MILLIMAN WHITE PAPER

Reentry for justice-involved individuals: A road map for state Medicaid agencies pursuing an 1115 demonstration

Libby Bunzli, MPH
Jeremy Hoffman, JD
Ali Marzolf, MPP
Mary Pat Stemnock, JD

Milliman

Background

Recent changes to federal Medicaid policy have afforded states new flexibilities to improve access to and continuity of healthcare services for individuals as they reenter the community post-incarceration. In announcing this policy change, the Centers for Medicare and Medicaid Services (CMS) acknowledged the layered barriers to health that justice-involved individuals face.[1] Previously, Medicaid agencies have had limited ability to support incarcerated individuals, and the new reentry 1115 waiver option allows states to test novel approaches to improve coverage, access, and continuity of care to ultimately promote health, recovery, and retention in the community. For states interested in pursuing this new policy flexibility, significant effort is required to align two complex systems. This paper discusses several reasons *why* states may pursue these authorities and offers considerations for *how* states can approach waiver design and implementation.

HEALTH AND SOCIAL NEEDS OF JUSTICE-INVOLVED POPULATIONS

Individuals leaving carceral settings are at particular risk for the negative impacts of gaps in care, given disproportionately high rates of physical and behavioral health conditions. The Bureau of Justice Statistics reports that 50% of justice-involved individuals have had a chronic condition and 17% have had an infectious disease.[2] Mental health concerns are also more prevalent, with 64% of jail inmates, 54% of state prisoners, and 45% of federal prisoners reporting mental health concerns, compared to 21% of the general population. [3,4] Additionally, the Substance Abuse and Mental Health Services Administration (SAMHSA) reports that 63% of people in jail and 58% of people in prison have a substance use disorder, compared to 17.3% in the general population.[5,6]

The disproportionate rate of health issues experienced by justice-involved individuals may be partly due to their limited access to healthcare before incarceration. Half of people in state prisons lacked health insurance at the time of incarceration, while those who had insurance typically received it through an employer (39%) or Medicaid (32%).[7] These health disparities are compounded by broader socioeconomic and structural factors. Minority populations, particularly Black individuals, are incarcerated at disproportionately high rates—nearly 12 times higher than white individuals.[8] Additionally, social factors contribute to their needs: about 20% of justice-involved individuals experienced homelessness before incarceration, early 40% were unemployed, and approximately 50% had earnings below the federal poverty level (FPL).[9]

HEALTHCARE IN CARCERAL SYSTEMS

Although states and the federal government are required to provide healthcare in jails and prisons, the quality of that care often lags behind what is available to the general public.[10] The Medicaid Inmate Exclusion Policy (MIEP), which prohibits using federal funds for ambulatory care services and medications for incarcerated persons, has prevented states from leveraging their Medicaid programs to improve care and care transitions for inmates held involuntarily in a public institution.[11]

In states with expanded Medicaid eligibility, many individuals transitioning out of carceral facilities are likely eligible for Medicaid.[12] Because MIEP is based on coverage rather than eligibility, states can suspend, rather than terminate, Medicaid coverage during incarceration.[13] Effective coordination and timely reactivation of coverage can improve continuity of care and reduce recidivism.[14]

The new reentry 1115 flexibility deviates from MIEP and builds on streamlined suspension and reactivation policies, allowing states to begin coverage of key services before an individual is released.

FEDERAL POLICY FOR REENTRY 1115 WAIVERS

Section 5032 of the Substance Use Disorder Prevention That Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT Act) directed the U.S. Department of Health and Human Services (HHS) to develop best practices for states to help justice-involved individuals transition to the community and establish opportunities for 1115 waivers for demonstration projects to test best practices.[15] CMS subsequently released guidance detailing how states can receive federal financial participation for expenditures for certain prerelease healthcare services furnished to individuals who are incarcerated and otherwise eligible for Medicaid.[16] Additionally, the Consolidated Appropriations Act of 2023 (CAA) requires Medicaid and the Children's Health Insurance Program (CHIP) to cover medically necessary screenings, diagnostic services, and case management for all eligible youth (under age 21 and former foster care youth under age 26) in public institutions 30 days prior to release. States must continue to provide case management services for at least 30 days post-release starting January 1, 2025.[17]

States are quickly taking advantage of these new flexibilities with notable variability in approaches, as each state customizes its waiver to operate within unique healthcare delivery and corrections systems. At the time of publication, 23 states and the District of Columbia have submitted Medicaid 1115 waiver proposals to CMS that would alter the MIEP to provide prerelease coverage to eligible incarcerated individuals.[18] Because the waiver process allows states to experiment and test different hypotheses, these proposals differ in several foundational ways—including the number of days that coverage would be available prerelease, the eligibility criteria, and the services provided prerelease. To date, 11 states have received approval for their waivers.

Administering Medicaid services to incarcerated individuals is far more complex than expanding eligibility. Carceral facilities are not traditional Medicaid providers or enrollment specialists, and significant effort is required to build capacity, align systems, and stand up processes to support eligibility determination, enrollment, service provision, and care coordination. Medicaid agencies must partner closely with their corrections counterparts to define roles and processes between state agencies, managed care entities, carceral facilities, and community-based providers prerelease, upon release, and post-release to create a person-centered program and facilitate a seamless care transition.

The purpose of this white paper is to provide a high-level road map for states to work through the layers of decisions needed to move from policy development to implementation. This road map can inform internal and external engagement approaches to make operationally feasible decisions and assure compliance with post-approval deliverables to CMS. This is the first in a series of white papers; subsequent papers will provide a deeper dive into subtopics such as managed care contracting and capitation rate development, to provide specific considerations for core components of reentry waivers.

Waiver implementation framework

An 1115 waiver implementation is a significant undertaking, with a long and not necessarily linear path. A clear implementation framework can help states maintain a guiding vision while conducting the detailed mapping of the process. In this section, we describe a phased approach to reentry waiver design and implementation planning, grounded in two overarching principles: engaging with experts and approaching decision-making as an iterative process.

ENGAGE WITH EXPERTS EARLY AND OFTEN

Successful implementation of a reentry waiver engages stakeholders throughout the life of the project, beginning at the starting line. Because a reentry initiative brings together multiple systems that are not always interacting with each other on an ongoing basis, states will need to invest time up front to identify a range of internal and external key subject matter experts and keep them involved in the visioning, planning, and operationalizing phases. In particular, CMS has emphasized the importance of elevating the experiences of individuals with lived experience in the reentry waiver initiative. States will need to build in ample time to engage communities that have not historically participated in state policy development. Ensuring that all stakeholders have a seat at the table where priorities are being set helps establish a common understanding and vision of Medicaid's new role as a payer of prerelease healthcare services and sets the foundation for stakeholder engagement as states' new programs evolve over time.

APPROACH DECISION MAKING AS AN ITERATIVE PROCESS

It is important to keep in mind that along the path to implementation there will be decisions that must be revisited and finetuned. For example, a decision made early in the waiver design process related to Medicaid eligibility suspension may no longer be viable once the Medicaid eligibility data batching process at the state human services agency is better understood. States will need to remain flexible in their approaches to solving issues raised during the multi-agency discussions necessary for implementing reentry waivers. Decision iteration is a normal part of the process, and requires planning for the time and flexibility to return to issues, and for continual engagement with stakeholders along the way.

THREE PHASES

We organize the process of designing and implementing a reentry waiver into three phases: visioning, planning, and operationalizing. The three phases provide a general road map that can be customized to reflect the waiver authorities requested and the unique state contexts. It is also important to note that activities within the phase are not necessarily sequential, and multiple implementation steps may need to occur concurrently and often must align with existing state processes such as agency budget appropriations.

1. Visioning

The first phase is a broad visioning stage, whereas the subsequent phases increasingly focus on details. States will need to have a high-level concept of what the waiver benefits are, who will receive them, which facilities and providers will participate, and how the program will roll out. Initiating engagement with corrections partners is key at this stage, and having Medicaid and corrections leadership endorse the initiative as a priority can support successful coordination across and within multiple organizations.

It is critical to engage with sister agencies in this stage to understand current efforts and lay the groundwork for ongoing collaboration. As states are designing a reentry waiver, it can be helpful to think about where the waiver fits into existing state agency objectives. Parallel work inside and out of the Medicaid agency can often be leveraged to facilitate stakeholder participation, buy-in, and program design feedback.

During the visioning phase, states are moving toward the development of a waiver application and special terms and conditions (STC) negotiations with CMS. The visioning phase includes budget neutrality projections and public comment. For reentry waivers the fiscal forecasting is important because any current spending on waiver services will be newly matchable for Federal Financial Participation (FFP), and states will have to start quantifying that spending for budget neutrality and reinvestment planning.

The iterative nature of the waiver implementation process necessitates fluidity and movement between the visioning, planning, and implementation phases. An important consideration at the visioning phase is avoiding the pitfall of locking your organization into decisions that later prove themselves unworkable, underscoring the importance of engaging subject matter experts within Medicaid and corrections agencies.

2. Planning

The planning phase should begin in earnest once a state submits its waiver application and includes all of the activities related to developing reentry implementation and reinvestment plans. This is where states need to work cross-agency and cross-functionally within the Medicaid agency to understand internally what is needed to stand up the waiver and comply with CMS requirements.

As states begin planning for waiver implementation it may be helpful to employ several parallel workstreams that categorize and break up the tasks, as described below. These workstreams can be tied back to the waiver milestones described by CMS reentry waiver guidance.[19] While the workstreams described below are not an exhaustive list of everything states must do, they provide a jumping-off point for discussions within your organization.

- **Managed care considerations:** Many states will implement all or part of their reentry waivers via managed care. Some states have considered the use of third-party administrators (TPAs) to streamline activities such as provider payment or credentialing. Defining roles between managed care organizations (MCOs), carceral providers, and other key entities within a reentry delivery system is critical for guiding ongoing planning. In the planning phase, states should consider existing timelines for MCO activities, such as contract amendments and rate setting.
- **Eligibility and enrollment:** States will need to consider how the existing Medicaid eligibility system may need to be modified to allow for suspension during incarceration, coverage of the waiver benefit package during the authorized prerelease period, and full coverage upon release. If implementing prerelease benefits in managed care, states will have to determine an approach to auto-assignment in the absence of plan selection.
- **Provider requirements and readiness:** Reentry waiver services may be delivered by community-based in-reach providers or clinical staff employed directly by the carceral facility. Medicaid provider enrollment, managed care contracting, and billing and claiming processes may be new to carceral providers, and substantial capacity building and training may be required. As states plan, they can clarify what facilities will need to implement the waiver and create processes for readiness assessment, technical assistance, and capacity development.

- **Service design and payment rates:** While a state's waiver approval will define the set of services included in the demonstration, during the planning phase states will have to define service requirements and reimbursement rates for reentry case management. For other included services, states can consider whether any enhancements must be made to service definitions or reimbursement rates for analogous state plan services given the unique nature of providing services within a carceral setting. States can also consider whether and how to enable the provision of services via telehealth.
- **Program authority:** Some states may need to consider additional program authorities other than the demonstration waiver for their reentry programs to support the transition to the community. For example, a state may wish to cover targeted case management or peer services specific to justice-involved populations. If changes to state regulations are needed, or states wish to make changes to their Medicaid State Plans, it is important to factor these timelines into the program plan as soon as possible.
- **Reinvestment:** Under a reentry waiver, states can receive matching funds for any existing carceral healthcare services that are currently funded with state and/or local dollars, as long as those dollars are reinvested into "activities and/or initiatives that increase access to and/or improve the quality of healthcare services" for justice-involved individuals.[20] States are required to develop a reinvestment plan that identifies the "freed up" state funds and what initiatives they will be reinvested in. For example, California states in its reinvestment plan that it will reallocate money previously used for laboratory services and medication costs and apply it toward planning and information technology (IT) investments to enable implementation of its reentry waiver.[21] To prepare for the reinvestment plan, states should engage with their corrections partners to identify the current spend on medical services and potential reinvestment obligation and develop a reinvestment strategy.

  Alignment with CAA requirements: Per the 2023 CAA, beginning in January 2025 states will be required to cover a limited package of Medicaid and/or CHIP services for incarcerated juveniles.[22] The required services include screening and diagnostic services, as well as targeted case management. These services are mandatory for juveniles post-adjudication, while states have the option to provide them to juveniles prior to adjudication (also referred to as "pending trial"). Services must be available at least 30 days prior to release. Additionally, the 2024 CAA requires states to implement suspension of Medicaid benefits rather than disenrollment for inmates of public institutions by January 2026.

Many states will have to undergo significant systems changes and upgrades in order to provide the services required under the 2023 CAA. To assist in these efforts, HHS may award up to $113.5 million in planning grants to develop operational capabilities.[23] Because some of the CAA-required services, like case management, are similar to those required under reentry waivers, states may already be undertaking some of the enhancements needed to provide services to incarcerated individuals, both juveniles and adults. Additionally, states may be able to receive funding for some of these efforts through a CAA planning grant. By ensuring that a state's work in implementing the CAA requirements is aligned with the build-out required for a reentry waiver, states can stand up streamlined processes and structures to utilize for the benefit of all incarcerated individuals who qualify for Medicaid services.

3. Operationalizing

The third phase—operationalizing—requires states to translate all of the decisions made during the planning phase into even more granular detail in the form of state policy, guidance, technical policies and procedures, managed care contract terms, and other vendor procurements. While these steps will vary for each state and waiver, many of these steps will need to be in motion early on, underscoring the importance of cross-functional engagement throughout waiver design and implementation planning. Operationalizing a reentry waiver can include activities such as:

- Forecasting anticipated state budget impact and securing state budgetary authority
- Implementing updates to eligibility and enrollment systems or other information technology systems to enable suspension and activation processes and comply with monitoring requirements
- Amending managed care contracts and determining fiscal impacts to managed care capitation rates
- Procuring new vendors, such as third-party administrators or technical assistance providers
- Developing processes and materials to conduct facility readiness assessments
- Developing any necessary provider requirements or regulatory updates

Many of these activities in the operationalizing phase will require states to conform to existing processes and timelines, such as state budget setting and managed care rate development processes. Other functions like procuring vendors or implementing system updates can be time-consuming. It is important for states to engage early and often with cross-functional teams and secure necessary buy-in from key leaders early on.

Conclusion

The reentry demonstration waiver initiative offers a groundbreaking policy flexibility for states to extend healthcare services to populations historically excluded from Medicaid. Although coordinating efforts across diverse sectors may seem daunting, adopting a phased approach can bring clarity to the implementation process. By breaking the project into manageable phases, states can systematically address each component, ensuring thorough and effective execution. Establishing a clear vision for the project, with well-defined goals and desired outcomes, will empower leaders to meet CMS expectations and achieve significant improvements in healthcare access and quality for incarcerated and recently released individuals.

CONTACT

Libby Bunzli
Libby.Bunzli@milliman.com

Jeremy Hoffman
Jeremy.Hoffman@milliman.com

Ali Marzolf
Ali.Marzolf@milliman.com

Mary Pat Stemnock
MaryPat.Stemnock@milliman.com

ENDNOTES

1. CMS (April 17, 2023). SMD 23-003: Opportunities to Test Transition-Related Strategies to Support Community Reentry and Improve Care Transitions for Individuals Who Are Incarcerated. Retrieved September 5, 2024, from https://www.medicaid.gov/federal-policy-guidance/downloads/smd23003.pdf.

2. Maruschak, L., Bronson, J., & Alper, M. (June 2021). Medical Problems Reported by Prisoners. U.S. Department of Justice. Retrieved September 5, 2024, from https://bjs.ojp.gov/sites/g/files/xyckuh236/files/media/document/mprpspi16st.pdf. Comparison provided using CDC prevalence data.

3. Collier, L. (October 2014). Incarceration Nation. American Psychological Association. Retrieved September 5, 2024, from https://www.apa.org/monitor/2014/10/incarceration.

4. National Alliance on Mental Illness. Mental Health by the Numbers. Retrieved September 5, 2024, from https://www.nami.org/about-mental-illness/mental-health-by-the-numbers/.

5. National Institute on Drug Abuse. Criminal Justice Drug Facts. Retrieved September 5, 2024, from https://nida.nih.gov/publications/drugfacts/criminal-justice.

6. SAMHSA (November 13, 2023). HHS, SAMHSA Release 2022 National Survey on Drug Use and Health Data. Press release. Retrieved September 5, 2024, from https://www.samhsa.gov/newsroom/press-announcements/20231113/hhs-samhsa-release-2022-nsduh-data.

7. Wang, L. (June 2022). Chronic Punishment: The Unmet Health Needs of People in State Prisons. Prison Policy Initiative. Retrieved September 5, 2024, from https://www.prisonpolicy.org/reports/chronicpunishment.html.

8. Carson, E. A., & Kluckow, R. (November 2023). Prisoners in 2022 – Statistical Tables, Table 5. Bureau of Justice Statistics (Report NCJ 307149). Retrieved September 5, 2024, from https://bjs.ojp.gov/document/p22st.pdf.

9. Trotter II, R. T., et al. (November 2018). A Survey of Health Disparities, Social Determinants of Health, and Converging Morbidities in a County Jail: A Cultural-Ecological Assessment of Health Conditions in Jail Populations. Int J Environ Res Public Health 15(11), 2500. Retrieved September 5, 2024, from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6267226/.

10. Cloud, D. H., Parsons, J., & Delany-Brumsey, A. (2014). Addressing Mass Incarceration: A Clarion Call for Public Health. AJPH, 104(3), 389–391. Retrieved September 5, 2024, from https://doi.org/10.2105/ajph.2013.301741.

11. CMS (April 28, 2016). SHO # 16-007: RE: To Facilitate Successful Reentry for Individuals Transitioning From Incarceration to Their Communities. Retrieved September 5, 2024, from https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/Downloads/sho16007.pdf.

12. Congressional Research Service (July 24, 2024). Medicaid and Incarcerated Individuals. Retrieved September 5, 2024, from https://crsreports.congress.gov/product/pdf/IF/IF11830.

13. Ibid.

14. Morrissey, J. et al. (2007). The Role of Medicaid Enrollment and Outpatient Service Use in Jail Recidivism Among Persons With Severe Mental Illness. Psychiatric Services 58, no. 6: 794–801.

15. The full text of the Substance Use–Disorder Prevention That Promotes Opioid Recovery and Treatment for Patients and Communities Act, H.R. 6, 115th Cong. (2018), is available at https://www.congress.gov/115/bills/hr6/BILLS-115hr6eah.pdf.

16. CMS, SMD 23-003, op cit.

17. The fullt text of the Consolidated Appropriations Act, 2023, H.R. 2617, 117th Cong. (2022), is available at https://www.congress.gov/117/plaws/publ328/PLAW-117publ328.pdf. See Section 5121.

18. Waivers have been submitted by Arizona, Arkansas, California, Colorado, Connecticut, the District of Columbia, Hawaii, Illinois, Kentucky, Maryland, Massachusetts, Montana, New Hampshire, New Jersey, New Mexico, New York, North Carolina, Oregon, Pennsylvania, Rhode Island, Utah, Vermont, Washington, and West Virginia.

19. CMS, SMD 23-003, op cit.

20. Ibid.

21. CMS (December 19, 2023). State Demonstration Group: California CalAIM demonstration approval. Retrieved September 5, 2024, from https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ca-calaim-dmnstn-aprvl-12192023.pdf.

22. CMS (July 23, 2024). SHO # 24-004: RE: Provision of Medicaid and CHIP Services to Incarcerated Youth. Retrieved September 5, 2024, from https://www.medicaid.gov/federal-policy-guidance/downloads/sho24004.pdf.

23. Dwyer, Anne (May 2024). Consolidated Appropriations Act, 2024: Medicaid and CHIP Provisions Mental Health and Substance Use Disorder Provisions Explained. Georgetown University McCourt School of Public Policy Center for Children and Families. Retrieved September 5, 2024, from https://ccf.georgetown.edu/wp-content/uploads/2024/05/CAA-2024-Explainer-Final-PDF.pdf.