How States Can Use New Federal Grants to Drive Health Equity Through Cross-System Collaboration

HARP
THE HEALTH AND REENTRY PROJECT

Considerations for States in Using New CMS Planning Grants to Support Continuity of Care for Medicaid Beneficiaries Leaving Incarceration

BACKGROUND AND LANDSCAPE

The last two years have seen a major increase in momentum, at both the federal and state level, in Medicaid policy changes designed to improve access to health care for people as they leave the justice system. These changes, which have had bipartisan support, have arisen from a recognition that too many people have fallen into gaps between the health and criminal justice systems and would benefit from enhanced continuity of care. Strengthening continuity as people return to communities represents a major opportunity to address health disparities, which persist across the U.S. health care system, and among people who experience incarceration. New Medicaid policies are also a response to the opioid epidemic and increased mental health needs, both of which significantly affect people who are in or leaving custody. Rates of behavioral health conditions are especially high among incarcerated youth, of whom more than 50% met criteria for a substance use disorder, and approximately 70% have a mental health condition.

In September, the federal Centers for Medicare and Medicaid Services (CMS) announced a new funding opportunity of $106.5 million in planning grants to support states in making progress toward these goals. Reflecting Congress' interest in advancing continuity of care, the amount of grant funding is significant, exceeding that of recent CMS grant programs to increase substance use provider capacity and to support expansion of school-based services. States can use the grants to fill operational gaps, drive collaboration, and improve oversight as states implement new policy changes. One of the most urgent uses will be supporting implementation of new national requirements for Medicaid and CHIP coverage of youth who are leaving incarceration, which take effect January 1, 2025. Full implementation of these new requirements will continue through 2025, making the grant funds a central implementation support. This brief will summarize the funding opportunity and highlight four priority areas of consideration for state investment to drive forward health equity.

PLANNING GRANTS OPPORTUNITY: SNAPSHOT

Authorizing Legislation	▪ Consolidated Appropriations Act of 2024, Section 206(a)
Goals	▪ Promote continuity of care post-incarceration and equitable health care access ▪ Provide states with funds to meet new requirements
Funding	▪ $106.5 million (up to 56 awards of $1 million to $5 million each) ▪ Cooperative agreement structure, amount based on budget and need
Eligible Recipients	▪ State and territorial Medicaid and CHIP agencies
Recommended Partners	▪ Non-federal public institutions (e.g. correctional facilities), human services agencies, Medicaid managed care, providers, community-based organizations
Allowable Uses of Funds	Funds may be used to: ▪ Address operational gaps needed to meet new requirements ▪ Establish standardized processes and automated systems (including for determining Medicaid/CHIP eligibility and/or facilitating enrollment/ renewal of coverage for incarcerated populations) ▪ Enhancements to information technology (IT) to support information sharing between relevant entities ▪ Establishing oversight and monitoring processes
Prohibited Uses of Funds	Funds may not be used to: ▪ Pay for or directly administer health care services ▪ Build prisons, jails, or other carceral facilities or pay for related improvements, other than improvements that are for directly meeting the health care needs of Medicaid-eligible incarcerated individuals
Timing	CMS will be accepting and approving applications from states in two cohorts. ▪ **Cohort 1:** applications are due November 26, 2024 ▪ **Cohort 2:** applications are due March 17, 2025 ▪ (States can reapply if not awarded in the first cohort)
Period of Performance	Grant periods are four years, comprised of four one-year budget periods ▪ **Cohort 1:** March 1, 2025 through February 28, 2029 ▪ **Cohort 2:** August 1, 2025 through July 30, 2029
Relevant Materials	▪ Notice of Funding Opportunity CMS-2T2-25-001 (grants.gov) ▪ CMS Webinar (with transcript) (medicaid.gov) ▪ CMS Webinar slides (medicaid.gov)

PRIORITY CONSIDERATIONS FOR STATES:

Four areas of potential investment stand out as priorities for state investment of grant funds to achieve continuity goals and advance health equity.

1. Support and strengthen partnerships and cross-sector collaboration

States can use grant funds to "identify and address operational gaps"—to do so, state Medicaid agencies should convene an inclusive, cross-sector "table" to coordinate and oversee efforts. Collaboration should start by building relationships that bridge mission and culture differences, identifying shared goals, challenges, and success measures. Cross-sector stakeholders should then align strategies and goals, create common terminology, and provide guidance to providers and correctional facilities on implementing new Medicaid policies. States and local governments must bring together the broad set of stakeholders that are involved in implementing new policies and leverage existing programs and policies. Ongoing engagement is needed at both the leadership and the staff levels, as well as among directly impacted people, to support strategic decision-making and implementation.

The new Medicaid youth continuity requirements which take effect nationwide in 2025 apply not just to people involved with the juvenile justice system, but to people who are incarcerated who are under age 21, and to former foster youth under 26. Cross-sector collaboration will be especially important to improving outcomes for this "emerging adult" population, who may experience involvement with multiple public systems, including criminal justice, child welfare, education, and health. This population also experiences some of the most severe racial health disparities nationwide, and early involvement with the justice system can have adverse effects on future life opportunities, including employment, education, and housing.

2. Bridge the gaps between community-based organizations, correctional health and Medicaid

To create true continuity of care, the new services that Medicaid covers in prisons and jails must connect people to post-release community health, behavioral health, and social services. This requires expanding access to community services. Many community-based organizations have both significant experience meeting the needs of the returning population, a focus on cultural competency and perhaps most importantly, established trust between the organization and the people they serve. Yet many such organizations, particularly reentry service providers, do not have the experience, capacity, or infrastructure that is needed to bill Medicaid.

States and localities are exploring different mechanisms to bridge that capacity gap and leverage the role of community providers as Medicaid plays a larger role. California has made this community capacity building part of its larger Medicaid waiver investment strategy through its Capacity and Infrastructure Transition, Expansion and Development (CITED) initiative. Washington State is developing a network of "community care hubs" as part of its waiver, that will work with networks of community organizations to ensure individuals are connected to community services and supports. Community health centers and other safety net providers are also poised to play a bigger role (including as intermediaries between Medicaid, corrections, and community-based organizations) and have a track record of driving equitable health outcomes.

3. Leverage new and existing mechanisms to promote leadership of directly impacted people in policy design and implementation

While grant funds under the new opportunity are not unlimited, states can strategically leverage these funds alongside existing mechanisms that are designed to maximize individual and community input into program design and implementation. States can leverage grant funds to incorporate the input of directly impacted people—including people who are currently and formerly incarcerated, their families and caregivers, and front-line correctional officers and staff—into program design and implementation.

One promising mechanism to convene stakeholders, including directly impacted people, are reentry councils. Reentry councils have been formed at the federal, state, and local level, typically with the goal of bridging public agencies, service providers, advocates, and other stakeholders to support more successful reentry. In many cases, people with lived experience of incarceration participate in and help lead reentry councils.

States also have a broader opportunity to incorporate the perspective of beneficiaries who have been incarcerated as they implement new Beneficiary Advisory Councils (BACs) next year. BACs must be comprised of Medicaid beneficiaries, their families, and caregivers, and can advise states on a wide range of topics, including coordination and quality of care.

These entities can also play an ongoing role in documentation, analysis, and public reporting of outcomes data and progress toward equity goals, so that increased transparency and accountability become a built-in part of the new changes.

4. Invest in data infrastructure and interoperability to support access, continuity and quality of care

Grant funds can be used for information technology investment to improve or build systems that support continuity of care by communicating information across correctional and community settings. This category of investment opens an opportunity for states to bridge longstanding gaps between systems in a way that can address the disproportionate health needs and inequitable health outcomes for people who experience incarceration. Model jurisdictions like Allegheny County, Pennsylvania, have developed data linkages across health, human services, and correctional facilities that allow for real time improvements to service delivery and ongoing analysis of outcomes.

Systems need to share data between prisons, jails, and state agencies that administer Medicaid to facilitate timely enrollment, suspension, and reactivation of full Medicaid coverage. They will also share clinical and service use information across community and correctional providers and with managed care organizations (MCOs) and protect privacy of information. These systems are the foundation of continuity of care that can prevent gaps in coverage and services and reduce the burdens patients face as they navigate reentry.

CONCLUSION

Rapidly evolving Medicaid reentry policy changes are taking place in states across the country, creating an historic opportunity for states and other leaders to advance health equity and other goals. As states apply for and use newly available resources from CMS, they can prioritize investments that will drive more equitable outcomes, improve coordination across correctional and community systems, elevate the ongoing input of directly impacted people and communities, and improve data infrastructure to drive equitable outcomes and accountability.

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