

Centers for Medicare & Medicaid Services
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Welcome

Welcome to today's assister webinar. First of all, I would like to apologize for the technical difficulties, but we are going to get through this. My name is Everett Smith, with the CMS Consumer Support Group. Before we start today's presentation, I'd like to go over a few technical details with you. All lines have been muted so that everyone can have a good learning experience. If you're listening through your computer speakers and have any audio issues, or if your slides don't appear to be advancing, please try to refresh the webinar. Press the refresh icon that looks like two arrows. It's the third icon in the row near the volume bar. If you continue to have issues try to log out, and back in again. Sometimes that helps to reset things. If you would like to ask a question during the presentation, please do so by typing them into the "ask a question tab" on your screen. Now I'll turn the webinar over to Ms. Deborah Bryant. Deborah, please go ahead.

Thanks so much, Everett, and in the interest of time I'm going to rush through this welcome. I want to welcome everyone to today's webinar. This call is intended for technical assistance for assisters and it is not intended for press purposes. So if you are a member of the press, please contact our press office at press@cms.hhs.gov. Also, I want to remind everyone that this information is intended as informal technical assistance and is not intended as official CMS guidance. Let's jump right in. We have several presenters today who are going to present on working with special populations. I'm going to turn it right over to Michelle Koltov, who is going to provide a couple of quick Marketplace updates, and then we are going to jump right in.

Marketplace Updates

Assister Certification Bulletin Now Available

Great, thanks. Our first Marketplace update of today: we just want to remind folks that CMS released the 2016 Assisters Certification Bulletin last week. This outlines the Navigator and CAC certification and re-certification requirements for the 2017 plan year. This bulletin can be found by clicking on the link on your screen. Earlier this week, we also provided a training webinar that outlined the certification and recertification process, what's new and the training MLMS system and different system requirements for accessing the training and all the information that was covered in this webinar including the slide deck can be found on Marketplace.gov and also be found by the link on the slide.

Effectuated Enrollment Snapshot

Our next update is that last week CMS released Marketplace enrollment numbers showing that as of March 31, 2016, approximately 11.1 million consumers have effectuated health insurance Marketplace coverage. This means those individuals have paid their premiums, and have active insurance as of that date. And again, there's a link for more information about this on your slides.

Tips And Resources To Help Enroll People Living With HIV In Health Insurance

With that, let's get started with our main presentation for today. First we are joined by Holly Berilla, Lieutenant Commander with the Division of Policy and Data of HIV/AIDS Bureau at HRSA and Mira Levinson, Director of the HRSA Supported Affordable Care Enrollment, Technical Assistance Center who will provide tips and resources to help enroll people living with HIV and health insurance. As a reminder, if you have any questions throughout the presentation, please submit them through the webinar chat feature. Holly?

Hi. Yes, good afternoon, and thank you for the introduction. I'm pleased to be here and I'm just going to quickly go through the slides. I know we have a lot of material to cover. I want to let you know that Mira Levinson is going to present following my presentation to you. The goal for today's webinar is to equip enrollment assisters, Navigators, CACs and their supervisors with the knowledge and tools to help people living with HIV enroll in health coverage. We're going to discuss key considerations when assisting people living with HIV through the application process and by the end of our session today you will understand how the ACA and the Ryan White HIV/AIDS program work together to support people living with HIV so that they can get the health care that they need; understand how the ACA intersects with the Ryan White HIV/AIDS program; learn what is unique about helping people with HIV enroll into health coverage and why this is so important to the population of people living with HIV. And also to learn strategies that can be used to help consumers living with HIV learn about coverage and get enrolled in the best plan that meets the unique health needs that is within their budget. The Ryan White

HIV/AIDS Treatment Extension Act legislature program that was enacted into law as cited in 1990 the last reauthorization occurred in 2009. The program is administered by HAB HIV/AIDS Bureau through the Department of Health and Human Services Health Resources and Services Administration or HRSA. The program plays a critical role in ensuring that people living with HIV in the US have access to life-saving care and treatment including antiretroviral medication. The Ryan White HIV/AIDS program, or the Ryan White program, exists to provide high quality HIV care, treatment and services to low income people living with HIV, the program has an important role to play in the public health response to HIV. Clients served achieve higher rates of viral suppression than those -- receiving services elsewhere. Mira and I will discuss viral suppression and its importance, please know that your role is essential.

The Ryan White program is not an insurance program. But it's a support service and survey dynamic and complex system of care that works with programs such as Medicaid and qualified health plans to the Affordable Care Act to ensure that clients served receive the essential core medical and support services. To provide primary medical care and essential support services for low income people with HIV who are uninsured or underinsured. It helps provide city, states, and local community-based organizations with a cohesive system of care. It also in 2014, served over 512,000 individuals with approximately half of all people living with diagnosed HIV. Most Ryan White program clients have incomes at or below 100% of the federal poverty level and I provided a link you can use for additional information.

The Ryan White HIV/AIDS program increases the access to care and treatment for people living with HIV. It is the only disease specific discretionary grant program for the care and treatment of people living with HIV. Many people living with HIV are experiencing health insurance for the first time. Some people with HIV may qualify for Medicaid if their state has expanded Medicaid. Not all people living with HIV are Ryan White HIV/AIDS program clients. Other insurance coverage always goes first, as Ryan White is the payer of last resort. Ryan White programs must really vigorously pursue insurance coverage or Medicaid coverage or other payment sources for its clients.

Again, it only pays for the services not covered or partially covered by health insurance or Medicaid. It essentially helps people with HIV who have both insurance, Medicaid and/or Ryan White program care take advantage of many of the services that the program offers. Some of those services are case management, counseling and in some instances transportation and other assistance. Also the Ryan White program has the AIDS Drug Assistance Program or ADAP that pays for a client's health insurance premiums and cost-sharing including in some instances copayments, and deductibles, coinsurance only if it is considered cost effective to do so. There are specific health plans that clients can enroll in and receive premium and cost-sharing assistance. It is critical for assisters to reach out to and form relationships with the local Ryan White programs in order to gain more information on these services and Mira will give resources on that.

As Ryan White HIV program must again work to enroll clients in other funding sources like Medicaid so it is really good to develop those relationships as assisters with other programs and communities. Before I get started I want to explain viral suppression to you. People living HIV have an amount of the HIV virus in their body that is measured in a sample of blood and it is called a viral load. The viral load is measured by the amount of HIV-RNA copies per millimeter or millimeter of blood. That's about as scientific hopefully as we are going to get. An important goal of antiretroviral therapy is to suppress a person's viral load to an undetectable level which is a level too low for the virus to be detected by a viral load test. If the viral load is suppressed or tested at a level that undetectable HIV still remains in the body but a suppressed viral load allows people to remain healthier and decreases the chance the virus is spread

to others. To explain the slide viral suppression is defined by a viral load test that was less than 200 copies per milliliter. Viral suppression is something that the Ryan White program and the Centers for Disease Control and Prevention or CDC measure in populations. Ryan White program data is based on data for people living with HIV who had at least one outpatient medical care visit and at least one viral load test during the measurement year. The Ryan White program reports data on clients served through 2014 and CDC reports data through 2012 on all people living with diagnosed HIV. This slide represents and compares all people living with diagnosed HIV to Ryan White clients living with HIV who are virally suppressed as of 2012.

So as you can see in 2012 75% of Ryan White program clients were virally suppressed. This slide shows that as of 2014 the Ryan White program clients do benefit from increased rates of healthcare coverage. Those receiving comprehensive medical services such as that provided by the program along with health insurance have higher rates of viral suppression and insurance again could be Medicaid. Ryan White programs core medical and support services help people to remain in care and achieve viral suppression. Also during 2014, and not shown on this slide, 80.4% of Ryan White program clients were retained in HIV care, 81.4% of Ryan White program clients had a suppressed the viral load at their most recent test. As stated before people living with HIV who are retained in care are more likely to be virally suppressed and have better health outcomes and out less likely to spread the virus. Moving forward the Ryan White HIV/AIDS program will remain a vital resource for low-income people living with HIV until the care continuum outcomes are met and the goal of optimal HIV care and treatment for all is reached. New infections can be averted by keeping people in care and on treatment. Thank you for all you do in helping individuals enroll in health insurance, your role is certainly vital.

I am now going to hand the slide over, the presentation over to Mira Levinson who is the Director of the Affordable Care Act Technical Assistance Center or the ACA Center, which is the national collaborative agreement with HRSA to build capacity among Ryan White HIV/AIDS program recipients to engage, enroll and retain diverse people living with HIV in health coverage. Mira?

Thank you, Holly and hello everyone. As Holly has already mentioned the Affordable Care Act plays a critical role in helping people living with HIV navigate the HIV care continuum. Remember the HIV care continuum which will be shown on the left-hand side of the next slide, includes knowing your HIV status, getting linked to care, staying engaged in care, getting access to HIV medications and ultimately getting to viral suppression. We put together this graphic to show how the ACA and the Ryan White HIV/AIDS program work together to support health outcomes for each stage. For example, the ACA provides coverage for HIV testing and primary medical care and also provides access to screening and diagnosis. Also many people living with HIV now have an expanded choice of medical providers including HIV specialists. And many people living with HIV are now able to receive care for other conditions like diabetes or heart disease often for the first time. The ACA provides coverage for the medications people living with HIV need, not only for their HIV care, but for non-HIV medications as well. As I'll explain in more detail, the Ryan White program supports the HIV care continuum by providing services that may not otherwise be covered filling in gaps and in many places providing financial support to get and maintain health insurance coverage. So what do you need to know as enrollment assisters to help people living with HIV find the best plan to meet their unique needs? Let's start by talking about some common fears and concerns related to enrollment. Here at the ACE TA Center we've been talking with people living with HIV since the beginning of the first open enrollment period all over the country as well as their Case Managers and medical providers. Here's what we've learned. First, some people living with HIV may not understand why they need health insurance. Many of them have been getting their HIV care through the Ryan White program and aren't aware of the benefits of health coverage like coverage

for non-HIV services and medications. Also many people are concerned that they would need to see a different doctor if they enroll and health insurance. In some cases this may be true, while in other cases they may be able to find a plan that allows them to continue seeing their HIV doctor as a primary care provider or as a specialist. Many consumers are working hard to take their HIV medications every day and they worry that they won't be able to get their medications through insurance or that they won't be able to afford them. Also consumers who applied in the past but were denied because of pre-existing conditions may be hesitant to apply again.

The ACE TA Center has identified eight ways you as enrollment assisters can help people living with HIV enroll in coverage. These steps include listening to consumers' needs and concerns, encouraging continuity of care, understanding why continuous medication coverage is essential, showing compassion and sensitivity, explaining insurance terms and benefits, knowing that the Ryan White program provides HIV care and support, knowing how to contact your state's Ryan White program or AIDS drug assistance program and helping consumers find plans that cover their current HIV drugs. I'm going to touch on each of these eight steps briefly in the next few minutes. We've also developed a one-page resource that summarizes these eight steps as a quick reference and a short animated video we designed especially for enrollment assisters about the needs of people living with HIV.

We are going to chat a link out to you now where you can access at this one-page tool and the video.

People living with HIV have unique needs and concerns when it comes to selecting healthcare coverage and medical providers and it is really important to find out what's most important to them. Health plan selection is important step in the coverage process for people living with HIV and consumers need your help to find the right plan. Their priorities often included making sure their medications are covered and affordable, and staying with a trusted medical provider. People also have varying levels of experience with insurance. Some have never had health insurance before, some may be new to private insurance coverage, and some may be switching from Medicaid coverage. Of course, they may have some concerns about non-HIV related health conditions too.

The ACE TA Center has created consumer materials to help educate people living with HIV about the benefits of getting health insurance. All of our consumer materials are available in English and Spanish and most are also available in Haitian Creole. We are unable to chat out links unfortunately but will make sure that there included that they are provided to CMS so that they can be shared with you at a later time in the newsletter. So the screen you are looking at now is a resource that addresses some top questions and concerns raised by Ryan White program clients. You can help reinforce some of the messages from the tool.

A second way you can help these consumers is to support their continuity of care. Continuity of care mean seeing the same providers and maintaining a consistent supply medicine. Ryan White program clients need to understand how the ACA could change their healthcare coverage or their relationship with their provider. As an enrollment assister you can help the consumer look at the various health plan options and find those that would allow them to see their current doctor if available. Many consumers have a trusted relationship with their HIV doctor who not only has HIV expertise, but accepts the person's identity, life experiences, and challenges. In some tightly knit communities a person living with HIV may also have concerns about going to a particular doctor's office, for fear that their health information might not be kept confidential. Continuity of care can make the difference between sickness and health for people living with HIV.

Now let's get to the most important message I'm going to share with you today. If you take home nothing else, understand that it is critical that people living with HIV have continuous access to their medication. People who consistently take their HIV medication can maintain viral suppression which means that there's a very low level of HIV in the blood. When the virus is suppressed the person is much less likely to get sick and they're also much less likely to pass HIV onto others. However, it can be hard to tolerate some HIV medications. When comparing plans or considering health insurance, people living with HIV are often concerned that they will have to change medicines after they've spent so much time finding the right ones to keep them healthy with minimum side effects. To have continuous access to medication consumers must have coverage that includes the medications they need, they must be able to afford the medicine and they must be able to get the medicine. Getting medications may include making sure consumers are able to get to the covered pharmacy. People may have transportation challenges or other challenges where a mail order option would not be practical. It depends on the individual.

Next, cultural sensitivity and compassion are key. In many cases people may not want to share details about their medical status and other sensitive topics because of concerns related to stigma. This includes negative reactions and treatment by others or discrimination because of their HIV status or for other reasons like race, ethnicity, sexual orientation or gender identity. Anxiety about stigma can keep people living with HIV from accessing HIV care either for fear of being treated with disrespect or because of concerns about confidentiality. Many people have had negative experiences with the healthcare system or individual providers and some may be reluctant for other reasons; such as, fears related to the immigration status of a family member or because of mistrust or myths related to what will happen if they report certain information. Let consumers know that your conversations are confidential and judgment free. Each person brings a unique cultural identity and life experience to their care visit. Accept each person and listen to how they talk about their concerns. Avoid making assumptions and give the people space to be themselves and to use the language they use.

As you all know, insurance and enrollment terms are complicated. There's a reason that enrollment assisters like you exist across the nation. It's difficult to navigate the enrollment process and health coverage and most individuals need some help to successfully enroll in coverage and access care. About 30% of people living with HIV who are served by the Ryan White program have never had health insurance before. This means that many of the terms we use every day can be new or confusing like premium, co-pay, deductible, and coinsurance. Terms we use all the time in the enrollment process like Marketplace, open enrollment and special enrollment period are also confusing. As you know, under the Affordable Care Act nobody can be denied insurance coverage or charged more because of the pre-existing condition including HIV; however, some consumers still don't know about this. And they may have been denied health insurance coverage or even charged more in the past because of a pre-existing condition. Also once a consumer's enrolled in coverage they may not know how to activate or use of their coverage. Navigating the world outside of HIV care can be confusing and complicated. Health insurance literacy is an important part of helping people living with HIV learn to make the most of their new coverage.

Now I'm going to show you two more ACE TA resources to help consumers understand their new coverage. Specifically to stay covered and to make the most of their coverage. The first, 'Making the Most of Your Coverage', can be shared with newly enrolled consumers to help them start using their benefits. This guide provides information in plain language about identifying important documents, key insurance terms, healthcare costs, where to go for care, and making the most of each medical visit.

The next tool I'm going to show you is called 'Stay Covered All Year Long'. It provides information to help people living with HIV avoid any gaps in coverage. This can happen if they don't make a premium payment or their income or eligibility for coverage changes. Maintaining coverage allows consumers continued access to the services and medication they need. This guide can be shared with consumers after they enroll in health insurance to help them understand what they can do to maintain their coverage like paying premiums on time, reporting income and housing changes and what to do if they lose coverage.

For consumers who transition between coverage through the Marketplace and Medicaid, the tool includes information on what they might need to do to manage the change in coverage. Ryan White program clients should ensure their communicating with the Case Manager to ensure that the Ryan White program is taking care of any eligible expenses and so that the program can step in to fill gaps if the consumer does lose coverage.

These last three steps are focused on how to make sure people living with HIV can get additional financial support for medications and HIV care from the Ryan White program. You can start by encouraging consumers to continue to stay engaged with the Ryan White program by staying enrolled in ADAP, that's the AIDS Drug Assistance Program and continuing to see a Ryan White Case Manager. Ryan White programs supports all consumers whether they're insured or not. Remember though the Ryan White program only covers services that help people stay in HIV care, so eligible individuals also need to enroll in comprehensive health insurance coverage. It's particularly important for enrollment assisters to know that the Ryan White program including the AIDS drug assistance program can often pay for premiums and out-of-pocket costs. I'm going to say that again to make sure you hear this. In many areas the Ryan White program helps consumers pay for the cost of health insurance. It's so important that people stay on their medications and maintain access to their doctors that the Ryan White program does everything possible to make sure there are very few potential barriers including financial ones. As enrollment assisters you can help by encouraging consumers to stay enrolled in ADAP. In fact, consumers have to stay enrolled if they want to get help from ADAP to pay for insurance costs. Also, you can encourage consumers to connect with or stay in touch with their Case Manager who can help them navigate their new insurance and help them if they have any gaps in coverage for unexpected costs.

Here are two ways you can find out what the Ryan White program has to offer in your community. The first option is to contact a local Ryan White service provider in your area. To do this, go to the [AIDS.gov](https://www.AIDS.gov) HIV testing sites and care services locator at locator.AIDS.gov. Your local Ryan White program can give you information about what services are available to people living with HIV in your area like help paying for insurance, medication assistance, and support services like transportation or housing assistance. A second option is to contact the Aids Drug Assistance Program Coordinator in your state. The ADAP coordinator directory is routinely updated. Contacting your ADAP directly is a great way to find out if the Ryan White program in your area has reviewed available insurance plans already. They will also be able to tell you if they provide financial support for any of these plans.

In many cases Ryan White programs only provide financial support for specific insurance plans usually at the silver medal level. HIV medications also known as antiretroviral therapy or ART are expensive, and the list of medications covered by health plans can vary widely. There are more than two dozen drugs approved for treating HIV and many people tolerate some medications much better than others. Single tablet regimens, one pill taken once a day, are especially important for many people because taking fewer pills a day makes much easier to stay on a medication schedule. People may also be prescribed additional drugs to prevent other conditions or manage HIV-related illnesses. Sometimes HIV

medications also cost more, especially if they're in higher tiers or if a plan requires increased cost sharing for HIV drugs. At the same time HIV medication regimens can differ significantly from one person to the next. As enrollment assisters you can help people living with HIV identify which medications are covered under the plan they are considering, and find out which plans are supported by the Ryan White program in your area. With this information you can help these consumers project their total out-of-pocket costs. Without the right coverage, medications can cost hundreds or thousands of dollars per month.

So I hope you've enjoyed learning about these ACE TA Center resources and about how you can help people living with HIV get enrolled in the best plan for their particular needs. In addition to using these resources yourselves, I invite you to share this information with any colleagues who provide enrollment assistance and also with any HIV providers you know so they can take advantage of all the ACE TA Center resources we've developed for consumers, HIV Case Managers, clinicians, and program administrators. The links on your screen are for the ACE TA centers General Information page, and for the HRSA HIV Bureau's website. Again you can find ACE TA resources specifically for enrollment assisters at targetHIV.org/assisters. Thank you.

Information and Tips for Assisting Justice-Involved Consumers Transitioning From Incarceration To Their Communities

Great, thank you so much, Holly and Mira. In the interest of time, we are going to move on to our next presentation, and I know there are some questions in the chat box and we will follow-up after the webinar. For our next presentation, we're joined by our colleague from CMCS, Nancy Kirchner, Deputy Director of the Division of Benefits and Coverage at the Centers for Medicare and Medicaid Services. Stephanie Bell, Deputy Director of the Division of Eligibility and Enrollment and the Children's and Adult Health Program Group at the Centers for Medicaid and CHIP Services and Annie Hollis, Health Insurance Specialist with the Division of Eligibility and Enrollment and the Children and Adult Health Program at the Center for Medicaid and CHIP services. Who will all present information that was included in the recently released State Health Official Letter on facilitating access to Medicaid services for individuals transitioning from incarceration to their communities. Nancy?

Hi, good afternoon, everyone. If we can go to the second slide in our slide deck please, the purpose of our guidance. Great. Okay, I know that we have limited time and a lot to get through today. We want to talk a little bit about the purpose of the guide. The focus of our guidance was for the Medicaid program and we recognize that as assisters are in contact with folks that there may be individuals that are going to be interested in Medicaid coverage so the focus of our presentation and the purpose of our guidance was strengthening access to care and supporting re-entry policies that promote health and well-being so as individuals move from incarceration to re-entry into the community and getting Medicaid, getting enrolled in Medicaid and receiving Medicaid benefits. In our guidance we very much encourage but did not mandate early eligibility and enrollment while folks are still incarcerated. We want to improve the continuity of care as individuals transition into the community.

Next slide, please. In Medicaid the inmate definition is listed in our regulations and the regulation site is on the slide and this is an inmate of a public institution and this is important for Medicaid because we consider anyone that is an inmate that's in custody and held involuntarily in a public institution under the operation of law enforcement to be an inmate. That is significant for Medicaid because for inmates there is a coverage exclusion so while someone is incarcerated and an inmate of a public institution, they may be able to be eligible or enrolled for Medicaid coverage, but they cannot receive Medicaid

coverage. That is a very important nuance for folks. Generally, individuals on probation or parole are not considered inmates of a public institution. People who are in home confinement, are not considered inmates of a public institution even though the correctional system may have rules and requirements that restrict them in some way, they are not an inmate in a public institution held involuntarily. They are in the community. Individuals that are voluntarily residing in a public institution; for example, if they're in some sort of institution and they're pending placement but they could leave if they so choose or if as soon as some place became available are not considered inmates but folks that are held involuntarily are considered inmates.

I'm going to turn over to Annie Hollis who is going to talk through a few slides related to eligibility and enrollment.

Thanks Nancy. Thanks everybody for joining us. I am a Health Insurance Specialist in our Division of eligibility and enrollment so I'll cover a couple slides based on those topics. Then turn it back over to Nancy to close out. I think for the assister community the first thing that I really want to note and make clear is that being incarcerated does not prevent an individual from being found eligible for Medicaid or from remaining enrolled in Medicaid while they are incarcerated. State Medicaid agencies must accept applications from individuals while incarcerated. The other important thing to note is that there are no special rules or exceptions to MAGI-based income eligibility for individuals who are incarcerated. When you are considering, if you're considering, helping folks put together an application just keep in mind that the sort of household rules and income rules follow the same constructs as they do with any other MAGI-based eligible individual. A couple of other things to note around eligibility is that generally individuals who are incarcerated are state residents of the state in which they are living. However we do know that a few states, quite a lot of states, place individuals who are incarcerated in other states. Perhaps they send them to a prison facility in a different state and if that's the case then the home state remains the state of residence for purposes of Medicaid eligibility. The other important thing to note is that in the situation like I described above or in any situation before they're released individuals can apply for Medicaid in a different state if they intend to reside in that different state after they are released. If they are intending on moving back to their home state they can definitely apply for Medicaid in the home state before they are released from incarceration.

The last thing that I wanted to touch on are things that state Medicaid agencies and individuals can do to promote enrollment. One of the things our guidance did was really encourage state Medicaid agencies to work with their local Departments of corrections, their prisons, their jails and all of those systems to promote enrollment for Medicaid eligible individuals who are incarcerated. And there's lots of opportunities right now for them to be able to do that; such, as collaboration on development and implementation of data exchanges, establishing outreach and enrollment efforts. The other thing that I want to note is that this is really sort of a state driven process in terms of how states are setting this up and making it work for individual who are incarcerated or individuals who are leaving incarceration. For the assister community we would really encourage you to have an open dialogue and active conversations with your state Medicaid agencies about what the state is doing or thinking about in terms of increasing access to coverage and care for this population. With that I will turn it back over to Nancy. Thank you.

Thanks very much, Annie. We want to go to the next slide. I think the eligibility and enrollment piece rather than the coverage piece is very very much key to the role that the assisters have with folks signing up for coverage. I do want to go ahead and point out one key piece, I had said earlier generally that coverage for folks Medicaid coverage for folks is not provided while individuals are incarcerated. It

wouldn't be Medicaid without an exception to our exclusion for inmate coverage and those exceptions to the exclusion are for qualifying in-patient services. It's one of the reasons why it is so important that individuals even while they are in fact incarcerated not only to make the transition smoother as they leave incarceration but while they are incarcerated if an individual goes into a qualifying in-patient hospitalization, then that is the exception to the exclusion, and if the individual is enrolled and eligible that person, the state can claim for those inpatient services for the individual.

Next slide, please. One of the areas that folks were most interested in and clarification and shift in terms of our existing policy was around halfway houses and community supervised residential centers. In our prior to our guidance before if folks were residing in halfway houses as a bridge to full release in the community, but they were not residing there voluntarily, Medicaid coverage could not be enforced and in fact with our guidance now in certain types of state and locally run, operated or contracted halfway houses individuals can access Medicaid coverage while they're residing there. Now there has to be certain access in terms of access to the community and certain freedom of movement and association and our guidance documents goes into a few more examples of what the parameters are around that, but to echo something that Annie said it's very, very important that you understand that this is a state-by-state dialogue. Medicaid is a combined Federal-State program and it looks different from state to state and so conversations and communication and collaboration between the criminal justice systems and the state, and the state Medicaid agency are key. We've gotten a lot of questions that have come to us about: "I work in a halfway house or I live in a halfway house, can I get Medicaid coverage?" It's really not a question for CMS. CMS lays out the parameters in Medicaid under which that coverage could be provided in those settings, but each individual state is going to have to assess those types of residents and whether they qualify under the federal guidance for that. The other point that we want to clarify because there are different kinds of settings in which people are incarcerated that for the federal Bureau of prisons they retain responsibility in their residential reentry centers which are the federal types of colloquially called halfway houses but the federal residential re-entry centers and Medicaid coverage is not available to individuals in those situations because the Bureau of prisons is responsible for payment for healthcare in those situations.

This is Stephanie, I just want to jump in and say just to reiterate that an individual can be eligible for Medicaid and enrolled in Medicaid while they're incarcerated and you know ideally the process would happen before the person is released, but the coverage for the most part isn't available until the person is no longer an inmate of a public institution as Nancy was explaining. But the more that you all can help to get those folks enrolled before they get out or while they are in the halfway house or if they've already been released working with the communities, the better! And that states are working to put better processes in place to get the coverage turned back on when someone is released in a lot of states have, if they haven't already and they're working to set up data exchanges so that they know when people are going in and out of facilities, so I think you all can play an important role in helping get this population access to coverage.

Thank you very much, Stephanie. I think that's a really good point because as seamless as it can be its going to be helpful to folks making that reentry. Healthcare certainly isn't the only piece of importance for folks as their transitioning back into community but it is a significant piece and particularly because such a high incidence of folks have chronic health conditions and behavioral health substance abuse disorder conditions it is very very important and if there on medications too that there's as much is possible a seamless transition.

We are going to skip to our last slide which is resources. On this slide you will see a link to our guidance. We also, our colleagues that work in survey and certification on the conditions of participation for the inpatient settings that I mentioned when I was talking about the exception to the inmate exclusion, they released guidance shortly after we did so there's a link to that. We also have a dedicated mailbox for Medicaid related questions around our inmate policy. So that we can respond to questions that come up. We know that there's another presentation after us and with the time limits I don't know if there are any questions in chat or if we really should make room for time for the next presenter.

Q&A

Thank you so much, Nancy, Stephanie, and Annie. We do have another presentation but there are a couple of quick questions we thought we would ask that we see in the chat feature. First, how does a state access FFP?

The state would access, there has to be some sort of a service that they claim for, for a person, if the person as we said before, even if the person is eligible and enrolled if they're an inmate they can't access payment or coverage for services. Once a person who's out of that inmate of a public institution then they can go ahead and claim for services for folks. But the Medicaid program looks different from state to state and so would recommend that folks become familiar with what the services are that are actually covered and how that would happen, that would be through the Medicaid agency. The one piece again that I would reiterate is that there is an exception to the inmate exclusion for qualifying inpatient services.

Okay, great. Another question; scrolling down.

I think there's a little bit of confusion, incarcerated individuals can apply and be approved for Medicaid but they aren't actually able to use the Medicaid while they're incarcerated, is that correct? I think you just clarified that but just one more time, since I think it is a confusing point.

Yes. I think that goes to what Stephanie was saying which is a person can be eligible and enrolled for Medicaid and we think we have encouraged states to go ahead and to do that early to set the stage so that when someone is released then they can get Medicaid covered services. But while the person is actually an inmate of a public institution they can't receive Medicaid services with the exception to the exclusion for inpatient care.

I guess our colleagues before said if there's a general takeaway let's say that the general take away is it's always good to get eligibility and enrollment going early to set the stage for coverage when someone is released.

And this is Stephanie, I would add that a lot of states have set up special, that states who've been most successful at getting justice involved populations enrolled have set up some special processes because there may be different hurdles to getting these folks enrolled than other folks in the community and so sometimes having a dedicated caseworker to handle these applications is helpful. So another reason why you should contact your state Medicaid agency and see what kind of processes they have in place.

Okay, fantastic. I know there are other questions in the chat feature and we are going to share these questions with our colleagues to follow-up with answers. But I want to make sure - Actually wait, just a second, actually what I would really strongly suggest since we have a dedicated Medicaid inmates

mailbox, it would be really helpful if folks haven't gotten their questions answered if they could go ahead and send them to our mailbox and we are diligent in attempting to respond to those.

Criminal Justice Involved Population Healthcare Enrollment Program

Okay. For our final presentation today, I'd like to introduce Julia Holloway, Senior Project Director for Affiliated Service Providers of Indiana. One of our Navigator programs, Navigator grantee and Bill Wilson, Jail Services Coordinator with the Indiana Sheriff's Association. Who are going to discuss the criminal justice involved population health care enrollment program. Julia?

Thank you, good afternoon, everyone. Thank you so much for allowing us to talk about what's going on in Indiana with enrollment for criminal justice involve populations. We're going to talk about, well I am going to give you some basic facts about and statistics of the folks that have been enrolled in Indiana. We're going to do an overview of our new law, 1269 in Indiana, we are going to discuss how Navigators can help with enrollment and how we are working with the local county sheriffs and their staff for enrollment.

Just a little bit about who ASPIN is, ASPIN's a network of community mental health and addiction providers, this map displays where our providers locations are and each of ASPIN's providers covers Indiana counties that are medically underserved and include health professional shortage areas. ASPIN also has four service lines training in workforce development, that's our Navigators and community health workers we do grants management, health improvement and third-party administration.

ASPIN is an enrollment, we were funded through CMS and we provide free assistance through the federal Marketplace and HIPP since 2013. We have 20 plus Navigators and our Navigators have provided outreach and enrollment appointments in all 92 Indiana counties.

So in Indiana the legislative session in 2015, a law was passed for enrolling inmates and since it was enacted on July 1, and the since that time 18,728 applications have been received to the state for incarcerated individuals pending release. 16,428 of those have been approved and 1,589 are pending. These are both Department of Correction and County applications. Sixty counties have signed the contract with FSSA, our Family and Social Service Administration for inpatient PE and enrollment upon release procedures. And our Department of correction has reported that \$2.3 million has been saved and this is from October 2015 to May 2016. ASPIN Navigators have had appointments with 794 individuals in jails and 145 in probation or correction.

I'm going to turn it over to Bill to talk about a law that was passed.

Thank you Julia. Bill Wilson. I'm currently the Jails Services Coordinator with the Indiana Sheriffs Association but I had way too many years-experience working first hand in jails. And kinda got involved in this legislative process 1269 and it went through several revisions before the final version was actually passed by the legislators. And what we try to do was we looked at this law and we kinda just attempted to break this down into four different components just for simplicity. So we could communicate this to our members.

And typically, there's a significant difference between inmates that are housed within a Department of Corrections and those inmates that are housed in county jails. And County jails we have a greater turnover of inmates. We have more in inmates coming in and we have more inmates being released and

of course that results in inmate serving typically shorter amounts of time in a County jail network. So one of the things that the legislators looked at because of the difference between those populations, was taking into consideration the type of inmates we have, the length of the stay and those special needs that they have.

And so the first component of 1269 really has to do with what's known as hospital presumptive eligibility. And in Indiana our executives are basically our County commissioners and so the County commissioners are responsible for contracts. So the County commissioners enter into a memorandum of understanding with the Family and Social Services Administration. And so if an inmate is experiencing some type of medical distress in the County jail that inmate's transported to the hospital. That inmate can apply for hospital presumptive eligibility, basically meaning that inmate could be considered for Medicaid coverage to all that inmates in the hospital for 24 hours receiving care, the financial responsibility of that bill typically then will shift from the County to the Medicaid program.

And so when we talked about, when Julia talked about the savings of the DOC a lot of that money the savings has come from this HPE eligibility. And I'm aware of one County Jail in Indiana where an inmate basically suffered a heart attack was transported to the hospital, was in the hospital for several days, and ended up with a \$56,000 bill that the County didn't have any financial responsibility for. So certainly this pays and benefits for counties and county jails we don't see a lot of inmates going to hospitals for 24 hours at a time to receive care, but you have one particular case every two or three years and it certainly makes a difference and could save the County considerable funding and politically it is also the right thing to do.

Part two of this, 1269 the Medicaid enrollment Bill, really has to do with those short term inmates and typically the legislators allow the Sheriff to not require that Sheriff to enroll that inmate into the Medicaid program if they're going to be in jail for 30 days or less. Certainly it's an option, it's probably in the benefit to get those inmates enrolled, but since we have such a large turnover of inmates coming in and out it doesn't really put that burden on the Sheriff to enroll those inmates 30 days or less. However those in jails 30 days or more then there is a requirement that the Sheriff get those inmates enrolled before their discharged or released from the county jail.

At least 30 days before the release, if we know often times we don't know the day of release, but we try and look at the population that we have and get those inmates enrolled through that particular process. And that's kind of significant as the last part of this bill basically talks about the Sheriff has to secure treatment for those offenders as they're released and a lot of sheriffs have partners with community mental health providers to provide those services for those inmates to get access to substance abuse treatment for the mental health concerns that a lot of that population is basically dealing with.

The state has provided funding for Recovery Works and this is promoting recovery through community support and treatment intervention and is of course critical in reducing the number of persons with mental health and addiction disorders that are entering our criminal justice system. As Navigators we're looking at two distinct groups and they're either the short term hospitalization or the folks re-entry into that community.

So here is a timeline that we can look at as Navigators to complete the application. If approved, HIPP or Medicaid is suspended and then when released the individual contacts a state to activate the coverage or the staff person at the jail might also do that, the suspension is removed and then the process for health coverage program begins.

This is just a little overview of Indiana's HIPP 2.0 program and so when we meet with each - with the Sheriff and we do that before we start each enrollment program, they may know or may not know about the coverage programs and we don't assume that they do so we want to make sure about and explain about HIPP 2.0 to them.

Another item that we share with the Sheriff and their staff when we meet with them is a screening tool. And so this is just a suggestion that we give to them and they could do the screening right before we are going to come in for appointments or as folks enter jail and just some basic questions like if they have insurance or not, or if they're an Indiana resident, and so forth to know if they should meet with us or not.

This is part of our HIPP application. These are questions specific to incarcerated individuals. After the question are you a US citizen, the application asks are you currently incarcerated. And if you say yes it triggers some more questions around the dates with incarceration.

This is talking about, as we talk to the Sheriff about the presumptive eligibility process, and they usually have lots of questions about that, and that allowing for that reimbursement for that 24 hour stay, we don't deal with the presumptive eligibility as Navigators but if they've gone to the hospital and they need the full application, it didn't get filled out during that stay, we can help with that when they come back to the jail.

This is a sample of the suspension letter that the inmate will get so we make sure the Sheriff understands that that inmate's Medicaid will go in suspension and, this is what the letter starts out to look like from family and social service administration.

This is just a page that talks about the authorized representative. The law allows that the Sheriff can be the authorized representative for the inmate and making sure that they understand that either the staff or the inmate upon release must call the HIPP line or the Division of Family Resources at the Family and Social Services Administration to make sure that this is released. The Sheriff if the inmate is not, doesn't want to be enrolled in Medicaid they can as the authorized representative go ahead and enroll them or if they are not able to make an appointment to be enrolled they could go ahead and enroll them as the authorized representative.

We also share a takeaway sheet with all the inmates and show this to the Sheriff to let them know that there is some important information that they're going to need as they leave incarceration. Their application number, we want to make sure they have our phone number as Navigators so we can do follow-up if they have any questions on how to get there enrollment unsuspended or how they are activating or if they have any other questions for us and any other pertinent information that we put down during the enrollment process.

This is just, maybe you might want to put together a MOU with the Sheriff so these are some things that we might suggest that the County and ASPIN as Navigators might agree to be doing and this would include how we are going to schedule, how we're going to organize the scheduling for enrollment. We might send them a list and they put together who we will enroll for that day, whether we're able to use the Wi-Fi or not and how the paperwork will be maintained by the inmate.

We also as a Navigator organization here in Indiana you have to be an Indiana certified Navigators so ASPIN is a certified provider and we do pre-certification for Navigators so if the Sheriff want some of the staff to be trained we tell them about that and we also are putting together a continuing education module for folks to take too around jail enrollment.

So some of our key lessons learned from enrollment have been that Navigators need to stay in contact as a resource for reentry. We need to take a working model and just really sit down and work with the Sheriff and his staff, his or her staff on what the enrollment process is going to be. We know that the inmates are grateful for the opportunity for insurance and we know that we need to stress the importance of staying on insurance and the Sheriffs have been very supportive and value his service. Each County Jail will have a process, will process this differently and might have some different expectations for Navigators.

I think it's also important, Julia talked about this process with the Navigators is what we've discovered talking with our members, is that it's really important that the Navigators establish relationships with the Sheriff's while they're starting kind of in the preliminary stages of this process and kind of get some of the issues worked out about what it's going to be like going to the jail to do those services to provide that navigation, how long they're going to be in there and just to be very open about as a Navigator, this is what we will need, this is what we will bring in, and then the Sheriff will also, or the Sheriff's staff will also share about concerns that they have working with this particular population. Because not all but there are some inmates who are let's just say they are kind of interesting to work with. It's kind of a new experience, this is a new experience for the Sheriffs to be involved in and it is been a new experience for the Navigators but from the information that we are getting back it's been something that's been very positive and we really seem to be gaining traction in the momentum and it seems to be something that's really positive right now in the state of Indiana.

A couple of things that we've had Sheriff's ask us to do like they perform, even though we've performed a background check on our Navigators, they want to perform the background check, they want you to leave your personal belongings might have to stay in a locker. And in the jails that we use our MyFi or our hotspots on our cell phones that we may need to put that in a pocket or something and not have that cell phone out of while we are doing the enrollment. So here is a picture of some of our Navigators. Bill and my information and we'll welcome any questions.

Q&A

Great, thank you so much, Julia and Bill for that on the ground experience of what you are doing, I think that's really helpful for folks to sort of think out-of-the-box as the new ways to reach consumers. So we do have a couple of questions. First I want to introduce Dana Krohn who is joining us to answer some questions. So the first question for Dana is, if a family member enrolled in the families qualified health plan is sentenced to serve time in jail or prison are there any impacts on the rest of their family's coverage?

Yeah, thanks Michelle, there definitely might be. So as I'm sure many of you know eligibility for financial assistance in the Marketplace such as advanced payments for premium tax credit and cost-sharing reduction as well as for Medicaid and CHIP is based in part on income and household size. So if a member of someone's family becomes incarcerated that might change the household income and family size and as a result change what the rest of the household is eligible for. So we recommend that an individual report any change in incarceration so report it for themselves or report it for someone in the

household within 30 days. As soon as possible but within 30 days to ensure that other members of the household are enrolled in the correct program and receive the correct amount of financial assistance. And also when that happens to someone if a household eligibility is updated they may be eligible for a special enrollment period depending on what the new eligibility determination is.

Great, thank you, Dana. I'm going to ask our presenters one question so Julia and Bill, can you again further describe and go over the business cost-sharing benefit for the County jail or prison you know how it is important to get buy-in from the Sheriff and jails. And discuss that a bit?

What we've had success doing is really trying to work with buy in. The first thing we did when this bill actually became law was effective for the Department of Corrections three months before the jails and so we kind of had a chance to take a peek at the Department of Corrections and what they were doing and kind of took a look at what worked for them, what didn't work and we kind of took that information when we made that approach to our members. And yeah very honestly at first it was a lot of Sheriff's and jail officials that were a little reluctant, was kind of the message the states requiring us to do something, they're not giving us the resources to do that. But we had several Sheriff's in the state who basically owned their own initiative said I think this is really good thing. We see a lot of recidivism, we see a lot of re-arrest rates coming into the jails we know medical cost is a concern that we have, typically in most jails it's next to staffing it is the second largest expenditure out of my budget. And what can I do to get these cost down and we have had some Sheriff's that basically were on the front line actually as an authorized rep doing the enrollment themselves so they could just see how burdensome this process would be. And when they discovered that it wasn't that big of a deal we actually used those Sheriffs to help convince a lot of the other population that hey it's time to get on board, it's time to work with this.

The other issue that we have right now is that with this particular law under the presumptive eligibility that's really the responsibility of the commissioners. As an elected official the Sheriff has no responsibility over the commissioners duties so we have had some, I wouldn't say issues, but we have had to kind of rethink about how we're working with that other County government so that both the Sherriff and commissioners can kind of get this piece of legislation so they can kind of meet the requirements of the legislation and move forward with that. But I think at the end of the day most Sheriff's now are the majority are kind of on board. They are starting to understand it and we are actually seeing those enrollment numbers increase.

Great. We've one more question for Dana. Is an incarcerated individual exempt from the individual shared responsibility provision because of his or her incarceration?

So generally, yes. An individual who's confined after the disposition of charges in a jail or prison or similar institution is eligible for an exemption from the individual shared responsibility payment. But this exemption only applies to someone confined following conviction, not someone who is confined pending disposition of charges so before they've been convicted. And the exemption can generally be claimed for any month in which the individual spent at least one day confined following a conviction. So someone who is confined for March through April 3 they can claim the exemption for March and for all of April.

And for the 2016 tax year the exemption has to be claimed through the IRS but for the 2015 tax year it can be claimed through the IRS or the Marketplace.

And in addition individuals who are incarcerated may be eligible for other exemptions depending on their situation so for example a hardship exemption or an affordability exemption to the extent that their income is low. And there's information on HealthCare.gov and IRS.gov about eligibility for the exemption.

Great.

Closing

Thank you Dana, and thank you, everyone for the questions you submitted today. A special thank you to all of our presenters, Holly, Mira, Nancy, Annie, Stephanie, Julia, Bill, and Dana for joining us today. Our next webinar will be in two weeks on Friday, July 22 at 2:00 PM. Finally thank you again for your hard work and for your patience today with our technical challenges. I hope you all found this helpful and I hope you have a great weekend.