Chapter 3:

Access to Medicaid Coverage and Care for Adults Leaving Incarceration

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Key Points

- Federal law prohibits the use of federal Medicaid funds for health care services provided to Medicaid enrollees while they are inmates of public institutions (e.g., state prisons and local jails), except in cases of inpatient care lasting 24 hours or more. This policy is known as the "inmate payment exclusion."
- Although Medicaid coverage is limited while individuals are incarcerated, it is an important source of coverage for eligible individuals released into the community, particularly in states that have expanded Medicaid to low-income adults under the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended).
- Medicaid-eligible adults leaving incarceration often experience delays obtaining Medicaid coverage upon release. They may also lack access to needed medications and connections to community-based providers to initiate or continue their care after release. Limited data sharing between carceral and community-based providers contributes to discontinuity of care and poor health outcomes for this population.
- People of color, low-income individuals, and men are disproportionately represented among adults in the criminal justice system. Justice-involved adults tend to have considerable physical health, behavioral health, and health-related social needs as well as an elevated risk of death after incarceration.
- To improve care continuity and health outcomes for this population, some states have undertaken state-funded efforts to expedite Medicaid coverage upon reentry and provide targeted services to adults nearing release.
- States experience a number of challenges in these efforts. For example, some states lack the data-sharing capabilities needed to ensure immediate access to Medicaid benefits upon release. Additionally, the inmate payment exclusion's prohibition on the use of federal Medicaid funds for health care services while an individual is incarcerated limits states' ability to expand and sustain reentry services before release.
- In April 2023, the Centers for Medicare & Medicaid Services (CMS) issued guidance on a reentry Section 1115 demonstration opportunity through which states meeting certain conditions can receive federal financial participation for prerelease Medicaid services provided to eligible individuals leaving incarceration. California was the first state to receive CMS approval for such a demonstration, and more than a dozen other states have similar pending applications.
- The Commission identified key considerations for implementing prerelease Medicaid services, which can inform state approaches for operationalizing reentry Section 1115 demonstrations as well as future guidance and activities undertaken by CMS and other federal agencies to support states in those efforts. These considerations focus on the following:
  - collaboration between Medicaid and state and local carceral authorities;
  - lengths of stay and predictability of release dates for adults in jail;
  - data sharing and infrastructure to identify eligible enrollees, support care coordination, and facilitate Medicaid billing;
  - selection of prerelease service providers (e.g., carceral or community based) and provider capacity; and
  - monitoring and evaluation.
- The experience of states providing prerelease services to facilitate care transitions for incarcerated individuals returning to the community will illuminate future policy considerations for Medicaid's role in serving this population. The Commission will monitor these state demonstrations, including any reporting on implementation and outcomes, and provide future guidance.

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Medicaid and the criminal justice system share responsibility for providing health care to Medicaid enrollees who are involved in the justice system. Medicaid generally covers health care services for eligible and enrolled individuals on parole and probation, while correctional authorities (e.g., counties and state departments of corrections) typically must pay for health care costs while individuals are confined in their facilities.[1] States can allow inmates of public institutions, such as state prisons and local jails, to maintain their enrollment or enroll in Medicaid while incarcerated. However, Section 1905(a)(31)(A) of the Social Security Act prohibits use of federal Medicaid funds for health care services for Medicaid enrollees when they are inmates of public institutions, except in cases of inpatient care lasting 24 hours or more (CMS 2016). This payment prohibition is commonly referred to as the "inmate payment exclusion."

Although Medicaid's role in covering services is limited while individuals are incarcerated, it is an important source of coverage for eligible individuals released into the community, particularly in states that have expanded Medicaid to low-income adults under the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended). However, Medicaid-eligible adults often face delays enrolling in Medicaid upon release. They may also lack needed medications and connections to community-based providers to initiate or continue their care after release, resulting in potentially concerning lapses in care. Limited data sharing between carceral health care providers and those in the community contributes to discontinuity of care and poor health outcomes for individuals leaving incarceration (ASPE 2023).

Adults in the criminal justice system are disproportionately low-income individuals and people of color (BJS 2022, MACPAC 2021). Disproportionate rates of incarceration among certain racial and ethnic groups are the product of decades-long inequities, stemming from structural racism and explicit and implicit biases that disadvantage communities of color.[2] A large body of scientific evidence shows racial disparities in outcomes and racial bias in nearly all aspects of the criminal legal system (Bailey et al. 2021).

Justice-involved adults also tend to have considerable physical, behavioral, and health-related social needs (HRSNs) (MACPAC 2021, Maruschak et al. 2021a, Maruschak et al. 2021b, Greenberg and Rosenheck 2008, Rabury and Kopf 2015). Formerly incarcerated individuals have a substantially elevated risk of death in the period immediately after release, including from drug overdose, cardiovascular disease, and suicide (Binswanger et al. 2007). People leaving incarceration often face a host of social and economic challenges, which can create difficulties in accessing needed care (Binswanger et al. 2012).

States and the federal government are interested in improving health care transitions for this vulnerable population as they leave incarceration.[3] Many states have undertaken state-funded efforts to expedite Medicaid enrollment and provide in-reach services to adults leaving incarceration, with goals of improving care continuity and health outcomes as individuals reenter the community.[4] In April 2023, the Centers for Medicare & Medicaid Services (CMS) issued congressionally mandated guidance on Section 1115 demonstration opportunities for states to improve care transitions and provide short-term prerelease Medicaid services for individuals leaving incarceration.[5] California is the only state to receive CMS approval for such a demonstration, though 14 other states have similar pending applications.[6]

To understand how states are addressing transitions for Medicaid-eligible adults leaving incarceration, MACPAC contracted with AcademyHealth to interview officials in 16 states and examine time to benefit activation and health care use for adults leaving incarceration in Kentucky and Virginia.[7] The Commission also heard from an expert panel about state efforts to improve reentry as well as considerations for implementing prerelease Medicaid services.[8]

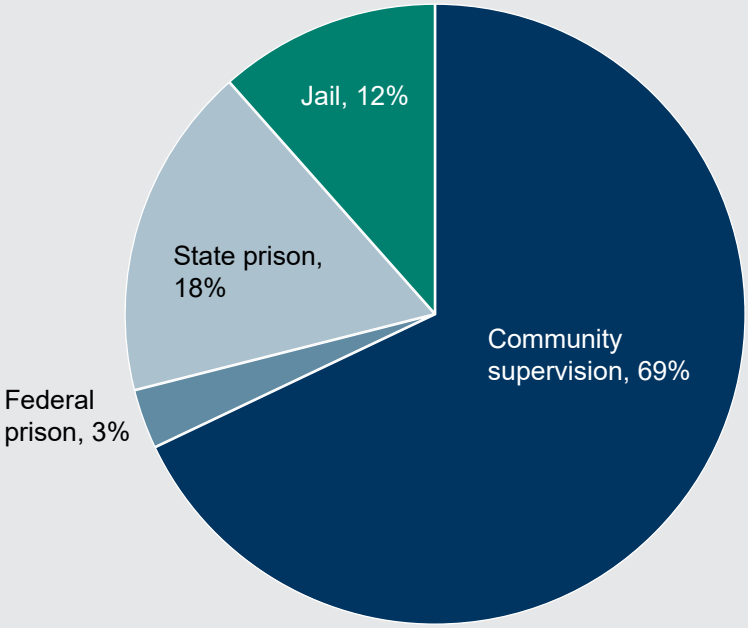
This chapter summarizes the demographic characteristics, health care status, and HRSNs of justice-involved adults as well as their ability to access Medicaid coverage.[9] Next, the chapter describes state efforts to provide timely Medicaid coverage, care continuity, and access to care for adults leaving state prisons and local jails, including Section 1115 demonstrations to provide Medicaid-covered

services during incarceration. We then examine key considerations for implementing prerelease Medicaid services, which can inform state approaches for doing so, as well as future guidance and activities undertaken by CMS and other federal agencies to support states in these efforts.

Adults in the Criminal Justice System

Adults involved in the criminal justice system include those serving sentences in prisons and jails, those awaiting trial or sentencing, and those under community supervision, such as parole or probation. At the end of 2021, roughly 7 in 10 (3,745,000) justice-involved individuals were supervised in the community, while about 3 in 10 (1,775,300) were incarcerated in a federal or state prison or local jail (Figure 3-1) (BJS 2023b).[10] Federal and state prisons detain individuals convicted of a felony who are typically serving sentences longer than one year. In contrast, jails house individuals awaiting trial or sentencing as well as those serving shorter sentences. In 2021, more than 6.9 million people cycled through local jails, and the average length of stay was 33 days, though stay lengths can vary substantially (Zeng 2022).[11]

FIGURE 3-1. Individuals Supervised by Adult Correctional Systems by Correctional Status, 2021



Total adult correctional population: 5,444,900

Notes: Estimates are rounded to the nearest percentage. Community supervision includes individuals on probation or parole. Prison counts are for December 31, 2021, while jail counts are for the last weekday in June 2021. The total correctional, community supervision, and incarcerated populations exclude persons with dual correctional statuses (defined as people on probation or parole who were held in prisons or jails, people on parole who were also on probation, or people in prison who were held in jail) to avoid double counting. This figure does not include individuals held in the U.S. territories, military facilities, U.S. Immigration and Customs Enforcement facilities, and jails in American Indian country.

Most correctional jurisdictions define adults as those age 18 or older. These data count as adults individuals age 17 or younger who were prosecuted as adults in criminal court. People age 17 or younger held in jail before or after they were adjudicated may be included in the count for local jails.

Source: BJS 2023b.

Demographic characteristics

People of color, low-income individuals, and men are disproportionately represented among adults in the criminal justice system.

Race and ethnicity. In 2021, Black adults were incarcerated in state and federal prisons at more than five times the rate of white adults—1,186 per 100,000 Black adults and 222 per 100,000 white adults (Figure 3-2). The imprisonment rate was also substantially higher for Hispanic and American Indian and Alaska Native adults compared with white adults. Similar disparities exist in jails. In June 2021, 35 percent of individuals in jail were Black, whereas Black people represented just 13.6 percent of the general population (Zeng 2022, U.S. Census Bureau 2021).

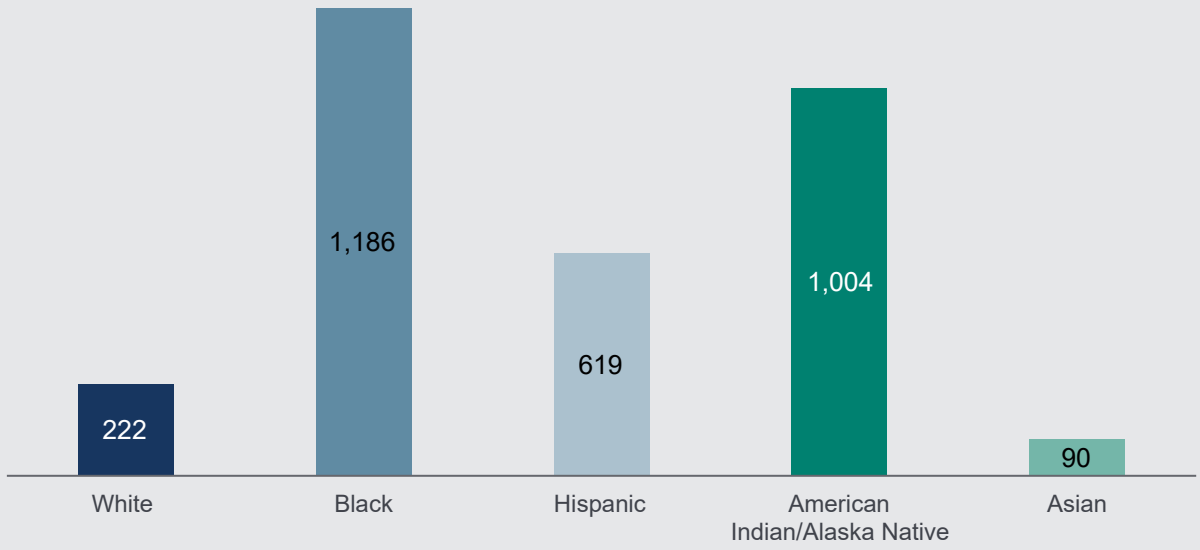
Income. Adults involved in the criminal justice system tend to be poorer than the general population. In 2014 dollars, the median annual income of state prisoners before incarceration was $19,185—41 percent less than the earnings of people who were not incarcerated. The majority of adults in state prisons (57 percent of men and 72 percent of women) earned less than $22,500 annually before incarceration (Rabury and Kopf 2015).

Gender. Men make up the vast majority of individuals incarcerated in state prisons (93 percent), and the composition of jails is similar, with men comprising 87 percent of all jail inmates in 2021 (BJS 2022, Zeng 2022). Though most incarcerated individuals are men, the incarceration rate for women has been steadily increasing since 1980 (BJS 2022). Most women incarcerated in state or federal prisons (66 percent) are of reproductive age (between age 25 and 44) (BJS 2022).

Health care needs and access

Adults involved in the criminal justice system report high rates of chronic physical and behavioral health conditions, disability, and traumatic experiences that can adversely affect their health (BJS 2021, MACPAC 2021, Maruschak et al. 2021a, Maruschak et al. 2021b, Maruschak et al. 2021c, Quandt and Jones

FIGURE 3-2. Imprisonment Rates of Adults Per 100,000 U.S. Residents by Race and Ethnicity, 2021



Notes: Imprisonment rate is the number of sentenced prisoners age 18 or older under state or federal jurisdiction per 100,000 U.S. residents age 18 or older in a given category. Rates are for December 31, 2021, and are based on prisoners with a sentence of more than one year. Resident population estimates are from the U.S. Census Bureau for January 1, 2022. Categories are non-Hispanic, with the exception of the group identified as Hispanic. Asian includes Native Hawaiians and Other Pacific Islanders.

Source: BJS 2022.

2021). After incarceration, justice-involved individuals are more likely to be hospitalized or admitted to the emergency department than those without criminal justice involvement (Frank et al. 2014). They also experience an elevated risk of death compared with the general population, including a 40 times higher risk of opioid overdose death in the first two weeks after incarceration (Ranapurwala et al. 2018).[12]

The relatively poor health status of justice-involved individuals may reflect, in part, the barriers they face in accessing health care services, such as cost and stigma (Moore and Tangney 2017, Sawyer 2017). They also tend to be mistrusting of the health care system and reluctant to seek care if they have experienced discrimination from community providers (MACPAC 2022). Individuals who are incarcerated are also often wary of the carceral health care system, which they may perceive to be low quality or unresponsive to their needs (Vandergrift and Christopher 2021, Young 2010).

Physical health. In 2016, 40 percent of state prisoners reported having a chronic physical health condition, the most common being high blood pressure (22 percent), arthritis (15 percent), and asthma (12 percent). Eighteen percent reported ever having an infectious disease, most commonly hepatitis C (9.5 percent) and sexually transmitted infections (4.4 percent).[13] However, nearly 20 percent of adults in state prisons did not have a health-related visit during their incarceration, and access to care, including curative therapies for hepatitis C, is often limited (Maruschak et al. 2021a, Thanthong-Knight 2018). Between April 2020 and April 2021, individuals who were incarcerated were more than three times as likely to contract COVID-19 and 2.5 times as likely to die from it than individuals who were not incarcerated (Marquez et al. 2021).[14]

Behavioral health. In 2016, more than half (56 percent) of state prisoners experienced serious psychological distress in the previous month or had a previously diagnosed mental health condition. The most commonly reported conditions were major depressive disorder (27 percent), bipolar disorder (23 percent), and anxiety disorders (22 percent). However, only 41 percent of state prisoners experiencing serious psychological distress in the past 30 days reported that they were receiving treatment (Maruschak et al. 2021b).

Substance use disorder (SUD), including opioid use disorder (OUD), is highly prevalent among adults involved in the criminal justice system. In 2016, nearly half (49 percent) of state prisoners met the criteria for SUD in the year before their incarceration (Maruschak et al. 2021c). Yet, state prisons in 18 states and most (90 percent) local jails do not offer any form of medication for opioid use disorder (MOUD) (Jail & Prison Project 2022). Most states offering at least one form of MOUD in state prisons do not make it available in every prison throughout the state.[15] Among individuals with a prior OUD diagnosis leaving state prisons or jails in Kentucky in 2019 to 2020, only 15 percent received MOUD within 30 days of release.

Trauma. Trauma is common among individuals with criminal justice involvement. The experience of incarceration can itself result in trauma, which can have consequences for an individual's physical and behavioral health. A growing body of research on the traumatic effects of incarceration has identified high rates of postincarceration syndrome, a condition similar to posttraumatic stress disorder (Liem and Kunst 2013). Additional research indicates that experiencing traumatic events while incarcerated is associated with a higher likelihood of posttraumatic stress disorder diagnosis after release and can trigger and worsen symptoms of mental illness (Quandt and Jones 2021).

Disabilities. In 2016, 40 percent of state prisoners reported having at least one disability, compared with just 15 percent of the general population.[16] The most commonly reported disabilities were cognitive (24 percent), ambulatory (12 percent), and vision related (12 percent). Roughly one in four state prisoners (26 percent) reported ever being told that they had an attention deficit disorder (BJS 2021).

Health-related social needs

Adults involved in the criminal justice system tend to have HRSNs such as homelessness and food insecurity (Couloute 2018, Wang et al. 2013, Greenberg and Rosenheck 2008). They also face barriers to addressing those needs as a result of policies and practices that limit access to housing, employment, and federal benefits (Levins 2023).[17]

Unemployment. Adults involved in the criminal justice system are less likely to be employed than the general population. In 2008, 27 percent of formerly incarcerated adults were unemployed, compared with approximately 5 percent of the general population. Unemployment rates are highest among formerly incarcerated Black women (44 percent) and Black men (35 percent) (Couloute and Kopf 2018).

Homelessness. Justice-involved adults are also more likely than the general public to experience homelessness. In the year before incarceration, more than 15 percent of jail inmates reported at least one episode of homelessness (Greenberg and Rosenheck 2008). After incarceration, the rate of homelessness among justice-involved adults is 10 times that experienced by the general public. The likelihood of homelessness also increases for individuals who have been incarcerated multiple times (Couloute 2018).

Food insecurity. Adults with justice involvement often face food insecurity. One survey estimated that 91 percent of adults recently released from state prisons were food insecure, with 37 percent reporting that they did not eat for an entire day at least once in the past month (Wang et al. 2013).

Access to Medicaid

A substantial portion of justice-involved adults living in the community are enrolled in Medicaid. Nationally, more than a quarter (28 percent) of adults under community supervision were enrolled in the program between 2015 and 2019 (MACPAC 2021). In states that cover low-income adults in Medicaid, the vast majority of those incarcerated may be eligible for Medicaid (Guyer et al. 2019). In Kentucky, for example, nearly 93 percent of adults released from state prisons and local jails in 2019 to 2020 were enrolled in Medicaid at some point in the previous five years.

The inmate payment exclusion prohibits the use of federal financial participation (FFP) for health care services provided to individuals who are incarcerated, except in the case of inpatient stays in a medical institution lasting 24 hours or more (CMS 2016). To ensure compliance, states have the option to suspend eligibility or benefits for adults who become incarcerated, which can expedite access to coverage upon release by eliminating the need to process new Medicaid applications.[18] Eligibility suspension involves the state suspending an individual's eligibility so they are no longer eligible to receive Medicaid benefits for the duration of incarceration; the state must lift the suspension for Medicaid to pay for services furnished to an enrollee while admitted to a medical institution for an inpatient stay of at least 24 hours. Under a benefits suspension, an eligible individual continues to be enrolled in Medicaid, but Medicaid coverage is limited to qualifying inpatient stays (CMS 2023a). As of state fiscal year (SFY) 2019, 42 states suspend Medicaid eligibility or benefits for enrollees in jail, and 43 states do so for enrollees in state prison.[19] The remaining states terminate eligibility for enrollees who become incarcerated, and thus, individuals seeking Medicaid upon release must submit new applications for enrollment (KFF 2019).[20]

States often reinstate Medicaid eligibility or benefits quickly once an individual is released, though delays can occur. In Kentucky and Virginia, the majority of individuals with prior Medicaid coverage leaving incarceration had active Medicaid benefits within one day of release (77 percent in Kentucky and 68 percent in Virginia) (Appendix 3-1). In other states, however, the time to benefit reactivation can range from approximately 30 to 60 days after release.

For adults whose Medicaid eligibility was terminated, as well as those who were not previously enrolled in Medicaid, the need to process new applications can contribute to delays in coverage when reentering the community. Although states have mechanisms for processing new applications before release, some states report that the process can take up to three months to complete. It can be particularly difficult for individuals in jail to complete their Medicaid applications far enough in advance of their release given the short duration of most jail stays and the difficulty predicting release dates for the pretrial population.

In states with Medicaid managed care delivery systems, policies pertaining to managed care plan enrollment can affect care continuity and delay plan engagement with Medicaid enrollees leaving incarceration. For instance, some state policies prohibit such individuals from enrolling in a plan until after their release. Additionally, in some states, enrollment in a plan is not effectuated immediately but

occurs later—for example, on the first day of the month after plan selection. Although Medicaid enrollees awaiting effectuated plan enrollment can obtain services through the fee-for-service delivery system, they may experience discontinuity of care if their fee-for-service providers do not participate in the selected plan's provider network.

State Strategies for Improving Access to Medicaid Coverage and Care

The health care needs of adults involved in the criminal justice system and the disproportionate effects of that system on individuals of color have prompted many states to pursue opportunities to improve access to Medicaid coverage and care upon release from state prisons and local jails. These efforts, which states undertook before the recent Section 1115 demonstration opportunity to provide release coverage, have primarily been financed with state funds due to the inmate payment exclusion.

Coordination between Medicaid and corrections agencies is the cornerstone of these efforts. Although most of the states we interviewed reported strong collaboration between Medicaid and corrections, particularly at the state level, working across state and local agencies to improve outcomes for adults leaving incarceration can be challenging because of siloed organizational structures, competing priorities, staff turnover, and limited funding due in part to the inmate payment exclusion.

The approaches taken by these states and the challenges they encountered, which are described in the following sections, may be instructive for other states considering similar state-funded efforts or Medicaid demonstration authority to receive federal matching funds for prerelease Medicaid services. Many of the states we interviewed cited the inmate payment exclusion as a barrier to timely Medicaid coverage and continuity of care for adults leaving incarceration and the state's goal of improving health outcomes among that population. Section 1115 demonstrations to provide prerelease Medicaid services, and considerations for implementing those initiatives, are discussed later in the chapter.

Facilitating Medicaid enrollment

States' approaches for facilitating Medicaid enrollment for adults leaving state prisons and jails include suspending rather than terminating Medicaid benefits, improving data-sharing between corrections and Medicaid, and providing enrollment assistance before release.

Suspending coverage. All of the states we interviewed suspend rather than terminate Medicaid coverage for adults to expedite access to full Medicaid benefits upon release. This requires corrections agencies to share information about individuals entering their facilities, so that the state Medicaid agency can identify and place enrollees in a suspended status or limited benefit category. This in turn allows payment only for qualifying inpatient stays in a medical institution. Once information about the individual's release date is known, the corrections agency shares it with the state Medicaid agency so the individual's eligibility status can be changed as quickly as possible after release. For example, New York partially reactivates suspended Medicaid benefits 30 days before release so that enrollees have an active Medicaid identification number. This allows an individual (before release) to make an appointment with a community provider for postrelease care. Some providers may not arrange appointments for individuals without an active Medicaid identification number.

Data transmission. The method and frequency of data sharing between corrections and Medicaid affect how long it takes to reactivate benefits for individuals with suspended Medicaid coverage. Among states interviewed, time to benefit reactivation ranged from 0 to 60 days. Some states reported having a central data repository accessible by Medicaid and corrections, which can provide real-time updates about an individual's incarceration status and eligibility. Other states email secure files on a daily, weekly, or monthly basis. Some states reported using different systems for state prisons and local jails, particularly those in rural and frontier areas with less capacity to adopt new health information technology (IT) systems. Arizona's Medicaid agency facilitates an automated process for sharing data between the state and county corrections agencies, which is currently operational in state prisons and 5 of the state's 15 county jail systems (MACPAC 2022).

Time to benefit activation can also depend on whether systems support changes to an individual's eligibility status through an automated or manual process. In Delaware, which suspends benefits during incarceration, data are transmitted daily from corrections to Medicaid using an automated process to update an enrollee's incarceration status. This allows benefits and the method of payment to change within a day of release. In contrast, in Massachusetts, data are shared on a weekly basis, and eligibility changes are completed manually. Though processing times can vary, changes to eligibility are processed, on average, within three days of the Medicaid agency receiving notification of an individual's change in incarceration status.

Enrollment assistance. Every state interviewed reported having a process to begin Medicaid enrollment before release. Several states have dedicated staff to facilitate Medicaid enrollment in prisons. Some also prioritize applications for individuals with certain health conditions or needs for medical supplies (e.g., oxygen) upon release. Rhode Island and New Mexico use presumptive eligibility to expedite and address barriers to enrollment upon release; however, since enrollment is temporary, individuals must complete a full Medicaid application to maintain coverage after the initial presumptive eligibility period ends.[21] The Virginia Medicaid agency established an eligibility unit to process Medicaid applications and redeterminations as well as benefit suspension and reactivation for justice-involved individuals. The daily transmission of data from corrections to this dedicated eligibility unit started with state prisons and has been expanded to include 67 local jails.

Challenges. Nearly all of the states interviewed emphasized that facilitating Medicaid enrollment and reenrollment upon release is challenging. States cite cost as a barrier to making data infrastructure improvements needed to ensure timely enrollment and benefit reactivation, such as implementing automated systems and more frequent data transmission from corrections to Medicaid. Additionally, some states shared concerns about data quality, such as having mismatched or incomplete Social Security numbers, addresses, and phone numbers that require manual and sometimes time-intensive fixes.

Aligning benefit activation with an individual's release date can be particularly challenging in jails where, relative to state prisons, individuals are incarcerated for shorter periods and release dates can be less predictable.

Providing reentry services

Some states offer targeted, state-only funded Medicaid reentry services beyond enrollment assistance to eligible adults leaving incarceration to minimize gaps in care and provide a more seamless transition to community living. Reentry programs may include services provided before release for which Medicaid payment is otherwise prohibited as well as services provided in the community after release that are eligible for federal reimbursement. Several states interviewed also reported providing reentry services funded through state general funds, the state department of corrections, and federal grants.

In-reach programs. In-reach programs are intended to assess the needs of individuals leaving incarceration and help them establish connections with community providers and managed care organizations (MCOs) (SHADAC 2019). Through the state-only funded MassHealth Behavioral Health Supports for Justice Involved Individuals program in Massachusetts, navigators work with individuals to develop personalized treatment plans and make referrals to social services such as housing and employment before release (MassHealth 2021). Other states require MCOs to conduct in-reach activities even though federal match is not available for these services. For example, Arizona provides administrative funding through capitation payments to support a requirement that all MCOs have justice in-reach care coordinators who help set up postrelease appointments with providers in the community and ensure that individuals have access to covered medical services (AHCCCS 2022). Several states also reported providing individuals with a 30- or 90-day supply of needed medications and naloxone kits, as well as training on how to use them, immediately upon release.

Postrelease services. Some states also provide Medicaid-covered services and supports designed to address the needs of enrollees who were previously incarcerated. For example, New York and Rhode

Island use Section 1945 health homes to provide care coordination and behavioral and physical health services to enrollees with criminal justice involvement.[22] In these states, health homes partner with certain entities (e.g., discharge units, parole boards, and the state behavioral health agency) to identify and address the needs of eligible individuals who have been recently released from prison or jail (MACPAC 2018, Spillman et al. 2017). In Arizona, MCOs are required to make incentive payments to providers who participate in integrated care activities, including 13 integrated clinics offering services to justice-involved individuals living in the community (CMS 2022). These clinics, which offer physical and behavioral health services and vocational training, are colocated with probation and parole offices, offering a "one-stop shop" for recently released adults (AHCCCS 2019).

Challenges. Although some states provide state-only funded in-reach services through the state Medicaid agency, these efforts are often limited in scope and scale. For example, Kentucky does not operate its jail in-reach program in every county, and Vermont limits in-reach services to certain high-risk populations (i.e., those with SUD, HIV, or hepatitis C). Several states noted that they lack resources to expand and sustain reentry programming, particularly before release, because the inmate payment exclusion prohibits Medicaid from paying for services.

States also reported limited or no health information sharing between corrections and community providers as well as difficulty helping individuals leaving incarceration set up prearranged appointments with community providers. Several states reported that some providers refuse to schedule appointments for individuals before their release if they do not have an active Medicaid identification number.

Reentry Section 1115 Demonstrations

The care fragmentation and poor health outcomes often experienced by individuals leaving incarceration have prompted a growing number of states to seek Section 1115 demonstration authority to provide Medicaid-covered services to eligible individuals who are incarcerated and nearing release. New federal guidance outlining the parameters for such demonstrations, as well as the recent approval of a reentry demonstration in California, may encourage additional states to pursue this opportunity.

Federal guidance

In April 2023, CMS issued congressionally mandated guidance to states describing demonstration opportunities to improve care transitions for Medicaid-eligible individuals who are soon to be released from incarceration (CMS 2023a). The guidance describes opportunities for states to receive FFP for prerelease services furnished to incarcerated enrollees for a defined period before their release. Such demonstrations must meet certain requirements specific to the reentry demonstration opportunity as well as those applicable to Section 1115 demonstrations generally (e.g., budget neutrality, monitoring and evaluation).[23] To identify individuals who are eligible for demonstration services, states will be required to make prerelease outreach, eligibility services, and enrollment support available to all individuals in facilities included in the demonstration and to suspend rather than terminate Medicaid eligibility for individuals entering those facilities.

Demonstration goals. CMS expects that state reentry demonstrations will be designed to do the following:

- increase coverage, continuity of care, and appropriate use of services through assessment of eligibility and coverage for services just before release;
- improve access to services before release and improve transitions and continuity of care into the community upon release and during reentry;
- improve coordination and communication between correctional systems, Medicaid systems, managed care plans, and community-based providers;
- increase investments in health care and related services that improve care quality for enrollees in carceral settings and in the community after release;
- improve connections between carceral settings and community services upon release to address

physical, behavioral, and health-related social needs;

- reduce deaths in the near-term after release; and
- reduce the number of emergency department visits and inpatient hospitalizations among recently incarcerated Medicaid enrollees through increased receipt of physical and behavioral health care.

Eligibility. States may cover prerelease services for individuals who are otherwise Medicaid eligible and soon to be released from state prisons, local jails, and youth correctional facilities.[24] CMS encourages states to propose broad criteria for inclusion among this group, though states have flexibility to target the populations covered (e.g., those with specified health conditions).

Benefits. At a minimum, states must cover prerelease case management, medication-assisted treatment (MAT) for all types of SUD, and a 30-day supply of prescription medications provided immediately upon release.[25] States may propose to cover additional services that promote coverage and quality of care to improve transitions for individuals being released back to the community.

Duration of prerelease coverage. States are expected to cover demonstration services beginning 30 days before release, though CMS will consider approving demonstrations that begin coverage up to 90 days before release.[26]

Implementation and reinvestment plan. Before claiming federal reimbursement for approved demonstration services, states must submit and receive CMS approval of an implementation plan documenting how the state intends to institute Medicaid coverage and delivery of prerelease services.[27]

As part of the implementation plan, states are expected to submit a reinvestment plan detailing how they will reinvest new FFP for demonstration services in cases in which those services are already provided or paid for by a correctional facility or authority. This requirement is intended to ensure that new Medicaid investments in reentry services do not supplant existing state and local investments and shift costs to the federal Medicaid programs.[28] States may reinvest FFP for demonstration services in activities that increase access to or improve the quality of health care services for individuals who are incarcerated or were recently released or in health-related social services that reduce the likelihood of criminal justice involvement.

Monitoring and evaluation. Consistent with the requirements for all Section 1115 demonstrations, states with approved demonstrations will be required to undertake certain monitoring and evaluation activities.[29] This includes submitting to CMS quarterly and annual monitoring reports as well as a midpoint assessment describing the state's progress toward specific milestones and goals and outlining any necessary mitigation strategies.[30] States must also conduct an independent evaluation of the demonstration and submit specific evaluation deliverables to CMS (i.e., an evaluation design, interim report, and summative report).[31]

Pending and approved demonstrations

In January 2023, California became the first state to receive approval under Section 1115 authority to provide Medicaid-covered services to certain individuals leaving incarceration. Under the demonstration, adults and youth incarcerated in state prisons and county jails meeting at least one specified health condition (e.g., mental illness, SUD, or HIV or AIDS) may be eligible for Medicaid-covered reentry services up to 90 days before their release.[32] Youth incarcerated in juvenile correctional facilities do not need to meet clinical criteria for eligibility. The state will receive federal Medicaid matching funds for specified prerelease services, such as in-reach case management, MAT, and peer navigation.[33]

The demonstration will be phased in over a two-year period as facilities demonstrate their readiness to provide prerelease services and meet other requirements.[34] To support implementation, CMS approved $410 million for planning and IT investments through the Providing Access and Transforming Health program (DHCS 2023).[35]

As of April 21, 2023, 14 additional states have submitted Section 1115 demonstration applications to provide Medicaid-covered services to certain individuals who are incarcerated.[36] The proposed

Section 1115 demonstrations vary in terms of eligibility, covered services, and the duration of coverage offered before release (Table 3-1):

- **Eligibility.** Almost all states would provide services to individuals in state prisons and jails, while a smaller number of proposals explicitly target youth in juvenile corrections facilities.[37] Ten states propose limiting eligibility for adults to those with specific conditions, such as SUD, serious mental illness, and intellectual and developmental disabilities. In Arizona, eligibility would also depend on an individual's risk for homelessness after incarceration.
- **Benefits.** Most of the states are proposing to offer a limited set of prerelease Medicaid services, often including case management and referrals to community providers, behavioral health care, and a supply of medication upon release. A smaller number is seeking to provide full Medicaid benefits to some or all of the populations that would be covered under the demonstration.[38]
- **Coverage duration.** The majority of states propose covering services up to 30 days before release, while others are looking at windows of up to 60 or 90 days.[39] Oregon would offer services

TABLE 3-1. Characteristics of Pending Medicaid Section 1115 Demonstrations to Waive the Inmate Payment Exclusion as of April 21, 2023

Characteristic	States
Eligibility	
All adults	4 states (OR, RI, VT, WA)
Adults with certain medical diagnoses	10 states (AZ,[1] KY, MA, MT, NH, NJ, NM, NY, UT, WV)
All youth	4 states (MA, OR, RI, WA)
Youth with certain medical diagnoses	1 state (NM)
Benefits	
Full benefits	5 states (MA, OR,[2] RI, UT, VT)
Limited benefits	10 states (AZ, KY, MT, NH, NJ, NM, NY, OR,[2] WA, WV)
Duration of prerelease coverage	
30 days	10 states (AZ, KY,[3] MA,[4] MT, NM, NY, RI, UT, WA, WV)
45 days	1 state (NH)
60 days	1 state (NJ)
90 days	2 states (OR,[5] VT)
36 months	1 state (KY[3])
Throughout incarceration	2 states (MA,[4] OR[5])

Notes: To receive demonstration services, individuals would have to meet all other Medicaid eligibility requirements under the state plan. The definition of youth varies by state (e.g., some states define youth as anyone younger than age 18, while others include individuals younger than age 19).

[1] In Arizona, eligibility would also be limited to individuals at high risk of homelessness upon release.

[2] Oregon would provide limited benefits to individuals in prison and state-run juvenile correctional facilities and full benefits to adults and youth in jail and youth in local juvenile correctional facilities.

[3] Kentucky would provide substance use disorder treatment and recovery services up to 36 months before release and care coordination services an average 30 days before release.

[4] Massachusetts would cover services 30 days before release for adults and throughout incarceration for youth.

[5] Oregon would cover services 90 days before release for individuals in prisons and certain state-run juvenile correctional facilities and throughout incarceration for adults and youth in jail and youth in local juvenile correctional facilities.

Source: MACPAC analysis of Section 1115 demonstration proposals on Medicaid.gov, 2023.

for the duration of stays in jail or certain juvenile correctional facilities, and Massachusetts would cover youth throughout their incarceration.

Considerations for Implementing Prerelease Services

The Commission identified several key considerations for implementing prerelease Medicaid services. These considerations can inform how states institute their reentry Section 1115 demonstrations and underscore areas in which additional federal guidance, technical assistance, or other support would be helpful to states, localities, and providers. Based on feedback from state and local officials representing Medicaid and corrections, as well as other national experts, these considerations include:

- cross-agency collaboration;
- application to jails;
- data sharing and infrastructure;
- pre- and postrelease health and social services providers; and
- monitoring and evaluation.

Instituting prerelease Medicaid services will require a substantial investment of time and resources in many of these areas. In its guidance on the reentry Section 1115 demonstration opportunity, CMS notes that it will consider requests for time-limited FFP for certain expenditures that support implementation of state demonstrations. New spending may include hiring and training staff who will be working with justice-involved individuals and expenditures associated with activities that promote collaboration between corrections, Medicaid, and other organizations involved in planning and supporting the demonstration. States may also request approval of enhanced FFP for state Medicaid agency IT system expenditures incurred during implementation.[40]

Cross-agency coordination. Successful implementation of prerelease services will require strong coordination between state Medicaid agencies and corrections officials who oversee state prisons and local jails (ASPE 2023, MACPAC 2022). The states MACPAC interviewed reported strong cross-agency collaboration; however, other state Medicaid agencies may have limited interaction with corrections agencies (MACPAC 2022). Although the state Medicaid agency is primarily responsible for designing and negotiating the terms of Section 1115 demonstrations, early engagement of state and local corrections leaders helps in gaining buy-in and anticipating and overcoming operational challenges associated with implementing prerelease Medicaid services (ASPE 2023, MACPAC 2022). Some corrections agencies may be reluctant to take on additional responsibilities they perceive to be beyond their scope. Yet in many instances, they are eager to partner with Medicaid to provide services that can improve health outcomes and reduce recidivism (MACPAC 2022). Medicaid and corrections agencies need to develop an understanding of each other's programs and collaborate in addressing areas in which their programs and goals may diverge (MACPAC 2022).

Some stakeholders have suggested that additional federal support is needed to promote cross-agency collaboration to support the adoption of prerelease Medicaid services as well as to disseminate promising approaches for improving the health of justice-involved individuals more generally (MACPAC 2022). This partnership should include convenings or other technical assistance provided jointly by CMS and the U.S. Department of Justice Bureau of Justice Assistance, which provides programmatic and policy support to state and local corrections agencies, reentry services providers, and other key partners (BJA 2023). Stakeholders have also suggested that additional investment is needed at the state and federal level to expand administrative capacity and enhance staff expertise so that agencies are better equipped to address the needs of justice-involved individuals (MACPAC 2022).

Application to jails. Determining how to implement Medicaid-covered services before release will be particularly challenging in jails, where individuals awaiting trial may be released without advanced notice—for example, when charges are dropped, an inmate posts bail, or the adjudication of a case results in an inmate's release (MACPAC 2022). Jail staff can estimate the expected length of stay for

individuals depending on the circumstances of their arrest; however, there is no set end-of-stay date for individuals awaiting trial, which represent 71 percent of the jail population nationally. This ambiguity may make it difficult for state Medicaid agencies and local correctional authorities to determine when an individual is eligible for reentry services under the state's approved Section 1115 demonstration. In addition, the length of jail stays—33 days on average—offers a limited window in which to identify and provide services to individuals who are eligible for them (Zeng 2022). State implementation plans will provide important insight into how states seek to address these challenges.

Data-sharing and infrastructure. State Medicaid agencies and state and local correctional authorities will need systems that support the timely exchange of relevant information, such as release dates and eligibility status. As of SFY 2019, only 23 states reported that their Medicaid and corrections agencies had electronic, automated data exchange processes to facilitate the suspension and reinstatement of benefits (KFF 2019).[41] Establishing these cross-sector data systems can be costly and time consuming and particularly challenging to accomplish with jails in rural and frontier areas that may have more limited resources and staff capacity (MACPAC 2022).

Improving data-sharing capacity between correctional and community providers is needed to promote care coordination and continuity as individuals leave incarceration. States should establish or update data systems to allow for timely and accurate sharing of relevant medical records, such as through an electronic health record or health information exchange. Currently, little information sharing occurs between correctional health care providers and providers in the community (ASPE 2023, Wishner and Mallik-Kane 2017). Correctional facilities often lack health care information systems capable of connecting to health information exchanges or other electronic data sharing methods. This disconnect can exacerbate issues in coordinating care for justice-involved individuals, both while incarcerated and upon their return to the community (Davis and Cloud 2015).

If correctional staff or their contracted health care providers are responsible for providing prerelease Medicaid services, correctional facilities will also need to establish systems for Medicaid billing. Most correctional institutions are currently unable to bill services to Medicaid due to the inmate payment exclusion. Thus, incorporating a Medicaid billing infrastructure into county jail systems will require additional guidance and staffing resources (MACPAC 2022).

Providers. States must determine which providers will deliver prerelease services. Although CMS describes the use of community-based providers as the preferred approach to build trust with individuals who are incarcerated and strengthen the connection to care in the community upon release, states may choose to rely on carceral health care providers for delivery of some or all prerelease services. CMS guidance generally requires states to ensure that carceral providers furnishing prerelease services under Section 1115 demonstration authority comply with the state's Medicaid provider participation policies; however, under California's demonstration, carceral providers of prerelease services are not required to enroll in the state's Medicaid program (CMS 2023a, CMS 2023b).[42]

The delivery of health care in state prisons and jails varies considerably across states and correctional facilities. In the majority of state prisons, primary care and common outpatient services are delivered by a clinician employed by the state corrections agency or a private contractor (Pew 2018a). Many jails also contract with vendors to provide health care within their facilities (Pew 2018b). These carceral providers may not be enrolled in Medicaid given the general prohibition against Medicaid payment for services when an enrollee is incarcerated.

States will need to decide whether to use correctional or community providers for non-clinical prerelease services, such as case management and housing supports.[43] States may provide these services through partnerships with community-based organizations, which may not already be Medicaid-enrolled providers (MACPAC 2022).[44] These entities will have to establish Medicaid billing systems and relationships with managed care plans, which can be challenging (Activate Care 2021).

Whether community providers or corrections staff provide prerelease services has implications for continuity of care and the ability of those providers to meet the care needs of individuals with criminal justice involvement. Relying on community providers

to deliver prerelease services either in person or via telehealth can contribute to care continuity if enrollees can continue to see those providers after release. However, the availability of community providers to deliver prerelease services will be limited in certain areas such as rural and other underserved areas. Moreover, some community providers will have less experience working in correctional environments and addressing the complex needs of justice-involved individuals, including those related to trauma and criminogenic risk factors (ASPE 2023).[45] Additional education and training to prepare community-based providers to offer prerelease services, in addition to the consideration of security issues and processes, would be beneficial (MACPAC 2022).[46]

Peer support specialists with a personal history of mental illness, SUD, or criminal justice involvement provide culturally competent care before and after release when individuals may struggle to access health care services and address their needs related to housing, employment, and family reintegration (ASPE 2023, MACPAC 2022). Although most state Medicaid programs cover some type of peer support, it will be important for states to address formal and informal policies that limit the employment of people with criminal records in such roles (MACPAC 2022, Adams and Lincoln 2021, MACPAC 2019a). These include, for example, certain background check or insurance policy requirements that prohibit hiring individuals with criminal records.

To improve continuity of care and health outcomes for individuals once they reenter the community, many states will need to expand the capacity of community-based systems to address the physical health, behavioral health, and HRSNs of individuals leaving incarceration.[47] One expert noted that prerelease services alone will not "move the needle" toward improved health outcomes for this population without corresponding investments to improve access to care in the community (MACPAC 2022). She noted that "for reentry to be successful, community providers need to play a bigger role and to be supported in growing into that role." Access to mental health and SUD treatment in particular is critical to preventing deaths and reducing substance use and decompensation, factors that often contribute to rearrest and incarceration (ASPE 2023, MACPAC 2022).

Monitoring and evaluation. Robust and timely monitoring and evaluation of initiatives to provide prerelease Medicaid services should be given priority because of the unprecedented nature of these efforts and the substantial physical health, behavioral health, and HRSNs of the populations affected (ASPE 2023, MACPAC 2022). However, Section 1115 demonstration evaluations have not historically been rigorous enough to assess whether demonstrations have achieved their goals, nor are they typically completed in time to inform decisions about the future of the policy being tested (MACPAC 2020). Moreover, evaluation results are not always distributed timely or made known to interested stakeholders (MACPAC 2022).

Given the typical lag in evaluation data, states should consider additional opportunities to enhance monitoring of implementation and progress toward the demonstration's identified goals (MACPAC 2022). CMS is requiring states operating reentry demonstrations to conduct an independent midpoint assessment of their progress toward specific milestones and goals—an additional monitoring activity that is not required of all Section 1115 demonstrations.[48] However, states and CMS should consider additional ways to strengthen monitoring and evaluation, including by ensuring that people with lived experience and other beneficiary advocates play a role in oversight of implementation and milestones (MACPAC 2022). Beneficiary surveys and interviews are an important avenue for assessing beneficiary understanding of the program as well as their perceptions of access and quality.

Policy-specific guidance and tools, tailored to reentry demonstrations, may be helpful in supporting timely and robust monitoring and evaluation results. MACPAC's prior work found that CMS guidance on strengthening state-led evaluations of certain Section 1115 demonstrations has been helpful in encouraging states to consider their demonstration goals and anticipated outcomes (MACPAC 2020). For example, CMS has provided monitoring templates and detailed guidance on developing hypothesis and research questions for evaluating Section 1115 demonstrations for enrollees with SUD, serious mental illness, and serious emotional disturbance.

Looking Ahead

As states implement Section 1115 demonstrations to provide prerelease Medicaid services to improve the health of Medicaid enrollees leaving incarceration, state Medicaid and correction agencies and CMS will confront numerous implementation considerations, including those described in this chapter. The evolving policy landscape provides opportunities for state Medicaid programs to design, implement, and assess approaches for improving outcomes for individuals involved in the criminal justice system. MACPAC will monitor these state demonstrations, including any interim and final reports on implementation and outcomes, and future guidance. The experience of state demonstrations in providing prerelease services to facilitate care transitions for incarcerated individuals returning to the community will shed light on future policy considerations for Medicaid's role in serving this population.

Endnotes

[1] Individuals on parole include people released through discretionary or mandatory supervised release from prison. In comparison, probation is a court-ordered period of correctional supervision in the community, typically viewed as an alternative to incarceration (MACPAC 2021).

Medicaid and the state corrections authority, which runs state prisons, are typically housed in different state agencies that report to the governor. Jails are generally operated at the local level by a sheriff, police chief, or other local official who may be appointed or independently elected (BJS 2023a). Six states (Alaska, Connecticut, Delaware, Hawaii, Rhode Island, and Vermont) do not have county- or city-operated jails. In these unified corrections systems, the state operates facilities that hold people awaiting trial or serving shorter sentences (Henrichson 2019).

[2] Structural racism is defined as "the totality of ways in which societies foster racial discrimination through mutually reinforcing systems of housing, education, employment, health care, and criminal justice" (Bailey et al. 2017). It is expressed as a set of institutional, multifaceted, and systemic laws and policies that result in more favorable outcomes for white communities and disadvantage communities of color (Michener 2022). Interpersonal racism, by contrast, is seen in biases and discriminatory behaviors of individuals (O'Kane et al. 2021).

[3] The Consolidated Appropriations Act, 2023 (CAA, P.L. 117-328), requires state CHIP and Medicaid programs, beginning January 1, 2025, to provide certain screenings and diagnostic services to eligible juvenile youth in public institutions in the 30 days before release or one week thereafter. States must also provide Medicaid-eligible youth-targeted case management services in the 30 days before release and for at least 30 days thereafter. For CHIP-eligible youth, states must provide case management services in the 30 days before release. States can receive federal financial participation (FFP) for these services. Also beginning January 1, 2025, states will have the option to receive FFP for Medicaid- and CHIP-covered services provided to eligible youth in public institutions during the initial period pending disposition of charges.

In Congress, there are bipartisan legislative efforts to provide Medicaid-covered services to adult inmates of public institutions, though these proposals have not become law. For example, the Medicaid Reentry Act (H.R. 2400, S. 1165) would require that state Medicaid programs cover services for eligible individuals up to 30 days before their release from incarceration and make FFP available for such services.

[4] Access to Medicaid is associated with a decreased likelihood of rearrest. For example, coverage for low-income adults under the ACA is associated with a 16 percent reduction in recidivism (Aslim et al. 2022). For those with serious mental illness released from jails, having active Medicaid coverage upon release is associated with a 16 percent reduction in the number of subsequent detentions (Morrissey et al. 2007).

[5] Section 5032 of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT Act, P.L. 115-271) required the Secretary of the U.S. Department of Health and Human Services (the Secretary) to issue guidance on Section 1115 demonstration opportunities to improve care transitions for Medicaid-eligible individuals leaving incarceration, including through coverage of Medicaid services up to 30 days before release. Section 5032 also required the Secretary to convene stakeholders to identify best practices and to summarize those best practices in a report to Congress. That report, issued by the U.S. Department of Health and Human Services assistant secretary for planning and evaluation in December 2022, informs the CMS guidance on Section 1115 demonstration opportunities.

[6] As of April 21, 2023, 14 states have pending Section 1115 demonstration applications to provide Medicaid-covered

services to certain individuals who are incarcerated. These states are Arizona, Kentucky, Massachusetts, Montana, New Hampshire, New Jersey, New Mexico, New York, Oregon, Rhode Island, Utah, Vermont, Washington, and West Virginia. CMS has indicated that it is engaging those states in review of their applications.

[7] MACPAC and AcademyHealth, in partnership with researchers at the University of Kentucky, conducted interviews with Medicaid officials in Arizona, Delaware, Kentucky, Louisiana, Michigan, Montana, New Mexico, New York, Pennsylvania, Rhode Island, Utah, Virginia, West Virginia, and Wisconsin as well as researchers at the University of Massachusetts Medical School with involvement in Massachusetts's Behavioral Health Supports for Justice-Involved Individuals demonstration. Interviews were also conducted with corrections officials in Delaware, Kentucky, Massachusetts, Michigan, New York, Rhode Island, Vermont, Virginia, and Wisconsin. Additionally, MACPAC and AcademyHealth partnered with researchers from Virginia Commonwealth University School of Medicine Department of Health Behavior and Policy and the University of Kentucky College of Medicine Institute for Biomedical Informatics to analyze Medicaid and corrections data in Virginia and Kentucky.

[8] MACPAC's work to date has not focused on justice-involved youth, who generally interact with different systems at the state and local level and often have different needs than adults. Similarly, this project did not examine reentry for federal prisoners, who are under the jurisdiction of the federal Bureau of Prisons. A 2023 report from the U.S. Government Accountability Office found little coordination between federal Bureau of Prisons and state Medicaid agencies to support the suspension and reactivation of Medicaid benefits for federal prisoners (GAO 2023).

[9] Adults are subject to the jurisdiction of an adult criminal court or correctional agency. In most states, the criminal justice system defines adults as individuals age 18 or older (BJS 2023b). This may differ from state definitions of adults for the purposes of Medicaid.

[10] The number of individuals supervised by the adult correctional system does not include those held in the U.S. territories, military facilities, U.S. Immigration and Customs Enforcement facilities, and jails in American Indian country. There are an estimated 102 federal prisons, 1,566 state prisons, and 2,850 local jails in the United States (Sawyer and Wagner 2022). Six states (Alaska, Connecticut, Delaware, Hawaii, Rhode Island, and Vermont) do not have county- or city-operated jails. In these unified corrections systems, the state operates facilities that hold people awaiting trial or serving shorter sentences (Henrichson 2019).

[11] In contrast, people released in 2018 spent an average of 2.7 years in prison (Kaeble 2021).

[12] Reduced drug tolerance after incarceration, when drugs are generally not available, contributes to higher rates of overdose death after release (Ranapurwala et al. 2018).

[13] Chronic physical health conditions include cancer, high blood pressure, stroke, diabetes, arthritis, asthma, cirrhosis of the liver, and heart- or kidney-related problems. Infectious diseases include tuberculosis, hepatitis B, hepatitis C, HIV and AIDS, and sexually transmitted diseases (Maruschak et al. 2021a).

[14] Researchers attribute documented high rates of COVID-19 in carceral settings to a number of factors, including overcrowding, poor ventilation, and limited resources for infection control and prevention (National Academies 2020).

[15] In the 32 states in which at least one form of MOUD is offered in state prisons, MOUD may not be available in every prison throughout the state. For example, in North Carolina, only 2 of the state's 57 prison facilities offer at least one form of MOUD (i.e., buprenorphine, methadone, and naltrexone) (Jail & Prison Project 2022).

[16] Any disability includes hearing, vision, cognitive, ambulatory, self-care (e.g., difficulty dressing or bathing), and independent living (e.g., difficulty doing activities on your own, including going outside, going to classes, going to meals) (BJS 2021). Justice-involved adults with disabilities, as well as those older than age 65 (representing 1 percent of the jail population and 4 percent of the prison population), may be dually eligible for Medicaid and Medicare (BJS 2022, Zeng 2022). However, national estimates of the share of inmates or formerly incarcerated individuals who are dually eligible are not available.

[17] For example, states can restrict benefits such as Supplemental Nutrition Assistance Program and Temporary Assistance for Needy Families based on an individual's criminal history (Wang et. al 2013).

[18] Section 1001 of the SUPPORT Act prohibits states from terminating Medicaid eligibility for eligible juveniles who become inmates of public institutions on the basis of their incarceration (CMS 2021a).

[19] States that reported suspending eligibility for individuals in state prisons and local jails were not asked to specify whether those processes were in place in every facility across the state (Gifford et al. 2019).

[20] For most states, SFY 2019 ran from July 1, 2018, through June 30, 2019. Exceptions include Alabama, the District of Columbia, and Michigan (October 1 through September 30); New York (April 1 through March 31); and Texas (September 1 through August 31) (KFF 2019).

[21] Medicaid programs often require multiple forms of identification for enrollment. Many incarcerated individuals may not have such identification, which may have been confiscated or absent at booking (MACPAC 2018). Presumptive eligibility allows individuals to quickly gain temporary Medicaid coverage before application completion, verification, and processing (Brooks 2014). The period of presumptive eligibility is the earlier between the day on which a decision is made on a Medicaid application and the last day of the month after the month in which presumptive eligibility was filed (42 CFR 435.1101, 42 CFR 435.1103(b)).

[22] Section 1945 of the Social Security Act allows states to establish health homes as a vehicle for coordinating primary, acute care, behavioral health, and long-term services and supports for individuals with certain chronic conditions, including those with SUD. Health home services must also include comprehensive transitional care from inpatient to other settings as well as referrals to social services and supports. States receive enhanced federal matching funds for health home services for an initial period.

[23] CMS will continue to require, as a condition of Section 1115 demonstration approval, that demonstrations be budget neutral. This means that the federal costs of the state's Medicaid program with the demonstration do not exceed what the federal government's costs would have been without the demonstration (CMS 2023a).

[24] States may not include federal prisons as a setting in which demonstration-covered prerelease services would be provided under their proposed Section 1115 demonstrations, given the role of the federal Bureau of Prisons in providing and paying for all health care for federal prisoners during incarceration (CMS 2023a).

[25] Case management services must assess and address physical, behavioral, and health-related social needs during and after incarceration. MAT includes medication in combination with counseling and behavioral therapies and should be available for all types of SUD as clinically appropriate, not just OUD. States may cover these and other required benefits under the demonstration or propose how they otherwise plan to ensure access to these services before release (e.g., through a state-only program or the carceral system directly).

[26] Section 5032 of the SUPPORT Act required CMS to issue guidance on Section 1115 opportunities to improve care transitions for soon-to-be-released individuals, including through prerelease coverage provided for a period not exceeding 30 days before release. Given the Secretary's general authority to approve Section 1115 demonstration projects and associated expenditure authorities, which is unaffected by the SUPPORT Act provision, CMS will consider state requests to provide prerelease coverage up to 90 days before an individual's expected release date. However, such requests must have a purpose and related experimental hypotheses that go beyond improving care transitions for soon-to-be-released individuals (CMS 2023a).

[27] CMS identifies several required components of state implementation plans, including anticipated challenges and mitigation strategies associated with each demonstration milestone. Implementation plans must also describe how improved health care quality for enrollees receiving demonstration services will reduce disparities and improve health equity (CMS 2023a).

[28] CMS states that the demonstration opportunity does not absolve carceral authorities of their constitutional obligation to provide health care to inmates in their custody, nor is it meant to transfer the financial burden of that obligation from a federal, state, or local carceral authority to the Medicaid program (CMS 2023a).

[29] Section 1115 of the Social Security Act and its accompanying regulations require states to monitor and evaluate demonstrations (42 CFR 431.428, 42 CFR 431.424). Monitoring provides ongoing updates on implementation and collects data on process and outcome measures, which may help states and CMS identify whether mid-course corrections are needed. Evaluations are completed later in the demonstration period or after the demonstration is complete; they are intended to assess whether the demonstration has achieved its goals and to inform decisions about the future of the policy being tested. States are required to submit a series of evaluation deliverables for each Section 1115 demonstration, including an evaluation design, an interim report, and a summative report (MACPAC 2020).

[30] CMS will provide guidance to each participating state for developing a monitoring protocol for quarterly and annual monitoring reports. The midpoint assessment must be completed by an entity independent of the state between years two and three of demonstration implementation (CMS 2023a).

[31] CMS will provide individual state technical assistance to support required monitoring and evaluation activities (CMS 2023a).

[32] The clinical criteria include but are not limited to a confirmed or suspected mental health condition, SUD, chronic or considerable non-chronic clinical condition, intellectual or developmental disability, traumatic brain injury, HIV or AIDS, or pregnancy or within 12 months postpartum.

[33] California's in-reach case management activities involve community-based providers evaluating the medical, behavioral, and social needs of individuals before release and developing a plan for addressing those needs. Other covered services include physical and behavioral health clinical consultation services, lab and radiology services, medications and medication administration, medication-assisted treatment and accompanying counseling, and services of community health workers and peer navigators with lived experience. Medicaid-eligible individuals who meet these criteria can also obtain up to a 30-day supply, as clinically appropriate, of prescribed and over-the-counter drugs and durable medical equipment (CMS 2023b).

[34] The California Department of Health Care Services (DHCS) will consider a number of factors when determining whether a facility is ready to participate in the reentry demonstration. This includes whether the facility can provide prerelease enrollment assistance and screenings to determine eligibility for prerelease services as well as the full set of covered prerelease services. DHCS will also consider the facility's ability to coordinate with health system partners and report data to support program monitoring, evaluation, and oversight (CMS 2023b).

[35] The Providing Access and Transforming Health program is a five-year initiative to increase participation of community providers in Medi-Cal. Funding is available to community organizations, such as public hospitals and community-based organizations, for necessary improvements to capacity and infrastructure (DHCS 2023).

[36] CMS encourages states that submitted demonstration applications before the release of the agency's guidance in April 2023 to review those proposals and engage with CMS about any changes they may wish to make (CMS 2023a).

[37] Montana proposes to provide prerelease services in state prisons only.

[38] In Massachusetts, Oregon, Rhode Island, and Vermont, Medicaid covers comprehensive adult dental services. Utah generally provides only emergency dental benefits to non-pregnant adults enrolled in Medicaid. Under its proposed Section 1115 demonstration, Utah would cover limited dental services only for certain incarcerated adults (NASHP 2022, Utah Department of Health 2020).

[39] Kentucky is proposing to provide MCO care coordination services 30 days before release and SUD treatment and recovery services up to three years before release (Kentucky 2020).

[40] States may request federal approval for a 90/10 enhanced federal match for the design, development, and implementation of Medicaid Enterprise Systems initiatives that contribute to the economic and efficient operation of the program, including technology that supports data sharing between state Medicaid agencies, state correctional agencies, and participating correctional facilities. States may also request a 75/25 enhanced federal match for ongoing operations of CMS-approved systems (CMS 2023a).

[41] These data are based on survey responses from state Medicaid officials. The survey did not ask respondents to specify which correctional authorities (e.g., state departments of corrections, local sheriffs) state Medicaid agencies have established automated electronic data-sharing relationships for the purposes of suspending and reinstating Medicaid benefits (KFF 2019).

[42] States use the Medicaid screening and enrollment process as the primary regulatory mechanism for ensuring that providers meet Medicaid standards. This process must be conducted before a provider can receive Medicaid payments; it gives states an opportunity to identify unqualified providers before they provide services to beneficiaries, which both protects patients and prevents improper payments. At regular intervals, providers must demonstrate that they continue to meet state requirements through a process known as "reenrollment" or "revalidation" (MACPAC 2019b).

[43] Medicaid programs can pay for housing-related services that promote health and community integration, such as assistance in finding and securing housing, and home modifications when individuals transition from an institution to the community. However, Medicaid cannot pay for rent or for room and board, except in certain medical institutions (CMS 2021b).

[44] Community-based organizations are public or private not-for-profit entities that address the health and social needs of their communities or a targeted population within the community (ASPR 2023).

[45] Criminogenic risk factors are aspects of a person's life that are associated with criminal behavior, such as a history of antisocial behavior, antisocial personality traits, family and/or marital strain, problems at school and/or work, and substance use (Van Deinse et al. 2021).

[46] In California, CMS is requiring that all providers and provider staff, including corrections providers, have necessary experience and receive appropriate training before furnishing services under the reentry demonstration (CMS 2023b).

[47] Concerns about shortages of mental health providers, for example, have been well documented over the past decade (Hogue et al. 2013; SAMHSA 2013, 2007). General shortages and geographic maldistribution of behavioral health providers, coupled with the unwillingness of some providers to service individuals enrolled in Medicaid, are key factors that limit access to mental health treatment.

[48] Midpoint assessments are typically required of states implementing systematic changes to delivery of services under Section 1115 demonstration authority (e.g., demonstrations to improve the continuum of care for beneficiaries with SUD, serious mental illness, or serious emotional disturbance).

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APPENDIX 3A: Medicaid Enrollment After Incarceration in Kentucky and Virginia

TABLE 3A-1. Cumulative Percentage of Individuals Released with Active Medicaid Benefits by Days After Incarceration, Kentucky and Virginia, 2019–2021

State	Individual characteristics	1 day	30 days	180 days
Kentucky	**Medicaid status**			
	All individuals	**73%**	**78%**	**89%**
	No prior Medicaid	23	41	77
	Prior Medicaid	77	81	90
	Prior OUD	79	84	93
	Prior mental health condition	78	83	92
	Race and ethnicity			
	White, non-Hispanic	74	80	90
	Black, non-Hispanic	71	76	88
	Hispanic	73	77	90
	Other	70	76	86
Virginia	**Medicaid status**			
	All individuals	67	75	82
	No prior Medicaid	62	66	72
	Prior Medicaid	68	76	85
	Prior OUD	77	82	90
	Prior mental health condition	70	78	85
	Race and ethnicity			
	White, non-Hispanic	68	76	83
	Black, non-Hispanic	67	73	82
	Hispanic	60	64	70
	Other	77	78	84

Notes: OUD is opioid use disorder. The table includes individuals released from state prisons and local jails between January 1, 2019, and December 31, 2020, in Kentucky and individuals released from state prisons between July 1, 2019, and June 30, 2021, in Virginia. This analysis excludes dually eligible individuals and others with partial benefits as well as those who never had benefits suspended. Prior and no prior Medicaid reflects whether an individual had Medicaid benefits at any point in the five years preceding incarceration. Individuals were identified as having a prior OUD or mental health condition based on prior Medicaid claims. Virginia expanded Medicaid under the Patient Protection and Affordable Care Act (P.L. 111-148, as amended) on January 1, 2019, whereas Kentucky implemented the expansion five years earlier on January 1, 2015.

Source: AcademyHealth 2022, analysis of Kentucky and Virginia Medicaid and corrections data.