Ohio's Medicaid Pre-Release Enrollment Program

Medicaid Areas of Flexibility to Provide Coverage and Care to Justice-Involved Populations

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Medicaid and the Justice-Involved Population

States have flexibility in deciding who will be covered under their Medicaid program within established federal guidelines. Many states have increased the number of justice-involved individuals covered by Medicaid by expanding eligibility to low-income adults. Medicaid cannot pay for medical services provided to persons while they are incarcerated, except when in-patient services are provided in a community based hospital setting. However, many other people involved in the justice system—from arrest through community-based supervision—are eligible to receive Medicaid benefits when they are not incarcerated, if they are income eligible and meet certain other criteria.. Providing health care services to people involved with the justice system could improve public health and public safety, given their high prevalence of mental health issues, substance abuse, and chronic health conditions including HIV and hepatitis. This series of briefs highlights areas of flexibility within Medicaid that can facilitate enrollment in health coverage and access to necessary care in the community for justice-involved people.

In 2014, the State of Ohio launched an initiative to enroll people into Medicaid before they are released from prison and to connect those with the highest health care needs to health care providers immediately after they are released. While several states have launched prerelease enrollment initiatives,[1] this brief focuses on three innovative elements of Ohio's program that build on multiple areas of flexibility within Medicaid: (1) using peer Medicaid educators in the prisons; (2) having individuals select a Medicaid managed care plan (MCP) before release; and (3) for people with serious chronic health conditions who need ongoing care, requiring the MCPs to develop a transition plan,

conduct a video conference with the member before release, and follow up with individuals after their release to connect them to health care providers.

This brief is based on conversations with key interviewees involved in Ohio's Medicaid Pre-Release Enrollment Program, published materials accessible to the public, and documents provided by the interviewees. It provides background on the program, explains how each of these three elements of the program works, and highlights lessons learned that may help other states interested in launching a similar initiative.

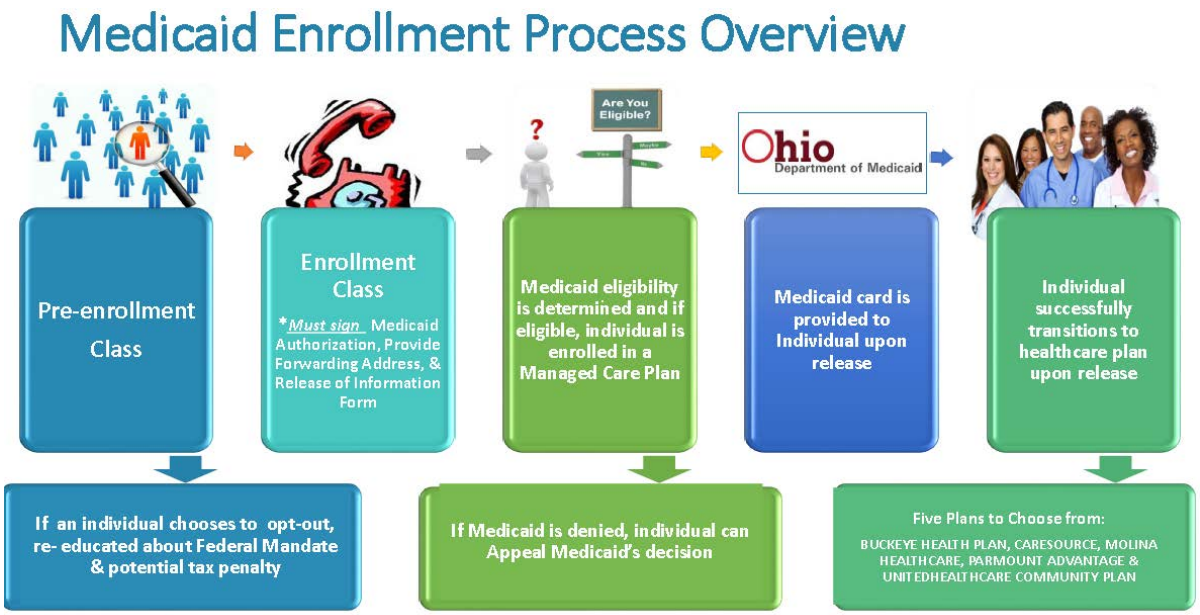
Overview: The Ohio Pre-Release Enrollment Program

In 2013, the Ohio Department of Medicaid (ODM), the Ohio Department of Rehabilitation and Correction (ODRC), and other state agencies began developing plans for Ohio's Medicaid Pre-Release Enrollment Program (MPRE).[2] These agencies built on the state's collaborative work on RoMPIR (Reinstatement of Medicaid for Public Institution Recipients), a system established to suspend Medicaid enrollment when people are incarcerated and to reinstate benefits when incarcerated people receive inpatient hospital services or are released from incarceration.[3] MPRE also built on the work of the Governor's Office of Health Transformation, which was focused on reforming the health care system in Ohio and brought together all agencies that provide health care. These efforts laid the groundwork for Ohio to innovate around Medicaid enrollment of people leaving prison when the state expanded Medicaid coverage to low-income adults in 2014.

With limited exceptions, most Medicaid-eligible Ohioans are required to enroll in a managed care plan to receive Medicaid benefits.[4] MPRE aimed to pre-enroll people in Medicaid, have them select a managed care plan before their release, and develop a health care plan for those with complex health care needs in an effort to avoid gaps in coverage, ensure continuity of care, and potentially reduce recidivism (ODRC 2015).

The Medicaid enrollment and plan selection process for people leaving prison consists of three main steps (figure 1). First, a pre-enrollment class run by peers provides people with the information necessary to understand whether they want to enroll in Medicaid and, if so, how to select from among the five available managed care plans. Potential enrollees attend the pre-enrollment class approximately 90 days before their release. Second, approximately two to three days after the pre-enrollment class, individuals attend an enrollment class, during which they fill out the necessary forms to facilitate eligibility and enrollment in Medicaid and select a managed care plan. Finally, people identified by ODRC as "critical risk"—that is, having a serious need for ongoing health care services to manage chronic conditions—participate in a videoconference with their MCP before release. ODM's contract with each MCP requires them to participate in these videoconferences and to follow up promptly with those identified as critical risk after they are released. ODM also requires the plans to submit monthly and quarterly reports relating to their follow-up with these individuals.

FIGURE 1.



Source: Ohio Department of Rehabilitation & Correction.

MPRE was piloted in the state's women's prisons beginning in fall 2014. Additional facilities were brought online gradually. As of May 2016, the program included 21 prison facilities that had enrolled more than 4,100 people in Medicaid before they were released into the community.

Peer Educators

Research has shown that peer health educators can help low-income and certain other populations manage chronic health conditions and maintain engagement with health care systems.[5] Practitioners such as the Transitions Clinic Network have extended this concept to hiring and training formerly incarcerated people as community health workers to engage with people returning from prison and ensure that they access care. Hiring the formerly incarcerated is based on the premise that their experiences give them unique knowledge regarding the reentry context and the ability to secure the trust of the recently incarcerated.[6] Ohio is using this concept of peer education within the prisons to help returning citizens learn about Medicaid and its benefits, and to help them enroll in coverage.

Ohio decided early in the development of the MPRE process, at the suggestion of the ODRC director, to make peer educators an integral component of its prerelease enrollment effort. These individuals, known as Peer-to-Peer Medicaid Guides (PTPMGs) are volunteers who educate their peers about the enrollment process. Additionally, the PTPMGs provide staff assistance throughout the entire process and serve as their peers' point of contact for any follow-up Medicaid or managed care questions (ODRC 2016, 4). This structure helps reduce the cost of the program and builds on relationships at each prison. As one interviewee explained: "The individuals that are part of this peer-to-peer group are at the

institutions 24/7 with the other individuals. They can do a lot more reach-out and discussion than we can do.... You're going to trust somebody who's more of your peer giving advice." Staff at each prison select the individuals whom they believe would be the best role models as educators; staff select six to eight PTPMGs in prisons anticipating 50 or more releases a month, and three to four in prisons with less than 50 per month.

The primary responsibilities of the PTPMGs are running the pre-enrollment classes, serving as information resources to fellow inmates on Medicaid enrollment, and providing support for the enrollment classes. PTPMGs can do more extensive outreach in the prisons than the staff associated with MPRE at either ODRC or ODM. PTPMGs are not expected to become experts in Medicaid or steer inmates to specific MCPs; rather, they are expected to be able to communicate to inmates what Medicaid is, why they would want to enroll in it, what the consequences of not doing so could be, what the MPRE process is, and what informational resources are available so inmates can learn more. The work of the PTPMGs makes Medicaid enrollment and MCP selection more efficient, as inmates come into the enrollment class well-informed.

There was just the recognition that inmates might be more receptive to applying for Medicaid if the message came from their peers, and that it was a great opportunity for skill-building for other inmates.
—Ohio Medicaid official

Medicaid does not provide funding to ODRC for any of its work coordinating or running the PTPMG program, but it supports the program in a number of ways. ODM and ODRC jointly train new volunteer PTPMGs at prisons when they begin implementing the MPRE. ODM also provides the PTPMGs with Ohio's managed care report card, which indicates how each managed care plan has performed in different categories in the past. The agency also provides promotional materials and short promotional videos about the MCPs, to help people choose a plan. The use of PTPMGs does not require many resources, but it does require a willingness to trust and invest in incarcerated people as colleagues and partners.

Managed Care Plan Selection

Medicaid enrollees in Ohio need to select one of five available managed care plans. All plans offer coverage statewide, making the process simpler than it might be in other states. There is no default enrollment or assignment; the inmate must choose one of the five plans. ODM and ODRC devised a

process by which people returning from prison would make their MCP selection before release, so it could be effective immediately upon their return to the community.

People are able to select a plan once they agree to participate in MPRE. The pre-enrollment class and general advising from the PTPMGs are critical preparation, ensuring that inmates are provided with the information and guidance necessary to think through plan selection. Each inmate receives a report card comparing the five statewide MCPs and a checklist of issues to consider in selecting a plan (ODRC 2015, 47–48). Inmates also are encouraged to "do some homework" between the two classes to determine which MCP is the best for them.

ODM established a dedicated toll-free number, separate from the one used for the general public, through which inmates are connected to an enrollment broker at the Ohio Medicaid Consumer Hotline (OMCH), who takes their application information and completes the managed care plan selection. During the enrollment class, Medicaid applicants complete their paperwork and have this short private telephone call with the enrollment broker. The phone line is available to inmates at each facility according to a master schedule that ensures that no more than two facilities are using the line at any time. Each facility is scheduled for these calls twice a month. The PTPMGs do not participate in the calls with the enrollment brokers. The plan selection conversation generally takes less than five minutes. For inmates who do not connect to OMCH during the scheduled time block for any reason, prison facility staff will schedule an appointment ("outlier call") through the OMCH.

This phone line is kept separate from the general public line to prevent confusion since the enrollment processes for these populations differ. Medicaid enrollment in Ohio is generally done by county government, but ODM decided to assign state staff to handle enrollment and eligibility determination for the ODRC population.

Eligibility determination occurs after MCP selection is completed for the prerelease program participants. ODM has a memorandum of understanding with ODRC and Automated Health Services, which serves as the Medicaid enrollment broker. Under this agreement, Automated Health Services accesses ODRC's inmate database and forwards key identifier information to Ohio Benefits, the state entity that handles applications for several benefit programs. Automated Health Services "holds" plan selection information until Ohio Benefits determines eligibility. Once that determination is made and ODM processes MCP selection, the file is transferred manually to ODRC. ODRC populates this file with additional information that is then shared with each MCP to conduct prerelease care management for individuals with critical chronic health needs. Including MCP selection as part of the application process eliminates the administrative complexity of trying to contact the participant for additional information after the person is released from incarceration.

Prerelease Videoconferencing to Begin Care Management for People with Significant Health Care Needs

In addition to the MPRE enrollment and MCP selection process developed for everyone returning from prisons to the community, the ODM, ODRC, and the MCPs developed a prerelease videoconference to facilitate access to care in the community for people leaving the prisons with serious chronic health conditions. The videoconference establishes a connection between the selected MCP and the individual, so they can confer on a care-focused transition plan. The expectation is that this will make the prompt connection to community-based care happen more consistently.

ODRC begins by establishing which individuals are eligible for the prerelease videoconferences. ODRC created a critical risk indicators (CRI) category for this purpose, including any individual with an indicator of infectious disease (e.g. HIV or Hepatitis C), or having at least two of three indicators: designation for serious mental illness, a certain recovery services level of care, or enrollment in at least one chronic condition clinic (ODRC n.d.). ODRC administrative staff are able to make CRI determinations based on diagnosis codes in the ODRC data system.

Once someone's CRI status has been determined, ODRC shares this information with the selected MCP. ODRC also provides the MCP with a clinical summary about the future enrollee that includes a list of medications and diagnoses, and they begin coordinating, via a SharePoint platform, the videoconference.[7] The conference should occur at least 14 calendar days, and no more than 30 calendar days, before release. In advance of the conference, an MCP care manager creates a transition plan for the individual. The care managers work with hospitals, doctors, and other providers to coordinate an individual's care and access to services after incarceration; the transition plan provides the road map for doing so, and documents additional needs in areas such as housing and transportation. The transition plan, which includes the name and phone number of the MCP care manager, is provided to the prison facility electronically before the videoconference, and facility staff share it with the individual. The transition plan is the basis for the conference, which typically lasts 30 minutes. The plan indicates primary medical, mental health, and recovery issues, as well as scheduled follow-up appointments with providers in the community to address them. If the individual expresses any additional or different needs while conferring on the transition plan, the MCP care manager updates the plan and provides a final copy to the facility electronically. The individual is provided a copy of the plan along with his or her MCP member identification card at release.

Any time that you can engage with that member face to face, you have a better opportunity to make immediate rapport. So they can see who you are, what you're about, and what you're willing to do for them. Making that initial connection is very important. Otherwise, the person may feel less obliged to follow through.
—Ohio Managed Care Plan official

The MCP contract also requires the MCP to contact the enrollee no later than five days following release from prison "to assist the member with accessing care according to the transition plan, including identifying and removing barriers to care, and addressing additional needs that are expressed by the member."[8] After three unsuccessful attempts to contact the individual within five days of his or her release, the MCP must send a letter to that individual with contact information for member services and the care management department to request assistance. MCPs are also required to submit monthly reports showing, among other things, how many critical-risk individuals are enrolled, how many have transition plans, how many were contacted within five days, and how many were assessed for any level of care management. Quarterly reports must be submitted regarding critical-risk individuals designated as having a serious mental illness; these reports include how many had a follow-up visit with a community mental health center and how many had a prescription filled within 30 days and from 31 to 60 days following release.

The MCPs do not receive any additional payment for creating the transition plan and conducting the prerelease videoconference beyond their per member/per month capitated payment rate that begins the month a person is released from prison. The MCPs benefit if the videoconferences increase post-release engagement in care by individuals leaving prison with substantial chronic care needs. MCPs may spend substantial time and energy attempting to find members in the community, and the prerelease videoconferencing can reduce that resource expenditure.

ODRC and ODM are developing an evaluation plan for MPRE. Evaluating the impact on people who received coverage, including potentially the impact on recidivism rates, is part of the project's next phase.

Lessons Learned

Eight lessons from the MPRE's experience implementing peer educators in the prisons, prerelease plan selection, and prerelease transition planning and videoconferencing for people with serious chronic conditions might be useful to other states considering similar initiatives.

Strong interagency collaboration, including director-level leadership from partner agencies, was critical. In Ohio, this collaboration and support was present all the way through the governor's office. This support helped ensure the contributions and coordination needed from multiple agencies, including ODM, ODRC, the Department of Mental Health and Addiction Services, and the Department

of Health. The MCPs were also highly engaged and flexible. ODM, ODRC, the MCPs, the Department of Mental Health and Addiction Services, and the Department of Health still hold regular meetings.

Special waivers or legislation were not required to develop and implement the activities described here. In Ohio, the expansion of Medicaid to childless adults provided all the additional authorization needed to develop the activities covered in this brief. However, core agency partners needed to think creatively and collaboratively to make the activities possible.

The program design was consistent with the available resources. The Ohio program design had to be lean. All the MPRE collaborative partners agreed the process could not be very staff intensive, particularly as the main components could not be paid for by Medicaid. The need to be lean was one reason peer-to-peer education was an attractive method for facilitating efficient enrollment and plan selection.

For in-prison enrollment activities, buy-in from wardens and staff was a necessary component. Ohio's institutions staff were initially concerned that MPRE would create more work for them. ODRC's commitment to leanness in the process included making sure it was not overly cumbersome for the participating institutions. In the words of one stakeholder: "Once I leave a facility, they're raving about how easy this is. We made sure to fit the business processes of the facility. We keep it simple."

Piloting the program identified and addressed challenges and ensured the Medicaid agency could manage the applications. Piloting and implementing in stages was important in Ohio, allowing the agencies to monitor and refine MPRE, conduct targeted outreach and training for each facility, and enable limited staff to address the concerns and secure the support of each prison.

Identifying the target population for the case conferencing and transition planning on health risk supports increased program impact. ODRC uses its health data to identify the individuals needing the highest level of care upon release, thus ensuring that prerelease videoconferencing and proactive connection to care management resources were allocated where they were needed most.

A sizable, cross-agency team and technology were needed to support the effort, especially in the planning stages. In Ohio, ODM and ODRC had to become familiar with each other's process and structure to develop a rational process. Both agencies had to be able to pull and share data to make MPRE work, and many processes for doing so were not automated. This did make the process more labor intensive to maintain; up-front investment in a fully automated process would have mitigated that. MCP participation and partnership were also critical for the CRI videoconferencing and transition planning.

Communication between partner agencies and nimbleness in responding to changing circumstances helped mitigate unpredictability. Some unpredictability is inherent in working with corrections populations. In some cases individuals had release dates earlier than anticipated, making it difficult to ensure they had completed their transition plan and videoconference before release. In other cases, the addresses and contact information provided by people returning were no longer accurate at the time of attempted contact. While these issues cannot be completely eliminated, close communication between ODRC institutions, MCPs, and parole supervision allowed the partners to respond to unpredictability as effectively as possible and mitigate its impact.

For years and years, we released individuals with serious, chronic addiction or medical needs without health care. We really wanted to fill that gap.
—Ohio Corrections official

Conclusion

Much of the focus on flexibility in Medicaid to work effectively with justice-involved populations focuses on what Medicaid funds can pay for under which circumstances. The work described in this brief, however, is only tangentially about funding. Instead, these practices show how Medicaid, managed care organizations, and criminal justice agencies can deploy their resources to make Medicaid enrollment and care coordination as seamless as possible for the agency partners and as approachable as possible for the people enrolling in Medicaid. Ohio started with a shared commitment to improving continuity of care and health outcomes for the justice-involved population, particularly for the most vulnerable among them. As one person involved put it, "This is not about money. It's costing [ODRC] money. But it's getting people care."

Notes

1. See Sachini Bandara, Lauren Riedel, Beth McGinty, Colleen Barry, and Haiden Huskamp, "State and Local Initiatives to Enroll Individuals in Medicaid in Criminal Justice Settings," Johns Hopkins Bloomberg School of Public Health, accessed September 26, 2016, http://www.jhsph.edu/research/centers-and-institutes/center-for-mental-health-and-addiction-policy-research/research/economics-and-services-research/arnold-foundation-project-map/; and Pew Charitable Trusts (2015).
2. ODM and ODRC are the lead agencies implementing the prerelease enrollment program, but the Ohio Department of Mental Health and Addiction Services, the Ohio Department of Health, and the Medicaid managed care plans are active partners.
3. ODRC, "Reinstatement of Medicaid for Public Institution Recipients," Number 07-ORD-14 (November 10, 2009). *See also* ORC Ann. 5163.45 (2016) (addressing the suspension of Medicaid eligibility while people are confined in a state or local correctional facility). One interviewee explained that RoMPIR was established primarily to facilitate Medicaid reimbursement for inpatient hospitalization of incarcerated people and that individuals were tracked for reinstatement upon release only if they were serving less than a year sentence.
4. See "Medicaid Managed Care Eligibility," Ohio Department of Medicaid, last updated May 2013, http://medicaid.ohio.gov/Portals/0/Providers/ProviderTypes/Managed%20Care/MedicaidManagedCareEligibility.pdf.
5. See, for example, Thom et al. (2013) and Kelly et al. (2014).
6. "Community Health Workers in the TCN," Transitions Clinic Network, accessed May 21, 2016, http://transitionsclinic.org/whychws/.
7. Interviewees indicated that MCPs can request additional clinical information from ODRC about specific enrollees, but ODRC had not instituted electronic health records at the time of our interviews, so manual reviews of records was required. Our interviews did not explore how often ODRC health records are shared with MCPs.

8. ODM, "Ohio Medical Assistance Provider Agreement for Managed Care Plan," Appendix K (Rev. 7/2016), p. 20. http://www.medicaid.ohio.gov/Portals/0/Providers/ProviderTypes/Managed%20Care/Provider%20Agreements/ManagedCare-PA-201609.pdf.

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