



ISSUE BRIEF

Meeting the Moment:

Opportunities to Improve Health and Safety by Changing Medicaid's Role When People are Incarcerated

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February 2024

HARP

THE HEALTH AND REENTRY PROJECT



■ ABOUT HARP

The Health and Reentry Project (HARP) bridges gaps between the health and criminal justice systems to build safer and healthier communities. HARP works with local, state, and federal leaders, stakeholders, advocates, and people directly impacted by incarceration to advance policy that expands access to health care for millions of people leaving prisons and jails every year.

This issue brief expands on recent HARP publications analyzing the role that Medicaid can play in meeting the health needs of people as they return to communities after incarceration:

- ▶ [Paving the Path to Healthier Reentry: How New Medicaid Policies Can Improve Mental Health and Substance Use Support as People Return to Communities](#) (October 2023)
- ▶ [Breaking Ground: How California is Using Medicaid to Improve the Health of People Leaving Incarceration](#) (May 2023)
- ▶ [Redesigning Reentry: How Medicaid Can Improve Health and Safety by Smoothing Transitions from Incarceration to Community](#) (July 2022)
- ▶ [Medicaid and Reentry: Policy Changes and Considerations for Improving Public Health and Public Safety](#) (March 2022)

HARP has also posted a set of three reports led by HARP Executive Director Vikki Wachino and published by Viaduct Consulting LLC that recommend approaches to using Medicaid to cover opioid use disorder services in prisons and jails:

- ▶ [Recommendations for Medicaid Coverage of Opioid Use Disorder Services in Jails and Prisons](#) (October 2023)
- ▶ [Recommendations for Medicaid Performance Measures for Opioid Use Disorder Services in Jails and Prisons](#) (November 2023)
- ▶ [Recommendations for Medicaid Payment Models for Opioid Use Disorder Services in Jails and Prisons](#) (January 2024)



■ ACKNOWLEDGEMENTS

The Health and Reentry Project is grateful to Arnold Ventures, which provided support for this issue brief, and to David Ryan, senior policy advisor of the Middlesex County Sheriff's Office and Strategic Advisor to HARP, and Adam Gelb, president and CEO of the Council on Criminal Justice, for their review of the brief. The authors are responsible for the information and findings contained in this issue brief.



■ INTRODUCTION

More than 440,000 people returned to communities from prisons in 2021,¹ and roughly 7 million people entered jails in 2021, many of whom returned to communities within a month.² Despite years of advances in reentry approaches and historically high rates of health coverage in the U.S., many people leave prison or jail with few health supports. People who are returning to their communities fall into gaps between the health care and criminal justice systems and are often left to navigate a fragmented patchwork of services on their own. As a result, health and public safety outcomes following release are extremely poor, despite a significant investment of public sector resources.

For the first time, Congress, the administration of President Joe Biden, and states are trying to break down these barriers and create continuity of care at reentry. New policies, carried out through state Medicaid waivers and federal statutory changes, allow states to use Medicaid to cover some services provided when people are incarcerated. The waiver changes, which have been in the works for several years, make it possible for states to use Medicaid to cover some services immediately before a person is released from prisons and jails both need to be plural to be consistent with youth facilities. Additionally, statutory changes Congress enacted in 2022 authorize Medicaid to cover services for youth during the pretrial period and require Medicaid to cover some services for youth at reentry. These changes take effect nationally starting in 2025. Congress is also considering legislation to make additional changes to Medicaid's role when people are incarcerated. These reforms have gained bipartisan, cross-sector support in the last decade, reflecting policy interest in improving public safety, the criminal justice system, racial equity, health outcomes, and access to mental health and substance use treatment.

NEW MEDICAID REENTRY POLICIES: OPPORTUNITIES AND CHALLENGES

Changing Medicaid policy is an opportunity to systematically strengthen reentry at a local, state, and national scale. Research shows that strong connections to health care through Medicaid and other services at reentry can improve health; reduce crime, recidivism and reincarceration; support successful reintegration; and potentially reduce spending in the justice system. The recent changes also provide an opportunity to improve both the quality of and access to some services that are provided in prisons and jails.

However, making these policy changes successful is extremely complex. It requires bridging health care and correctional systems and the government agencies that oversee them, which historically have not interacted and operate in vastly different ways. Standards of care and accountability structures between these systems differ considerably and vary even within the correctional system itself. The policy changes also shift financial responsibility for some services from state and local governments to the federal government.



The Health and Reentry Project, a cross-sector initiative to improve the health of people returning to communities after leaving prisons and jails, produced this issue brief to describe the health care needs of people who are incarcerated, the evolution of Medicaid's role in covering services when people are incarcerated, recent policy reforms, and the cross-sector goals that those reforms seek to advance. The brief closes by discussing the most significant implementation issues that must be tackled to translate these new policies into strong service provision and takes into account the perspective, context, and aims of both the health and the criminal justice systems and makes meaningful improvements to people's health and lives and to public safety. The brief focuses on the needs of people who have been incarcerated, reflecting the emphasis of the current Medicaid policy changes, but recognizes that investments in services for people who have been victims of crime are also needed.

HARP published a companion paper to this issue brief, [*From Policy to Practice: Seizing the Moment to Transform Health and Reentry*](#), which synthesizes the perspectives of cross-sector stakeholders on implementing new Medicaid and reentry policy changes.

The importance of addressing the needs of people who are incarcerated as they return to communities

Reentry is a high-risk moment for peoples' health, and people leaving incarceration would benefit from stronger connections to services as they return to communities after periods of incarceration.

- ▶ **People who are incarcerated have high rates of many physical and behavioral health conditions.** These conditions include higher rates of mental health disorders, substance use disorders, and chronic issues such as asthma, diabetes, and heart disease than are experienced by the general population.^{3,4,5} Because of the significant racial disparities in the correctional system,⁶ these problems disproportionately impact incarcerated people of color.

KEY STATISTICS ON HEALTH AND INCARCERATION

- ▶ An estimated **40%** of people incarcerated in prisons and jails reported currently having a chronic medical condition and about **50%** reported ever having a chronic medical condition, as compared to **27%** and **31%** of the standardized general population, respectively.⁷
- ▶ About **66%** of people incarcerated in prisons and **40%** in jail with a current chronic condition reported currently taking prescription medication.⁸
- ▶ An estimated **37%** of adults incarcerated in prisons and **44%** in jails had a previous mental health condition, with rates higher for women than for men.⁹
- ▶ Approximately **70%** of youth incarcerated in youth correctional facilities have a mental health condition, compared to only **9%** to **22%** of the youth in the general population.¹⁰
- ▶ An estimated **63%** of people incarcerated in prisons and **58%** in jails meet criteria for a substance use disorder.¹¹



High rates of physical and behavioral health conditions in prisons and jails are the product of a range of personal and social factors. These include laws about what activities are criminalized and how those laws are enforced. For example, laws about illicit drug use are associated with higher incarceration rates for people with substance use disorder. At times, health and behavioral health conditions go untreated in the community. Lack of access to physical and mental health services means that the community misses opportunities to address risk factors, making it more likely that people become involved with the justice system.

Incarceration itself can have many negative impacts on health, including worsening mental health and chronic health conditions.¹² People who are incarcerated may face traumatizing conditions, such as solitary confinement, overcrowding, and violence, as well as a lack of access to adequate health care. Some people with serious mental illness who are incarcerated receive treatment and services, but others may experience harsh environments that make their symptoms worse, face a lack of resources to care for them, and live in settings that were not designed for their needs.¹³ Medications for people with a range of conditions — including asthma, diabetes, and serious mental illness — are underused in prisons and jails,¹⁴ and failure to connect people with serious mental illness to needed medications has been associated with suicide attempts in jails.¹⁵ The Louisiana Death Behind Bars project found that many prison deaths in the state are attributable to medical conditions, as well as suicide and overdose.¹⁶

- ▶ **Reentry is a high-risk time that is often associated with poor health outcomes.** One study estimated that people who are formerly incarcerated are over 12 times more likely to die than other people in the two weeks following release, from causes that include heart disease, homicide, suicide, and cancer.¹⁷ Death by overdose is a particular risk, with estimates of overdose death rates ranging from 40 to 120 times that of the general population, depending on the study and location.^{18, 19} Hospitalizations and emergency room use are also higher for people in the weeks immediately following release from prison or jail than they are for the general population.^{20, 21} Rates of accessing outpatient medical care, including treatment, are low.²² Failing to meet the health care needs of people as they return from periods of incarceration hinders their ability to get back on their feet.

BARRIERS TO MEDICAID COVERAGE FOR PEOPLE WHO ARE INCARCERATED

The Medicaid program can be a key lever to improving the health of people who are incarcerated. Despite high rates of Medicaid eligibility among the incarcerated population, policies of exclusion have prevented them from receiving benefits. These federal policies are starting to change, following a period of more incremental improvements.



- ▶ **Most people who are incarcerated are eligible for Medicaid.** They disproportionately earn low incomes prior to incarceration and earn little to no money while incarcerated, so the vast majority qualify for Medicaid benefits as they return to their communities.²³ People who qualify for Medicaid prior to incarceration remain eligible while inside, but the statutory “inmate exclusion” prevents Medicaid from paying for services other than inpatient hospital stays during incarceration. Congress established this exclusion when it created Medicaid in 1965,²⁴ and it has prevented the federal government from contributing to what has historically been a state and local financial obligation.
- ▶ **Expansions of health care coverage and the growth of incarceration has prompted health and criminal justice leaders to reconsider the “inmate exclusion.”** When this exclusion was established, both the Medicaid program and the correctional system were much smaller than they are today, limiting the exclusion’s impact.^{25, 26} For most of Medicaid’s history, relatively few people who were incarcerated qualified for Medicaid, because Medicaid eligibility was generally limited to children, seniors, people with significant disabilities, pregnant women, and parents with very low incomes. This changed in 2014 when the Affordable Care Act (ACA) expanded Medicaid eligibility to low-income adults. Many more people, including those involved in the justice system, became eligible for Medicaid due to the ACA, which also required significant expansions in mental health and substance use benefits. Currently, 41 states have adopted Medicaid expansion, which a Supreme Court ruling made optional for states in 2012.²⁷
- ▶ **States have made incremental changes to connect people to Medicaid coverage at release, but until 2023 the “inmate exclusion” remained intact.** The expansion of coverage through the ACA generated stronger interest on the part of state and federal Medicaid officials in using Medicaid to meet the health needs of people in the justice system. Since 2014, federal and state governments have adopted incremental policy and operational reforms to strengthen connections to health services at reentry. In 2016, the Centers for Medicare and Medicaid Services (CMS), the federal agency that administers Medicaid, issued policy guidance reinterpreting federal law as authorizing Medicaid to cover services in many community correctional settings.²⁸ Most states have tried to make Medicaid eligibility more continuous by temporarily placing a person’s Medicaid coverage in suspended status rather than terminating it altogether when they become incarcerated.²⁹ In 2018, building on this reform, Congress required states to suspend, rather than terminate, Medicaid coverage for youth in the correctional system.³⁰ States are increasingly requiring Medicaid managed care organizations (MCOs), which deliver services to beneficiaries, to provide care coordination to people before they leave prisons. A third of all states that use managed care impose such requirements. Finally, a few states have launched initiatives to use Medicaid to connect people to housing and employment services after they leave prison or jail.³¹




▶ **Interest by correctional officials in leveraging Medicaid has grown, driven in part by interest in improving mental health and substance use services.** At the same time that these Medicaid policies were developed, correctional and criminal justice officials became more interested in finding ways to better meet the health needs of people in the justice system. Because people with mental health and substance use conditions are incarcerated at high rates, prisons and jails have come to play a major role in providing treatment services — although how and whether they meet people’s needs varies significantly across facilities.^{32, 33} Some correctional and criminal justice officials have launched treatment programs in prisons and jails or are developing reentry plans that include needs assessments and efforts to create continuity of care upon release. A large majority of state prisons reported in 2016 that they offered medications and referrals to mental health services to some or all people as they left prison.³⁴ Some are also offering services for substance use disorder; nearly a third of jails reported offering some form of medication for opioid use disorder.³⁵ Gaps in Medicaid coverage can make it challenging to coordinate care between correctional and community providers as people prepare to return from periods of incarceration. For example, providers may be reluctant to book appointments for people post-release if they do not have active coverage.

BARRIERS THAT PERSIST BETWEEN THE HEALTH AND CRIMINAL JUSTICE SYSTEMS

Over the past 10 years, many states and the federal government have made modest improvements, including focusing on facilitating Medicaid enrollment post-release. However, significant barriers still stand in the way of providing strong continuity, access, and quality of care.

▶ **States have made incremental progress in getting or keeping people who are incarcerated enrolled in Medicaid coverage, but they have not achieved seamless coverage.** Some states that made efforts to enroll people in Medicaid pre-release have achieved high coverage rates, and some reported associated cost savings. But in a 2019 study of four states that were leading efforts to connect people to Medicaid coverage and opioid use disorder treatment at release, officials reported technological hurdles to establishing automated processes, administrative challenges, and difficulty predicting release dates.³⁶ In a separate examination of eight states that had undertaken initiatives to connect people to services at release through Medicaid MCOs, state officials reported that gaps in coverage at release persisted due to problems sharing information across health and correctional settings, and in one state across counties.³⁷ Reinstatement of full benefits at release may take so long that people experience coverage lapses at release. These coverage lapses can affect care coordination between carceral and community providers as people prepare to leave incarceration: for example, providers may be reluctant to book appointments for people post-release if they do not have active coverage. Even in states



that suspend coverage, suspension processes do not necessarily apply to all prisons or jails within the state, since each facility may operate its own separate system.³⁸ Fewer than half of states use automated systems to transmit enrollment and release information between prisons and jails or state and county agencies that review Medicaid eligibility.³⁹ This challenge has likely meant that people leaving the justice system have lower rates of health insurance coverage than other people.

- ▶ **Even when people have continuous coverage, they can face service gaps.** While states have taken steps toward connecting people to services at release, they have also identified gaps. Some officials in states with Medicaid coverage for opioid use disorder treatment during reentry reported that a lack of Medicaid funding for assessment and care coordination made it hard to provide services.⁴⁰ Absent Medicaid coverage, state and local governments bear the cost of connecting people to services on their own. For that reason, states may gravitate toward lower-cost options and approaches whose costs can be borne by their MCOs. States also described several barriers to continuity of care, including unpredictable release dates, difficulty accessing facilities, geographic differences between a release location and where a beneficiary lives post-release, not having accurate contact information for beneficiaries post-release, and social challenges such as lack of access to transportation and housing.⁴¹
- ▶ **The divide between the health and criminal justice systems is difficult to bridge.** The major divide between the health and criminal justice systems drives the lack of continuity and access that people experience during reentry. Historically, most corrections administrators perceived their responsibility to a person who is incarcerated as ending when that person walked out of prison or jail. Meanwhile, Medicaid administrators viewed the program's responsibility as ending when a person entered a correctional facility, and then picking up again at some point post-release. Because there have historically been few active efforts to serve people after they return from periods of incarceration, "post-release" can mean that the health system's next interaction with a person occurs weeks, months, or even years later, when Medicaid pays a hospital bill. Maintaining separate administrative structures and financing systems widens this divide and leaves each system with little incentive to collaborate, much less to invest in the underlying staffing, infrastructure, and policies needed to bridge this divide and support people during reentry. Policy decisions and political priorities have not historically dedicated resources to people returning from periods of incarceration.



■ HOW MEDICAID POLICY IS CHANGING TO ALLOW COVERAGE OF SOME SERVICES DURING INCARCERATION

At the federal level, policymakers are changing Medicaid’s role both legislatively and administratively. Initially, these changes focused on starting Medicaid coverage of some services immediately prior to a person’s release from prison, jail, or a youth correctional facility.⁴² More recent changes have expanded Medicaid’s role at reentry specifically for youth, including by allowing some services to be covered for youth who are incarcerated but whose cases are pending disposition.


▶ **CMS is allowing Medicaid to cover pre-release services through demonstration waivers in some states.** In 2018, as part of legislation to address the opioid epidemic, Congress required CMS to issue guidance for states on how to improve people’s transitions from incarceration to the community using Medicaid demonstration waivers.⁴³ CMS issued this guidance in 2023, announcing that it would waive Medicaid’s “inmate exclusion” to allow state Medicaid programs to cover a specific set of services for up to 90 days before a person’s anticipated release date from incarceration.⁴⁴ For a limited time, CMS also offered states the opportunity to apply for funding to support hiring and training staff, as well as to develop new processes and systems. Additionally, states have a continuing opportunity to obtain a favorable Medicaid matching rate as they develop, implement, and operate information technology systems to support the implementation of the new policies.

MEDICAID REENTRY DEMONSTRATION WAIVERS: GOALS AND COVERED SERVICES

Medicaid reentry demonstration waivers aim to use Medicaid coverage to build a bridge between a person’s period of incarceration and their release into the community. The new policy starts by providing targeted services before a person is released and strengthens connections to the comprehensive Medicaid benefits available post-release. CMS set specific health care goals for the policy: “increase coverage, continuity of coverage, and appropriate service uptake” prior to release; improve access to services and transitions, coordination, communication, and connections between correctional and community settings; increase investments in health care to improve quality; and reduce post-release deaths, hospitalizations, and emergency department visits.⁴⁵

In its guidance, CMS set a floor of three pre-release services that states taking up waivers must cover:

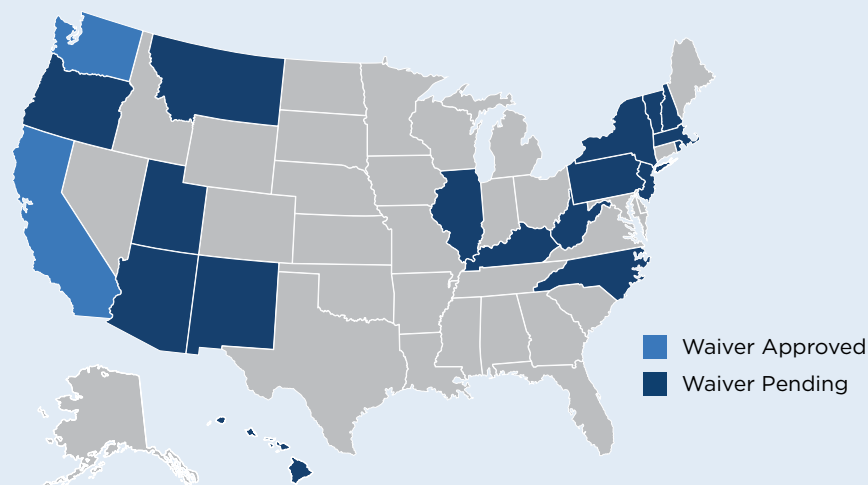
- ▶ case management for physical, behavioral health, and health-related social needs such as housing;
- ▶ medication-assisted treatment (MAT) for people with substance use disorders; and
- ▶ provision of a 30-day supply of all prescription medications upon release.



These services are likely to be especially beneficial to people with behavioral health and substance abuse conditions, for whom case management, MAT, and medication continuity are important.⁴⁶ States can go beyond this benefits floor, define which specific groups of incarcerated Medicaid or CHIP beneficiaries are eligible for services, and determine which correctional facilities provide Medicaid-covered pre-release services, as well as whether services are provided by community or correctional providers.

- ▶ **States must also build a plan to reinvest savings.** CMS requires states to submit a reinvestment plan, to be approved by the agency, agreeing that any federal funds that replace pre-existing state and local funding for correctional services will be reinvested to increase access to and continuity of care.⁴⁷ CMS also requires that states promote enrollment in Medicaid among people who are incarcerated by helping those who are eligible to apply for and renew coverage, by suspending rather than terminating Medicaid benefits when people are incarcerated, and by reactivating coverage at the time of release.
- ▶ **CMS has approved two states' reentry waivers, and 17 additional states have proposed waivers.** State interest in taking up reentry waivers has been unusually strong. As of February 2024, 19 states have submitted waiver proposals to CMS. In January 2023, CMS approved California's waiver proposal, which modestly exceeds the floor that CMS set in its waiver guidance. California is currently implementing its new policies, and they will gradually begin to take effect starting in October 2024. In June 2023, CMS approved Washington State's reentry waiver proposal, which contains the same elements as California's but makes pre-release services available to all incarcerated Medicaid beneficiaries rather than limiting them to beneficiaries with specific health conditions. It also "tiers" some of the benefit requirements, allowing correctional facilities to decide which tier to implement. Washington plans to implement the waiver in 2025. Meanwhile, CMS is reviewing 17 additional waivers over the coming year. The specifics of the proposals vary, but all prioritize people with behavioral health needs.⁴⁸

States with approved or pending Medicaid reentry waivers, as of February 2024






- ▶ **Congress has also made the first statutory changes to Medicaid’s “inmate exclusion,” which affect youth.** In 2022, Congress enacted the first nationwide changes to Medicaid’s role in corrections as part of the Omnibus Consolidated Appropriations Act of 2023. This act requires all states to cover screenings, diagnostic services, and case management for incarcerated youth during the pre- and post-release periods and gives states the option to use Medicaid to cover some services for youth who are incarcerated pretrial. These policy changes apply to all youth under age 21 as well as former foster care youth, who remain eligible for Medicaid until they reach age 26. When they take effect in January 2025, the changes will affect youth who are in state prisons and jails in addition to those in youth correctional and other facilities. As of January 2024, CMS had not issued implementation guidance, and it is unclear whether the policy requirements that CMS established in its waiver guidance, such as reinvestment requirements, will apply to the youth provisions.

POTENTIAL ADDITIONAL LEGISLATIVE REFORMS

Congress is demonstrating continued interest in expanding Medicaid’s role by considering broader changes to the program’s “inmate exclusion.” As of early 2024, Congress has been discussing two additional pieces of legislation:

- ▶ **The Reentry Act** would revise the “inmate exclusion” to require that Medicaid cover services provided to eligible people who are incarcerated in all states for the 30-day period prior to release. The legislation has been introduced in the House and Senate with bipartisan cosponsors. The bill, which was previously called the Medicaid Reentry Act, passed the House three times in prior Congresses, but the Senate did not pass it. The Reentry Act has yet to advance in the current Congress, but the bill – or a modified version of it – is under discussion as part of this year’s reauthorization of the Substance Use Disorder Prevention That Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act of 2018.
- ▶ **The Due Process Continuity of Care Act** would amend the “inmate exclusion” to give states the option to cover health care services through Medicaid for people who are detained pretrial, which includes the majority of people in jail. This bill also has bipartisan cosponsors and would build on the state option that Congress passed in 2023 to provide services to youth who are detained pretrial. Congress may also include a version of the Due Process Continuity of Care Act in a SUPPORT Act reauthorization. The reauthorization bill passed by the House includes a similar provision that pertains only to pregnant women, while the version passed by the Senate Finance Committee includes a provision that grants seven days of coverage to people with a diagnosed substance use disorder.



Some members of Congress have made more far-reaching proposals. [The Humane Correctional Health Care Act](#) would end the Medicaid “inmate exclusion,” meaning that Medicaid and CHIP would cover health services for eligible people who are incarcerated throughout a prison or jail stay, a major financing shift. Additional legislation, the [Rehabilitation and Recovery During Incarceration Act](#), would create an option for states to provide Medicaid coverage for mental health and substance use services throughout a person’s incarceration.

It is not entirely clear how much these new policies would cost the federal government. In 2021, the Congressional Budget Office (CBO) estimated the additional spending that would result from the Medicaid Reentry Act at \$3.7 billion over 10 years, or about \$400 million each year.⁴⁹ This is relative to the \$594 billion that the federal government spent on Medicaid last year.⁵⁰ CBO’s estimates do not account for any potentially offsetting reductions to criminal justice spending. The CBO has not yet officially estimated the cost of the Reentry Act currently pending before Congress, nor scored the Due Process Continuity of Care Act.⁵¹ Because it is much more extensive than the Reentry Act, the Humane Correctional Health Care Act will likely cost significantly more than the Reentry Act, although the CBO has not scored it. Lack of available information about spending on health care services in prisons and jails challenges the development of robust estimates of the spending impact of changing Medicaid policy in this area.

HOW MEDICAID POLICY CHANGES SUPPORT THE GOALS OF HEALTH AND JUSTICE SYSTEM LEADERS

The priorities and policy objectives of leaders in the health and justice systems have driven interest in allowing Medicaid to cover some services provided in prisons, jails, and youth correctional facilities.

- ▶ **Health care officials wish to expand earlier efforts to develop services for people involved in the justice system.** State officials who have led efforts to use Medicaid to provide people with services during reentry argue that these services would be stronger if they begin prior to release rather than after the fact. They also suggest that using Medicaid financing would provide a more continuous and less fragmented source of support for reentry than grant or state and local funding can alone. Some officials point out that Medicaid often incurs costs after people are released, such as from avoidable hospital and emergency room use, and those costs could be better managed if Medicaid were able to identify and meet a person’s health needs prior to release.⁵²



- ▶ **Criminal justice officials wish to address public safety and provide a new, ongoing financing source for some correctional health care services.** Many correctional and law enforcement leaders see a connection between health care access and public safety. This belief has led to a broad coalition of public safety officials who advocate for eliminating or amending the “inmate exclusion.” The National Sheriffs’ Association, the National Association of Counties, and other groups have advocated for modifying the “inmate exclusion” as a measure to improve public safety and help local governments better manage spending associated with incarceration.⁵³
- ▶ **Policymakers want to broaden access to substance use services in correctional settings.** As the toll of the opioid epidemic continues to grow, policymakers have expressed an increasing interest in strengthening access to substance use treatment in prisons and jails. People with substance use disorder are incarcerated at high rates, overdose death rates in prisons⁵⁴ and jails⁵⁵ have increased, and few prisons or jails provide access to MAT,⁵⁶ although the number of facilities doing so is growing.^{57, 58, 59}
- ▶ **Policymakers seek ways to address racial disparities, advance public health, and improve quality of care in correctional settings.** In recent years, public awareness about racial disparities in both incarceration rates and access to health care services has grown. During the COVID-19 pandemic, public recognition of the high rates of viral transmission and deaths in prisons and jails, along with the racial justice protests during and after 2020, spurred interest from policymakers in better addressing the health care needs of people who are incarcerated.⁶⁰ Legislative activity on the Medicaid Reentry Act increased in 2020 and 2021.⁶¹ More recently, policymakers have expressed greater interest in leveraging Medicaid to expand access to services prior to, during, and after incarceration, describing these policies as a way to address health-related social needs.⁶²

ESSENTIAL ELEMENTS OF EFFECTIVE MEDICAID REENTRY POLICY IMPLEMENTATION

Effective implementation of the new Medicaid policies will determine how fully they realize their potential to improve people’s lives, strengthen public safety, and use public resources more effectively. By working collaboratively across federal, state, and local governments, officials can help build systems that more effectively connect people to services, improve outcomes, and prevent future justice system involvement. The essential elements of effective implementation are as follows:




▶ **Bridge the longstanding divide between the health and criminal justice systems.**

Authorizing Medicaid to cover some services in prisons and jails requires collaboration between two different systems to change the practice and culture around reentry. The health and criminal justice systems have very little history of collaboration — or even interaction. Few community-based health care providers maintain active relationships with prisons and jails. There is little shared infrastructure or common understanding of terms. One central difference is that the financing of Medicaid and other health insurance programs is designed to ensure that all beneficiaries who meet eligibility, clinical, or medical necessity criteria receive services, whereas in many correctional settings, service availability is instead determined by available resources. Because of these differences, a significant risk exists that the new Medicaid policy changes could merely shift financing from one level of government to another, which would fall short of the potential benefits. To overcome these risks, officials must bridge major differences between their mission, culture, goals, process, administration, oversight, and operations. Both health and criminal justice entities need to be actively involved in developing, implementing, and overseeing the new policies. States and local governments should build formal and informal coordination mechanisms that build cross-system understanding and encompass policy development, system implementation, and governance and include input from all involved entities, stakeholders, and the public, including people with direct experience of incarceration.⁶³

▶ **Accommodate variations in correctional settings and health care provision.** The correctional system is highly federated.⁶⁴ There are approximately 2,000 state and federal prisons and 3,000 jails.⁶⁵ Prisons and jails play very different roles in the criminal justice system, are managed and overseen at different levels of government, and are characterized by key operational differences that may challenge the effective application of new federal policies. For example, new Medicaid policies establish specific pre-release service coverage time periods, such as allowing Medicaid coverage 30 or 90 days prior to release. These time periods do not take into account key differences between state and federal prisons, local jails, and youth correctional facilities, such as significant differences in lengths of stay and challenges establishing expected release dates, especially in jails, where release typically is determined by the outcome of a court proceeding. State officials implementing new policies should develop approaches to release dates that accommodate the circumstances and needs of different settings. These approaches should be developed with input from prison and jail administrators, health care providers, courts, and law enforcement, among others, to determine feasibility and ensure that establishing release dates does not inadvertently prolong incarceration.

▶ **Address major differences in health care quality and access standards.** Medicaid, like other health insurers, has a set of established programmatic, service, and coverage standards. Applying these standards to some services in a correctional setting has the potential to increase their quality and broaden access. It can also improve accountability by increasing state and federal oversight of health care services provided in state prisons and local jails. Current accountability mechanisms are limited. But bringing correctional services



into alignment with the standards that have previously only applied in community health care settings will require significant effort and attention and could be a source of tension between Medicaid agencies and prisons and jails. Health and justice system officials must be careful when translating Medicaid standards into a correctional setting, doing so in a way that accounts for security concerns, high turnover rates, short jail stays, the inherent unpredictability of prison and jail settings, and other factors. Officials should develop structures to ensure that the system delivers care at a high standard, pays for it appropriately, and integrates it with community-based services. Developing these structures involves clarifying questions about provider accreditation, clinical decision-making and authority, monitoring, and governance. The underlying goal is that officials provide health care services according to clinical standards; historically, clinical needs have taken a back seat to safety and security concerns and other correctional priorities in prisons and jails.

CORRECTIONAL HEALTH CARE STANDARDS

Governments have a constitutional mandate to provide people in prisons and jails with health care. The 1976 Supreme Court case *Estelle v. Gamble*⁶⁶ found that deliberate indifference to the medical needs of people who are incarcerated constitutes a violation of the Eighth Amendment prohibition on cruel and unusual punishment. However, beyond this minimum threshold, there is no commonly accepted standard of care for prisons or jails. Methods of health care delivery, amounts spent on health care, and the quality of care provided vary widely across facilities and on the whole differ from those provided in the community. States and counties finance services on their own and 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.⁶⁷ There is little transparency in information about health care services and outcomes.

- ▶ **Address feasibility and administrative challenges.** Covering Medicaid services requires governments and correctional facilities to develop systems for billing, coding, and documentation, which have not yet been built in many correctional settings. It is also unclear how many correctional facilities use electronic health records. Data and systems need to be upgraded and expanded to share enrollment and patient clinical information and accord with rules regarding privacy of information. Governments and correctional facilities must develop approaches to minimizing administrative burdens while also promoting accountability and service provision. One key challenge will be overcoming physical environments that were designed to restrict movement rather than to facilitate care. Today, both corrections and health care workforces face high vacancy rates, and states must increase staffing and training of health care and correctional professionals in order to meet these demands.



- ▶ **Ensure access to community services post-release.** After people are released from periods of incarceration, they should have immediate access to the community health and behavioral health services they need, so that the services they receive pre-release connect to robust and comprehensive services post-release. State and local governments, as well as insurers, must devote specific attention to ensuring that these services are available and that providers are trained, capable, and paid adequately to meet the behavioral health, chronic health, and criminogenic needs of people who have been incarcerated.
- ▶ **Coordinate and communicate with law enforcement, courts, and probation and parole systems.** State Medicaid and corrections officials must work actively with law enforcement and courts to ensure that they are aware of new services available in prisons and jails and in the community. Close engagement is necessary to help ensure that these new policies reduce reliance on the justice system by connecting people to the services they need, both in the community and in correctional settings. Without close coordination and communication, there is a risk that courts and parole boards will see prisons and jails as more available sources of treatment than community-based service providers.
- ▶ **Build staffing, data systems, and other implementation infrastructure.** In addition to Medicaid financing some services provided in prisons and jails, state and local governments will need to dedicate resources to building capacity and infrastructure to provide those services in alignment with Medicaid standards. Additional staff, information-sharing systems, and other services, as well as physical changes to facilities, may be needed.⁶⁸ Two federal mechanisms that states can use to fund capacity and infrastructure related to waiver implementation are CMS transitional implementation resources and reinvestment plans. State and local funding and philanthropic resources could also be used to develop the capacity needed to implement waivers or other reforms.

Additional elements of effective implementation are emerging from the efforts of health and criminal justice leaders. In July 2023, HARP held a cross-sector convening to discuss and evaluate implementation priorities for the new Medicaid policies. HARP synthesized stakeholder perspectives offered at that convening on how to implement new policies in [*From Policy to Practice: Seizing the Moment to Transform Health and Reentry*](#).



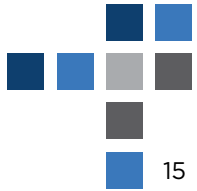
■ CONCLUSION

Newly issued Medicaid and criminal justice policies present a first-of-its-kind opportunity to address the health needs of people who have been incarcerated. These policies offer a major new lever to advance public safety by systematically building stronger reentry approaches across the country and ensuring that people can access the care they need, when and where they need it. They have the potential to advance key health and justice system goals, improve outcomes for people and communities, and produce offsetting savings by reducing health care, justice system, and broader social costs. Realizing these goals requires active, ongoing, and unprecedented collaboration between health and criminal justice system actors, both inside and outside of government, and sustained attention and commitment to implementation as these complex systems are brought together for the first time.



REFERENCES

- 1 Carson, E.A. (2022). *Prisoners in 2021—Statistical Tables*. U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics.
<https://bjs.ojp.gov/sites/g/files/xyckuh236/files/media/document/p21st.pdf>
- 2 Zeng, Z. (2022). *Jail Inmates in 2021—Statistical Tables*. U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics.
<https://bjs.ojp.gov/sites/g/files/xyckuh236/files/media/document/ji21st.pdf>
- 3 Maruschak, L.M. & Berzofsky, M. (2016). *Medical Problems of State and Federal Prisoners and Jail Inmates, 2011-12*. U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics.
<https://bjs.ojp.gov/content/pub/pdf/mpsfpj1112.pdf>
- 4 Bronson, J. & Berzofsky, M. (2017). *Indicators of Mental Health Problems Reported by Prisoners and Jail Inmates, 2011-12*. U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics.
<https://bjs.ojp.gov/content/pub/pdf/imhprpj1112.pdf>
- 5 Bronson, J., Stroop, J., Zimmer, S., & Berzofsky, M. (2017). *Drug Use, Dependence, and Abuse Among State Prisoners and Jail Inmates, 2007-2009*. U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics.
<https://bjs.ojp.gov/content/pub/pdf/dudaspi0709.pdf>
- 6 Sabol, W.J. & Johnson, T.L. (2022). *Justice System Disparities: Black-White National Imprisonment Trends, 2000 to 2020*. Council on Criminal Justice.
<https://counciloncj.foleon.com/reports/racial-disparities/>
- 7 Maruschak, L.M. & Berzofsky, M. (2016). *Medical Problems of State and Federal Prisoners and Jail Inmates, 2011-12*. U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics.
<https://bjs.ojp.gov/content/pub/pdf/mpsfpj1112.pdf>
- 8 Ibid
- 9 Bronson, J. & Berzofsky, M. (2017). *Indicators of Mental Health Problems Reported by Prisoners and Jail Inmates, 2011-12*. U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics.
<https://bjs.ojp.gov/content/pub/pdf/imhprpj1112.pdf>
- 10 Youth.gov. (n.d.). *Youth Involved with the Juvenile Justice System*.
https://youth.gov/youth-topics/juvenile-justice/youth-involved-juvenile-justice-system#_ftn
- 11 Bronson, J., Stroop, J., Zimmer, S., & Berzofsky, M. (2017). *Drug Use, Dependence, and Abuse Among State Prisoners and Jail Inmates, 2007-2009*. U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics.
<https://bjs.ojp.gov/content/pub/pdf/dudaspi0709.pdf>
- 12 Smith, A. (2013). *Health and Incarceration: A Workshop Summary*. Washington (DC): National Academies Press.
<https://www.ncbi.nlm.nih.gov/books/NBK201966/>
- 13 Shaffer, J.S., Russo, J., Woods, D., & Jackson, B.A. (2019). *Managing the Seriously Mentally Ill in Corrections*. RAND Corporation.
https://www.rand.org/content/dam/rand/pubs/research_reports/RR2600/RR2698/RAND_RR2698.pdf
- 14 Curran, J., Saloner, B., Winkelman, T.N.A., et al. (2023). Estimated Use of Prescription Medications Among Individuals Incarcerated in Jails and State Prisons in the US. *JAMA Health Forum*, 4(4):e230482. doi: 10.1001/jamahealthforum.2023.0482



- 15 Cohen, S. & Eckert, N. (2021). *AP investigation: Many US jails fail to stop inmate suicides*. AP News. <https://apnews.com/article/ap-top-news-ut-state-wire-ia-state-wire-ca-state-wire-us-news-5a61d556a0a14251bafbeffc26d5f15>
- 16 Loyola University New Orleans College of Law. (2023). *Louisiana Deaths Behind Bars: 2015–2021*. Incarceration Transparency. <https://www.incarcerationtransparency.org/wp-content/uploads/2023/06/Death-Behind-Bars-Report-2023-Final-06.05.23.pdf>
- 17 Binswanger, I.A., Stern, M.F., Deyo, R.A., Heagerty, P.J., Cheadle, A., Elmore, J.G., & Koepsell, T.D. (2007). Release from prison--a high risk of death for former inmates. *The New England Journal of Medicine*, 356(2), 157-165. <https://doi.org/10.1056/NEJMsa064115>
- 18 Ibid
- 19 Ranapurwala, S.I., Shanahan, M.E., Alexandridis, A.A., Proescholdbell, S.K., Naumann, R.B., Edwards, D. Jr., & Marshall, S.W. (2018). Opioid Overdose Mortality Among Former North Carolina Inmates: 2000- 2015. *American Journal of Public Health*, 108(9), 1207-1213. <https://doi.org/10.2105/AJPH.2018.304514>
- 20 Frank, J.W., Andrews, C.M., Green, T.C., Samuels, A.M., Trinh, T.T., & Friedmann, P.D. (2013). Emergency department utilization among recently released prisoners: A retrospective cohort study. *BMC Emergency Medicine*, 13(1). <https://doi.org/10.1186/1471-227X-13-16>
- 21 Wang, E.A., Wang, Y., & Krumholz, H.M. (2013). A high risk of hospitalization following release from correctional facilities in Medicare beneficiaries: a retrospective matched cohort study, 2002 to 2010. *JAMA Internal Medicine*, 173(17):1621-8. doi: 10.1001/jamainternmed.2013.9008
- 22 Mallik-Kane, K. & Visher, C.A. (2007). *Health and Prisoner Reentry: How Physical, Mental, and Substance Abuse Conditions Shape the Process of Reintegration*. The Urban Institute Justice Policy Center. <https://www.urban.org/sites/default/files/publication/31491/411617-Health-and-Prisoner-Reentry.PDF>
- 23 It is difficult to estimate how many people who are incarcerated are Medicaid-eligible. In 2013, the Government Accountability Office reported that an estimated 70-90% of people incarcerated in state prison are likely eligible for Medicaid in some Medicaid expansion states (GAO). Anecdotal reports from prisons and jails that have estimated eligibility rates generally fall within that range.
- 24 Section 1905(a) of the Social Security Act (42 U.S.C. 1396d(a)), subdivision (A) following paragraph (30).
- 25 Minor-Harper, S. (1986). *State and Federal Prisoners, 1925-85*. U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics. <https://bjs.ojp.gov/content/pub/pdf/sfp2585.pdf>
- 26 Carson, E.A. (2022). *Prisoners in 2021—Statistical Tables*. U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics. <https://bjs.ojp.gov/sites/g/files/xyckuh236/files/media/document/p21st.pdf>
- 27 National Federation of Independent Business v. Sebelius, 567 U.S. 519 (2012). <https://tile.loc.gov/storage-services/service/ll/usrep/usrep567/usrep567519/usrep567519.pdf>
- 28 Centers for Medicare & Medicaid Services. (2016). *To Facilitate successful re-entry for individuals transitioning from incarceration to their communities*. <https://www.medicare.gov/sites/default/files/Federal-Policy-Guidance/Downloads/sho16007.pdf>



- 29 In 2014, the National Association of Counties estimated that [all but 12 states](#) terminated an person's Medicaid coverage when that person entered prison or jail. In 2019, the Kaiser Family Foundation reported that [42 states suspend coverage in jails; 43 states do so in prison](#).
- 30 Section 1001, Public Law No. 115-78, Substance Use Disorder Prevention That Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act of 2018. The provision pertains to all people under age 21 and people under age 26 who were formerly in the foster care system. It is unclear how widely this requirement has been implemented.
- 31 Haldar, S. & Guth, M. (2023). Section 1115 Waiver Watch: *How California Will Expand Medicaid Pre-Release Services for Incarcerated Populations*. Kaiser Family Foundation. <https://www.kff.org/medicaid/issue-brief/state-policies-connecting-justice-involved-populations-to-medicaid-coverage-and-care/>
- 32 Kuehn, B.M. (2014). Criminal Justice Becomes Front Line for Mental Health Care. *JAMA*. doi: 10.1001/jama.2014.4578
- 33 Preston, A.G., Rosenberg, A., Schlesinger, P., & Blankenship, K.M. (2022). "I was reaching out for help and they did not help me": Mental healthcare in the carceral state. *Health Justice* 10(23). <https://doi.org/10.1186/s40352-022-00183-9>
- 34 https://www.pewtrusts.org/-/media/assets/2017/10/sfh_prison_health_care_costs_and_quality_final.pdf
- 35 Sufrin, C., Kramer, C., Terplan, M. et al. (2023) Availability of Medications for Opioid Use Disorder in U.S. Jails. *J GEN INTERN MED* 38, 1573-1575. <https://doi.org/10.1007/s11606-022-07812-x>
- 36 Wachino, V. & Artiga, S. (2019). *How Connecting Justice-Involved Individuals to Medicaid Can Help Address the Opioid Epidemic*. Kaiser Family Foundation. <https://www.kff.org/medicaid/issue-brief/how-connecting-justice-involved-individuals-to-medicaid-can-help-address-the-opioid-epidemic/>
- 37 California Health Policy Strategies. (2019). *Medicaid Managed Care Organizations and Reentry*. <https://calhps.com/wp-content/uploads/2019/01/Policy-Brief-MC-Managed-Care-model-Final.pdf>
- 38 Wachino, V. & Artiga, S. (2019). *How Connecting Justice-Involved Individuals to Medicaid Can Help Address the Opioid Epidemic*. Kaiser Family Foundation. <https://www.kff.org/medicaid/issue-brief/how-connecting-justice-involved-individuals-to-medicaid-can-help-address-the-opioid-epidemic/>
- 39 In 2019, the Kaiser Family Foundation reported that 23 states have developed some kind of data transfer arrangement across health entities and at least some correctional entities in the state. Individual reports from state and local jurisdictions suggest that it is not uncommon for eligibility and release date information to be provided in excel files that are transferred via email.
- 40 Wachino, V. & Artiga, S. (2019). *How Connecting Justice-Involved Individuals to Medicaid Can Help Address the Opioid Epidemic*. Kaiser Family Foundation. <https://www.kff.org/medicaid/issue-brief/how-connecting-justice-involved-individuals-to-medicaid-can-help-address-the-opioid-epidemic/>
- 41 Ibid
- 42 CMS excluded the Bureau of Prisons from the Medicaid reentry waivers.
- 43 This requirement was established in section 5031 and 5032 of Public Law 115-78, the Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act of 2018.



- 44 Centers for Medicare & Medicaid Services. (2023). *State Medicaid Director Letter 23-003: Opportunities to Test Transition-Related Strategies to Support Community Reentry and Improve Care Transitions for Individuals Who Are Incarcerated*. <https://www.medicaid.gov/sites/default/files/2023-04/smd23003.pdf>
- 45 Centers for Medicare & Medicaid Services, SMD#23-003, Opportunities to Test Transition-Related Strategies to Support Community Reentry and Improve Care Transitions for People Who Are Incarcerated, April 17, 2023.
- 46 Cronin-Furman, M., Wachino, V., Pedersen, K., Lomax, S., & Sawyer, J. (2023). *Paving the Path to Healthier Reentry: How New Medicaid Policies Can Improve Mental Health and Substance Use Support as People Return to Communities*. The Health and Reentry Project. <https://healthandreentryproject.org/wp-content/uploads/2023/10/Paving-the-Path-to-Healthier-Reentry.pdf>
- 47 Reinvested funds can be used to develop new or enhanced services in correctional settings, build health information technology or data sharing capacity, expand community provider capacity and support for people reentering the community, or conduct other efforts that directly support people reentering the community and lower risk of reincarceration.
- 48 The waiver proposals differ in which benefits they seek to cover, pre-release coverage time periods, and which facilities provide Medicaid services. Some of the states that have submitted waivers are modifying their initial waiver proposals to conform to the CMS guidance. To see updated waiver information, please view [KFF's waiver tracker](#).
- 49 Congressional Budget Office. (2021). *Cost Estimate*. <https://www.cbo.gov/system/files/2021-02/EnergyandCommerceReconciliationEstimate.pdf>
- 50 Congressional Budget Office. (2023). *Medicaid*. <https://www.cbo.gov/system/files/2023-05/51301-2023-05-medicaid.pdf>
- 51 CBO estimated the cost of the new youth provisions in the Consolidated Appropriations Act at \$130 million over 10 years.
- 52 National Association of Medicaid Directors. (2022). *Re-Entry from Incarceration*. <https://medicaiddirectors.org/wp-content/uploads/2022/04/Re-Entry-NAMD-Federal-Policy-Briefs.pdf>
- 53 National Association of Counties & National Sheriffs' Association. (2020). *NACo-NSA Joint Task Force Report: Addressing the Federal Medicaid Inmate Exclusion Policy*. <https://www.naco.org/sites/default/files/documents/NACo-NSA-Report-FINAL-v3.pdf>
- 54 Carson, E.A. (2021). *Mortality in State and Federal Prisons, 2001-2018 – Statistical Tables*. U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics. <https://bjs.ojp.gov/content/pub/pdf/msfp0118st.pdf>
- 55 Carson, E.A. (2021). *Mortality in Local Jails, 2000-2018 – Statistical Tables*. U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics. <https://bjs.ojp.gov/content/pub/pdf/mlj0018st.pdf>
- 56 The Center for Health and Justice Transformation. (2024). *Welcome to the Jail and Prison Opioid Project (JPOP)*. Jail and Prison Opioid Project. <https://prisonopioidproject.org/>
- 57 O'Neill Institute for National and Global Health Law. (2022). *Dying Inside: To End Deaths of Despair, Address the Crisis in Local Jails*. O'Neill Institute, Georgetown Law. https://oneill.law.georgetown.edu/wp-content/uploads/2022/12/ONL_Big_Ideas_Dying_Inside_P5.pdf



- 58 American Society of Addiction Medicine. (2020). *Public Policy Statement on Treatment of Opioid Use Disorder in Correctional Settings*. American Society of Addiction Medicine, Inc.
<https://www.asam.org/docs/default-source/public-policy-statements/2020-statement-on-treatment-of-oud-in-correctional-settings.pdf>
- 59 De la Guéronnière, G., Gardner, T.M., & Reid, D.A. (2022). *The Time is Now for Medicaid Justice: Strengthening Equitable Health Outcomes for People in the Criminal Legal System*. Legal Action Center.
<https://www.lac.org/resource/the-time-is-now-for-medicaid-justice-strengthening-equitable-health-outcomes-for-people-in-the-criminal-legal-system>
- 60 National Association of Social Workers. (2020). *NASW supports the Medicaid Reentry Act*.
<https://www.socialworkers.org/LinkClick.aspx?fileticket=XeBcEZYWfMg%3D&portalid=0>
- 61 American Medical Association. (2021). *AMA Supports the Medicaid Reentry Act*.
<https://searchf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2F2021-7-16-Letter-to-Braun-and-Baldwin-re-S-285-Medicaid-Reentry-Act.pdf>
- 62 Koutoujian, P. (2023). *Medicaid should cover the incarcerated*. Commonwealth Beacon.
<https://commonwealthbeacon.org/criminal-justice/medicaid-should-cover-the-incarcerated/>
- 63 Health and Reentry Project. (2022). *Redesigning Reentry: How Medicaid Can Improve Health and Safety by Smoothing Transitions from Incarceration to Community*. Washington, D.C.: Council on Criminal Justice.
https://healthandreentryproject.org/wp-content/uploads/2023/05/Issue_Brief_-_Redesigning_Reentry_-_July_2022.pdf
- 64 Carson, E.A. (2022). *Prisoners in 2021—Statistical Tables*. U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics.
<https://bjs.ojp.gov/sites/g/files/xyckuh236/files/media/document/p21st.pdf>
- 65 The new Medicaid pre-release reentry waiver policy does not apply to federal prisons.
- 66 In *Estelle v. Gamble* (1976), the Supreme Court established that a person who is incarcerated must show that there was a “deliberate indifference” to his or her medical needs or injuries in order to claim an Eighth Amendment violation.
- 67 Huh, K., Boucher, A., McGaffey, F., McKillop, M., & Schiff, M. (2018). *Jails: Inadvertent Health Care Providers*. The Pew Charitable Trusts.
<https://www.pewtrusts.org/en/research-and-analysis/reports/2018/01/jails-inadvertent-health-care-providers>
- 68 DeGarmo, A., Williams, G., & Wachino, V. (2024). *Recommendations for Medicaid Payment Models for Opioid Use Disorder Services in Jails and Prison*. Viaduct Consulting, LLC.
<https://healthandreentryproject.org/wp-content/uploads/2024/01/Recommendations-for-Medicaid-Payment-Models-for-Opioid-Use-Disorder-Services-in-Jails-and-Prisons.pdf>