

Medicaid and Reentry

Policy Changes and Considerations
for Improving Public Health and
Public Safety

Council on Criminal Justice
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ABOUT THE HEALTH AND REENTRY PROJECT

The [Health and Reentry Project](#) (HARP) is a collaboration between the [Council on Criminal Justice](#), former Deputy Administrator for Medicaid and CHIP Services Vikki Wachino, now of Viaduct Consulting, LLC and [Waxman Strategies](#).

Its goal is to help states, the federal government, local governments, and relevant stakeholders maximize the benefits of proposed Medicaid policy changes for public health and public safety. As part of its work, the project is convening actors across the health and criminal justice systems, as well as affected individuals and stakeholders, to discuss how to carry out the potential reforms.

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Introduction

State and federal policymakers have long considered a wide range of changes to Medicaid policy to better support the health of people as they leave prison or jail.

Many of the proposed changes aim to advance specific goals, from improving health equity to reducing recidivism, strengthening public safety, and addressing public health crises related to mental health, substance use disorders (SUDs), and COVID-19.

Bipartisan legislation introduced in 2021 and under active consideration by the 117th Congress would establish Medicaid coverage for eligible individuals 30 days before release from prison or jail. Even as federal policymakers consider this change, more than half a dozen states have asked the Biden administration to make similar policy changes administratively through Medicaid's 1115 demonstration waiver process.¹ Whether through changes to federal law or administrative action, it appears likely that changes extending Medicaid coverage to incarcerated individuals prior to their return to the community (their "reentry") may occur soon.

This issue brief is the first in a series of publications from the Health and Reentry Project (HARP). It describes Medicaid's role as well as the policy changes that are under consideration, health care in the criminal justice system, and key implementation issues that will be central to the success of changing Medicaid's role at reentry. The brief is intended to inform and advance discussion of that changing role among health and criminal justice system leaders, advocates, and people and communities that will be affected by new policies in this area. HARP is facilitating discussion among a wide group of these stakeholders during a March 2022 convening and will use the results of that discussion to develop a second issue brief for publication in late spring 2022 that will explore implementation issues in greater depth.

This brief is structured in five sections:

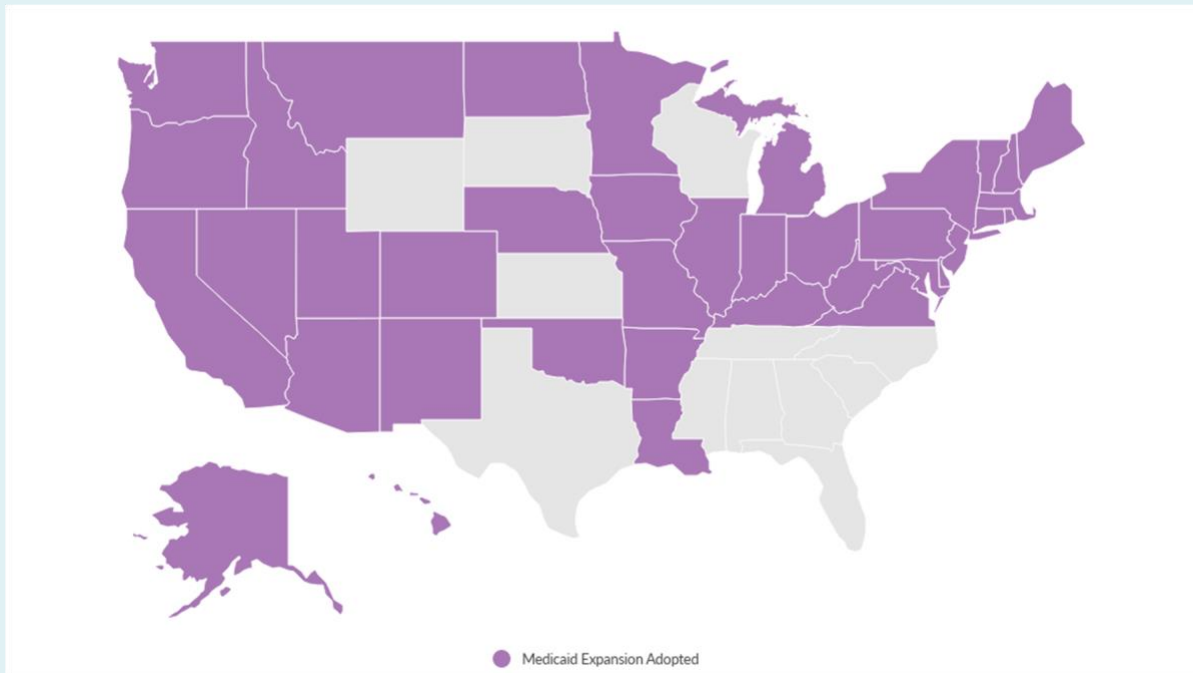
1. Medicaid and its Role in the U.S. Health Care System
2. Corrections and Health Care in the Criminal Justice System
3. Medicaid's Role for People Who Are Incarcerated
4. Medicaid and Reentry: Recent and Potential Changes
5. Key Implementation Challenges and Questions

MEDICAID AND ITS ROLE IN THE U.S. HEALTH CARE SYSTEM

Medicaid provides health and long-term care coverage for low-income people in the United States. As of June 2021, the program covered more than 83 million individuals.² Along with private insurance and Medicare, Medicaid is one of three main pillars of the U.S. health care coverage system.³

Medicaid operates as a joint state/federal program. The federal government, specifically the Centers for Medicare & Medicaid Services (CMS) within the United States Department of Health and Human Services (HHS), is responsible for administering and overseeing the program. States and territories make policy decisions regarding eligibility, benefits, delivery system, provider payment, and other areas within federal standards and above federal minimums. For this reason, Medicaid programs vary a great deal from state to state. Like Medicare, Medicaid is an entitlement program, guaranteeing coverage for people who are eligible.

FIGURE 1: STATES ADOPTING ACA MEDICAID EXPANSION



Since passage of the Affordable Care Act in 2010 and the subsequent Supreme Court ruling in *NFIB v. Sebelius* (2012), states have had the option to expand Medicaid coverage to all adults with incomes below 138% of the federal poverty level. To date, 39 states (including the District of Columbia) have adopted the ACA Medicaid expansion and 12 have not.

Medicaid covers low-income children, people with disabilities, seniors, and pregnant women. Medicaid was expanded to offer coverage for all low-income adults by the Affordable Care Act (ACA). Since a 2012 United States Supreme Court decision made that coverage optional for states, 39 states (including the District of Columbia) have adopted the ACA's Medicaid expansion, and 12 have not.⁴

Medicaid is funded by the federal government and state governments, which together spent more than \$630 billion on the program in 2019. The federal government provides most of the funding and matches state spending at a rate that varies by state, and by some populations and services. Medicaid is a major source of health care financing in the U.S., accounting for one out of every six dollars that the nation spends on health care. It serves as a significant financing source for a range of providers, including hospitals, doctors, and community health centers.⁵ Medicaid is also a leading financing source of many services, including mental health and substance use services.

Services to most Medicaid beneficiaries are provided, in whole or in part, through managed care plans, which contract with states to organize and deliver services on their behalf.⁶ Some states provide some or all services on a fee-for-service basis, in which case the state directly organizes services and pays providers. Federal law establishes standards that providers who participate in Medicaid and Medicare must meet.⁷

In addition to the states' flexibility to design their programs within federal law and regulation, they can in some cases operate beyond the bounds of federal law with the approval of the federal government. CMS has the authority to waive some provisions of federal law, provided that the change serves the objectives of the Medicaid program. This takes place through a "demonstration authority" in federal Medicaid law and a process called "Section 1115 demonstrations," which are often referred to as "1115 waivers."⁸ Many states operate significant portions of their Medicaid programs under this authority. Because most 1115 demonstrations are complex and all demonstrations authorize states to depart from federal law, negotiating the terms of a demonstration can be complex.⁹

HEALTH OF PEOPLE LEAVING THE CRIMINAL JUSTICE SYSTEM

Incarceration is a major social determinant of health, and the health care needs of people who are incarcerated in the U.S—including needs related to mental health, substance use disorders, and chronic conditions such as asthma, diabetes, and heart disease—are high. This increased need continues after people are released. In the period following release from jail or prison, formerly incarcerated people are 12 times more likely to die than are other people, from causes that include heart disease, homicide, suicide, and cancer. Rates of death from overdoses are extremely high in the period immediately following incarceration.

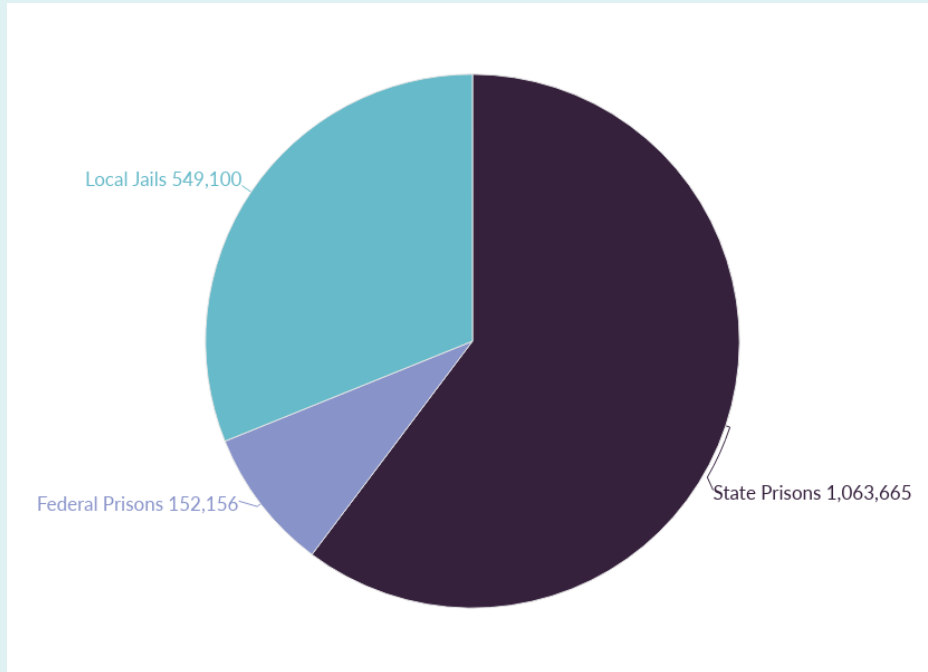
For some groups, the risks persist over the long-term. Recent longitudinal research found higher mortality among Black people who had been incarcerated than among other groups, suggesting that incarceration may be associated with lower life expectancy for Black people in the U.S. Rates of hospitalization also are higher for recently incarcerated people than they are for other individuals. In recent years, the opioid epidemic and the COVID-19 pandemic have highlighted the acute need for robust medical services for people in America's prisons and jails, and those returning to the community after incarceration.

CORRECTIONS AND HEALTH CARE IN THE CRIMINAL JUSTICE SYSTEM

The American correctional system is large and complex, a web of interconnected local, state, and federal institutions and actors. Across U.S. prisons and jails, there is no single approach to providing health care services. This complexity presents both challenges and opportunities for policymakers seeking to advance changes to the correctional health system to improve public health and public safety outcomes.

In 2020, 1.8 million people were incarcerated in the U.S. Of that total, over 1.2 million individuals were serving sentences in state and federal prisons¹⁰, while nearly 550,000 individuals were held in local jails.¹¹ Over the course of the year, 8.7 million people cycled through local jails.¹² People who are incarcerated have significantly lower incomes than people who are not, and the incarcerated population is disproportionately comprised of people who are Black or other people of color.¹³

FIGURE 2: US CORRECTIONAL POPULATION BY SETTING



Sources: Bureau of Justice Statistics, *Prisoners in 2020 – Statistical Tables*, December 2021. Bureau of Justice Statistics, *Probation and Parole in the US, 2020*, December 2021. Bureau of Justice Statistics, *Jail Inmates in 2020 – Statistical Tables*, December 2021.

Jails are typically county or city institutions that house individuals awaiting trial on state or local charges, along with those convicted of a crime and serving sentences of less than one year. Prisons, on the other hand, are state or federal facilities that usually incarcerate people who have been convicted of a crime and are serving sentences longer than one year. Compared to prisons, jails tend to experience far greater turnover of individuals and more unpredictable release dates, particularly for those awaiting trial who may secure bail or have their charges dropped.¹⁴

In addition to incarcerated populations, an estimated 3.9 million adults were under community supervision (probation or parole) across the U.S. at the end of 2020.¹⁵ A person may be sentenced to probation in lieu of or in addition to serving jail or prison time. Parole is a conditional early release from prison for those who have already served a portion of their sentence. Both probation and parole usually involve regular supervision and rules to which individuals must adhere. Violating supervision conditions can result in a range of penalties, including reincarceration.

The juvenile justice system operates in parallel (and occasional overlap) with the adult criminal justice and correctional system, with its own network of state and local courts, facilities, and community-based service systems. In 2019, 36,479 youths were held in facilities away from home as a result of juvenile justice or criminal justice involvement. These facilities include juvenile detention centers, long-term secure facilities, residential treatment centers, adult prisons and jails, group homes, and others.¹⁶

Governments have a constitutional mandate to provide people in prisons and jails with health care, as a 1976 Supreme Court case, *Estelle v. Gamble*, found that deliberate indifference to the medical needs of incarcerated individuals constitutes a violation of the Eighth Amendment prohibition on cruel and unusual punishment.¹⁷ Yet with nearly 2,000 state and federal prisons, more than 3,000 local jails, more than 1,700 juvenile detention facilities, and other carceral settings¹⁸ operating under different laws, regulations, administrative structures, and budgetary constraints, there is significant variation in the quality of care and the delivery models used to provide it to people who are incarcerated. State prisons typically provide on-site primary care and basic outpatient services. Many states designate one or more prisons within their system to house specialized medical clinics or units, but prisons also rely substantially on local hospitals to provide care.¹⁹

Less is known about the type and extent of health care services provided in local jails. A 2018 study found wide variation in the amount of jail budgets spent on health care. It described jail health services as being more similar to urgent care (responsive to crisis and critical needs) than primary care (ongoing and often focused on disease prevention and mitigation). It also noted that many jails must meet ongoing patient needs, such as Medication for Opioid Use Disorders (MOUD) for substance use disorders. Some jails provide discharge planning, including connections to health coverage.²⁰

Correctional settings employ a range of approaches when it comes to the provision of health care services. States and counties may provide medical services directly by employing their own health care providers, contract with outside organizations, or rely on a combination of in-house and contract providers. In some cases, community providers such as hospital systems or community health centers provide services in jails. Data on health care contracting in carceral settings—especially jails—is scarce, and the financing of health services in prisons and jails varies widely, with most on-site care funded out of state and local correctional budgets. To control costs, some jurisdictions contract with service providers for a fixed amount of care per-person within their facility. Compared to the general health system, insurance coverage plays a very small role in correctional health.²¹

MEDICAID'S ROLE FOR PEOPLE WHO ARE INCARCERATED

Because people who are incarcerated are more likely to be low income, many incarcerated individuals may meet the eligibility criteria for Medicaid. Historically, however, the program has played a limited role in providing services to people in prisons and jails. The roots of these limitations are statutory and legal barriers, though these have given rise over time to administrative and operational barriers as well.

The primary obstacle is a provision within Medicaid statute known as the “inmate exclusion,” which prohibits Medicaid programs from providing any *“payments with respect to care or services for any individual who is an inmate of a public institution (except as a patient in a medical institution).”*²² This prevents Medicaid from covering services for people who are incarcerated unless that care is provided in a medical institution, defined primarily as inpatient hospital stays of more than 24 hours.²³ Medicaid *can* cover services provided to many people in the community corrections system, to whom the inmate exclusion does not apply. This includes people on probation and parole, and many people who reside in “halfway houses.”²⁴

The “inmate exclusion” does not make incarcerated people who otherwise meet Medicaid eligibility criteria ineligible for Medicaid, but rather prohibits Medicaid payment for services received during incarceration. Despite that fact, until recently, most states terminated Medicaid beneficiaries’ eligibility if they became incarcerated. Terminating a beneficiary’s eligibility ensured that Medicaid was not erroneously billed for services provided during incarceration, but also introduced a major barrier to reenrollment and coverage post-release.

In recent years, it has become more typical for states to suspend, rather than terminate, Medicaid eligibility when people are incarcerated. This makes it easier for Medicaid to finance inpatient hospital stays and can make it easier for a beneficiary’s coverage to be reactivated upon release, although operational challenges to timely reactivation persist in most places. Since 2018, federal law has prohibited states from terminating Medicaid eligibility for people in the juvenile justice system and for those who recently aged out of the foster care system.²⁵ For others, federal policy encourages states to suspend, rather than terminate, eligibility during incarceration, and to promote enrollment in and renewal of coverage.²⁶

As of State Fiscal Year 2019, 43 States reported in a survey²⁷ that they suspend, rather than terminate, Medicaid coverage for enrollees who enter prisons, and 42 states report the same policy for jails. Only 23 states, however, reported having automated data exchange processes in place to facilitate suspension and reinstatement of enrollment.

Recently, some state Medicaid programs, criminal justice and corrections officials, and Medicaid plans and providers have worked to strengthen the health coverage, health care, and social support services for Medicaid beneficiaries returning to the community after a prison or jail stay.

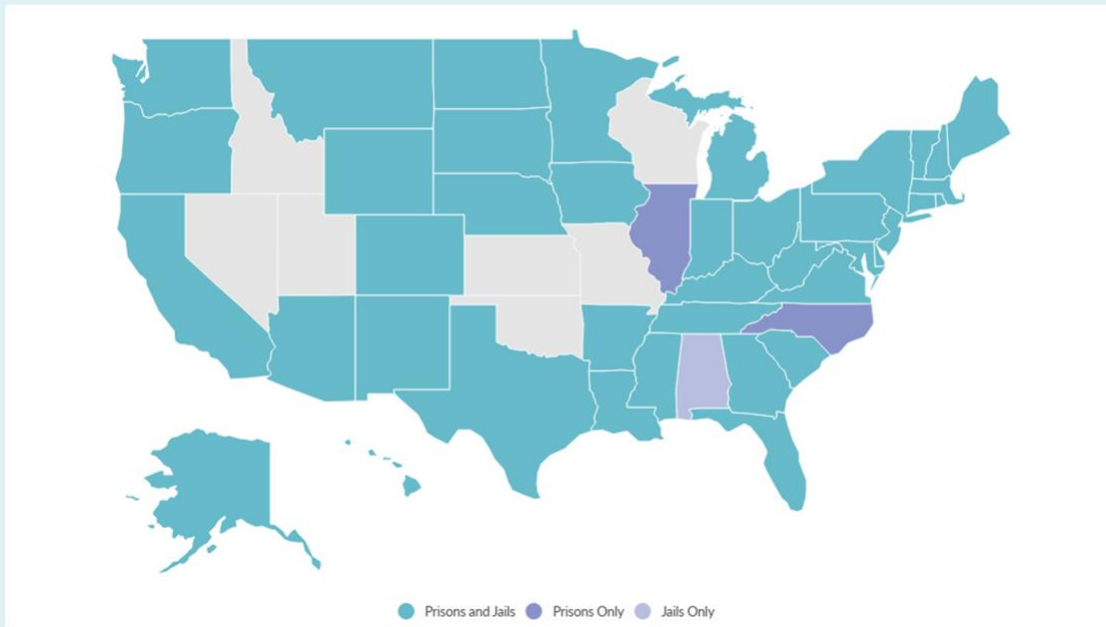
Approaches states are using include the following:

- + promoting enrollment in Medicaid coverage for incarcerated populations at the point of correctional-community transition
- + using data exchange to connect individuals to providers and health plans upon release
- + establishing “in-reach” to help incarcerated people establish relationships with primary care providers, transition medical records, and set up community-based care
- + use of peer support specialists, to help individuals navigate health care and related social service resources.²⁸

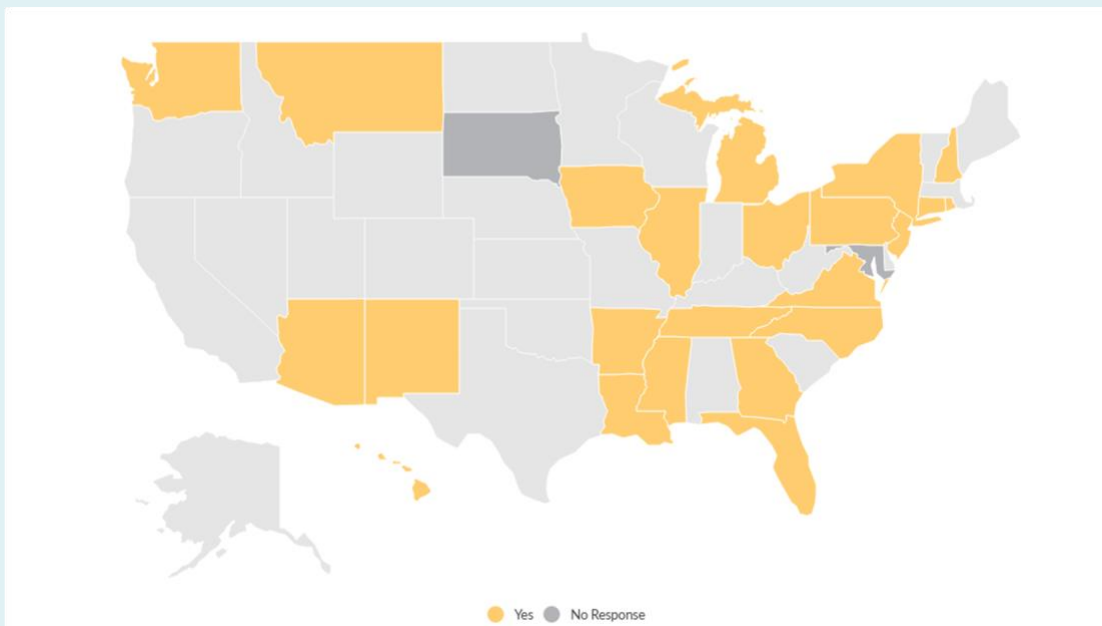
In addition, an increasing number of states are directing Medicaid managed care organizations to play a larger role in pre-release care coordination and the provision of wrap-around services upon release.²⁹

FIGURE 3: DIFFERENCES IN STATE APPROACHES

States that suspend, rather than terminate, Medicaid enrollment during incarceration.



States with automated data exchange systems between health and criminal justice agencies.



Source: Kaiser Family Foundation, *States Reporting Corrections-Related Medicaid Enrollment Policies in Place for Prison or Jails*, February 2022.

MEDICAID AND REENTRY: RECENT AND POTENTIAL CHANGES

Efforts to better meet the health needs of Medicaid beneficiaries at reentry are increasing. Bipartisan federal legislation passed in 2018 required HHS to meet with stakeholders to develop best practices for transitioning Medicaid coverage for beneficiaries leaving incarceration and work with states to develop innovative transition practices.³⁰ It also required CMS to issue guidance to states identifying opportunities to design Section 1115 waiver proposals improving reentry transitions. The law requires this guidance to promote enrollment and provide services to Medicaid beneficiaries in the 30-day period prior to release.³¹ The guidance has not yet been issued by CMS, but multiple states have proceeded with proposed reentry waivers, as discussed below.

Interest in amending or repealing the Medicaid inmate exclusion, thereby allowing Medicaid to cover services *inside* correctional settings, has grown substantially over the past two years. As one of 15 priorities for improving the federal justice system, the Federal Priorities Task Force of the Council on Criminal Justice in 2020 called on HHS to “issue guidance on demonstration projects under Section 1115 of the Social Security Act to improve care transitions for soon-to-be formerly incarcerated persons who are otherwise eligible for Medicaid.”³² Some proposals currently under consideration by Congress, federal agencies, and states would amend, repeal, or waive the Medicaid inmate exclusion.

Federal legislation, the Medicaid Reentry Act, would revise Medicaid’s inmate exclusion to require that Medicaid cover services provided to eligible inmates for the 30-day period prior to release.³³ The legislation has been introduced in the House and Senate with bipartisan cosponsors, as well as support from a range of health care and criminal justice system stakeholders.³⁴ The Medicaid Reentry Act has passed the House twice in two years, most recently as part of the Build Back Better Act;³⁵ as of mid-March, the Senate had not voted on the legislation and its fate remained uncertain.³⁶ In addition to the Medicaid Reentry Act, other legislative proposals that have been introduced would either repeal or revise the inmate exclusion (see chart below).³⁷

On a separate track, multiple states are pursuing similar changes through Medicaid’s 1115 Waiver process. Nine states have submitted waiver proposals to CMS that would alter the inmate exclusion to provide pre-release coverage to some or all inmates.³⁸ Because the waiver process allows states to tailor their proposals, these nine proposals differ in several ways—including the number of days that coverage would be available pre-release, the groups of beneficiaries who would become eligible for coverage, and the services covered.³⁹ CMS has not yet acted on these proposals.

FIGURE 4: FEDERAL LEGISLATIVE PROPOSALS

Bill Title	Bill Number and Lead Sponsors	Summary of Major Provisions	Status (as of March 2022)
Medicaid Reentry Act	H.R. 955 (Tonko/Turner) S. 285 (Baldwin/Braun)	Amends the Medicaid inmate exclusion to require that Medicaid cover services provided to eligible incarcerated individuals during the 30-day period prior to release from prison or jail. Requires Report from Medicaid and CHIP Payment and Access Commission (MACPAC) on impact of changes.	Passed House as part of Build Back Better Act (H.R. 5376) on 11/19/2021; awaiting Senate action*
Due Process Continuity of Care Act	H.R. 6636 (Trone/Emmer) S. 2697 (Cassidy/Merkley)	Amends the inmate exclusion to give states the option of extending Medicaid coverage of services to eligible incarcerated individuals who are in custody pending disposition of charges. Authorizes \$50 million for planning grants to ten states to prepare for implementation.	Introduced in House (2/7/22) and Senate (8/10/21)
Humane Correctional Health Act	H.R. 3514 (Kuster/Fitzpatrick) S. 1821 (Booker)	Repeals the inmate exclusion, thereby requiring states to provide Medicaid coverage to all eligible incarcerated individuals for the duration of their incarceration. Requires a report from the Government Accountability Office (GAO) on impact of changes.	Introduced in House and Senate (5/25/21)

*The Medicaid Reentry Act provision in the Build Back Better Act omitted the MACPAC report.

Source: HARP Team analysis of federal legislation, www.congress.gov.

FIGURE 5: PENDING STATE MEDICAID 1115 WAIVERS

State	Eligibility	Service Provided Pre-Release	Coverage Initiation
Arizona	Inmates with serious behavioral and physical health conditions at high risk of experiencing homelessness upon release	Housing-related case management, tenancy supports, linkages with physical and behavioral health providers, medication	30 days prior to release
California	Inmates with complex health care needs, Substance Use Disorder (SUD), or mental health diagnosis	Enhanced care management and 30-day supply of medication	90 days prior to release
Kentucky	Inmates with an SUD diagnosis	SUD treatment services, medication management, Managed Care Organization (MCO) selection at 30 days prior to release	Throughout entire period of incarceration (including pre-trial)
Massachusetts	Adult Inmates with a chronic condition, mental health condition or SUD; all otherwise eligible youth in state custody (including in juvenile justice facilities)	Full set of Medicaid State Plan benefits	<u>Adults:</u> 30 days prior to release <u>Juveniles:</u> throughout the entire period of commitment
Montana	Inmates with SUD, Serious Mental Illness (SMI) or Serious Emotional Disturbance (SED)	Limited community-based clinical consultation services, in-reach care management services, and a 30-day supply of medication	30 days prior to release

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FIGURE 5: PENDING STATE MEDICAID 1115 WAIVERS (CONT.)

State	Eligibility	Service Provided Pre-Release	Coverage Initiation
New Jersey	Individuals with behavioral health diagnoses	Up to four (4) behavioral health case management visits	60 days prior to release
Oregon	All inmates	<p><u>Adults in Prison:</u> limited set of benefits (prescription drugs, navigation, transition services)</p> <p><u>Adults in Jails:</u> full set of Medicaid State Plan benefits</p> <p><u>Juveniles in Custody:</u> full set of Medicaid State Plan benefits</p>	<p><u>Adults in Prison:</u> 90 days prior to release</p> <p><u>Adults in Jails:</u> entire period of incarceration</p> <p><u>Juveniles in Custody:</u> entire period of incarceration</p>
Utah	Inmates with chronic physical or behavioral health condition, mental illness or an opioid use disorder	Full set of Medicaid State Plan benefits	30 days prior to release
Vermont	All inmates	Full set of Medicaid State Plan benefits	90 days prior to release

Source: Sweta Haldar and Madeline Guth, [State Policies Connecting Justice-Involved Populations to Medicaid Coverage and Care](#), Kaiser Family Foundation, December 2021, updated with HARP Project team analysis of Massachusetts and Oregon Waiver proposals, March 2022 based on information available on Medicaid.gov.

KEY IMPLEMENTATION ISSUES

The policy changes under consideration by the federal government and states would be groundbreaking. Medicaid has never before covered services that are provided to individuals during incarceration. And despite the efforts of some states and local jurisdictions, there are currently few touchpoints between the community health care system, which serves people post-incarceration, and the correctional health care system.

HARP was launched to help inform successful implementation of changes to Medicaid's role in this continuum. Implementing these changes will require engagement from a broad range of stakeholders and communication among officials at all levels of government and within the health and criminal justice sectors.

Champions of proposals to extend Medicaid coverage to incarcerated individuals prior to release are trying to achieve a set of goals through these policy changes, including:

- + fostering continuity of care between corrections and the community
- + reducing overdoses and promoting access to mental health services
- + lowering recidivism and furthering efforts to safely reduce prison populations
- + improving the lives of the individuals, families, and communities most impacted by incarceration and health disparities.⁴⁰

Achieving these goals will require overcoming significant disconnects between the health and criminal justice systems and developing policy and operational approaches that promote continuity of care. HARP has identified a preliminary set of five areas in which further development of policy and operational approaches could help advance successful implementation of changes to Medicaid's role at reentry. These areas were identified during interviews in January and February 2022 with a variety of stakeholders, including health care providers, researchers, advocates, formerly incarcerated people, and officials from law enforcement, the courts, and corrections. As a follow-up to those interviews, HARP is facilitating discussion among a wide group of these stakeholders during a March 2022 convening. HARP will use the results of that discussion to develop a second issue brief exploring the goals outlined below, as well as other implementation issues.

CREATING CONTINUITY OF CARE BETWEEN COMMUNITY AND CORRECTIONAL SERVICES

One of the key benefits of allowing Medicaid to cover services for incarcerated people prior to release is the opportunity to create greater continuity of health care for people leaving jail or prison. This continuity has historically been lacking, leaving significant gaps in care that are associated with poor health outcomes post-release. Building strong services at reentry may require stronger linkages between community and correctional providers, stronger approaches to maintaining Medicaid coverage at release, and development of stronger infrastructure, such as data sharing and electronic health records. The role of managed care organizations in overseeing and coordinating services

also needs to be developed. Finally, continuity may require an expanded workforce with specific skills to address the needs of incarcerated and recently released patients.

DESIGNING A BENEFIT PACKAGE AND ELIGIBILITY FOR SERVICES

It is unclear whether prisons and jails can or should provide the full scope of benefits required under state Medicaid programs. Correctional health care is not insurance coverage, and it is not known how the services that are provided today in correctional settings would measure up to Medicaid benefits, or which specific Medicaid-covered services should be provided to people prior to release.

Some have suggested that any federal Medicaid reentry legislation should limit pre-release Medicaid coverage to a subset of benefits such as case management and care coordination.⁴¹ This could help facilitate coordination of care as people re-enter communities, but would not significantly strengthen access to some services that are needed by many people to support a healthy return to the community. Those services include Medications for Opioid Use Disorders, treatment for other SUDs, COVID-19 testing, HIV treatment, and prescription drugs.

The current Medicaid waiver proposals under consideration by CMS take a range of approaches to many of the questions around extending Medicaid coverage to people while incarcerated. These questions include:

- + which services would be covered
- + which groups of eligible individuals would be covered pre-release
- + the period of time during which that coverage would be extended
- + how and whether specific consideration should be made for jail versus prison settings, and for juveniles in custody versus adults.

See Figure 5 for additional detail on these proposals.

AVOIDING UNINTENDED CONSEQUENCES IN THE CRIMINAL JUSTICE SYSTEM

Strengthening health care services at and before release has the potential to promote successful reentry. Reducing recidivism, in turn, reduces rates of crime and incarceration. This public safety potential is recognized by a broad range of stakeholders, from advocates for people who have experienced incarceration to law enforcement officials.⁴²

Some stakeholders, however are concerned that pre-release Medicaid coverage, and any resulting increase in the scope or quality of services provided inside correctional facilities, could unintentionally increase incarceration in some places. If judges or law

enforcement officials believe that treatment, particularly for behavioral health conditions, is more available or of higher quality in jails or prisons compared to community-based options, they may be more likely to incarcerate defendants in need of care.⁴³ Successful implementation will require active engagement with correctional officials, courts, law enforcement, and other key criminal justice system actors and organizations, as well as community health care providers, and alignment of new health policies with ongoing efforts to safely reduce the prison population.

ADDRESSING OPERATIONAL CONSIDERATIONS

Criminal justice and health systems have historically been distinct entities, a disconnection that will create operational challenges if and when Medicaid reentry policy changes are made, whether through legislation or waiver. Successful implementation will depend upon increased collaboration and dialogue between and across systems to resolve operational issues. The issues identified to date fall into three broad categories:

- + **Logistical considerations.** Some operational complexities relate to the timing and logistics of extending Medicaid coverage to an incarcerated population. These include questions about the appropriate pre-release coverage period (30 days, 90 days, other), how that period intersects with the determination of individuals' release dates, and how to improve eligibility and enrollment processes. Different approaches will be required for prisons and jails, given their different roles, populations, and release procedures.
- + **Operational structures and capacity.** Additional operational questions relate to the provision of care, and the structures needed to ensure that care is delivered at a high standard, paid for appropriately, and structured in a way that allows for smooth integration with care provided in the community. These challenges involve questions of provider accreditation; clinical decision-making and authority; the hiring, monitoring, governance, and oversight of service providers; physical space and standards; systems and capacity necessary to bill Medicaid for services; data sharing and exchange questions; and provider workforce capacity and burnout.
- + **System culture and alignment of goals.** Beyond the operational and logistical challenges surrounding implementation, there are major cultural differences and barriers between the corrections system and the community health system. These differences arise from the different underlying purposes, goals, needs, and priorities of each system, and they can both diverge and intersect when it comes to promoting individual and public health and safety. These differences require attention above and beyond the logistical and operational questions at play.

These and other questions will be explored in more depth during the March 2022 stakeholder convening and in the second HARP issue brief. Future phases of the project will include analyses of these operational, logistical, and cultural barriers as well as examinations of innovations and best practices that can have the greatest impact.

ENSURING EFFECTIVE USE OF NEW RESOURCES

A primary reason for Medicaid's inmate exclusion was the desire to prevent cost-shifting to the federal government from state and local governments. One implementation challenge will be ensuring that resources made available as a result of extended Medicaid coverage are reinvested rather than used by counties and states for other purposes. Putting new Medicaid policies into practice will require investments in new approaches, infrastructure, and capacity. These investments can support the provision of evidence-based services that improve peoples' health.

Conclusion

The broad bipartisan support for historic federal and state proposals to extend Medicaid coverage into correctional settings at reentry reflects the potential these changes hold to improve a range of outcomes for public health and public safety. Recent national crises, including the opioid epidemic and the COVID-19 pandemic, have demonstrated the costs of a fractured health care system. Both crises also have demonstrated how the disconnect between correctional and community health can further exacerbate daunting challenges. In a time of significant interest in the effectiveness and fairness of the criminal justice system, the potential of these changes to reduce recidivism and ease community reentry only adds to their appeal. Realizing that potential, and ensuring that new Medicaid reentry policies translate into effective practice will require collaboration and determination to overcome the longstanding divide between the health and criminal justice systems.

¹ *1115 Medicaid Waivers: From Care Delivery Innovations to Work Requirements*, The Commonwealth Fund, Apr. 6, 2018, <https://www.commonwealthfund.org/publications/explainer/2018/apr/1115-medicaid-waivers-care-delivery-innovations-work-requirements>.

² *Analysis of Recent Trends in Medicaid and CHIP Enrollment*, Henry J. Kaiser Family Foundation, January 2022, <https://www.kff.org/coronavirus-covid-19/issue-brief/analysis-of-recent-national-trends-in-medicaid-and-chip-enrollment/>.

³ Katherine Keisler-Starkey and Lisa N. Bunch, *Health Insurance Coverage in the United States: 2020*, U.S. Census Bureau, September 14, 2021, <https://www.census.gov/library/publications/2021/demo/p60-274.html>.

⁴ *Status of State Medicaid Expansion Decisions: Interactive Map*, Henry J. Kaiser Family Foundation, January 2022, <https://www.kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map/>.

⁵ *National Health Expenditures 2020 Highlights*, Centers for Medicare & Medicaid Services, . <https://www.cms.gov/files/document/highlights.pdf>.

⁶ *Provider Payment and Delivery Systems*, Medicaid and CHIP Payment and Access Commission, 2022. <https://www.macpac.gov/medicaid-101/provider-payment-and-delivery-systems/>.

⁷ *Quality, Safety & Oversight – Certification & Compliance*, Centers for Medicare and Medicaid Services, January 2022, <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc>.

⁸ Section 1115 is the section of Medicaid law, the Social Security Act, that provides HHS with the demonstration authority. https://www.ssa.gov/OP_Home/ssact/title11/1115.htm.

⁹ *1115 Medicaid Waivers: From Care Delivery Innovations to Work Requirements*, The Commonwealth Fund, Apr. 6, 2018, <https://www.commonwealthfund.org/publications/explainer/2018/apr/1115-medicaid-waivers-care-delivery-innovations-work-requirements>.

¹⁰ E. Ann Carson, *Prisoners in 2020 – Statistical Tables*, 2021. <https://bjs.ojp.gov/content/pub/pdf/p20st.pdf>.

¹¹ Todd D. Minton and Zhen Zeng, *Jail Inmates in 2020 – Statistical Tables*, 2021. <https://bjs.ojp.gov/content/pub/pdf/ji20st.pdf>.

¹² *Ibid.*

¹³ Camhi, Natasha, Mistak, Dan, and Wachino, Vikki. *Medicaid’s Evolving Role in Advancing the Health of People Involved in the Justice System*. November 18, 2020.

<https://www.commonwealthfund.org/publications/issue-briefs/2020/nov/medicaid-role-health-people-involved-justice-system>.

¹⁴ Natasha Camhi, Dan Mistak, Vikki Wachino, *Medicaid’s Evolving Role in Advancing the Health of People Involved in the Justice System*, The Commonwealth Fund, November 2020,

<https://www.commonwealthfund.org/publications/issue-briefs/2020/nov/medicaid-role-health-people-involved-justice-system#jailprison>.

¹⁵ U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics, *Probation and Parole in the United States*, December 2020. <https://bjs.ojp.gov/content/pub/pdf/ppus20.pdf>

¹⁶ Sickmund, M., Sladky, T.J., Puzzanchera, C., & Kang, W., *Easy Access to the Census of Juveniles in Residential Placement*, 2021. <https://www.ojjdp.gov/ojstatbb/ezacjrp/>.

¹⁷ Jeremy Travis, Bruce Western, and Steve Redburn, eds., *The Growth of Incarceration in the United States: Exploring Causes and Consequences* (Washington: National Research Council, 2014), 216, <https://www.nap.edu/read/18613/chapter/1>; Douglas C. McDonald, “Medical Care in Prisons,” *Crime and Justice* 26 (1999): 427–78, <http://www.journals.uchicago.edu/doi/abs/10.1086/449301>.

¹⁸ Wendy Sawyer and Peter Wagner, *Mass Incarceration: The Whole Pie 2020*, Prison Policy Project, March 2020. <https://www.prisonpolicy.org/reports/pie2020.html>.

¹⁹ *State Prisons and the Delivery of Hospital Care: How states set up and finance off-site care for incarcerated individuals*, Pew Charitable Trusts, July 2018, . <https://www.pewtrusts.org/en/research-and-analysis/reports/2018/07/19/state-prisons-and-the-delivery-of-hospital-care>.

²⁰ *Jails: Inadvertent Health Care Providers*, Pew Charitable Trusts, January 2018 <https://www.pewtrusts.org/en/research-and-analysis/reports/2018/01/jails-inadvertent-health-care-providers>.

²¹ *State Prisons and the Delivery of Hospital Care: How states set up and finance off-site care for incarcerated individuals*, Pew Charitable Trusts, July 2018, <https://www.pewtrusts.org/en/research-and-analysis/reports/2018/07/19/state-prisons-and-the-delivery-of-hospital-care>.

²² 42 U.S.C. Sec 1396d(a)(30)(A). [https://uscode.house.gov/view.xhtml?req=\(title:42%20section:1396d%20edition:prelim](https://uscode.house.gov/view.xhtml?req=(title:42%20section:1396d%20edition:prelim)

²³ Medicaid and Marketplace coverage also exclude coverage for services when someone is incarcerated, although their specific legal parameters differ from Medicaid’s inmate exclusion. See *Incarcerated and Recently Released Consumers*, Centers for Medicare and Medicaid Services, 2022.

<https://marketplace.cms.gov/technical-assistance-resources/incarcerated-and-recently-released-consumers.pdf>.

²⁴ Centers for Medicare and Medicaid Services, State Health Official Letter 16-007, *RE: To Facilitate successful re-entry for individuals transitioning from incarceration to their communities*, April 2016, <https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/Downloads/sho16007.pdf>.

²⁵ P.L. 115-271, The Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act of 2018, Sec. 1001, <https://www.congress.gov/115/plaws/publ271/PLAW-115publ271.pdf>.

²⁶ Centers for Medicare and Medicaid Services, State Health Official Letter 16-007, *RE: To Facilitate successful re-entry for individuals transitioning from incarceration to their communities*, April 2016, <https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/Downloads/sho16007.pdf>.

²⁷ *States Reporting Corrections-Related Medicaid Enrollment Policies In Place for Prisons or Jails*, Henry J. Kaiser Family Foundation, State Fiscal Year 2019, <https://www.kff.org/medicaid/state-indicator/states-reporting-corrections-related-medicaid-enrollment-policies-in-place-for-prisons-or-jails/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>.

²⁸ Jocelyn Guyer, Kinda Serafi, Deborah Bacharach, Alixandra Gould. *State Strategies for Establishing Connections to Health Care for Justice-Involved Populations: The Central Role of Medicaid*, Commonwealth Fund, January 2019, https://www.commonwealthfund.org/sites/default/files/2019-01/Guyer_state_strategies_justice_involved_Medicaid_ib.pdf.

²⁹ Sweta Haldar and Madeline Guth, *State Policies Connecting Justice-Involved Populations to Medicaid Coverage and Care*, Kaiser Family Foundation, December 2021, <https://www.kff.org/medicaid/issue-brief/state-policies-connecting-justice-involved-populations-to-medicaid-coverage-and-care/>; Gabrielle de la Gueronniere and Deborah Reid, *Utilizing Medicaid to Strengthen Access to Opioid and Other Substance Use Disorder Care Throughout the Criminal Legal System*, Legal Action Center, February 2022; State Health Access Data Assistance Center, *Targeting Justice-Involved Populations Through Medicaid 1115 Waiver Initiatives: Implementation Experiences of Three States*, https://www.shadac.org/sites/default/files/publications/Justice-involved1115-waiver-initiatives_01.2020.pdf; Wachino and Artiga, *How Connecting Justice-Involved Individuals to Medicaid Can Help Address the Opioid Epidemic*, Kaiser Family Foundation, 2019; <https://www.kff.org/medicaid/issue-brief/how-connecting-justice-involved-individuals-to-medicaid-can-help-address-the-opioid-epidemic/>

³⁰ P.L. 115-271, Sec. 5032, <https://www.congress.gov/115/plaws/publ271/PLAW-115publ271.pdf>.

³¹ U.S. Department of Health and Human Services, Meeting of Medicaid Reentry Stakeholder Group, August 2021, <https://youtu.be/auDN5IA7GhM>.

³² *Independent Task Force on Federal Priorities. Next Steps: An Agenda for Federal Action on Safety & Justice*. Washington, D.C.: Council on Criminal Justice, May 2020. <https://counciloncj.foleon.com/taskforce/federal-priorities/rec15/>

³³ US Congress, Senate, *Medicaid Reentry Act of 2021*, S.285, 117th Congress, 1st Sess, introduced February 8, 2021, <https://www.congress.gov/117/bills/s285/BILLS-117s285is.pdf>.

³⁴ Press release following introduction of the Medicaid Reentry Act of 2021. Baldwin, Braun, Whitehouse and Brown Lead Senate Introduction of Bipartisan Medicaid Reentry Act, February 10, 2021, <https://www.baldwin.senate.gov/news/press-releases/medicaid-reentry-act>.

³⁵ US Congress, House, *Build Back Better Act*, H.R. 5376, Section 30725, 117th Congress, 1st Sess, introduced in House September 27, 2021. <https://www.congress.gov/bill/117th-congress/house-bill/5376/text>.

³⁶ Michelle Cottle, *This Bill Could Save the Lives of Formerly Incarcerated People*, New York Times, December 20, 2021, <https://www.nytimes.com/2021/12/20/opinion/medicaid-reentry-act.html>.

³⁷ The Humane Correctional Health Care Act (H.R. 3514, Kuster/Fitzpatrick; S. 1821, Booker) would repeal the inmate exclusion entirely, and the Due Process Continuity of Care Act (H.R. 6636, Trone/Emmer; S. 2697, Cassidy/Merkeley) would give states the option to remove the inmate exclusion for inmates who are "in custody pending disposition of charges."

³⁸ A number of states proposed waivers of the inmate exclusion during the previous federal administration, but they did not move forward.

³⁹ Sweta Haldar and Madeline Guth, *State Policies Connecting Justice-Involved Populations to Medicaid Coverage and Care*, (Kaiser Family Foundation, December 2021) <https://www.kff.org/medicaid/issue-brief/state-policies-connecting-justice-involved-populations-to-medicaid-coverage-and-care/>.

⁴⁰ Press release following introduction of the Medicaid Reentry Act of 2021. Baldwin, Braun, Whitehouse and Brown Lead Senate Introduction of Bipartisan Medicaid Reentry Act, February 10, 2021, <https://www.baldwin.senate.gov/news/press-releases/medicaid-reentry-act>.

⁴¹ Letter from American Association of People with Disabilities, Autistic Self Advocacy Network, Bazelon Center for Mental Health Law, Center for Public Representation, Connecticut Justice Rights Project, Disability Rights Education and Defense Fund, National Association of County Behavioral Health and Developmental Disability Directors, National Disability Rights Network, National Health Law Program, New York Association of Psychiatric Rehabilitation Services to House Energy and Commerce Committee, February 22, 2021. <https://www.ndrn.org/wp-content/uploads/2021/02/2021-2-11-Medicaid-Reentry-provision-in-COVIDpackage.pdf>

⁴² Letter from more than 135 organizations to the Senate Finance Committee urging consideration of the Medicaid Reentry Act, June 2021, https://www.apha.org/-/media/Files/PDF/advocacy/letters/2021/210630_Medicaid_Reentry_Act.ashx

⁴³ HARP Team interviews with Stakeholders, January and February 2022.