and the information that the individual is incarcerated
  - Information about incarceration status helps agency to assess whether data is reasonably compatible
- ✓ Update information in the beneficiary's case file to reflect the new prison or jail mailing address so that renewal notices and pre-populated forms can be sent to the prison or jail rather than the last known home address
  - This process would require the prison or jail to include mailing address as part of the suspension/reclassification data exchange
  - Individuals would need to notify Medicaid agency of new mailing address upon release
- ✓ Send consumer notices via email, if beneficiary elects that option and has access to email

Sources: 42 CFR 435.916; 42 CFR 457.343

Enrolling Eligible Individuals in Medicaid

Strategies for Improving Connections to Coverage and Care

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Application Assistance Overview

- All states have an existing network of individuals and community-based organizations trained to assist applicants with enrollment in Medicaid (e.g., application counselors, Navigators, and state Medicaid agency eligibility workers)

- States can identify available application assisters to conduct enrollment at prisons/jails prior to discharge:
  - ✓ Look to prisons or jails with the highest number of high-need uninsured inmates and begin initial efforts at targeted facilities
  - ✓ Enrollment could occur at any point during incarceration (requires suspension/reclassification if occurs prior to discharge)
- Medicaid agencies may also consider placing state eligibility workers in correctional facilities to complete enrollment activities

Application Assistance Benefits	Application Assistance Challenges
• Leverages existing workforce already trained in submitting Medicaid applications	• Requires application assisters willing to conduct enrollment at jails/prisons • Lack of internet access • Need for security clearances

Sources: 42 CFR 435.916; 42 CFR 457.343

Assign Application Counselors for Onsite Enrollment

Implementation Approach

Identify a point person in the Medicaid agency and a point person in each jail/prison to coordinate logistics and implement the following:

Medicaid Agency Tasks

- Map application counselors to targeted prisons/jails
- Provide additional training for counselors on sensitivities required for serving justice-involved population
- Expedite application processing needs
- Assist with suspension/reclassification or renewal
- Process telephonic applications
- Elevate systemic issues for leadership review
- Function as a general point of contact for application counselors and justice officials with questions
- Provide training to justice agency and Medicaid call center and other eligibility staff
- Assist with identity proofing

Justice-Involved Agency Tasks

- Enable security clearance for enrollers
- Identify uninsured inmates close to discharge for enrollment
- Establish routine schedule for enrollment activities (e.g. every other Monday at 4:00 pm)
- Develop application approach for each facility: laptops/tablets where internet is available; paper applications where internet is unavailable

Source: Urban Institute and Manatt Health Solutions, "Strategies for Linking Justice Involved Populations to Health Coverage," (March 23, 2017) available at http://www.urban.org/policy-centers/justice-policy-center/projects/connecting-criminal-justice-health-care

Operationalizing Application Counselors Strategy

Additional Considerations

- **Justice Agency Involvement:** Requires willingness, commitment and coordination with justice agencies
- **Initial Focus on Prisons:** Ideal to start with prisons (vs. jails) due to higher predictability of inmate discharge dates and more time for discharge planning
- **Financing:**
  - ✓ Community-based application assistance is eligible for 50% FFP as a Medicaid Administrative Expenditure
  - ✓ Certain eligibility determination-related costs are eligible for 75% FFP (for on-going costs of operating approved eligibility determination systems that meet the seven conditions and standards)
- **Needed Policies**:
  - ✓ Medicaid agencies may need to amend contracts as part of the RFP renewal cycle for navigators/assisters to emphasize responsibilities associated with the justice-involved population
  - ✓ It may be beneficial for justice agencies to issue a policy directive encouraging or requiring facilities to partner with enrollment assisters
  - ✓ Medicaid agencies may want to enter into an MOU with justice agencies to formalize relationship and enrollment processes

CMS-2392-F, "Medicaid Program; Mechanized Claims Processing and Information Retrieval Systems (90/10)," (December 4, 2015); SMD # 16-009, "Mechanized Claims Processing and Information Retrieval Systems—APD Requirements," (June 27, 2016); Affordable Care Act: State Resources FAQ, "Enhanced Funding for Mechanized Eligibility Systems Operation and Maintenance," (April 25, 2013).

Enrollment Process as Part of Discharge Process

Some state Medicaid agencies work with justice agencies to make Medicaid enrollment a routine part of the discharge process

- Enrollment could also be implemented as part of the intake process and would require suspension/reclassification coordination

Enrollment as part of routine discharge planning could be conducted by application counselors (see previous strategy), justice agency staff, or outstationed Medicaid eligibility workers

Enrollment at Discharge Benefits	Enrollment at Discharge Challenges
• Ensures justice-involved have Medicaid coverage upon discharge and access when hospitalized for 24+ hours	• Requires investment and resources to institutionalize enrollment processes

Establish Enrollment Process as Part of Discharge

Implementation Approach

Initially target high-need inmates, including those with:

- ✓ Severe or complex physical conditions
- ✓ Reliance on medical technology
- ✓ Substance use disorders
- ✓ Severe, persistent mental illness
- ✓ HIV/AIDS
- ✓ Multiple prescriptions
- ✓ Or those that are pregnant

Coordinate closely with justice agencies to establish:

- ✓ Standardized prison/jail discharge process that incorporates a Medicaid enrollment process
- ✓ An enrollment timeline to ensure Medicaid is activated at the point of release (e.g. enroll 30-45 days prior to discharge, suspend until release date, re-activate upon release)
- ✓ Increased staffing support and resources to conduct enrollment; enrollers may be justice agency staff OR application assisters/navigators/eligibility workers

Leverage presumptive eligibility, which requires a process for:

- ✓ Prisons/jails to be deemed “qualified entities”
- ✓ A full application to be completed in tandem with presumptive eligibility application

Operationalizing Enrollment as Part of Discharge Planning

Additional Considerations

- **Justice Agency Involvement:** Requires willingness, commitment and coordination with justice agencies
- **Financing:**
  - ✓ Medicaid can claim 50% FFP for time spent by application counselors or justice staff enrolling inmates into Medicaid
  - ✓ Out-stationed eligibility workers may be eligible for 75% FFP
  - ✓ Justice departments will need to work with State Medicaid agencies to submit Medicaid Administrative Claiming plans in order to claim reimbursement for Medicaid administrative expenditures related to justice-involved populations
- **Needed policies:** Justice entities may need to amend internal policies to require Medicaid enrollment as part of discharge planning.

CMS-2392-F, "Medicaid Program; Mechanized Claims Processing and Information Retrieval Systems (90/10)," (December 4, 2015); SMD # 16-009, "Mechanized Claims Processing and Information Retrieval Systems—APD Requirements," (June 27, 2016); Affordable Care Act: State Resources FAQ, "Enhanced Funding for Mechanized Eligibility Systems Operation and Maintenance," (April 25, 2013).

Connecting Individuals to Care Coordination Upon Re-Entry

Strategies for Improving Connections to Coverage and Care

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Health Homes Overview

The Affordable Care Act established the option for states to receive enhanced funding for Health Home models addressing the needs of Medicaid enrollees with multiple chronic conditions

- Health Home providers deliver comprehensive care coordination for Medicaid enrollees with chronic conditions
- Payments determined by the State and can be tiered based on severity, provider capabilities or incentives
- States may have multiple Health Home models, serving beneficiaries with different types of chronic conditions and/or beneficiaries in different geographic areas
- States may draw down a 90% federal match for specified care coordination services for 2 years for each Health Home model
- As of May 2017, 32 Medicaid health homes have been approved in 21 states and the District of Columbia, and more than one million beneficiaries have been enrolled in health homes to date.

Health Home Benefits	Health Home Challenges
• Provides care coordination infrastructure for high-needs population • Allows for state to leverage enhanced match for high-needs justice population	• Requires financial commitment to support health homes • Necessitates extensive coordination between Health Homes and Justice agencies • Requires system changes (including data transfers) which may be complex

Sources: SSA § 1945; HHS "Interim Report to Congress on the Medicaid Health Home State Plan Option"; CMS "Health Homes (Section 2703) Frequently Asked Questions" (May 2012); SMD #10-024 (November 2010); Health Home SPA Template; CMS "Approved Medicaid Health Home State Plan Amendments" Map (June 2015); CMS "Medicaid Health Homes: An Overview" (May 2015)

Health Home Services and Eligibility

Health Home Services

- Comprehensive Care Management
- Care Coordination
- Health Promotion
- Transitional Care/Follow Up
- Individual and Family Support
- Referral to Community and Social Support Services

Health Home Eligibility

To participate in a health home, an individual must be Medicaid-enrolled with one or more of the following:

- Serious mental illness
- Two or more chronic conditions (including substance abuse disorder and HIV/AIDS)
- One chronic condition and the risk of developing a second

Sources: SSA § 1945; HHS "Interim Report to Congress on the Medicaid Health Home State Plan Option"; CMS "Health Homes (Section 2703) Frequently Asked Questions" (May 2012); SMD #10-024 (November 2010); Health Home SPA Template; CMS "Approved Medicaid Health Home State Plan Amendments" Map (June 2015); CMS "Medicaid Health Homes: An Overview" (May 2015)

Enroll Eligible Justice-Involved Populations in Health Homes

Implementation Approach

Identify justice-involved populations who meet health home eligibility criteria through data sharing and referrals and develop care coordination plans upon release

Identify Individuals Eligible for Services

- Institute referral process to assess for health home eligibility
- Establish **data-sharing arrangement** between health home and justice entity to compare real-time prison/jail rosters with health home membership in order to identify:
  - ✓ Current health home members who have been incarcerated
  - ✓ Potentially eligible justice-involved individuals who meet health home criteria

Coordinate Care Prior to Release

- Health home staff:
  - ✓ Develop transitional care plan
  - ✓ Schedule behavioral and physical health appointments
  - ✓ Review medication
  - ✓ Assist with other social determinants of health
- Individual must provide consent before information other than demographic data can be shared between health home and prison social work staff

Operationalizing Health Homes

Additional Considerations

- **Catchment Area:** When enrolling new health home members, provider network referral should match area of inmate's home, which may differ from the discharging jail or prison's catchment area
- **Legal Authority:**
  - ✓ State Medicaid Agencies must submit and seek approval for a new or amended State Plan Amendment (SPA) to establish a health home
- **Financing:**
  - ✓ Underlying Medicaid services for people enrolled in a health home are matched at the usual FMAP rate after an initial eight quarters of enhanced 90% match

Spotlight on New York

New York Health Home Initiative

- New York Department of Health (NYDOH) began its health home initiative in 2012 with 10 counties, expanding statewide by July 2012
- As of April 2016, 31 health homes were in 62 counties, serving roughly 230,000 out of an estimated potentially eligible 900,000 individuals

Criminal Justice Efforts

Overview

- NYDOH began a Criminal Justice Health Home demonstration in six of its 31 health homes in 2012-2013 to add infrastructure that would bridge Medicaid-eligible, justice-involved individuals with health homes.
  - Five downstate with Rikers Island; others with state correctional facilities, Division of Parole, and court systems for early identification of potential candidates.
- The Criminal Justice Health Home demonstration is financed through an 1115 Waiver, grants, and state-only dollars to support the connections to Health Homes.
- Perceived outcomes include improved medication adherence, decreased inpatient service use, more regular use of outpatient support services, and person-level reduction in jail days.

Best Practices

✓ *Cross-Agency Data Sharing:*
  - State level sharing between NYDOH and Division on Criminal Justice Services
  - CHS (Riker's Island health services provider) shares data with 9 health homes; health home status noted the electronic medical record
  - Department of Probation shares data with state Mental Health department for "bottom-up" referrals

✓ *Specialized Training and Support*
  - All care managers from the six health homes in the criminal justice health homes demonstration receive additional ongoing training and support by health home team

✓ *High Touch Connections Around Release:* (1) health home care managers communicate with justice-involved enrollees through the jail social worker, who consents the patient if they are new to the health home; and (2) transportation and accompaniment to health care or social service provider, depending on need

Source: Urban Institute, "Connecting Justice-Involved Individuals with Health Homes at Reentry: New York and Rhode Island," (January 2017).

Medicaid Managed Care: Care Coordination Overview

- States may leverage their existing Medicaid managed care plans to conduct care coordination for justice-involved populations prior to discharge
- Medicaid agencies would amend existing Medicaid managed care contracts to require the managed care plans to develop a care coordination plan for newly discharged justice-involved populations
- Managed care plans have an incentive to manage high-needs population and ensure they receive physical and behavioral health services rather than receive treatment in more costly emergency room settings

Care Coordination Benefits	Care Coordination Challenges
• Leverages existing care coordination infrastructure • Positions care coordination at point of re-entry	• Requires managed care plan selection prior to care coordination • Some plans may be unwilling to work with justice-involved populations

Engage Medicaid Managed Care in Care Coordination

Implementation Approach

Managed care plan activities to include:

- ✓ Assigning a care coordinator, who would connect with enrollee during incarceration to develop care plans, confirm medication, select primary care physician, schedule behavioral and physical health appointments
- ✓ Scheduling an initial post-release appointment
- ✓ Establishing managed care plan referral process to behavioral and physical health providers
- ✓ Creating systems for sharing medical records and other key information with behavioral and physical health providers

Justice agency involvement to include:

- ✓ Creating rosters for managed care plan care coordination, potentially prioritizing high-need populations with substance use disorders, mental health diagnoses, or serious physical conditions such as HIV/AIDS or Hepatitis C
- ✓ Notifying Medicaid Agency and managed care plans 60-90 days prior to an individual's release to initiate care coordination processes
- ✓ Enabling care coordination contact with inmate via video linkage or clearing managed care staff for in-person visits prior to release

Operationalizing Managed Care Care Coordination

Additional Considerations

- **Justice Agency and Managed Care Involvement:** Requires support and cooperation from both justice agencies and managed care plans to be successful
- **Coverage:** Requires enrollment and managed care plan selection prior to release
- **Patient Self-Determination**: State health agencies will need to develop strategies that protect privacy and address consent issues to safeguard patient self-determination while facilitating treatment
- **Implementation strategy:** Beginning with a staged implementation or triaging highest need populations could be beneficial
- **Financing:** No capitated payments can be made to plans while an individual is incarcerated.
  - ✓ State could require managed care plans to engage with justice-involved populations as part of their contracts with the state
- **Needed Policies:**
  - ✓ Medicaid agency would need to modify existing managed care plan contracts to formalize agreement

Spotlight on Ohio

Program Overview

Medicaid Pre-Release Enrollment Program

- Began in 2013
- Partnership between Ohio Department of Medicaid (ODM) and Ohio Department of Rehabilitation and Correction (ODRC)

Goals

- Pre-enroll people in Medicaid, selecting a managed care plan before release
- Develop care plan for those with complex needs to avoid gaps in coverage and care

Three Innovations

1 Peer-Led Pre-Enrollment Class

Peers provide information about whether to enroll and how to select a plan *(90 days before release)*

2 Enrollment Class

Inmate fills out forms to facilitate eligibility and enrollment, and selects managed care plan *(2 days after Pre-Enrollment Class)*

3 Videoconference for "Critical Risk" Inmates

Videoconference participation and prompt follow-up after release are required by ODM in the managed care contract; monthly and quarterly reports on follow-up also required by ODM

No changes to managed care PMPM payments or additional waivers or legislation were required to implement the Medicaid Pre-Release Enrollment Program.

http://www.urban.org/research/publication/ohios-medicaid-pre-release-enrollment-program

Discussion

Join us **August 24, 2017, 3:00 pm – 4:30 pm** for a Coverage LC meeting:

Integrating Non-MAGI Populations into Modernized Systems to Simplify Eligibility and Enrollment

To participate, register here at any time before the meeting. If you would like more information about the session, please contact MACLC@mathematica-mpr.com.

THANK YOU!

APPENDIX

Suspension Resources from Arizona

- **Intergovernmental Agreement: Model Template for Suspension**
  - https://www.azahcccs.gov/AHCCCS/Downloads/Initiatives/091615ESIGATemplate.pdf
- **Model IT specifications for transferring data from Justice Agency to Medicaid Agency**
  - **https://www.azahcccs.gov/AHCCCS/Downloads/Initiatives/CountyInmateEnrollmentSuspensionTechnicalDocument.pdf**